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CDD-WATSAN STUDY

A report of the study in Delhi
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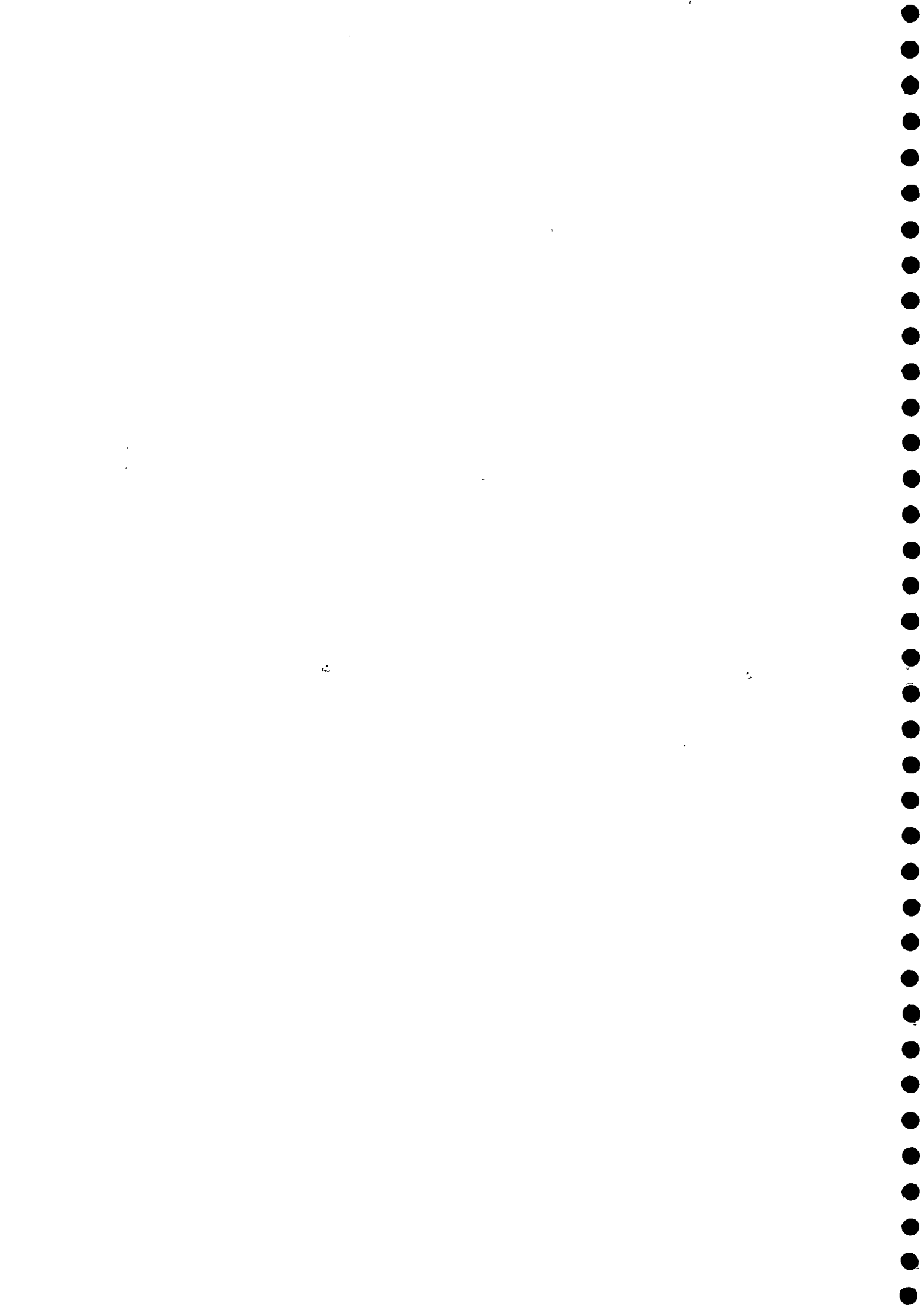
February, 1993

Prepared for UNITED NATIONS CHILDREN'S FUND
by SOCIAL AND RURAL RESEARCH INSTITUTE
(A specialist unit of Indian Market Research Bureau)

DELHI

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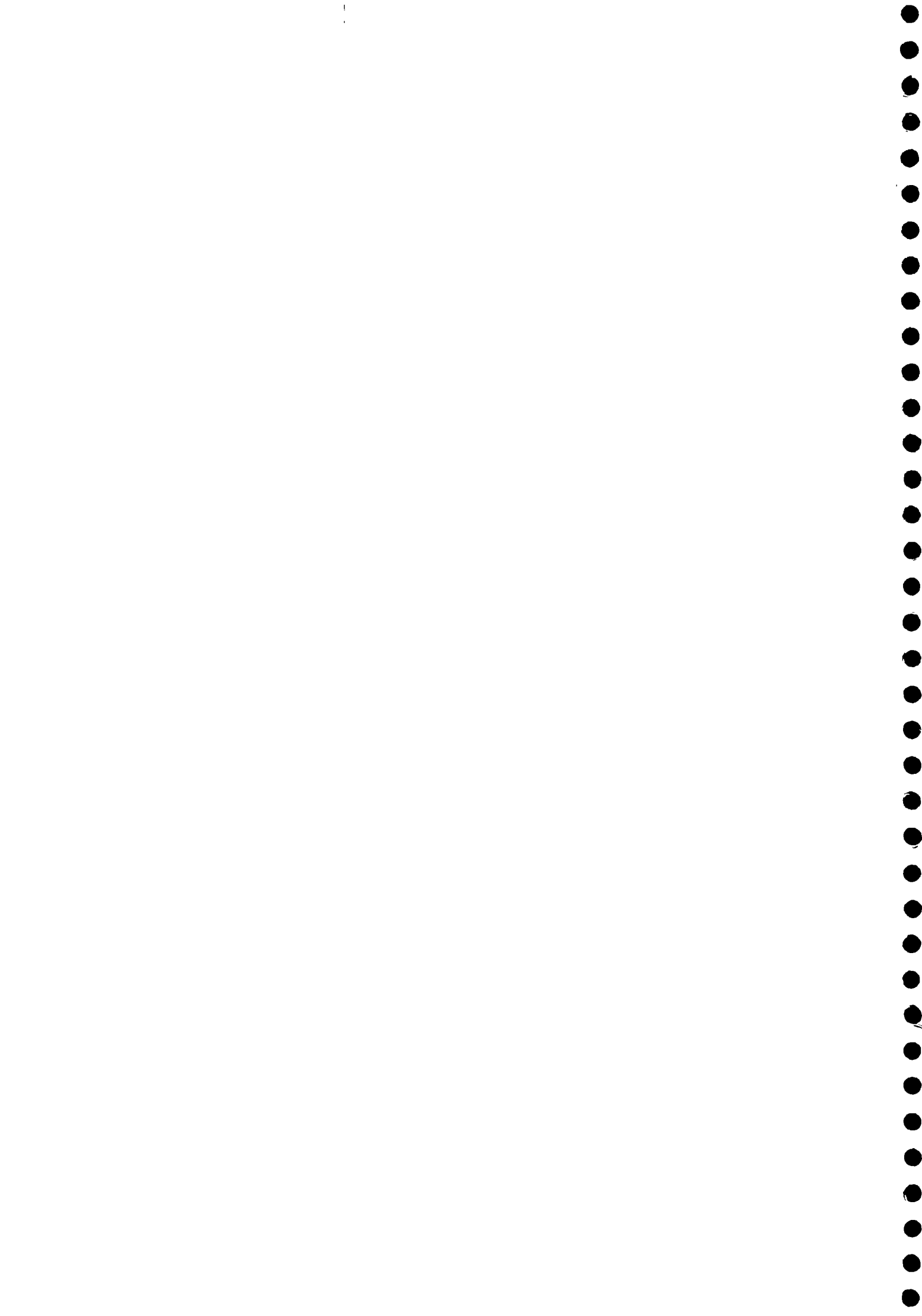
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LIST OF ABBREVIATIONS USED IN THIS REPORT.

SC	- Scheduled Caste
ST	- Scheduled Tribe
ORS	- Oral Rehydration Salts
PHC	- Primary Health Centre
incl.	- including
PG	- Post Graduation
Ltrs.	- Litres
mts.	- metres
SSC	- Secondary School Certificate
HSC	- Higher Secondary School Certificate
DK/CS	- Don't know/ Can't say
SEC	- Socio Economic Classification
VOI	- Villages of India
PHED	- Public Health Education Department
NS	- Not specified
HS	- Health system



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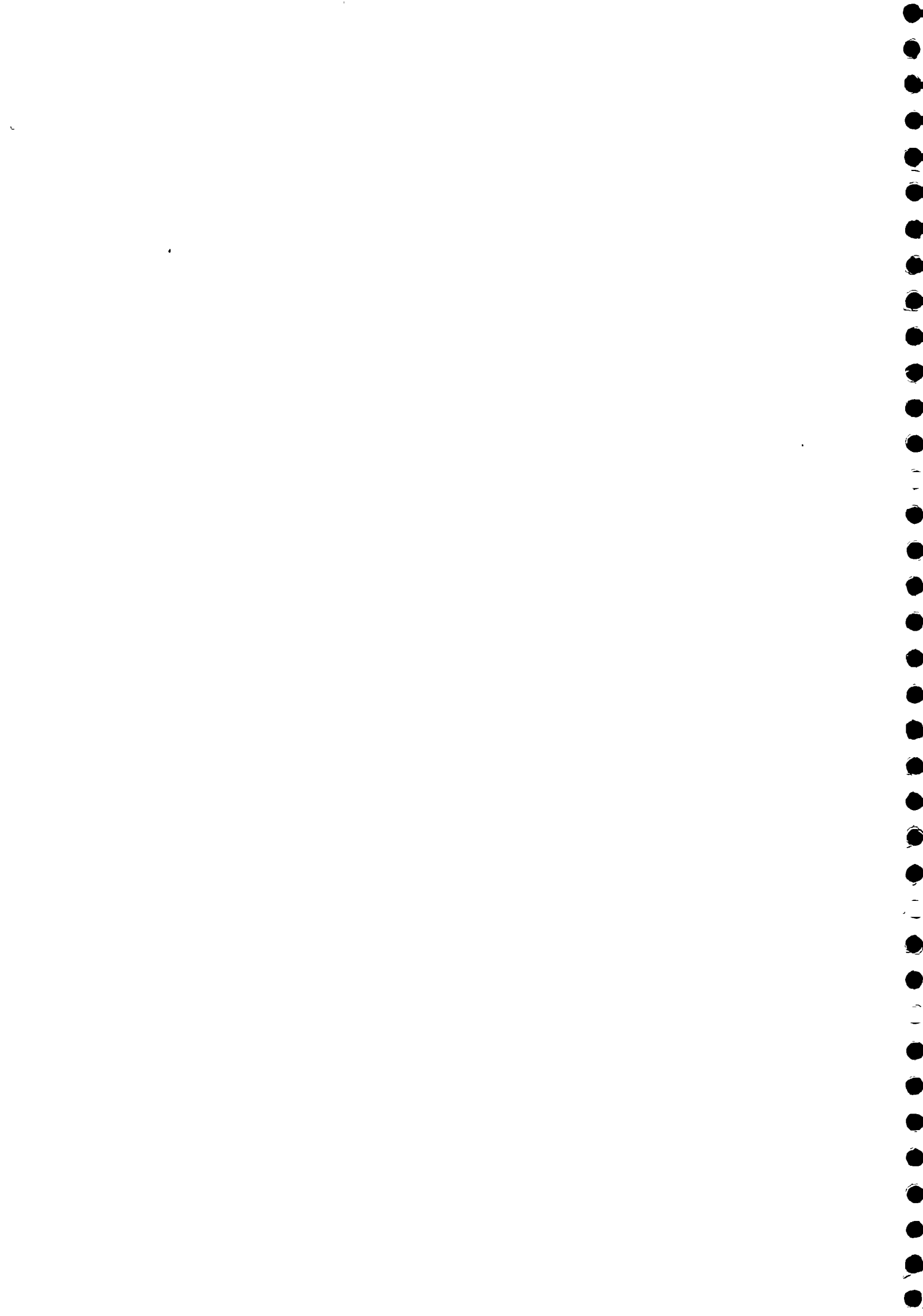
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SECTION I
MANAGEMENT SUMMARY





The CDD WATSAN strategy being introduced in 15 districts of India in as many states aims at reducing the incidence of diarrhoeal cases among children below 5 years. The objectives envisaged for this study are improving access to services, promoting key practices for prevention and for management of diarrhoea system.

