



Addressing Exclusion in Sanitation for Equity

An assessment of WASH status in
Flood affected villages of Uttar
Pradesh

Policy Paper

September 2012

In collaboration with:

Government of Uttar Pradesh
UNICEF Lucknow

Supported by:

MCH-STAR Initiative, USAID



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Charts

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Abbreviations

AIP	Annual Implementation Plan
APL	Above Poverty Line
AWC	Anganwadi Center
BPL	Below Poverty Line
GP	Gram Panchayat
HP	Hand Pump
IEC	Information Education and Communication
IM-II	India Mark – II
NBA	Nirmal Bharat Abhiyaan
OBC	Other Backward Class
PHC	Primary Health Center
PPS	Probability Proportional to Size
PRI	Panchayati Raj Institution
SC	Scheduled Caste
SDMA	State Disaster Management Authority
SPSS	Statistical Package for Social Services
ST	Scheduled Tribes
TSC	Total Sanitation Campaign
UP	Uttar Pradesh
UNICEF	United Nations Children’s Fund
WASH	Water Sanitation and Hygiene

1.0 The Context

Pronounced inequalities between marginalised groups as compared to others persist in India, with strong correlations between deprivation, discrimination, exclusion amongst socio-religious groups and disparities along gender and rural-urban lines.

India has significant constitutional, legal and institutional provisions to safeguard and promote the interests and status of its marginalised citizens. The current policy frameworks of key national flagship programmes also have strongly articulated commitments to reduce disparities. However this strong articulation on equity does not translate into commensurate outcomes for the vulnerable and marginalised. Policy and programme documents offer little disaggregated analysis on causal pathways, and fail to uphold this prioritisation consistently within planning, resource allocation, monitoring and evaluation.

This calls for sustained efforts to address inequalities through focused actions for and with deprived communities, something that is underlined through the continued commitment in both the *Approach Paper to India's 12th Five Year Plan: Faster, Sustainable and More Inclusive Growth*.

Social inclusion for equity is both a programming lens and a key strategy for development programming. Its objectives are to improve the realisation of basic rights for all children, irrespective of ethnicity, caste, gender or any other marker which is used to prevent children, their families and communities from freely gaining access to information, public services and institutions. Also important is to address the lack of voice, and empowerment which further influence the ways in which marginalised social groups are able to articulate their needs and claim their entitlements.

As noted by the *Approach Paper to India's 12th Five Year Plan*, to achieve inclusiveness in all these dimensions requires multiple interventions, and success depends not only on introducing new policies and government programmes, but on institutional and attitudinal changes, especially to improve the implementation of existing flagship programmes. This suggests the need for a multifaceted strategy that can operate simultaneously to address different kinds of barriers faced by the excluded.

An **equity lens** is needed to ensure that disaggregated and other forms of data are used to identify where the most excluded or vulnerable communities are located and to identify the access to public services. The identified groups and areas need to be addressed as a matter of priority for the sanitation programme, supported by sound evidence, communication strategies, documentation, monitoring and evaluation and appropriate policy advocacy.

It is important to address structural and systemic factors through different and complementary strategies notably, strengthening capacities of stakeholders to understand and identify facets and manifestations of discrimination, and employ strategies to address this through public and policy advocacy for social change. This is central to promoting a human rights based approach to programming.

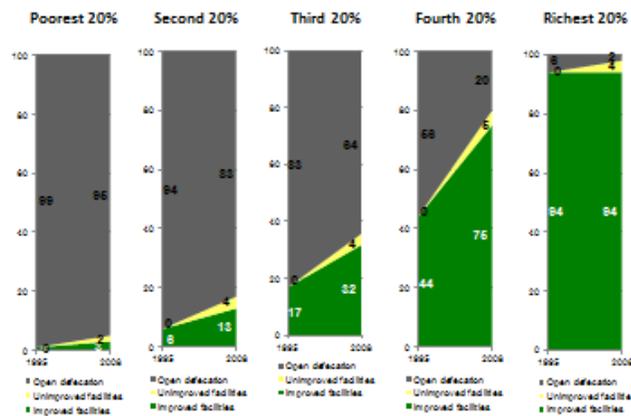
2.0 Background for the study

In order to bring sanitation and hygiene practices among the masses Total Sanitation Campaign (TSC) a flagship of Government of India is being implemented in all 75 districts of Uttar Pradesh for last ten years. As of January 2012, Uttar Pradesh reports impressive sanitation coverage of 88% households and 100% schools and anganwadi with toilet facilities. However, census 2011 reveals completely opposite picture. As per census only 22% rural households have toilets. Further, there are huge anomalies in the toilet availability within a district. The gaps further increases in some pockets which are excluded from toilet facilities. One such pocket is flood hit villages from 22 flood prone districts of U.P. Anecdotal studies have revealed that toilet availability in these pockets is abysmally low. These are the pockets where other mother and child care services are also in shambles and poverty level is very high due to nature of high fragility of the region. Poor availability of toilets promotes rampant open defecation and further exacerbates diarrheal diseases due to excess faecal load in the environment, which adds to the increased mortality and morbidity of children in these areas.

In addition to above there are challenges of over reporting and inequities. UNICEF and Government led



National trends in sanitation by wealth quintiles



Source: NFHS (DHS) 1995, 1999, 2006

Prepared by UNICEF Statistics and Monitoring Section, May 2010

concurrent monitoring (which was conducted in March 2010) shows gaps in reported and actual coverage. The second challenge is inequitable distribution of sanitation facilities. The bar chart on the left hand side shows that in the lowest wealth quintile there was hardly any progress in sanitation facilities between 1995 and 2008. The only gainer were the among the top wealth quintiles.