The Union Territory of Delhi is the only of its kind which has been included in the list of 15 districts. Delhi is only one district having under it, the two tehsils of Delhi and Mehrauli. Almost nine tenths of the total population of the district are in the urban areas. Of a total of 231 villages in the district, a sample of 30 villages have been covered in this survey. However in the urban areas, the survey has been conducted in the slums.

The villages of Delhi, by virtue of their proximity to a metropolis, are developed significantly and enjoy modern amenities as compared to a typical village of India. The villages in our sample are quite big in terms of population. By contrast there is a high prevalence of small families in these villages something unusual in rural India. The Hindus are in a majority in these villages, with there also being some Sikhs, Buddhists and Muslims. However, it should be noted that Delhi district does not have any scheduled tribe population though the scheduled castes form a fifth of the population. These sample villages are also marked by an absence of an agrarian economy - a result of proximity to urban areas and subsequent commercialization. There is a high presence of infrastructural facilities in these villages. Almost all have electricity facility with a high proportion of the households being electrified. All the villages are connected by bus and rail routes. Trade and industrial activities are prominent in these villages with there being a large presence of different types of shops and markets. Different institutions such as post office, bank and co-operatives/associations exist in these villages. Educational facilities are developed with almost all village having a primary school. Secondary schools and high schools also exist. The villages have easy access to recreational and entertainment facilities in terms of a wide television coverage and proximity to movie theatres.



An important aspect of these villages to be noted is the large presence of sources from where ORS is available.

Diarrhoea is a common malady in this district with the incidence rates being higher than in the other districts. The urban areas are more susceptible to diarrhoeal attack than the rural areas. The two week incidence rate for the entire district as based on our sample was 217 per 1000 children aged below 5 years while the point prevalence rate was 142 per 1000 under 5 years children.

The respondents covered in this study, both in the rural and urban areas, were the caregivers of children below 5 years of age suffering from diarrhoea in the last 24 hours prior to the interview. In Delhi district a total of 782 such respondents were interviewed, of which 39% were in the rural areas and the rest were in the slums which for our study comprised the urban areas. All respondents were females with the average age being 25 years. These respondents were mainly from nuclear families; there was a low presence of joint families in our sample. More than four-fifths of our respondents (86%) were Hindus with the rest being Muslims. The Hindu respondents belonged to families which were well off in terms of income and education of the Chief Wage Earner (SEC categories, as explained in Appendix I) while the Muslim respondents were concentrated in the lower SEC ranges. A third of our respondents had received formal schooling, this proportion being much higher in the rural areas than in the urban areas. The incidence of having been to school was lower amongst the lowest SEC categories and amongst the Muslims. Very few of our respondents had crossed the SSC/HSC level. Literacy for this study has been defined in terms of reading ability and schooling less than 4 years. On this basis, slightly more than a third (36%) of our respondents qualified as literates. For every urban literate respondent there were two such rural respondents. The proportion of literates was higher in the upper SEC category and joint family respondents. The average monthly household income for our sample of respondents was Rs. 1423 per month, higher in the rural areas than in the urban areas. Most of the respondents had brick walled houses which was however more prevalent in the rural areas. Temporary shelters were common in the urban slum areas.



A study of the breastfeeding practices among our respondents revealed that the average age of exclusive breastfeeding (ie. when no other food items or any other form of milk were given) for children was upto 5.4 months. Water, gripe water and janam ghutti were commonly provided to breastfed children. Immunization against measles was a common phenomenon amongst children in the age group of 12-24 months (57%). The incidence of immunization was high amongst the rural children (67%) than the urban children (51%). The average age of immunization was reported at 9 months.

Information was also sought on the behaviour of the households pertaining to the prevention and management of diarrhoea. Mothers have traditionally recognised diarrhoea as having several forms ranging from the simple "loose motion" to other manifestations, some of which could be complex and some could be serious. Our respondents exhibited a certain degree of anxiety and concern for the diarrhoeal attack of the child. However this degree of worry was more amongst the rural respondents as compared to the urban respondents. More of the upper SEC category households (47%, n=732) treated the attack as something "very serious" while the lower SEC category households were content to treat it as something of a routine nature. At this point, it is interesting to note that the lower SEC households were concentrated in the urban areas where the diarrhoeal incidence rates were higher than in the rural areas.

A close perusal of the results obtained in our sample of respondents revealed that the main symptoms of diarrhoea becoming a problem as perceived by the mothers, were increased frequency of motions and loose consistency of stools. The average mother felt concerned and anxious when the frequency of motion increased.

Seriousness of diarrhoea

	Motions passed in 24 hours prior to the interview				
	1-6	7-10	11-15	16-20	21 +
	times	times	times	times	times
	%	%	%	%	%
Very serious	37	48	58	74	100
Somewhat serious	16	21	11	26	-
Not serious/ routine	47	31	32	-	-

The respondents also reported changes in the behaviour of the affected child. The child, mothers said, had been irritable, lethargic and crying more than usual.



Diarrhoea was widely seen as an indication of the breakdown of the digestive system, when mothers believed that the system needs rest. At the time they felt that the child's body must be nourished. Thus nourishment with the least strain on the digestive system seemed to be the principle that guided the feeding practices adopted by the mothers, during the child's diarrhoeal attack. The general tendency was to provide the same or less than normal quantity of food. Very few increased the quantity of food or stopped it altogether. However, the general feeling was that nourishment had to be provided to combat weakness but this had to be done in a manner that imposed the least strain on the digestive system. Fluids were also provided by the mothers, which besides being carriers of nutrition, combated dryness and dehydration. The general practice was to maintain the same quantity of fluids as given to the child under normal circumstances. Some of the commonly used fluids were breastmilk, milk, water and tea. Others continued to breastfeed their child even during diarrhoea (55%).

It should be noted that the usage of ORS was very limited. The ORS users mostly procured the powder from chemist's shops (38%), prepared the solution on their own (88%), and used it over half a day (71%).

The quantity of food and fluids given to the child depended on a lot of factors. The perception of the seriousness of the attack by the respondents influenced their decisions. With an increasing concern for the attack, the feeding practice shifted from same as normal to less than normal. Mothers, also tended to provide more food and fluids to elder children; the practice of giving less than normal food or stopping all foods or fluid was adopted for the younger children (below 18 months). There was a fairly well developed knowledge level amongst our respondents on the different issues pertaining to diarrhoea management among children.

As discussed earlier, an increase in the frequency of stools was a danger signal for the mother; this also was an indication that the condition of the child warranted medical attention/treatment. The existence of the different symptoms (eg. starts passing many stool., has repeated vomiting, develops fever etc.) influenced the mother's perception of seriousness and her subsequent decision to seek treatment.



Consulted for treatment

Seriousness of diarrhoea

	Very serious	Somewhat serious	Not serious/ routine
	%	%	%
Yes	65	51	35
No	35	49	64

A typical mother in our sample used a variety of practitioners in her quest for curing her child of diarrhoea. The allopathic doctors - both government and private were mostly referred to (25% and 69% respectively).

While in general, syrup/mixture/tonic was prescribed by most of the persons consulted (61%), the items prescribed also varied across the type of persons consulted. The allopathic doctors prescribed syrup/mixture/tonic while the non-allopathic doctors, chemists and sub-centres prescribed pills and tablets. Very few of the consultants had prescribed ORS (7%) for treatment and those who had done so were the health worker/anganwadi worker.

It is also interesting to note that while syrup, tonics, milk, tablets were being randomly prescribed irrespective of the age of the child, the advisors appeared to restrict usage of injections, ORS and non-ORS powder to small children aged upto 3 years.

The WATSAN section of the questionnaire was designed with the aim of studying the household behaviour and practices related to collection, storage and usage of drinking water and issues related to personal hygiene and sanitation.

The community sources of water (viz. tap and handpump) were reported to be the main sources of drinking water (65% respondents saying so). There was also a high existence and usage of taps, for this purpose. It is important to note that the usage of the open sources of water as the main sources was almost non-existent unlike in other districts. For general water related activities such as cooking, bathing, washing vessels and washing clothes, taps and handpumps were mostly used. For almost all the respondents (93%) the drinking water source was less than half a kilometre from their house.

The litres per capita per day water requirement for our respondents in Delhi district was at 78 litres.



There was some adoption of safe water storage practices amongst the respondents in our sample. The respondents' behaviour in terms of position where drinking water was stored was equally divided between "on the floor" and "on the platform". Almost all the respondents (95%) covered the vessel in which drinking water was stored. There was also a high prevalence of narrow mouthed vessels for storing drinking water (76%). However, the respondents were not too specific about the way in which water was taken out, with almost half of them (47%) dipping any glass/cup for this purpose into the water container. The incidence of filtration and purification was very low in Delhi district, with only 4% of the respondents doing something to clean the water. The most common water purification method adopted was the use of a cloth filter. A significant point to be noted is the fact that irrespective of storage practices (viz position, size of mouth of vessel and covering of mouth of vessel) the incidence of cleaning drinking water before using was very low.

Almost half of the total respondents had the facility of a latrine (both private and community) (47%). There were no mobile latrines accessible to the respondents. However, the prevalence of private latrines in the household was very low (only 17% of the respondents affirming this). The usage of the community latrine was high in the urban areas (45%) while private latrines were used in the rural areas to a larger extent (26%). Amongst the different types of latrine that were reported to be present in the households which had such a facility, the service latrine (37%) and the flush system (34%) were the most common ones. The pit type of latrine was barely used.

Even in households where a latrine was present, there was a low degree of usage of the facility. Only in a quarter of the households where latrine was present, all the members used it. In terms of age and sex, almost all the males and females above 15 years of age having a latrine in the household, used the facility. The usage of a latrine was looked at more in terms of convenience and availability; no particular reason emerged strongly for the usage of the latrine. Very few respondents felt that the latrine was more hygienic than open air defecation. With regards to non-usage, the inconvenience of a latrine was the major reason that emerged from the non-users.

The spot of open air defecation varied across the sex and age of the people going out for defecation. The less than five years males and females usually defecated at a site near the house. By contrast above 6 years old males and females went to a spot away from the house (either within village or outside village) for defecation.

The faeces of children below 5 years of age were disposed off near the house only, primarily outside the compound or at the drain. However, three-fifths of the respondents who disposed off the faeces of children below 5 years wrapped them in some form before doing so. The incidence of this practice was higher when the disposal was done away from the house. It is also interesting to note that hardly a tenth of the respondents left these faeces lying around for some time before attending to them. Prompt disposal was widely practised.

The usage of footwear on the way to defecate, was very high. More than nine tenths of the respondents (92%) adopted this practice. Females used footwear to a larger extent while on the way to defecate, than males. The usage was higher in the age group of 15 years and above.

General hygiene practices were being adopted to a large extent by the respondents. There was a very high prevalence (all or almost all respondents) of the practice of washing hands before eating food, before serving food, before cooking food, after using the latrine/defecation, after cleaning the child's stools and after disposing it. The usage of soap was restricted to the rural respondents and the upper SEC category respondents. On the other hand the urban and lower SEC category respondents used only water and water with ash.

The above summary provides a brief overview of the relevant findings. Differences in results were observed across the different classification variables. These are explained and discussed at length in the main report.



2.0 BACKGROUND

Among the various causes of diarrhoeal diseases, which remain a major cause of childhood morbidity and mortality in India, a large number can be traced back to poor sanitation and unsafe drinking water. Research has shown that not only is this relationship not recognised by mothers of young children, but the concept of diarrhoea prevention is also one of low interest.

By and large, people seemed to believe that diarrhoea was too complex in terms of its myriad causes and yet too ordinary in terms of its commonly known consequences, for prevention to be worthwhile.

The Government of India, however, has recognised that prevention of diarrhoeal diseases can be achieved by means of macro-level intervention and education. It has therefore made provision of safe drinking water and promotion of improved sanitation and personal hygiene a part of its policy on Management of Diarrhoeal disease.

The policy now aims to attack the problem of diarrhoeal disease with a three pronged strategy of :

- a) Providing universal access to safe drinking water and improved sanitation coverage.
- b) Promoting correct diarrhoea management practices.
- c) Promoting correct diarrhoea prevention practices, including education and communication on the subjects of safe drinking water, proper hygiene and sanitation practices.