Despite above fact there are significant gains in sanitation program which have contributed in improving child mortality and morbidity. One of the significant results that sanitation program has contributed is in 18 polio high risk districts where over two years no polio case is reported till date. This result has contributed for India to come out from Polio Endemic list. This result testifies the significance of sanitation and hygiene program for improving mother and child health.

In order to overcome these problems MCH-STAR and UNICEF jointly undertook assessment of sanitation conditions in one of the most difficult geographical areas of the state i.e. 22 flood affected districts of Uttar Pradesh. Out of 3000 flood affected villages (5% of total villages of the state) a survey was done in 220 villages to identify the gaps.

3.0 Purpose of the study

Sanitation program is being implemented by the Panchayati Raj Department in unilateral manner and as of now during its ten years journey there was no major strategic consideration for the prioritisation of resources. District was focus as of now has remained on the achievement of physical and financial targets. On the question of the addressing exclusion the project managers reflect that by design the program is focusing on below poverty category of people. However, the wealth quintile analysis presented on the previous page negates the claim. To strengthen the argument on bringing equity within the ambit of the Sanitation Program the present study has been done with the following objectives:

- To build evidence for policy support in improving sanitation facilities in flood affected areas for making overall reduction in mortality and morbidity of children due to diarrheal diseases, and
- To identify the gaps in in the service delivery mechanism of Total Sanitation Campaign for reaching to the Households, Schools and Anganwadis by assessing current situation of these facilities.

4.0 Study Methodology

The state of Uttar Pradesh has been divided into 18 divisions for administrative purpose. The 22 flood-affected districts in UP are spread across seven divisions. A sample of 220 flood-affected villages was selected from the study districts.

4.1 Selection of villages:

All tehsils from each of the study districts were covered. From each tehsil, one block with maximum number of flood-affected villages was selected. The number of villages to be sampled from each tehsil was determined based on probability proportional to size (PPS) methodology (see Table-1 for details). From each block, selection of villages was done using systematic random sampling. From each of the selected village, all households were covered to elicit information on WASH.

Table 1: Distribution of sample villages by districts Table-A:

District	Number of Villages Sampled
Azamgarh	10
Badaun	24
Bahraich	3
Ballia	14
Balrampur	5
Barabanki	8
Basti	10
Deoria	5
Faizabad	6
Gonda	6
Gorakhpur	7
Hardoi	21

District	Number of Villages Sampled
Lakhimpur Khiri	3
Maharajganj	11
Pilibhit	4
Sant kabirnagar	8
Rai Bareli	3
Shahjahanpur	46
Sidharth Nagar	8
Sitapur	4
Srawasti	14
Unnao	16
Total	220

For conducting bottleneck analysis, one block from each of the study districts with a maximum number of flood-affected villages was selected.

4.2 Study instruments

Three types of study instruments – (i) household questionnaire, (ii) village, school and anganwadi center questionnaires, and (iii) proforma for bottleneck analysis – were developed to capture information on access to water, sanitation and hygiene situation and to identify bottlenecks for poor status of Total Sanitation Campaign (TSC). Both the questionnaires were translated into Hindi and back translation into English was done to make sure that meaning and essence of the questions did not in the translation process. Investigators were instructed to collect information from head of the household or any responsible adult member of the household for collecting information from households. *Gram Pradhan* or village head, school headmaster / teacher, and anganwadi worker were contacted to collect data on WASH situation from villages, schools and anganwadi centers.

4.3 Quality Assurance:

Three pronged approach was adopted to monitor quality of field data collection. MCH-STAR had placed a full-time consultant to coordinate the field activities, monitor the field teams closely throughout the data collection period. WASH specialist and his team from UNICEF/Lucknow also made surprise field visits to observe and monitor the data collection. MCH-STAR staff and a senior consultant from Delhi office visited flood-affected study districts several times to monitor the quality and progress of field data collection and reviewed filled-in questionnaires. Field interviewers were debriefed based on the field observations. After two weeks of data collection, a review meeting was organized at UNICEF office, Lucknow and reviewed the progress of survey work. UNICEF team members involved in overseeing the field data collection in different districts were present along with the representatives from the Study Point Samiti, the agency hired for data collection and Mexcels, the agency hired for data entry. Discussed the difficulties faced by the team members in accessing the villages and data collection and necessary remedial action was taken to complete the data collection on time. One percent of the household formats were back checked to assess quality of data collection.

4.4 Data entry and analysis:

Data entry templates/software was developed for entering household data and village, school and anganwadi center formats. In-built checks and skips were incorporated to minimize the data entry errors. Data entry work was outsourced to M/s Mexcels after following competitive bidding process. Data entry personnel's qualifications and experience in handling similar type of exercises was assessed and found satisfactory.

The data entered in the software was exported to Statistical Package for Social Services (SPSS) 16.0 and necessary editing, labeling and data cleaning was completed before data analysis. Data analysis plan with dummy tables was prepared and data analysis was carried out by generating frequency tables and cross-tabulations with select background characteristics.

5.0 Study Findings

5.1 Demographic Profile

The assessment was carried out in 22 districts covering 220 revenue villages. There were total of 36,985 households which were contacted and information was gathered from. Of the 36,985 household, 7,553 belonged to Schedule Caste, 218 were from Schedule Tribe, 23,049 from Other Backward Class and remaining 6165 were from General (non SC/ST).

Population wise the survey covered 2,25,867 people, comprising of 1,21,631 (53.85%) male and 1,04,236 (46.14%) females (6 years and above). Almost half the population surveyed was literate (48%).