The implementation of this strategy will involve improved delivery systems, creation of conditions for better access to services provided and information, education and communication that will lead to better utilisation of services. It is expected that these interventions will result in change in knowledge, attitudes and practices and, therefore, in diarrhoeal morbidity.

In order to assess the extent of reduction achieved in diarrhoeal morbidity it is necessary to measure the morbidity as well as the practices that exist today, through a set of indicators.

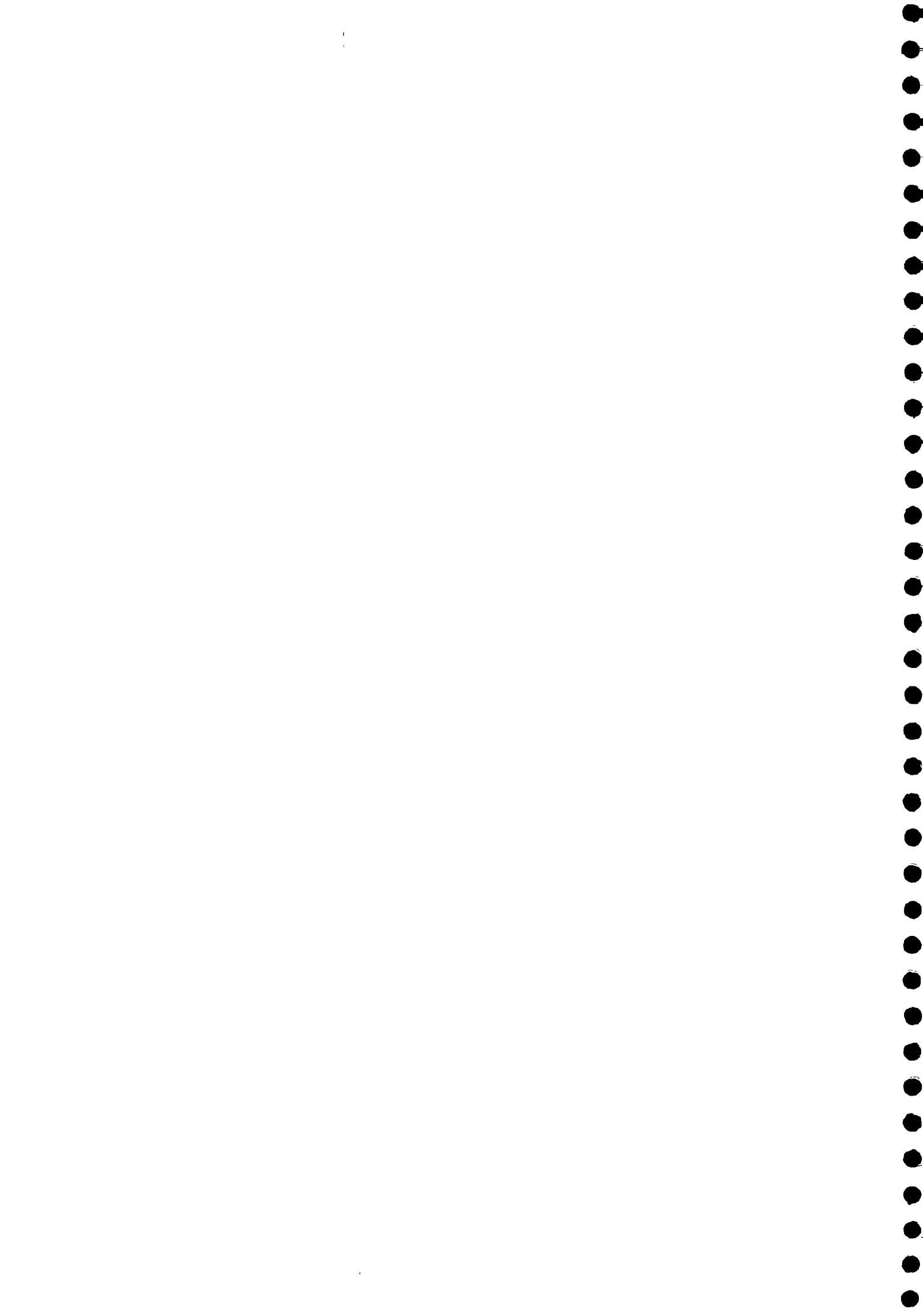
UNICEF had approached the Social and Rural Research Institute (SRI) for a study that would enable the required measurement.



SECTION II

INTRODUCTION





2.1 RESEARCH DESIGN

a) Target respondent

The target respondent for the study was the caregiver (in most cases the mother) of the child who had been suffering from diarrhoea in the past 24 hours. In households where such a case was found, the caregiver was interviewed at length. In cases where such a child was not found, the interviewer collected data on diarrhoea incidence for all her under-5 children in the two weeks preceding the interview.

b) Technique

Quantitative research techniques of structured questionnaires, rigorous sampling methods and computerised analysis were used. For our analysis, urban and rural data have been weighted in proportion to their presence in the district population. Our findings are based on these weighted figures.

c) Centres and sample sizes

The districts in which the study was to be carried out had been specified. Our fieldwork was carried out in these 15 districts. A total sample size of 780 (390 rural and 390 urban) was to be achieved per district. In Delhi district, out of a desired sample size of 780, the achieved sample size was 782. In addition to this, 38 interviews were conducted with the health system functionaries.

d) Fieldwork

As had been agreed upon, the 30 cluster sampling technique developed by WHO was adopted. In this process, 30 urban clusters and 30 rural clusters were chosen using the population proportional to size (PPS) method. In case the desired number of 13 interviews could not be achieved in the originally selected ward or village, the quota was completed in a neighbouring ward/village.

All the interviews were conducted by trained and experienced interviewers who were thoroughly trained and briefed for the study. To ensure consistently high quality of fieldwork, almost a fifth of all interviews were back checked by Field Executive/Supervisors. This fieldwork in Delhi District was conducted in the period August - September 1992.

3.0 DISTRICT PROFILE

The district of Delhi is bounded by Sonapat (Haryana) and Meerut (Uttar Pradesh) in the North, Ghaziabad in the East Gurgaon and Faridabad in the South and Rohtak (Haryana) in the West.

The present district of Delhi was first constituted in 1819. At present Delhi enjoys the status of a Union Territory. Delhi is now made up of one district having two tehsils - Delhi and Mehrauli.

There are a total of 231 villages in Delhi with 144 being under Delhi tehsil and the rest being under Mehrauli tehsil.

The total population of Delhi district as per the 1991 Census is 9,420,644 persons; 10% of the population are in the rural areas with the rest being in the urban areas.

The decennial population growth rate of Delhi over the period 1981-91 was 51%. The total area of the district is 1483 square kilometres with the population density being 6319 persons per square kilometre (the all India density of population is 216). The sex ratio as per the 1991 Census was 830 females per 1000 males.

Delhi district has a high literacy rate of 76%. The all India literacy level is 52% as per 1991 Census.

Occupation wise, almost a third of the population are engaged in the main line of activities (32%).

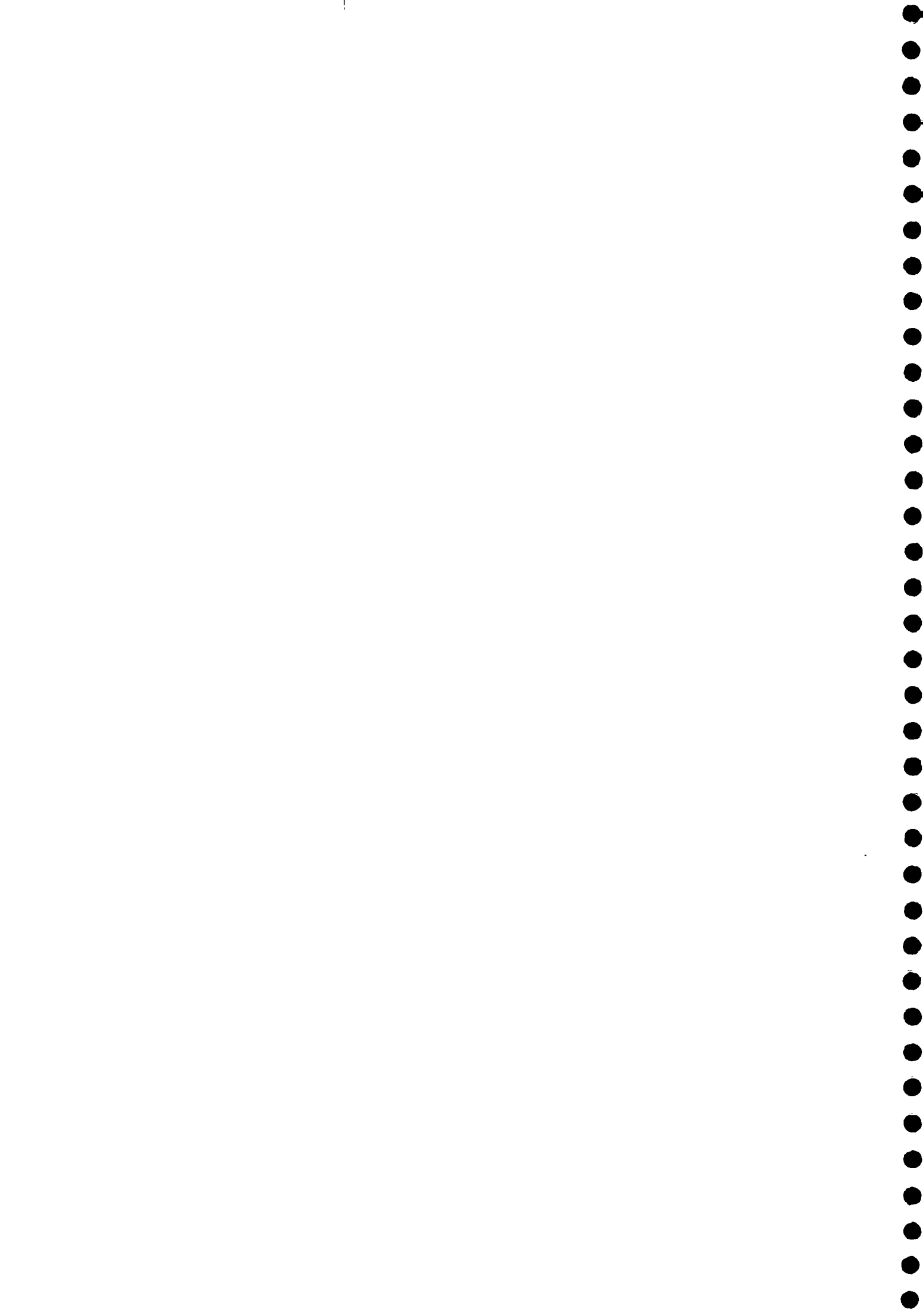
Religion wise, Hindus and Sikhs dominate the district. In terms of caste, 18% of the total population belongs to scheduled castes, with there being 36 such castes in Delhi. (See Appendix III for list). These scheduled castes are found only amongst the Hindus and Sikhs, and amongst no other religions. There are no scheduled tribes in Delhi.

The urban areas of Delhi district, being very close or actually comprising the capital of the country, enjoy several amenities and modern facilities. The villages, in the rural areas are also significantly developed as compared to the other villages of India. All the villages have drinking water and power supply. While almost nine-tenths of them have educational institutions and communication facilities. Medical set ups are also quite prevalent in these villages. Most of these villages (48%) have a population between 500 - 2000 with there being no village with a population of above 10,000 people.



SECTION III
SOCIO ECONOMIC PROFILE OF
SAMPLE AREAS





3.1 DEMOGRAPHIC CHARACTERISTICS

The Union Territory of Delhi has 10% of its population in the rural areas.

Of the 231 villages in Delhi district, 30 villages were covered. For this study, all villages with a population of upto 1500 shall be considered as 'small' villages, those with a population between 1501 - 3500 shall be called 'medium' villages and those with population above 3500 shall be termed as 'large' villages.

The Chief of the village panchayat or the revenue office was contacted in each village and a village schedule was administered to him to elicit information leading to a profile of the villages.

3.1.1 Size, Religion, Caste

19 of the 30 villages were 'large' ones. Seven of these large villages had a population of above 9000. These large villages had an average population of 6750 people. There were only two small villages and nine medium sized villages.

Base : All villages	Total population of the village			
	All total	Small	Medium	Large
	30	2	9	19
	Number of villages	Number of villages	Number of villages	Number of villages
< 500	1	1	-	-
501 - 2500	7	1	6	-
2501 - 5000	10	-	3	7
5001 - 8000	5	-	-	5
8001 and above	7	-	-	7
Average village population	5347	705	2556	6750

(Refer VOS Table 1)

The average village population, considering all these 30 villages was 5347 people. This average is quite high compared to the all India average village size of 1031 people and the North Zone average of 901 people. (Source: VOI *)

* VOI :- Villages of India, SRI publication, 1991. In this report wherever data has been used from this source, this abbreviation has been used.

Base : All villages	Total number of households in the village			
	All total	Small	Medium	Large
	30	2	9	19
	Number of villages	Number of villages	Number of villages	Number of villages
< 150	-	-	-	-
151 - 500	10	-	7	3
501 - 1000	12	1	2	9
1001 - 2000	5	1	-	4
2001 - 2500	2	-	-	2
2501 - 5000	1	-	-	1
Average number of households	1028	900	422	1194

(Refer VOS Table 2)

Almost three fourths of the villages (73%) had less than 1000 households in the village. The average number of households for the medium villages is less than half of the average number of households for the small villages

Considering the average village population against the average number of households, we find that the average family size for Delhi district works out to 5.2 people. This average family size is much smaller than the all India village average family size of 6.4 people and the North Zone village average family size of 6.9 people (Source:VOI). However, the average family size for all the villages covered by this study is lower (at 4.2 people) than the Delhi district average family size.

People of all major religions, except Jainism and Buddhism, were found in our sample villages. Hindus were predominant with the average percentage of Hindu population being 96%. Almost the entire population in the medium and large villages was Hindus (98% and 97% respectively). However, in the small villages the average percentage of Hindu population was 75%. Muslims, Sikhs and Christians were also reported to be living in the villages.



The religion wise percentage of households in the villages also revealed the predominance of Hindus.

Religion	Base : Villages having population of this religion	Percentage households
----------	--	-----------------------

Hindu	30	96
Muslim	16	2
Sikh	5	1
Christian	4	1

(Refer VOS Table 3a - 3d)

All the 30 villages in our sample had scheduled castes. There were no scheduled tribe households in the villages.

3.1.2 Crops grown and occupation

The prevalence of agriculture and cultivation in Delhi district was not as marked as in the case of the other districts. The proximity of these villages to a metropolis and the gradual trickle down effect of commercialism could be the reasons for a lower degree of farming and agricultural related activities.

In almost a quarter of these villages (23%) less than 25% of the households were involved in farming. There were only five villages (17%) where more than three fourths of the households were involved in farming. In the rest of the villages, between one fourths and three fourths of the households were engaged in this activity. It should be pointed out here that on an average across 15 districts for this study, in almost three fifths of the villages (56%) more than three fourths of the households were involved in farming.

In all the villages where the households were involved in farming, more than one crop was grown.

Slightly more than half of the total cropped land irrigated (52%). The remaining was possibly dependent on rain.



Percentage of total cropped land being irrigated				
Village population				
Base : All villages	All total	Small	Medium	Large
	30	2	9	19
	%	%	%	%
Upto 10%	3	-	-	5
11 - 40%	-	-	-	-
41 - 60%	30	50	22	32
61 - 70%	-	-	-	-
71 - 90%	17	-	33	11
91%+	23	-	11	32
None	27	50	34	20
Average	52	25	50	55

(Refer Table VOS 20c)

As a point of comparison, in other districts in this study the percentage of cropped land being irrigated on the average was 39%. For our sample of villages, the average percentage of irrigated land was the highest for the large villages.

3.2 PHYSICAL AND SOCIAL INFRASTRUCTURE

3.2.1 Electrification

Barring one large village (Kusumpur in Mehrauli) all the other villages in our sample from Delhi, had electricity facility. The availability of electricity in our sample of villages is quite high compared to other districts in this study.

Proportion of houses electrified				
Village population				
All village having electrical facility	All total	Small	Medium	Large
	29	2	9	18
	Number of villages	Number of villages	Number of villages	Number of villages
<u>In percentage</u>				
None	2	1	-	1
Less than 70	-	-	-	-
71 - 80	2	1	-	1
81 - 90	3	-	-	3
91+	22	-	9	13
Average percentage of household electrified	89	38	98	85

(Refer Table VOS 4a-1)



In one small village, no electrical connection was available at the households, though the village had electricity. All the medium villages had more than 90% of the households under electrification.

In slightly more than half of the villages (52%) power was available for almost the entire day (between 21 - 24 hours). The average duration of time power was available in our sample was longer (19.7 hours) than other villages covered in this study. Across the different types of villages in Delhi on an average power was available between 20-22 hours a day.

It should also be noted that in almost three fifths (59%) of the villages there was no streetlight, which was functioning at the time of the interview. All the small villages, slightly more than three fourths (i.e 78%) of the medium villages and 44% of the large villages did not have a functioning streetlight at the time of the interview.

3.2.2 Presence of shops/markets

Information was sought on the shops and establishments existing in the village, so as to have an understanding of the trade and industrial activities prevalent in these villages. The proportion of villages that had at least one of the following types of shop is given below :

Type of shops/establishments existing in the village				
	All total	Small	Medium	Large
Base : All villages	30	2	9	19
	%	%	%	%
Paan/cigarette/bidi	73	100	78	68
Tea stall	87	100	67	95
Groceries/provisions	100	100	100	100
Vegetables	90	100	78	95
Medicine/chemist	33	100	22	32
Ration/fair price	97	100	22	32
Agricultural items (Seeds/fertilisers)	7	-	-	11
Agricultural implements (tools)	3	-	-	5
Textiles/cloth/ tailoring	87	100	67	95

(Refer Table VOS 7a)



For the different types of shops, more than 70% of the villages reported the existence of at least one of each type of shop (except medicine shop and agricultural implements and items shops). Both the small villages had a paan/cigarette/bidi shop, a tea stall, a grocery and provision store, a vegetable shop, a medicine shop, a ration shop and a textile shop. All the villages had a grocery/provision store. The difference in the proportion of small and medium and large villages having medicine shop is statistically significant (*).

A comparison can be made between the existence of shops across our sample villages and the villages in India as well as the villages in the North Zone (Source: VOI).

Base : All villages	% of villages with					
	Provision store	Paan/bidi shop	Ration shop	Vegetable shop	Textile store	Chemist shop
All India	66	60	32	14	14	8
North Zone	70	52	18	9	14	6
This sample of 30 villages in Delhi district	100	73	97	90	87	33
	100	73	97	90	87	33

The different types of shops were existing to a larger extent in our sample of villages as compared to the all India and North Zone villages.

We may also compare the presence of the different types of shops across the villages (in terms of population strata) for our sample.

* --> (All tests of statistical significance for this report have been done at 5% level of significance).



Average number of shops by type of village
Village population

Type of village	Small	Medium	Large
	Average No. of shops	Average No. of shops	Average No. of shops
Paan/bidi/cigarette	9	4	8
Tea stalls	20	9	6
Groceries/Provision	30	10	18
Vegetable shops	3	5	9
Medicine/chemist	4	2	2
Ration/fairprice	4	2	2
Agricultural items (seeds fertilisers)	-	-	-
Agricultural imple- ments	-	-	2
Textiles/cloth	16	5	9

(Refer VOS Table 7a-1 to 7a-9)

The small villages had a higher average number of different types of shops except for vegetables shops, as compared to the medium and large villages.

The proximity of these villages to urban centres, has influenced their development and there has been an effective penetration of commercial activities into these villages.

Across our sample of 30 villages, only 7 reported the existence of weekly market, as compared to only 18% of the small and medium villages. By contrast a smaller proportion of the large villages (74%) reported the non-existence of a weekly market as compared to 82% of the small and medium villages. Thus a higher proportion of our sample villages reporting the presence of weekly markets, is an indication of the fact that the proximity to Delhi city has affected the growth of these villages and subsequently easy availability of goods and materials.

This has also been facilitated by the existence of a developed network of bus and rail connections in these villages.

3.2.3 Presence of infrastructural facilities

Information was sought on the existence of different infrastructural facilities in these villages so as to obtain a general profile of these villages.



1) Post office

Four fifths of the villages in our sample reported the existence of a post office in the village. A higher proportion of the large villages (90%) reported the existence of a post office as compared to only 64% of the small and medium villages.

The other villages did not have a post office. 31% of the villages on an all India basis and a quarter of the North Zone villages reported the existence of a post office (Source: VOI).

In terms of the population strata of the villages, the existence of a post office was reported on a larger scale in our sample of villages as compared to the all India percentages. (Figures from VOI).

Type of village	Existence of post office	
	All India % of villages	Our sample % of villages
Small	15	50
Medium	50	67
Large	77	89

2) Banks

Half of the villages in our sample reported the existence of banks, while the others did not have one. A higher proportion of the large villages (58%) as compared to 36% of the small and medium villages reported the presence of a bank.

On an all India basis and North Zone basis, 16% and 12% respectively of the villages reported the existence of banks. (Source : VOI).

3.2.4 Existence of schools

Primary schools

Almost all the villages (93%) had a primary school. One large village and one medium village did not have a primary school.

78% of all the villages across India and 74% of the villages in the North Zone reported the existence of a primary school in the village (Source : VOI)

57% of these villages in our sample having a primary school had two such schools in the village. There was only one village, a large one, having three primary schools. The rest of the villages had one such school each.



Three fifths of the villages had a boys' school, 57% of them had a girls' school while 36% had a co-educational school.

Secondary schools

Only one fifth of the villages out of the 30, reported the presence of a secondary school. The others did not have a secondary school.

On an all India and North Zone basis, 32% and 27% of the villages respectively had a secondary school (Source: VOI).

Of the 6 villages having a secondary school, five had one secondary school each while a large village had three such schools.

Half of the villages having a secondary school had a girls secondary school while two had a coeducational school.

High schools

Three fifths of the villages reported the existence of a high school in the village. The rest of the villages did not have a high school.

In all the villages in India and North Zone, only 17% and 10% respectively of the villages had a high school in the village (Source : VOI). Two thirds of the villages having a high school had one such school in the village while the rest had two such schools in the village.

Half of these villages having a high school had a coeducational one.

The larger villages, in general, had better educational facilities, as compared to the medium villages. We are not considering the small villages as there are only 2 such villages in our sample.

Average number of schools

	Village population	
	Medium (n=9) Average number of schools	Large (n=19) Average number of schools
Primary schools	1.4	1.8
Secondary schools	1.0	1.5
High schools	1.3	1.3

The prevalence of the different types of schools was more in the large villages.



3.2.5 Sources of entertainment

Our sample of 30 villages had better and easily accessible entertainment and recreational facilities as compared to the other villages covered in this study. This is explained by the proximity of these villages to an urban centre.

All these villages received television transmission.

There was also a high degree of ownership of television sets in these villages.

Almost all the villages (i.e 97%) had 100 or more private television sets in the village. There was only one small village where there were no private sets. The average number of T.V sets privately owned across all types of villages was as high as 98 sets.

The availability of community T.V sets was not as high as the private sets ownership. Only 23% of the villages had community sets in the village while the others did not have any such set. None of the small villages had any community set. The average number of community T.V sets across these villages was 4 sets.

For our sample of villages receipt of T.V transmission and availability of electricity did not entirely coincide. There was a large village where there was no electricity available; however, this village (Kusumpur) reported the receipt of T.V transmission as well as the existence of private T.V sets being run on battery.

The average distance of the nearest cinema theatre for our sample of villages was only 9 Km. from the village. Two thirds of the villages in our sample had a cinema hall within 10 Kms. of the village while the rest had one between 11-20 Km. from the village. A greater proportion of the small and medium villages (78%) had a cinema theatre within 10 Km. of the village as compared to 68% of the large villages.



3.3 AVAILABILITY OF COMMUNITY ORGANISATIONS

In our sample of 30 villages, one sixth of them reported the existence of cooperatives/societies in the village. The rest of the villages did not have any co-operative/society in the village. None of the medium villages had a cooperative/society in the village. A higher proportion of the large villages (21%) as compared to 9% of the small and medium villages reported the presence of this institution.