As far as the type of housing conditions are concerned, it is evenly distributed, 32% households living in "pucca" houses, 28% in "semi-pucca" and 40% in "kuchcha" houses. Most of the households were reportedly large, 56%, with number of family members ranging from 5-10 and approx. Little over one-third of the households (35%) had less than 5 members in their family. Age wise composition of the population in the surveyed revenue villages is as follow;

Table 2: Disaggregated demographic profile

Population	Sex		Total
	Male	Female	
<6 years	17,137	16,373	33,510
6-18 years	38,681	31,422	70,103
19 years or more	65,813	56,441	1,22,254
Total population	1,21,631	1,04,236	2,25,867

Of all the households covered, 42.8% belonged to APL (Above Poverty Line) and 31.6% were from BPL (Below Poverty Line) households. Nearly one-fifth of households (19.2%), did not know their status and 6.3% reported that they did not have any card.

Most of the villages surveyed, 85.2%, had faced the floods during last one year itself. Of these 55.3% households reported of partial loss of property during flood and 23.5% reported complete loss of property during floods in last three years.

Table: 2.1: Caste / Tribe distribution of households in the 220 villages surveyed

Caste/tribe	Percentage	Number of households
Scheduled caste (SC)	20.4	7,553
Scheduled tribe (ST)	0.6	218
Other backward caste (OBC)	62.3	23,049
Non SC/ST/OBC (General)	16.7	6,165
Total	100	36,985

Most of the households surveyed belonged to either OBCs (Other Backward Caste) or SC (Schedule caste). The whole region is dominated by the presence of people from these caste which are considered socially vulnerable.

5.2 Drinking Water

In Uttar Pradesh availability of drinking water is very high compared to other parts of the country. Almost all the habitations are provided with hand pumps for drinking water and other use.

Table 3: Source of Drinking Water (during normal times)

Source of drinking water	Type of house			Caste/tribe				Total
	Pucca	Semi-Pucca	Kachha	SC	ST	OBC	General	
Piped water in residence/yard/plot	0.1	0.2	0.1	0.2	0	0.1	0.3	0.2
Public tap	1.2	2.2	2.5	2	5.5	2	1.8	2
Shallow Hand pump in residence/yard/plot	85	81	76	73.6	82.6	82	81.9	80.2
IM-II Hand pump in residence/yard/plot	3.5	3.4	3.4	3.6	3.2	3.1	4.5	3.4
IM-II Public Hand pump	8.2	10.8	13.7	17.7	6.4	9.7	8.7	11.1
Well water in residence/yard/plot	0.5	0.5	1	0.6	0.5	0.7	0.9	0.7
Public well	1.2	1.2	2.1	1.7	1.4	1.7	0.8	1.5
Other sources	0.3	0.7	1.3	0.7	0.5	0.8	1	0.8
Total	100	100	100	100	100	100	100	100

n=36,985

Most of the population in the flood prone area largely depends on the shallow hand pumps within the premises (80.2%). This is true across all sections of the population be it SC/ST or general. But most of these were available to the household which are “pucca” in type. Although the Govt. of Uttar Pradesh largely promotes India Mark (IM)-II hand pumps as safe source for drinking water still most of the rural

habitant of these areas is using shallow hand pumps as main source for drinking. There is an urgent need to address the issue of safe drinking water using IM-II hand pumps.

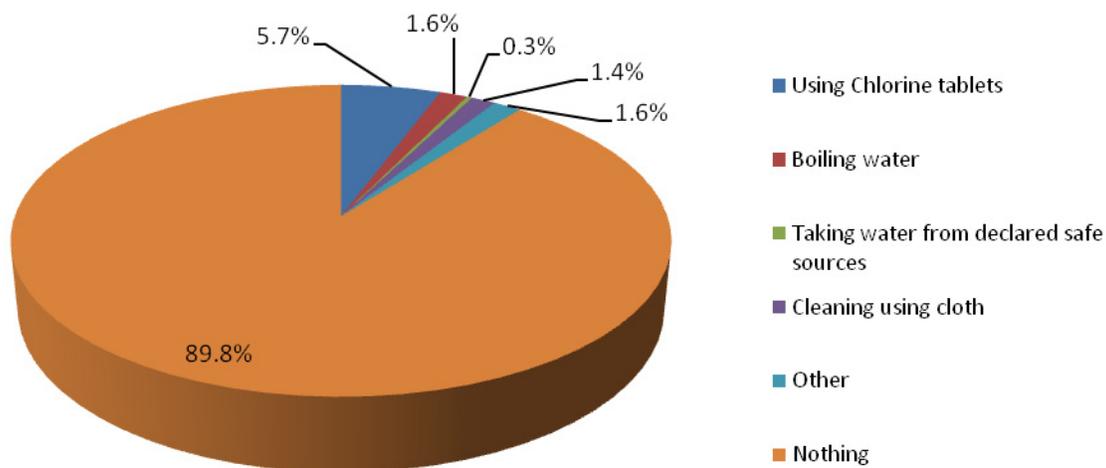
Table 4: Source of Drinking Water (during floods)

Source of drinking water		Type of house			Caste/tribe				Total
		Pucca	Semi-Pucca	Kachha	SC	ST	OBC	General	
Piped water residence/yard/plot	in	0.1	0.1	0	0.1	0	0	0.1	0.1
Public tap		1.5	4.3	3.1	2.4	5.5	3.3	2.2	3
Shallow Hand pump residence/yard/plot	in	78.2	63.3	61.3	63.9	78.4	66.8	72.2	67.1
IM-II Hand pump residence/yard/plot	in	3.5	5.1	4.4	3.9	2.8	4.5	4.3	4.3
IM-II Public Hand pump		13.3	21.8	21.8	24.8	8.7	18.3	15.8	19.1
Well water residence/yard/plot	in	0.4	0.5	0.8	0.4	0	0.6	0.8	0.6
Public well		1	0.8	1.7	1.1	0.5	1.3	0.9	1.2
Other sources		1.9	4.2	6.9	3.3	4.1	5.2	3.7	4.6
Total		100	100	100	100	100	100	100	100

n=36,985

The trend which is evident during the normal times also followed even during the flood times. Largely the population is dependent on the shallow hand pumps for drinking water (67.1%). The use of IM-II marginally gets increased during the flood times