Of the 5 villages reporting the existence of cooperatives/societies in the village, two each reported the existence of agricultural credit and consumer credit societies, while one reported the presence of an agricultural credit cum marketing society. The only small village reporting the presence of an institution of this type mentioned the existence of a house-construction related cooperative.

In slightly more than 70% of the villages (73%) there were no clubs/mandals/associations in the village. The rest of the villages had an institution of this type. A greater proportion of the large villages (32%) as compared to 18% of the small and medium villages had a club/mandal/association. Also, none of the small villages had a club / mandal / association.



These clubs/mandals/associations were involved in a variety of activities.

Areas of activities of the clubs/mandals/association in the village

Village population

Base : All villages where clubs/mandals are existing	All total	Medium	Large
	8 %	2 %	6 %
Literacy programme/ adult education	13	-	17
Community development programmes/repairing road/park/school building	25	-	33
Child welfare/creche/anganwadi	25	-	33
Youth welfare	38	100	17
Helping poor/feeding poor	25	50	17
Others	25	-	33

(Refer VOS Table 10a-1)

The clubs, mandals and associations were all engaged in developmental and community welfare activities.



3.4 ACCESS TO COMMUNICATION LINK

These villages in our sample being very close to the metropolis of Delhi, have well developed transport network as compared to the other villages across 15 districts covered for this study and in general.

Barring one medium village, all the other villages had a bus coming upto and stopping at the village.

The frequency of buses stopping at the villages was quite high, as given in the table below :

Number of times buses stop in a day

Base : All villages where buses are coming	Village population			
	All total	Small	Medium	Large
	29	2	8	19
	%	%	%	%
2 - 8 times	7	-	13	5
10 - 15 times	21	-	13	26
20 times +	72	100	74	67
Average number of times	21	25	21	20

(Refer VOS Table 5c)

In more than 70% of the villages, buses stopped more than 20 times a day.

While for all the villages covered in this study, buses stopped on an average 13 times a day, this average was as high as 21 times for the sample villages in Delhi district.

The medium villages, where buses did not stop had the nearest bus connection only a kilometre away.

One fifth of the villages in our sample had a railway station present in the village. Both the small villages did not have a railway station.

For those villages without a railway station, the average distance of the nearest railway station was 9.1 Kms. from the village. This average distance is much lower compared to the average distance of 22 Kms. reported for the other villages covered in this study.

Combining the bus and railway connections available, we find that there was only one village in our sample of 30 villages where there was no bus connection and the nearest railway station was within 15 Kms. from the village. On an all India basis, 16% of the villages did not have a bus connection and the nearest railway station was within 15 Kms. (Source : VOI)



4.0 INTRODUCTION

The general objective of the baseline survey is to establish benchmarks on the incidence of diarrhoeal disease among children below 5 years of age.

Diarrhoea, per se, for this study has been defined as the occurrence of at least one loose motion (as perceived by the respondent mother or caregiver) in the 24 hours prior to the actual interview, in all the households. These households were randomly selected addresses in each town and village covered in this study.

4.1 INCIDENCE RATES

Diarrhoea incidence rates were established by checking for any reported occurrence of diarrhoea in the under five children in the two weeks prior to the interview. This was done in all the households.

Diarrhoea point prevalence rates were established by checking for any reported current existence of diarrhoeal problems in under five children in all households, current being defined as the 24 hours preceding the interview.

In Delhi district, the results obtained were as follows:

	All total	Rural	Urban
Households contacted	6023	3625	2398
Proportion of households with under five children	61	57	67
All children of age under five years	6114	3557	2557
Diarrhoea in past two weeks (proportion of children)	22	22	22
Diarrhoea in past 24 hours (proportion of children)	14	12	17

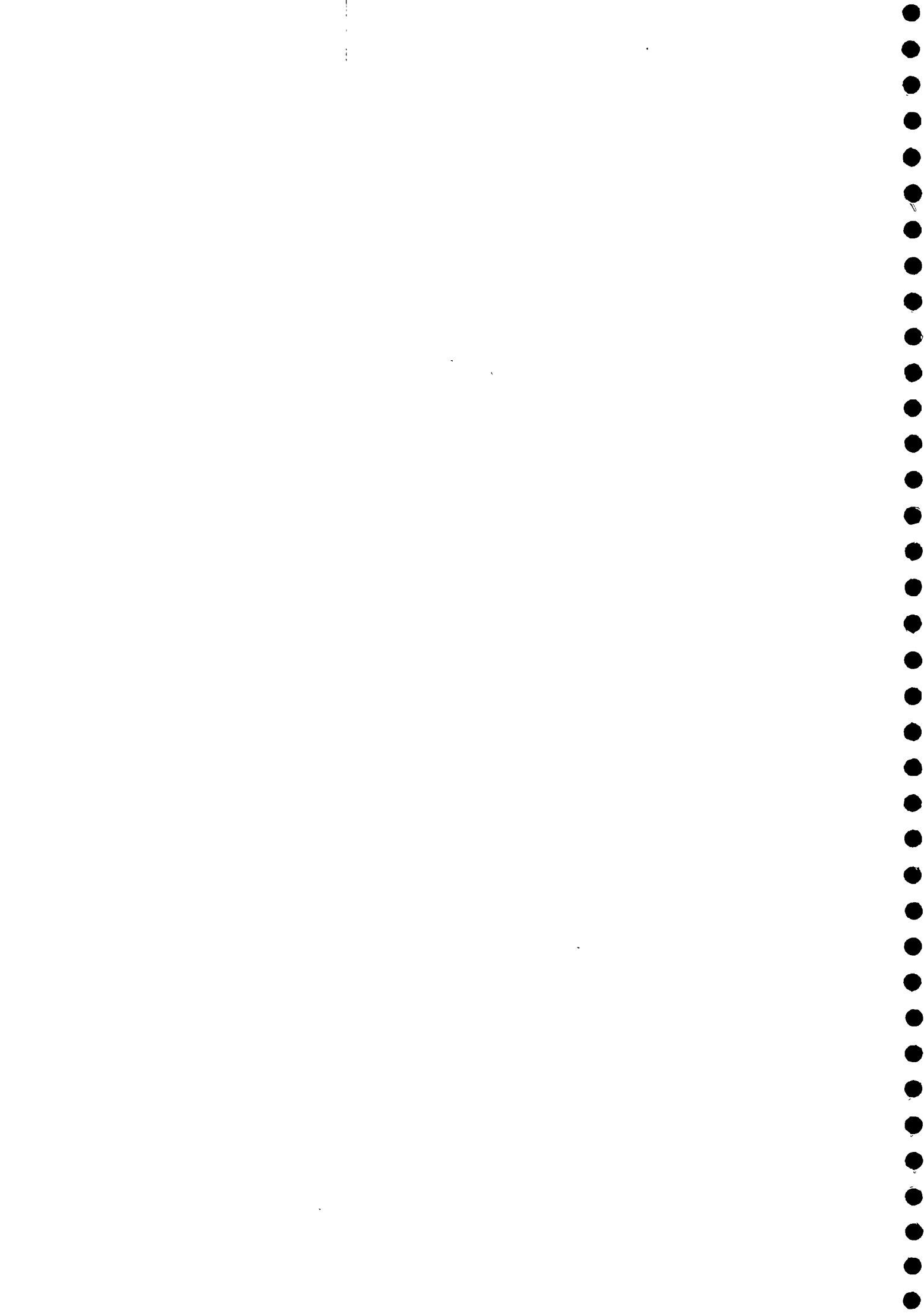
Thus in Delhi district, the two week incidence of diarrhoeal disease and the point prevalence in under five children, were established as follows :

	All total	Rural	Urban
Two week incidence	220 per 1000	220 per 1000	220 per 1000
Point prevalence	140 per 1000	120 per 1000	170 per 1000



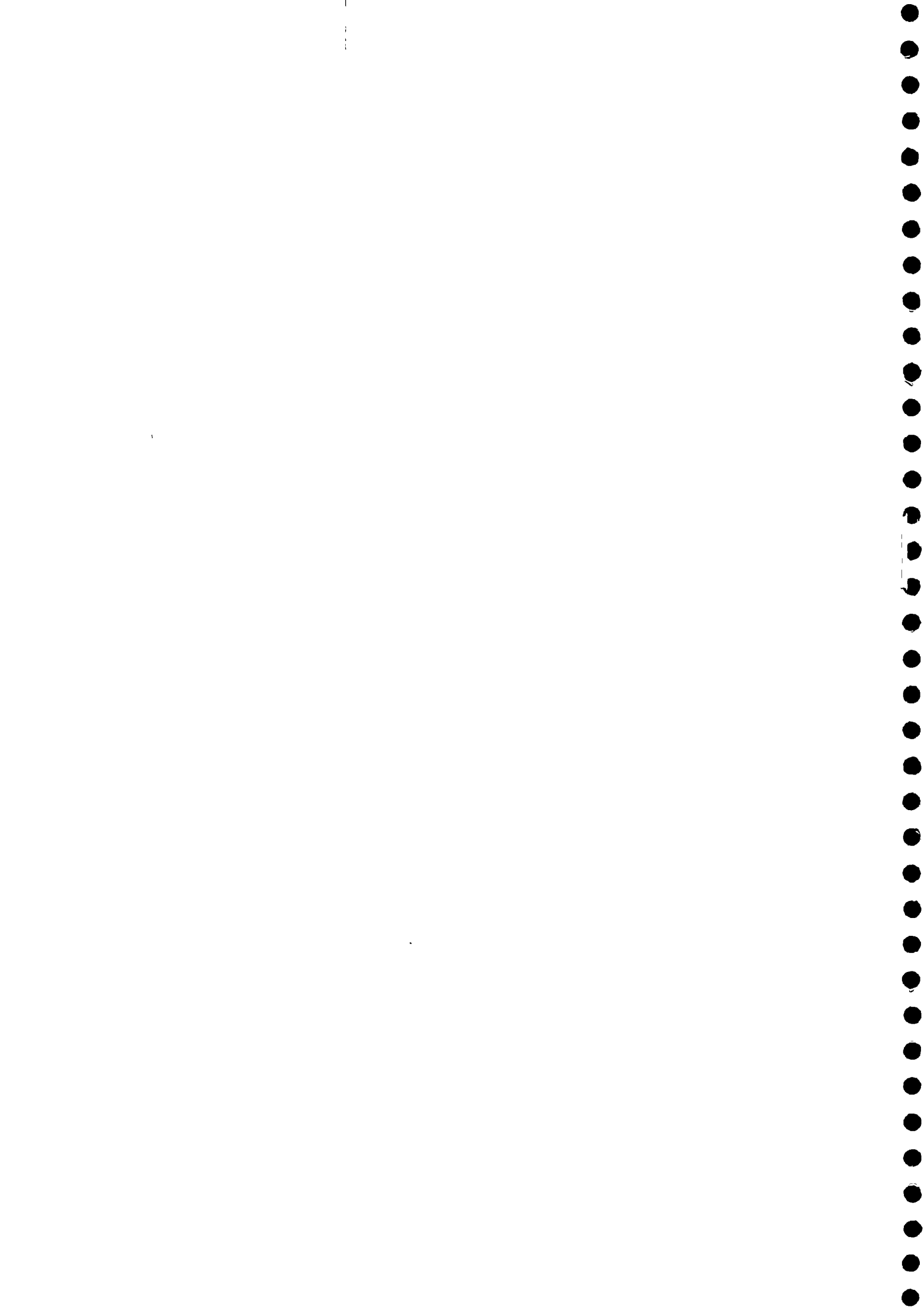
SECTION V
PROFILE OF THE CHILD
WITH DIARRHOEA





SECTION IV
DIARRHOEAL INCIDENCE





5.0 INTRODUCTION

The survey for this study at the very outset identified those children below 5 years suffering from diarrhoea within the last 24 hours prior to the interview. The main questionnaire or household schedule was then administered to the mothers or caregivers of such children. In those households where there were two or more children suffering from diarrhoea within the last 24 hours prior to the interview, multiple interviews were held as long as the care givers of those children were not the same.

Information was sought from the respondents (i.e. the mothers/caregivers) on their age, religion and such classification variables so as to obtain a profile of the respondent.

5.1 DEMOGRAPHIC CHARACTERISTICS

5.1.1 Sex and age of respondents

In the rural and urban areas covered in Delhi district for this study, there were a total of 782 respondents who were selected by us. Of these, 50% belonged to the rural areas and the rest belonged to the urban areas. Here it should be stated that the 'urban' areas for Delhi district for this study, were the slums in and around Delhi. The urban areas of Delhi city were not covered.

Almost all the respondents (98%) were females.

Slightly more than three fifths of the total respondents (61%) were in the age group of 16-25 years. 32% of the respondents were in the age group of 26-35 years, the rest of them were above 35 years of age. The average age of the respondents across the entire sample works out at 25 years.

5.1.2 Family type and number of family members

More than three fourths of the total respondents belonged to nuclear families (77%). The rest of them belonged to joint families.

A greater proportion of the rural respondents belonged to joint families as compared to the urban respondents most of whom belonged to nuclear families.

The concept of joint family was more strong amongst the lower SEC category people as compared to the higher SEC people. By contrast a greater proportion of the higher SEC category respondents belonged to nuclear families.

More of the literate respondents belonged to joint families as compared to the illiterate respondents.



The respondents were asked to state the total number of family members living together in the household. The average family size was 6.2 persons as given below :

Number of family members living together

Base : All respondents (weighted)	All total	Rural	Urban	SEC				Joint family	Nuclear family
	782	303	479	1-4	5-6	7	8	183	599
	%	%	%	%	%	%	%	%	%
Upto 3 members	8	6	9	11	6	8	8	1	10
4- 5 members	41	37	44	31	40	40	44	9	51
6- 7 members	31	26	33	27	31	34	28	30	30
8- 12 members	18	23	14	26	19	16	16	47	9
13 -17 members	2	7	-	2	4	2	2	11	**
18 + members	**	1	-	3	-	-	2	2	-
Average family size (No.)	6.2	7.0	5.7	7.1	6.4	5.9	9.2	5.3	6.2

(Refer Table CL2b)

(Note: ** denotes less than 0.5 percent)

The small family was more predominant in the urban areas as compared to the rural areas. A higher proportion of the urban respondents belonged to families having (4-5) members as compared to the rural respondents.

None of the urban respondents belonged to families having more than 12 members.

* --> SEC :- Socio-Economic Classification; explained in Appendix II. This abbreviation will be used in this report.

Households belonging to the upper SEC categories (1-4 and 5-6) had larger number of members as compared to the households from the lower SEC categories of 7 and 8. While 29% of the upper SEC category (1 - 4) belonged to households having 8-17 members, only 18% of the lowest category respondents (8) were in such households.

The average size of the joint family was more than one and a half times that of the nuclear family.

Very large sized families (18+ members) were found in the rural areas and amongst the upper SEC category (1-4) people.



5.1.3 Religion and caste

More than four fifths (86%) of the respondents were Hindus. The rest were Muslims, with 1% being Christians and Sikhs.

A greater proportion of the Hindu respondents (95%) lived in the rural areas as compared to 81% staying in the urban areas. More of the Muslim respondents stayed in the urban areas (18%) as compared to 5% in the rural areas.

More of the upper SEC category respondents were Hindus than Muslims. While 95% of the upper SEC category (1-4) respondents were Hindus, 78% of the lower category (8) people were Hindus. By contrast one fifth of the lower SEC category (1-4) respondents were so. These differences are indicative of the fact that the Hindu respondents belonged to families which were well-off in terms of income and education of the Chief Wage Earner, (*) as compared to the families from which the Muslim respondents hailed.

The study of the 30 villages covered in Delhi district has also shown that Hindus were in a majority in those villages with the average percentage Hindu population being 96%.

5.1.4 Education and literacy

The education and literacy levels of the respondents need to be understood so as to assess the awareness and perceptions of these people with regards to the different issues of water and sanitation and diarrhoea management.

Almost seven out every ten respondents (68%) had not been to school.

* Chief Wage Earner :- In this report, the abbreviated form shall be used.

Schooling of respondents

Base:all respondents (Weighted)	All Total	Rural	Urban	1-4	5-6	7	8	Literate	Illiterate	Hindu	Muslim
	782	303	479	55	238	194	295	284	498	674	108
	%	%	%	%	%	%	%	%	%	%	%
Yes, been to school	32	52	20	69	51	24	15	86	2	34	
No, not been to school	68	48	80	31	49	76	85	14	98	66	

(Refer Table CL5)

* 8 respondents belonged to the two religions of Christianity and Sikhism.



In the other districts covered for this study it was reported that on an average, 36% of the total respondents had been to school.

The incidence of having been to school was very high in our sample, amongst the upper SEC category respondents as compared to the lower SEC category respondents. With a decrease in the SEC category of the respondent, the proportion of those having been to school decreased.

It is also interesting to note that a higher proportion of Hindu respondents as compared to the Muslim respondents had been to school.

Those respondents who had been to school were asked to state the level upto which they had studied.

Base : All who studied in a school (weighted)	Level of schooling						
	All total	Rural	Urban	SEC			
				1-4	5-6	7	8
	252	157	95	38	122	46	46
	%	%	%	%	%	%	%
Less than 4 years	15	8	26	-	10	22	34
5-9 years	56	57	56	40	58	69	54
> 10 years (SSC/HSC)	25	31	14	43	30	9	12
Some college (including diploma but not graduate)	2	2	3	7	1	-	-
Graduate/Post graduate (General)	2	3	1	10	1	-	-

(Refer Table CL5b)

More than half of the respondents (56%) had attended school for between 5-9 years.

A higher proportion of the rural respondents had been educated upto SSC/HSC level, as compared to the urban respondents. By contrast, a greater proportion of the urban respondents had done schooling upto less than 4 years, as compared to their rural counterparts. These differences are statistically significant.

It is also to be noted that there is very little difference across the rural and urban respondents with respect to schooling at a higher level (i.e beyond SSC/HSC level).



The level of schooling attained by the respondents varied across their SEC categories. A higher proportion (43%) of the upper SEC category (1-4) respondents had reached the SSC/HSC level, while this proportion was as low as 12% for the lowest SEC category respondents. This difference is statistically significant. None of the lower SEC categories (7 and 8) respondents crossed the SSC/HSC level while 17% of the SEC category (1-4) respondents and 2% of the SEC category (5-6) respondents had attended college and studied upto graduation/post graduation level.

A higher proportion of the Hindu respondents (26%) as compared to the Muslim respondents (4%) had attained the SSC/HSC level and beyond.

For this study, a literate respondent is considered as one who can read any language and has been to school for four years or more.

In our sample of respondents, those who had not been to school or had attended school for less than 4 years were asked about their reading ability. Only 12% of such respondents indicated their ability to read any language.

Combining the above findings, we arrive at the literacy levels amongst our respondents, as per the definition of literacy for this study.

Literacy of respondents

Base : All respondents (Weighted)	All total	Rural	Urban	SEC			
				1-4	5-6	7	8
	782	303	479	55	238	194	295
	%	%	%	%	%	%	%
Literate	36	55	24	74	54	29	20
Illiterate	64	45	76	26	46	71	80

(Refer Table CL 5a-5c)

In Delhi district sample, the literacy percentage is higher for the rural respondents as compared to the urban respondents. This difference is statistically significant. However, it should be remembered that the urban areas of Delhi district were the slums in and around Delhi.

More of the upper SEC category respondents were literate when compared with their counterparts in the lower categories. With a decrease in the SEC category of the respondent, the proportion of respondents who were literate also decreased.

A greater proportion of the respondents who belonged to joint families (55%) were literate as compared to the proportion of respondents belonging to nuclear families.



5.1.5 Chief Wage Earner

As explained in Appendix II, the SEC category of a respondent is arrived at by considering the education and occupation of the Chief Wage Earner (hereinafter referred to as CWE) of the household to which the respondent belongs.

Thus the respondents in our sample were asked to specify the education and occupation of the CWE of the household. The CWE was defined as the person who made the biggest contribution to the family budget.

As regards occupation, there was a predominance of unskilled workers, skilled and petty traders in our sample of respondents.

Occupation of Chief Wage Earner in the family

Base : All respondents (weighted)	All total 782	Rural 303	Urban 479
	%	%	%
Unskilled worker (or farm labourer)	36	28	41
Skilled worker (or <5 acres owner farmers)	38	41	35
Petty traders (or 6-10 acre owner farmers)	13	9	16
Shop owners (or 20+ acre owner farmers)	3	5	3
Businessmen/Industrialists	2	3	1
Clerical/salesman	6	10	3
Professionals	2	4	1

(Refer Table CL-6)

The above pattern of occupational distribution of the CWE across the rural areas is indicative of the fact that the proximity of the villages to Delhi city has influenced the pattern of their commercial activities.

It should also be noted that a higher prevalence of shop owners, businessmen, salesman and professionals in the rural areas as compared to the urban areas, has to be looked at in light of the fact that the urban areas of Delhi district comprised slums only.

A perusal of the education of the CWE indicated the almost one-third of them were illiterate. 63% of the CWEs had done schooling till the SSC/HSC level. Very few of the CWEs (4%) had been to college for graduation/diploma and further.

The occupation and education of the CWE of the household was combined to arrive at the SEC category of the households and the respondent.

Socio-Economic Class of Respondents

Case : All respondents (Weighted)	All total	Rural	Urban	Literacy of mother		Religion	
				Literate	Illiterate	Hindu	Muslim and other
	782	303	479	284	498	674	108*
SEC	%	%	%	%	%	%	%
1	7	12	4	14	3	8	3
6	30	43	22	45	22	33	16
7	25	23	26	20	28	25	22
8	38	22	48	21	47	34	59

(Refer Table CL 6/6a)

* The 'others' included Christians and Sikhs

A higher proportion of the rural respondents as compared to the urban respondents belonged to upper SEC categories of (1-4) and (5-6). By comparison more of the urban respondents belonged to the lower SEC categories of 7 and 8, as compared to the rural respondents. These differences are statistically significant. The literacy level of the mother (respondent) was influenced by the SEC category to which she belonged. While a greater proportion of the literate mothers belonged to the higher SEC categories of (1-4) and (5-6), more of the illiterate mothers were from the lower SEC categories of 7 and 8.

Religion wise it was reported that a greater proportion of the Hindus as compared to the Muslims and others, belonged to the upper SEC categories of (1-4) and (5-6). By contrast, a greater proportion of the Muslims and others belonged to the lower SEC categories of 7 and 8. These differences are statistically significant.

5.1.6 Monthly household income

The respondents were asked to state the average monthly income of the household to which they belonged. This income included earnings from all sources.

Slightly more than half of the respondents (52%) belonged to households in the monthly income range of Rs 751 - Rs. 1500. Almost three out of every ten respondents (28%) were from households having their monthly income upto Rs. 750. The rest of the respondents were in the household monthly income range of above Rs. 1500.



The average monthly household income for the entire sample at Rs. 1423/ was higher than the average monthly household income for all the respondents across other districts covered for this study which was reported at Rs. 1150.

Average Monthly Household Income

Base : All respondents (Weighted)	All Total	Rural	Urban	SEC				Religion	
				1-4	5-6	7	8	Hindu	Muslim and Others
	782	303	479	55	238	194	295	674	108
	%	%	%	%	%	%	%	%	%
Upto Rs. 750	28	10	39	6	15	30	40	26	37
Rs. 751-Rs. 1500	51	49	52	34	52	55	50	51	54
Rs. 1501 +	21	41	9	60	33	15	10	23	9
Average Monthly Household Income (Rs.)	1423	2073	1015	2628	1695	1277	1076	1496	970

(Refer Table: CL-3)

The SEC category of the respondent had an association with the average monthly household income.

Average Monthly Household Income	SEC			
	1-4	5-6	7	8
	%	%	%	%
Upto Rs. 750	6	15	30	40
Rs. 751 - Rs. 1500	34	52	55	50
Rs. 1501+	60	33	15	10

A higher proportion of the upper SEC category (1-4) respondents belonged to families with average monthly household income of above Rs. 1500. By contrast only 10% of the lowest category 8 respondents belonged to households with this monthly income. This association leads to the fact that the SEC category of a respondent may be looked upon as a surrogate of the average monthly income of the household to which she belongs.

5 1 7 The interviewers who conducted the field survey noted down the type of construction of the dwelling of the respondent. 68% of the respondents lived in houses with brick walls. These houses had either tin/asbestos roof or had concrete/cemented ceiling. The rest of the houses had mud walls with either thatched roof or roof of shingle/tin/asbestos

A very high proportion of the rural respondents (91%) stayed in houses with brick walls as compared to 53% of the urban respondents who did so. More of the urban respondents stayed in mud walled houses as compared to the rural respondents.