Figure 1: Method of Water Treatment



Availability of safe drinking water is of utmost concern during floods and it is imperative that the population must take measures to ensure that the drinking water used by the community and people is either from safe source or made safe for drinking by applying purification methods. But it seems missing in the context of the people surveyed. Most of the people are ignorant about the methods of water treatment and thus doing nothing (89.8%) for the same. There are very few, only 5.7% who were using chlorine tablets or boiling water (1.6%) for making drinking water potable. Even the safe handling of drinking water is great concern in these areas. The habit of not using any long handle ladle to draw water is rampant. Only 3.7% of the households reportedly use long handle ladle. There is a large section, 27.4% which reported inserting hands in the vessel to draw drinking water.

5.3 Sanitation Facilities

Open defecation is a traditional behaviour in rural India. This, along with the relative neglect of sanitation in terms of development priorities, was reflected in the country's low sanitation coverage at the close of the 1990s when it was found that only one in five rural households had access to a toilet (Census 2001). This fact, combined with low awareness of improved hygiene behaviour, made the achievement of the goal of total sanitation a pressing challenge in rural India.

In response to this challenge, the Government of India launched the TSC in 1999 with the goal of achieving universal rural sanitation coverage by 2012. The responsibility for delivering on programme goals rests with local governments (Panchayati Raj Institutions — PRIs) with significant involvement of communities.

Availability of toilet in rural Uttar Pradesh has always been a concern since the launch of sanitation programmes. The pace of growth is almost negligible but it is more so in these excluded areas which are also flood prone.

Table 5: Type of Toilet facilities

Type of toilet facility	Caste / tribe				
	SC	ST	OBC	General	Total
Own flush toilet	4.3	0.9	3.8	15.2	5.8
Public shared flush toilet	0.1	0.5	0.3	0.5	0.3
Own pit toilet	5.7	1.8	4	9.9	5.3
Public/shared pit toilet	0.5	0	0.4	0.6	0.4
Dry toilet	0.2	0.5	0.2	0.9	0.3
No facility/Bush/Field	89	92.7	91.2	72.5	87.6
Other (specify)	0.1	3.7	0.2	0.4	0.3

n=36,985

When it comes to people having toilet at home or having access to latrines, all section of the population are following only one habit – going out in open for defecation. Alarmingly 3 out of 4, were practicing open defecation. People having “pucca” house have made some efforts to construct toilets at home, 12.5% people living in “pucca” house also had toilets at home.

As the availability of the toilet is low so is the usage. Of all the households having toilet at home, only 3% of the toilets were used during flood. One reason sited commonly was that the toilets were not built to work even during the floods. Most of the toilets were affected or submerged in water and used to become unusable. There’s great need to address the technology that can be suitable even during the floods.

Use of toilet is also very low during the non-flood times. Overall only 8.9% of the total population is using household latrines for defecation. It is high in general caste (non SC/ST/OBC), approx. 23% compared to all other caste.

Several reasons were specified by the respondent for not having toilet facilities. This ranged from lack of space to poor economic condition of the households in constructing toilets. Lack of toilet at home of BPL population is a matter of concern because under Total Sanitation Campaign (now Nirmal Bharat Abhiyan-NBA) they were provided with incentives (covering almost 90% of the cost of toilet). This also suggests that somehow the message didn’t reach to these excluded pockets.

Figure 2: Use of toilet during Floods (n=36,985)

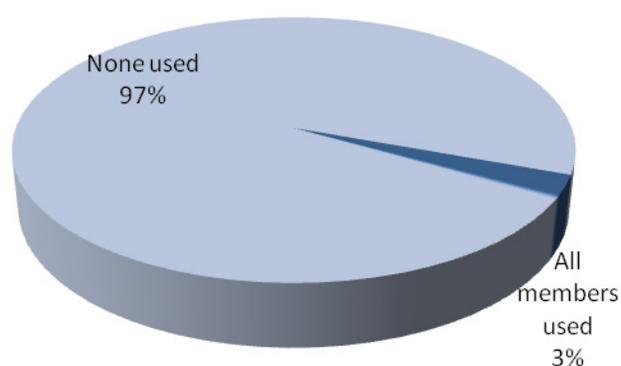


Table 6: Reasons for Non-Usage of Toilet facilities

Background characteristics	Lack of Space	of Economic Condition	Lack of Water	Belief that toilet pit is not Sufficient	Social Norms	Feel comfortable in open	Other	Total
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Type of House								
Pucca	0.7	90.1	2.5	0.4	0.2	5.2	1	100
Semi-Pucca	0.5	91.3	3.3	0.3	0.1	3.5	0.9	100
Kachha	0.4	91.6	3.2	0.1	0	3.8	0.8	100
Household Size								
< 5 persons	0.4	91.2	3.3	0.2	0.1	4.1	0.8	100
5-10 persons	0.5	91.2	2.9	0.2	0.1	4	0.9	100
10+ persons	0.9	90.1	2.5	0.4	0.1	4.6	1.3	100
Household have APL / BPL card								
APL card	0.5	90.4	2.8	0.3	0.2	5.2	0.7	100
BPL card	0.6	91.2	2.9	0.2	0.1	4.1	0.8	100
Do not know	0.4	91.7	3.2	0.1	0.1	3	1.5	100
No card	0.6	93.2	4.5	0	0.2	0.7	0.7	100
Caste / Tribe								
SC	0.3	91.3	3.4	0.1	0.2	3.9	0.8	100
ST	0	82.8	7.4	0	1	3	5.9	100
OBC	0.5	91.6	2.9	0.2	0.1	3.8	0.9	100
Non SC/ST/OBC (General)	0.9	88.8	2.6	0.4	0.2	6	0.9	100
Total	0.5	91.1	3	0.2	0.1	4.1	0.9	100

Traditionally, it has always being the belief that lack of space and non-availability of water is the key constraints making people not to adopt latrines. But during the assessment, it was found that only 0.5% households agreed that they lack space for latrines and only 3% households mentioned that they have not constructed latrines because of lack of water. Most of the households (91.1%), across all characteristics, cited economic condition as the key deterrent for not having latrine at home. It is now believed that with the launch of revised programme (NBA), the issue of cost of toilet has been adequately addressed and people will have more resources to construct quality latrines at home.