Also, while 88% of the respondents belonging to the highest SEC category, (1-4) stayed in houses with brick walls, only 56% of the lowest SEC category 8 respondents lived in such houses. Thus it was reported that brick walled houses were more prevalent amongst the higher SEC category respondents as compared to the lower sec category respondents, the latter staying predominantly in mud/other non-permanent walled houses.

5.2 TIME AND FREQUENCY

As discussed earlier, a total of 782 children aged less than 5 years were identified who were suffering from diarrhoea at the time of the interview and/or in the preceding 24 hour period. Half of these children were males.

The age of the child suffering from diarrhoea was as follows :-

Age	Percentage of Children
0 - 6 months	12
6.1 - 12 months	23
12.1 - 24 months	29
24.1 - 36 months	19
36.1 - 48 months	11
48.1 - 60 months	6

The average age of these children was 21 months.

It was reported that for all these children, on an average, the diarrhoeal attack had commenced 5 days prior to the interview. For almost half of the children (47%) the attack had begun (4-14) days prior to the interview.

The respondents were asked to indicate the number of motions passed by the affected child in the 24 hours prior to the interview. The average number of motions was reported at 6 motions for the entire sample in Delhi district.

5.3 FORM AND COLOUR

Four fifths of the respondents (81%) also indicated that the stools passed by the child were watery/water-like, 17% reported it to be of a curdled form, while the rest reported it to be seed like/grain like.

As regards the colour of the stools, 65% reported it to be yellow and 36% reported the colour to be green.



5.4 CONDITION OF CHILD

The respondents in our sample were questioned on some aspects of the child's behaviour to look for changes, if any, which they might have observed. Their responses were noted on a list of predecided descriptions.

Base All respondents (Weighted)	Behaviour of child		
	All total	Rural	Urban
	782	303	479
	%	%	%
Child has been irritable	64	64	64
Child has been crying more than usual	72	66	75
Child is feeling lethargic	63	66	62
Child is feeling unusually sleepy	23	21	24
Child has been unusually silent	28	22	32

(Refer Table CDD - 3a)

The child was reported to be irritable in nature, crying more than usual, felt lethargic, unusually sleepy and was more silent than usual.

5.5 MOTHER'S PERCEPTION ON SERIOUSNESS

An all India diarrhoea study conducted by IMRB in 1985 reported that diarrhoea was considered a common, non-serious health problem, that occurred frequently enough to be deemed almost inevitable. At the same time, however, mothers recognised diarrhoea as having several forms ranging from the simple 'loose motion' to other manifestations some of which could be complex and some could be serious.

Our respondents were asked to indicate their opinion on the seriousness of the diarrhoeal attack of the children. Their responses were marked on a scale ranging from very serious to not serious. A weight was given for very serious, since it was considered to be a more forceful response than the next one. 'causes some concern' which received a weight of two and 'not serious/routine' was given a score of one. Using these scores, a mean score was computed.



Perceived seriousness of the diarrhoeal attack

Base : All respondents (Weighted)	Total	Rural	Urban	SEC			
				1-4	5-6	7	8
	782	303	479	55	238	194	295
	%	%	%	%	%	%	%
Very serious	42	51	36	47	48	43	35
Causes some concern	17	16	18	11	16	18	19
Not serious/routine	41	32	47	42	36	40	46
Mean score	2.4	2.7	2.2	2.5	2.6	2.4	2.2

(Refer Table CDD-2)

A higher proportion of the rural respondents looked upon the diarrhoeal attack as something very serious. By contrast, a greater proportion of the urban respondents treated the attack as something of a routine nature and not serious. These differences are statistically significant. A higher perception of seriousness amongst the rural respondents was also reflected in the difference of the mean score between the rural and urban respondents.

The concern for the diarrhoeal attack was more amongst the respondents from the higher SEC categories of (1-6) as compared to the lower SEC category respondents (7 and 8).

The religion of the respondent made some difference to the perception of seriousness of the attack. A higher proportion of the Hindu respondents (45%) as compared to the Muslims and others (22%) looked upon the attack as something very serious. The others included Christians and Sikhs.

We shall now try and examine the associations between perceived seriousness of diarrhoea by the respondents and the time of commencement of the diarrhoeal attack, the number of motions passed in the last 24 hours prior to the interview, and the form and colour of the stools passed by the affected child.



Seriousness of diarrhoea

Base All respondents (Weighted)	In the past		Past 1-3		4-14 days	
	24 hours		days			
	%		%		%	
Very serious	46		37		44	
Somewhat serious	10		16		19	
Not serious/routine	43		46		37	

The above cross analysis shows that as the time of commencement of the diarrhoeal attack increased in duration prior to the interview, more of the respondents looked upon the attack as something of concern and not to be ignored of.

The all India diarrhoea study conducted by IMRE in 1985 reported that the main symptoms of diarrhoea becoming a "problem" were increased frequency and loose consistency of stools. Similar results were obtained in our study in Delhi district.

Seriousness of diarrhoea

Motions passed in 24 hours

Base All respondents (Weighted)	1-6		7-10		11-15		16-20		21 +	
	times		times		times		times		times	
	%		%		%		%		%	
Very serious	37		48		58		74		100	
Somewhat serious	16		21		11		26		-	
Not serious/ routine	47		31		32		-		-	

As the number of stools passed by the affected child in the 24 hours prior to the interview increased a greater proportion of the respondents saw the diarrhoeal attack as something very serious; the attitude shifted from the attack as being of a routine nature to 'somewhat serious'. None of the respondents treated the attack as something not serious/routine once the child had passed more than 15 motions.



The form and colour of the stools also affected the perception of the respondents about the seriousness of the attack.

Form of stools -----	Percentage of respondents mentioned 'very serious' (n=782)
Milky	38
Watery/Water like	43
With mucus	79
 Colour of stools -----	
Yellow	42
Black	50
Blood	61



SECTION VI
ACCESSIBILITY TO WATER,
SANITATION AND HEALTH
FACILITIES





2.0 ACCESSIBILITY TO WATER, SANITATION AND HEALTH FACILITIES

A. WATER

1) Villages reporting safe drinking water sources

This survey aims at studying the household behaviour and practices related to collection, storage and use of drinking water and issues related to personal hygiene and sanitation

As part of the village profile, the Chief of the village panchayat or the revenue office, was asked to specify the main sources of drinking water in the village.

For 70% of the villages, the in-house tap was the main source of drinking water (there were 21 such villages). Of the rest 9 villages, 8 of them reported the use of the handpump as the main source and one medium village reported the existence of an open well for this purpose. Besides the main source, amongst the 'other' sources of drinking water, the handpump was the major one, with almost half of the villages (14 out of 30) reporting so. Four villages also had a community tap which was being used for drinking water. It should also be noted that 9 villages out of 30 reported that there were no other sources of water and the main source was the only one in the village for drinking water.

For all the villages that were covered across other districts for this study, 42% reported the usage of the handpump as the main source of drinking water and only 7% used the in-house tap as the main source. By contrast, the proportion of villages using the in-house tap is ten times as large, in Delhi district.

All the villages having tap within house, had more than 100 taps each in the village, with the average number of such taps being 99 per village. The average number of handpumps in the village was 72 per village.



Number of sources for drinking water
(Base : 30 villages)

Sources	Upto 30	31 - 60	61 - 100	More than 100	Average No. of sources
In house tap	-	-	-	24*	99.0
Outside house/ community tap	4	-	-	-	4.0
Handpumps	4	2	1	11**	72.0
Open wells	1	-	-	-	1.0

* and ** denotes for in-house tap and handpumps one and four respondents respectively could not specify.

Three-fifths of the villages (60%) reported the use of in-house taps as the main sources of water for general use. One-third of the villages (30%) used a handpump while one village each used a sanitary well and an open well.

As regards the other sources of water for general use in the village, half of the villages did not have any other source beside the main one for this purpose. One third of the villages (30%) used a handpump while one fifth (20%) used a tap (private and community).

All the villages in our sample from Delhi district, with in-house taps being the source of water for general use, had more than 100 taps per village.

2) Average population covered per safe source

Of the 30 villages covered in Delhi district, 18 were using the tap and the handpump as the sources of drinking water. The average village population being covered per safe source was reported at 5347 people.

3) Per capita availability of safe drinking water and by purpose

86% of the respondents in our sample stored drinking water in the house.

In order to estimate the quantity of water used by the respondents for performing different activities, the container capacity used by them was noted down. This was done for all those respondents who performed the activities

inside the house by collecting water from outside and storing it and those who stored drinking water in the house.

The average capacity of the container in litres was reported at 12.4 litres for all the respondents, 13.4 litres for the rural respondents and 11.8 litres for the urban respondents. It was also reported that on an average 15 such containers were collected by the respondents in a day for drinking and other purposes. This average was as high as 21 containers for the joint families and as low as 13 containers for the nuclear families. Thus the total quantity of water collected on the average worked out to 184 litres. This average was higher for the rural households (241 litres) compared to the urban households (154 litres) and also more for the joint families (279 litres) as compared to the nuclear families (156 litres). In other districts covered for this study, the total quantity of water collected on the average was reported to be 162 litres.

There were some respondents who had indicated that they either did not store drinking water in the house or they performed the different activities inside the house (from private water source) or they did so outside the house without water being collected. These respondents were asked to state the number of containers of water that they would need if they had to store water and perform the different activities. The responses are given below :

Average number of containers had to store for different activities :

	Average number of containers
Drinking water	3
Cooking	2
Eating	9
Washing vessels	3
Washing clothes	8
Washing cattle	14
Drinking cattle	12



The water requirement per capita for our sample in Delhi district is shown below :

	Delhi district
Average quantity of water collected (for water stored activities)	184 litres
Average quantity of water had to collect (if water had to store)	300 litres
Therefore total quantity of water (average)	484 litres
Average household size	6
Quantity of water required per capita per day (LPCD) in Delhi district	81 litres

The per capita per day requirement is quite high for Delhi district as compared to the figures across other districts.

The rural-urban variations in the per capita requirement of water are also interesting to note :

	Rural	Urban
Average quantity of water collected (for water stored activities)	241 litres	154 litres
Average quantity of water had to collect (if water had to store)	378 litres	201 litres
Average household size	7	6
LPCD	88 litres	61 litres

4) Frequency of collection and time taken

All the respondents were asked to state the distance travelled by them to obtain drinking water and the time taken to walk upto the source (one way). Almost all the respondents (93%) travelled less than half a kilometre to collect drinking water. 5% of the respondents travelled between a half and one kilometre while the rest (2%) walked between 1.1 - 3 Kms. for this purpose.

The average distance travelled to get drinking water for all the respondents worked out to 0.3 Kms

For nine tenths of the respondents in our sample (89%), it took them less than 5 minutes to walk upto the source of drinking water.

The same results were obtained with regards to access to safe drinking water sources; this is because there were virtually no open sources in the areas.

Almost seven out of every ten respondents (68%) collected drinking water between 1-3 times a day. For almost a quarter of the respondents (24%) nothing was fixed as to the frequency of collection of drinking water, and they collected any number of times a day. The rest of the respondents collected between 4-6 times a day. A higher proportion of the upper SEC category respondents as compared to the lower SEC category respondents collected drinking water 1-3 times a day.

The frequency of collection in a day was also more for the joint families as compared the nuclear families. A higher proportion of the Hindu respondents as compared to the respondents of the other religions, collected drinking water 1-3 times a day.

Frequency of collecting drinking water

Base : All respondents (Weighted)	All total	Rural	Urban
	782	303	479
	%	%	%
Nothing fixed, any number of times	23	20	25
1 - 3 times	68	72	65
4 - 6 times	7	5	8
7 times or more	2	2	2
DK/CS	-	1	-

(Refer Table Watsan 3)

In the village observation sheet, the Chief of the village panchayat or the Revenue office, was asked to spell out some information on maintenance of water sources.

None of the villages had a source for information on maintenance of water sources.



The Water Works Department repaired handpumps when they broke down in the villages. The maintenance of the handpump in the villages was done by the Water Supply Department. These was only one village where the breakdown of the handpump in the village was reported to the Water Works Departments, this job of reporting was done by the Chief of the village. On an average, 3 days were taken for repairing a handpump when it broke down. At the time of the survey, however it was reported that across all the villages, on an average, 18 handpumps were out of order.