The habit of going out in the open for defecation is also being associated with traditional / social behavior of rural India. But during the assessment it turn out to be very clear that no one enjoys like going out for defecation and it has nothing to do with our social norms.

Table 7: Participation in total sanitation campaign (TSC) and contribution for construction of IHHL

Background characteristics	HHs interested in participating in TSC (in %)	Number of households	HHs willing to contribute for construction of IHHL (in %)					
			<Rs 900	≥Rs 900	Material	Labour	Nothing	
Type of house								
Pucca	85.8	11,620	20.2	9.9	4.4	89	5.3	
Semi-Pucca	90.3	10,429	14.4	5.4	3.3	87.9	7.7	
Kachha	96.3	14,936	10.9	4	2.2	89.5	7.4	
Household size								
< 5 persons	93	12,891	11.5	4.7	2.4	88.5	8.3	

Background characteristics	HHs interested in participating in TSC (in %)	Number of households	HHs willing to contribute for construction of IHHL (in %)				
			<Rs 900	≥Rs 900	Material	Labour	Nothing
5-10 persons	91.1	20,718	15.7	6.3	3.4	89.3	6.3
10+ persons	86	3,376	20.7	10.3	5	88.1	5.3
Household have APL/BPL card							
APL card	89.5	15,828	17.3	6.7	4.1	88.6	6.2
BPL card	91.4	11,703	15.5	6.3	2.9	89	6.9
Do not know	94.4	7,111	10	5.7	2	88.6	8.5
No card	93.8	2,343	7.9	2.2	1.9	91.1	6.6
Caste/tribe							
SC	92.1	7,553	13.9	5.4	2.8	89.1	7.2
ST	99.1	218	10.6	1.4	2.8	87	10.2
OBC	93.5	23,049	13.7	5.8	2.8	89.5	6.7
Non SC/ST/OBC (General)	81.8	6,165	19.7	8.5	5.2	86.3	7.3
Total	91.3	36,985	14.6	6.1	3.2	88.9	6.9

One of the important aspects of the assessment was to understand the willingness of the households to participate in the sanitation programme (here being referred to as TSC or NBA). It has always been said, anecdotally, that in general people are not interested in participating in the government sanitation programmes. But contrary to this, there's a large section, be it household living in pucca or kuchcha houses or belonging to any section of the society, most of the people (91.3%) are not only interested in the programme, they are also ready to contribute to the programme. Although small (14.6%), still there are people willing to contribute more than Rs. 900 or more than 10% of the cost required to construct toilets. There are very few (only 6.9%) people who said that they cannot contribute anything for construction of latrines at their home. Most of the respondent, 88.9% agreed that toilet is vital for health and they can, if not anything else, can contribute as labour in the construction of toilet.

5.4 Hand Washing Practices

Hand washing with soap is among the most effective and inexpensive ways to prevent diarrheal diseases and pneumonia, which together are responsible for the majority of child deaths. Every year, more than 1.5 million children in India do not live to celebrate their fifth birthday because of diarrhea and pneumonia. Yet, despite its lifesaving potential, hand washing with soap is seldom practiced and not always easy to promote. More hand washing with soap would make a significant contribution to meeting the Millennium Development Goal of reducing deaths among children under the age of five by two-thirds by 2015.

Table 8: Handwashing practices

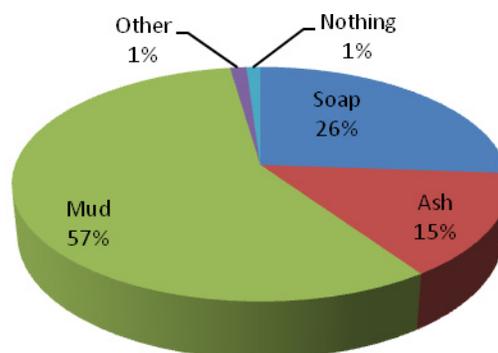
Background Characteristics	Before food	After defecation	Before feeding children	Other
Type of House				
Pucca	69.6	93.4	20.9	0.3
Semi-Pucca	72.5	93.7	16.6	0.9

Background Characteristics	Before food	After defecation	Before feeding children	Other
Kachha	70.7	94	16.9	0.4
Household Size				
< 5 persons	69.6	93.6	14.1	0.5
5-10 persons	70.9	93.7	18.7	0.6
10+ persons	75.7	93.8	29.2	0.4
Household have APL / BPL card				
APL card	73.1	93.7	18.9	0.5
BPL card	72.1	94	19.2	0.5
Do not know	63	92.7	15.1	0.7
No card	73.7	95.8	15.8	0.6
Caste / Tribe				
SC	68.8	93.6	16.1	0.3
ST	72	91.7	22.5	0.9
OBC	69.2	93.5	16	0.7
Non SC/ST/OBC (General)	79.5	94.8	28.2	0.3
Total	70.9	93.7	18.1	0.6

The practice of hand washing is very high among all the respondents. Most of the people washing hands at critical times, before taking food (70.9%) and after defecation (93.7%). But this crucial habit is not followed while feeding small children, only 18.1% of the respondents are practicing this.

But when it comes to the cleaning material for hand washing, only 26% of the respondents are using soap. Use of soap among non SC/ST/OBC, i.e among general caste is higher than others (51.7%). Mud is used as the most common material to wash hand (57%) and more than half the population uses this as cleaning material to keep their hands clean. And there are people (1.3%) who are not using anything to wash hands!!!

Figure 3: Type of Cleaning materials used for Hand Washing



5.5 Diarrhea Management

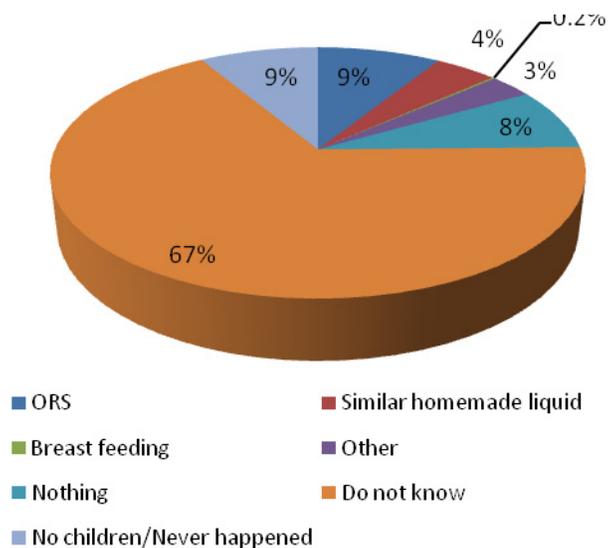
Flood prone areas are also prone to various water borne diseases and most common among this is diarrhea. Flood is always followed by outbreak of water borne disease and in most cases it is diarrhea. Children are the worst recipients of this disease. During the assessment, the knowledge and practices of mothers were captured. It was found that the knowledge of mothers' is very high regarding diarrhea. Large number of women were able to point out that contaminated water, food and unhygienic conditions were responsible for spread of diarrhea.

Table 9: Knowledge of Diarrhea Management

Background characteristics	Washing hands before food	Washing hands after defecation	Use of Toilet	Use safe drinking water	Other	Aware of all methods ¹
Type of House						
Pucca	22.2	27.3	22.1	45.9	28.1	3.9
Semi-Pucca	17.4	18.2	15.9	37.9	38.6	1.4
Kachha	16.9	19.7	15.4	39.5	36.8	1.6
Household Size						
< 5 persons	16.1	19.5	15.9	38.7	37.5	1.5
5-10 persons	19.2	21.9	17.7	41.6	33.9	2.3
10+ persons	25.4	28.7	23.3	46.4	27.7	5
Household have APL / BPL Card						
APL card	21.1	22.6	19.8	43.2	31	2.8
BPL card	20.7	24.9	19.1	43	31.4	2.5
Do not know	11.5	17.1	12.2	34.6	44.6	1.1
No card	14.2	12.8	12	36.3	44.3	1
Caste / Tribe						
SC	18.9	22	17.3	41.9	33.2	1.9
ST	22.9	21.6	14.7	49.1	26.1	3.7
OBC	18.1	20.6	15.7	39.9	35.7	1.6
Non SC/ST/OBC (General)	20.5	25.4	25.5	43.8	32.4	5.5
Total						
	18.7	21.7	17.6	41	34.6	2.3

Although the knowledge regarding cause of diarrhea is very high among respondent, the same cannot be said regarding their knowledge regarding ways to prevent the same. There were very few, only 2.3% respond Treatment of Diarrheants who are aware of all the methods to prevent diarrhea. Most of the responded replied that using safe drinking water (41%) can prevent them from getting diarrhea. During flood safe drinking water is the most important concern and if the population is aware of this fact

Figure 4: Treatment of Diarrhea



they can take good measures to prevent themselves and their family members. Awareness among general caste (non SC/ST/OBC) is higher compared to people from other caste.

Knowledge regarding treatment for diarrhea is again is very low among the respondents. Very few, only 9%, of the respondent knew about using ORS and only 4% has the knowledge about something similar to use as treatment for diarrhea. A very high number of respondent, approx. 67%, do not have any knowledge regarding treatment of diarrhea and this was true to all section of the population.

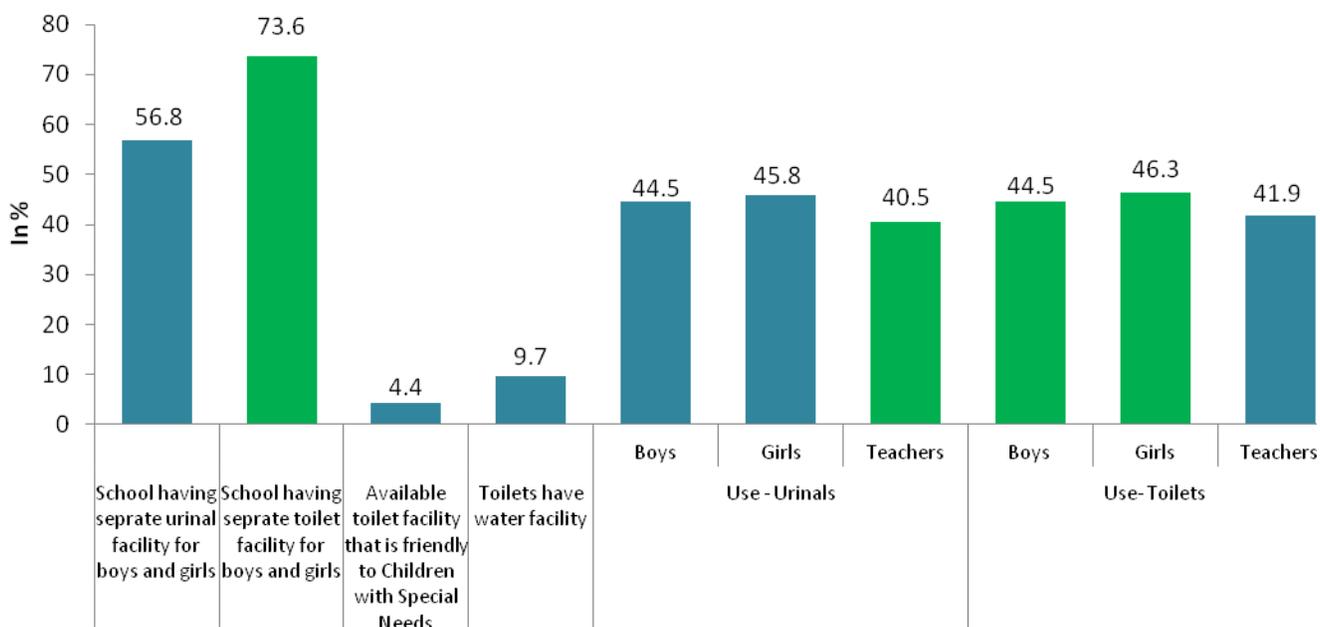
5.6 Water and Sanitation in Institutions – Schools and Anganwadi

5.6.1 Sanitation Facilities

Safe and child-friendly water, sanitation and hygiene (WASH) in schools improves health, boosts education achievement, promotes gender equity and has a positive impact on communities. However, most schools in rural areas lack even functional water and sanitation facilities, and hygiene education programmes are often inadequate. This is even more evident in the schools situated in excluded regions like flood prone areas of Uttar Pradesh. In the 220 villages where the assessment was carried out, it is seen that availability of water and sanitation facilities in institutions, such as schools and anganwadi, are there but the functionality and use of the same is not adequate. Somewhere down the line the availability is not translated into improved practices by the children.

In 220 revenue villages, 68.2% have government Primary School, 27.4% have Upper Primary Schools and 4.5% have private schools. Most of these villages also have Angawadi Centres, 84.9%.

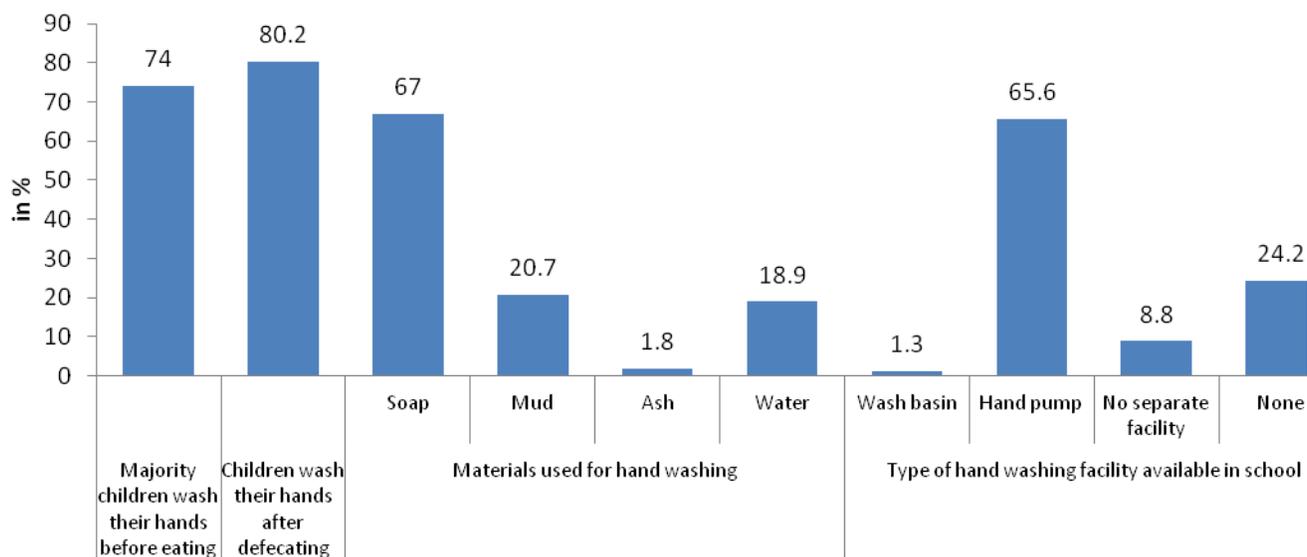
Chart 1: Availability of WASH facilities in the Schools



One of the key concerns of WASH is to ensure availability of separate toilet for girls and boys in the schools. This is encouragingly high in the schools surveyed, 73.6% schools do have this provision but on the other hand the usage of the toilet remains a big concern only 46.3% girls and 44.5% boys are using the same in the schools. One reason is lack of running water in the toilets as only 9.7% toilets in the schools have water facility. This needs to be addressed to ensure proper use of toilet by children. Availability of separate urinal is also low compared to toilets, only 56.8% schools reported to have this facility. This needs to be expedited as there are provisions to have the same under the Government of India's flagship programme for sanitation. One area of concern is child friendly toilet for children with special needs. It is concerning that only 4.4% toilets can be accessed by the children with special needs.

Anganwadi centers needs special attention as the availability and use of sanitation facility is minimal in this institution. Although 84.9% villages surveyed had anganwadi centers but only 7.1% reported to have baby friendly toilets and of these only approx. 7% of the children use it!!!

Chart 2: Status of Hygiene Behaviours in the Schools



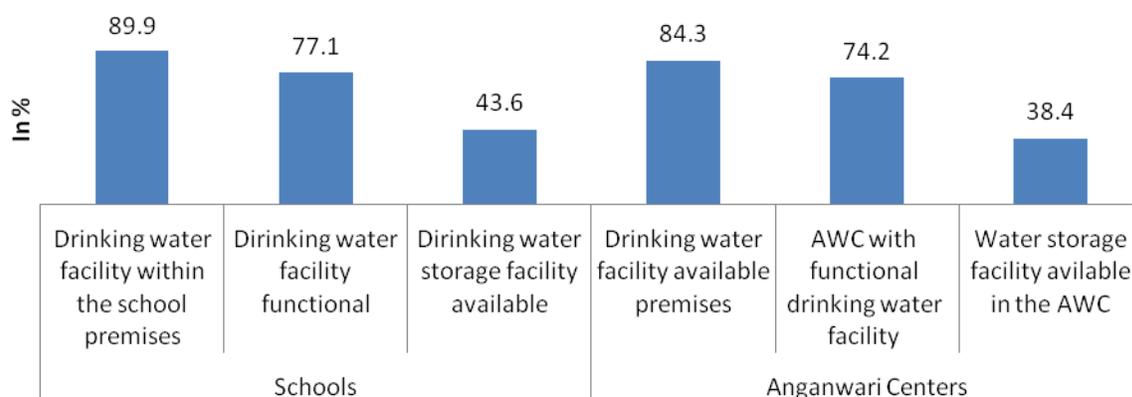
Hand washing practices among school children is another area of concern for the children in these villages. Although majority of the children do wash hands after defecation, 80.2%, there are still 1 out of 4 not doing the same before taking food. This critical habit is key determinant of health among children. But the bigger concern is that only 67% of the children are using soap for washing hands!!! Use of mud (20.7%), Ash (1.8%) and only water (18.9%) is still high and needs to be addressed properly.

In Anganwadi Centers, the hand washing practices are higher compared to the same in schools. Most of the children in angawadi centers wash hands after defecation (80.8%) and before taking food (78.3%). One reason being the availability of caretaker (*sahayika*) to help small children in these centers. But again the use of soap for hand washing is low in these centers also, only 54%.

5.6.2 Drinking Water Facilities

One of the key WASH issues in schools is the availability of safe drinking water for children in the schools. In Uttar Pradesh availability of drinking water in schools is very high compared to other parts of the country. Almost all the schools are provided with hand pumps for drinking water and other use.

Chart 3: : Status of drinking water facilities in the Schools and Anganwadis



Schools and Anganwadis in the villages surveyed also reflect the same trend. The availability of drinking water source, mainly hand pumps, is very high, 89.9% and 84.3% respectively. But when it comes to the functionality of these sources, a large numbers of them seem to be out of order, 77.1% and 74.2% reported to be functional in schools and anganwadis respectively.

One key question still remains is the way we treat drinking water sources and our habit of using the sources. Still the schools have not developed a system to store water in water containers. Children drink it directly from the water source and in this process we tend to waste lot of water. There are very few schools, only 43.6% which are using water containers storing for drinking water. Similarly, only 38.4% of the anganwadi centers use containers to store drinking water.

6.0 Policy Variables and recommendations

1. Overall 80 percent population living in flood affected areas is using drinking water from shallow hand pumps. This figure becomes high at 85 percent, for the people living in Pucca houses. Since shallow hand pumps are considered as unsafe source this poses a threat for safe health. This warrants specially designed behavior change package on the use of safe drinking water, from IM-II Hand pumps, for the flood affected populations. Customised Information, Education and Communication (IEC) programmes need to be organized in this area.
2. Another issue of concern for the consumption of safe drinking water is absence of water purification practice among the 90 percent population, during the flood period. Since the water quality gets compromised during flood period absence of water purification practice exacerbates the problem and people, especially children, are posed to this threat. State Disaster Management Authority

(SDMA) needs to immediately look into the matter and it should start the pre-positioning of water purification devices before the onset of monsoon. It should also promote spread of water purification methods among the masses through its revenue department wing, which is the main face of the Government service delivery mechanism during flood periods. For this purpose there has to be cascade mode training plan of revenue officials.

3. During the survey it was observed that 3 percent population is using the toilet facilities during the flood time and during non-flood periods the usage becomes 9 percent. These figures are far less from the figure of 22 percent as per census. Also, since ninety percent people could not construct toilet due to their poverty level therefore NBA provides a very good opportunity to address this gap. There is need to have clear policy directive on the selection of Gram Panchayats (GPs) from the flood prone area, which are clearly excluded in terms of access and usage of toilet facility. A good portion of Annual Implementation Plans (AIP) of NBA can be demarcated towards these excluded pockets.
4. Knowledge of diarrhea management among the masses is low as 67 percent people are not aware of the safe practices. Health department needs to look into the matter. From all the Community Health Centers, Primary Health Centers (PHC), Additional PHCs and sub-centers of flood affected areas, there is need for proper dissemination of messages on diarrhea prevention and management.
5. Considering the universal coverage of separate toilets for boys and girls there is gap of 24 percent in this and 43 percent in urinal facility. By taking cognizance of the directives of Honourable Supreme Court to ensure 100 percent toilet facilities in the schools, particularly for girls this is a most important task which needs to be performed immediately both by the Panchayati Raj and Education Departments.
6. The survey has revealed that In the Anganwadis *Sahayikas* have a very positive role in the promotion of hygiene education among the small children therefore their capacity building needs to be mainstreamed in the NBA programme.

7.0 Way Forward

In order to implement above recommendations there is need to immediately form a Task Force, to look into the issue of social exclusion in general and issues of flood hit areas, in particular. The Task Force is to have the representatives of Panchayati Raj, Education, Rural Development, Health, SDMA and ICDS departments. This task force needs to provide guidance to their respective departments on the planning, resource allocation and monitoring related aspects. This task force would need to meet on monthly basis and meetings minutes of this group needs to be shared with the respective head of departments.

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