B. SANITATION

1) Habitation reporting latrine

In order to assess the existence and usage of sanitary facilities amongst our sample respondents, specific questions were asked on these issues both in the village observation sheet and in the main questionnaire.

The data pertaining to existence of latrines in the villages is exhibited below :

Existence of private/community latrines in the village				
Base : All villages	All total 30 Number of villages	Small 2 Number of villages	Medium 9 Number of villages	Large 19 Number of villages
Private latrines present	28	2	8	18
Community latrines present	3	-	1	2

(Refer Table VOS 12a)

All the villages had either one or the other type of latrine present. Almost all the medium and large villages had private latrines. None of the small villages had community latrines, but both had private latrines.

The number of private latrines existing also varied across the villages as shown below :

Number of private latrines in the village				
	All total	Small	Medium	Large
Base : All villages	28	2	8	18
	Number of villages	Number of villages	Number of villages	Number of villages
Upto 20	4	-	1	3
21 - 30	1	-	-	1
31 - 50	5	-	3	2
50+	18	2	4	12
Average number of private latrines	76	98	70	74

(Refer Table VOS 12b-1)

Both the small villages had more than 50 private latrines and the highest average number of latrines.

2) Places of open defecation

Of the total 782 respondents in our sample, there were 693 respondents who belonged to households where there was at least one member not using the latrine for defecation. These respondents were asked to indicate the places used by such members for defecation. The responses obtained age and sex wise, have been summarised in the following table.



Places of defecation (open air)

Base : All households where at least one member not using latrine (weighted)	All total 693 %	Rural 258 %	Urban 435 %
<hr/>			
<u>Less than 5 years male</u>			
Just near the house	26	25	26
Near house on/at the drain	13	14	12
Near house, outside compound	10	9	11
<u>Less than 5 years female</u>			
Just near the house	22	26	19
Near house on/at the drain	13	13	13
Near house, outside compound	11	9	12
<u>6-14 years, male</u>			
At a place away from house, in the village	23	27	21
<u>6-14 years, female</u>			
At a place away from house, in the village	22	27	19
<u>15+ years, male</u>			
At a place away from the house, in the village	48	63	38
At a place away from the house, away from the village	19	20	18
<u>15+ years, female</u>			
At a place away from the house in the village	47	64	37
At a place away from the house away from the village	17	19	15

(Refer Table Watsan 8)

The following points emerge from the above table :

- a) In the less than five years age group, both for males and females, the majority of them defecated just near the house and near the house on/at the drain and outside the compound of the house

- b) In the 6-14 years age group, both for males and females, almost a quarter of them defecated at a place away from the house but in the village. However in this group, no answers were obtained for both the males and females, in the majority of the cases.
- c) In the 15 years and above category, both for males and females, almost half of them defecated at a place away from the house but in the village. Almost a fifth of such males and females defecated at a place away from the house away from the village.

Those respondents who mentioned that there was at least one member in the household who went for open air defecation, were asked to specify the distance of the spot from some predecided locations and the time taken to walk to that spot (one way). The predecided locations were any residential area, a playground and water source.

- a) From any persons home/place of human inhabitation :-

51% of the total respondents stated that the spot of defecation was within 400 metres. 38% mentioned that this spot was beyond 400 metres. However 11% could not specify the distance.

The average distance of the spot of defecation from a place of human inhabitation was 345 metres.

- b) From nearest playground :-

Half of the total respondents, mentioned that the spot of defecation was within 400 metres. For a quarter of the respondents, this spot of defecation was beyond 400 metres while the rest could not specify.

The average distance of the spot of defecation from the nearest playground was reported at 272 metres.

- c) From any drinking water source :-

51% of the respondents indicated that this spot was within 400 metres. 27% said the location to be beyond 400 metres while the rest 22% could not specify.

The average distance of the spot of defecation from any drinking water source was 267 metres.

The average time taken (in minutes) to walk (one way) to the spot of defecation from the predecided location was as follows :-

Average time taken (in minutes)

	All total	Rural	Urban
Base : All for whom any household member goes for open air defecation (Weighted)	700	639	61
From any person's place/human inhabitation	8	10	7
From nearest playground	7	9	6
From any drinking water source	7	8	7

3) Households having latrine and type :-

It is interesting to note that there is a low prevalence of latrines in the households contacted in Delhi district.

Presence of latrine in household

Base: all respondents (Weighted)	SEC		LITERACY		RELIGION							
	All	Total	Rural	Urban	1-4	5-6	7	8	Lite-rate	Illiterate	Hindu	Muslim
782	303	479	55	238	194	295	284	498	674	108		
	%	%	%	%	%	%	%	%	%	%	%	%
Yes	17	26	11	48	20	12	11	27	11	14	31	
No	83	74	89	52	80	88	89	73	89	86	67	

(Refer WATSAN Table: 7a)

The prevalence of latrines was higher amongst the rural households as compared to the urban households. With a decrease in the SEC category of the respondent, the presence of latrine, in the households also decreased. The prevalence of latrines was more in the non-Hindu households as compared to the Hindu households.

The alternative to private latrine in the household was the community latrine. The facility of a mobile latrine was not available to any of the respondents. The large extent of absence of private latrine across the urban households was compensated by the high accessibility of community latrines amongst such households. While half of the urban households without a private latrine had a community latrine accessible to them, only 6% of the rural households had such an accessibility.

Thus, combining the presence of private latrine in the household and accessibility to community latrine, we arrive at the proportions of the different classification variables who enjoyed the facility of a latrine.

Latrine in the household/accessibility to community latrine

Respondent type	Base : Total no. of such respondents in our sample	Proportion having access to latrine (private/community) (%)
All total	782	46
Rural	303	31
Urban	479	55
SEC		
1-4	55	55
5-6	238	45
7	194	45
8	295	46
Literacy		
Literate	284	50
Illiterate	498	43
Religion		
Hindu	674	42
Muslim and others	108	70



Different types of latrine were reported to be present in the households which had such a facility. The service latrine and the flush system were the more common ones. (37% and 34% respectively). About a quarter (22%) used the septic tank type while the pit type (in this case single pit) was hardly used (4%).

However there were some differences across the classification variables with regard to the type of latrine being used. The usage of the service type was more amongst the urban households as compared to the rural households.

In our sample it was found that there was a concentration of lower SEC category (7 and 8) respondents in the urban areas; consequently the usage of the service type of latrine was reported to be more amongst these type of SEC category respondents. The usage of the flush system and septic tank was concentrated amongst the upper SEC category respondents (1-4 and 5-6). The usage of the service type was also more amongst the non-Hindu respondents as compared to Hindu respondents. The latter type of respondents were using the flush system and the septic tank to a larger extent.

C. HEALTH

1) Diarrhoea treatment unit

In the village observation sheet, the respondents were asked to state the persons/institute to whom they referred for information on case management of diarrhoea.

Only 2 of the 30 villages, one medium and one large village, had such a source for information on case management of diarrhoea. The rest 28 villages did not have any such source.

For the large village, this source was the health worker, while for the medium village it was the hospital staff.

The respondent from the large village felt that as the health worker visited regularly, he was being referred to for information on case management of diarrhoea.

However, in the medium village, no reason was specified by the respondent for referring to the hospital staff.

2) ORT corners

In order to assess the existence of ORT facility in the project area and the availability of ORS, the health functionaries in our sample were asked specific questions on these issues.

Only 7 of the 38 respondents indicated the presence of an ORT corner in their respective centres. Five such respondents were from the rural areas and the remaining two were from the urban areas. All seven respondents stated that the ORT corner was permanent in nature.

Total number of rural centres : 28
 Total number of urban centres : 3
 Total 31

	Having ORT corners	Permanent corner	Presently operational
Total no. of centres	7	7	1
Rural centres	5	5	-
Urban centres	2	2	1

(Refer HS Tables, 4a, 4b, 4c)

3) Availability of ORS by source

It was felt essential to establish the existing sources of availability of ORS, which could be used as potential sources for distribution of ORS.

In Delhi district, more than two fifths (43%) of the villages had a shop/centre from where ORS could be obtained.

Source of obtaining ORS

Base : Villages having sources for ORS	Village population			
	All total	Small	Medium	Large
	13	2	3	8
	%	%	%	%
PHC/Dispensary/Hospital	69	100	67	63
Sub centre	8	-	-	13
Anganwadi centre	23	50	-	25
Chemist/Private	31	50	33	25

(Refer VOS Table 13a)



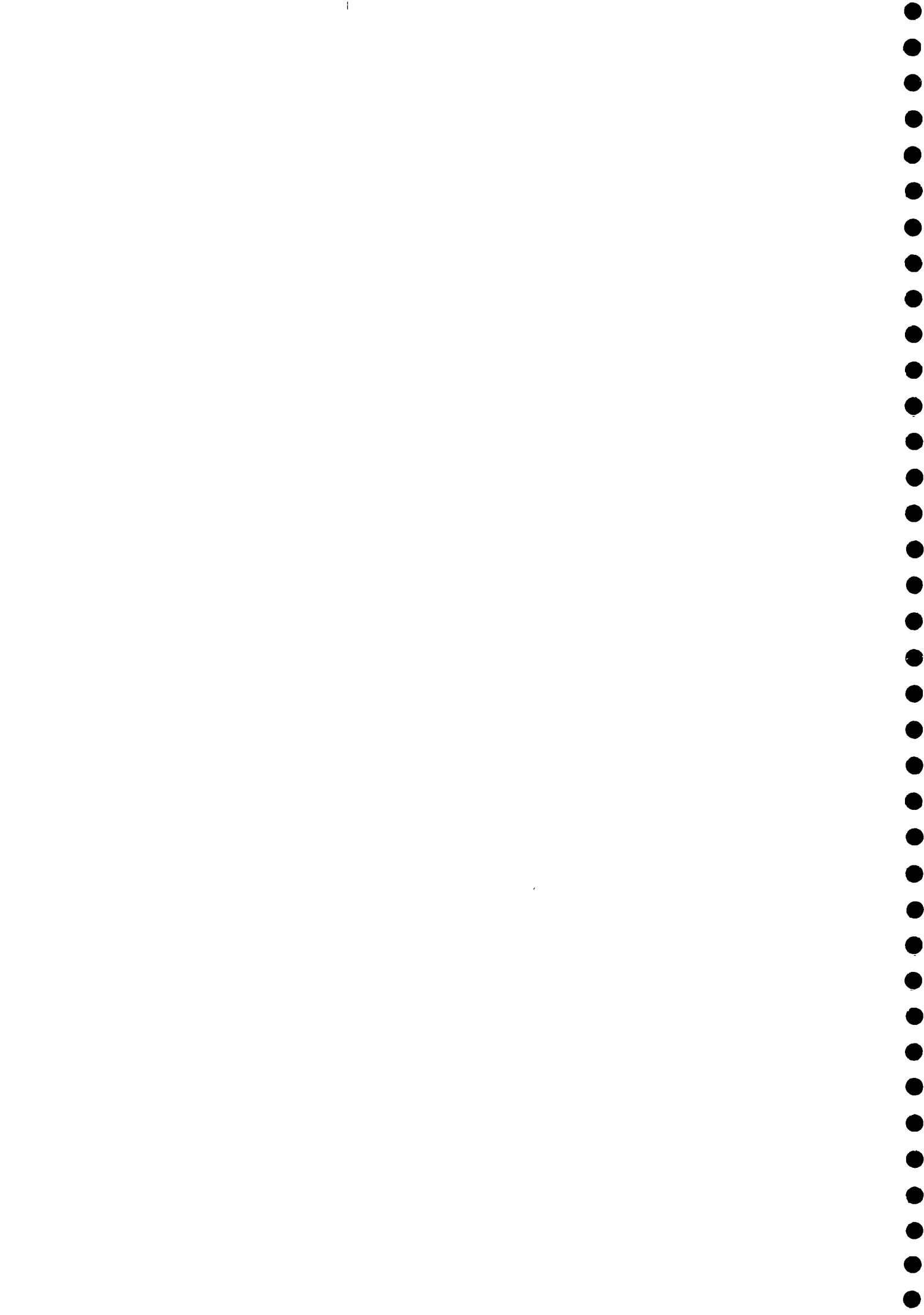
Almost 7 out of every 10 villages had a PHC or dispensary or hospital from where ORS could be procured. None of the small and medium villages had any subcentre from where ORS could be procured. The prevalence of private chemist as a source of ORS was lower in the medium and large villages as compared to the small villages.

The storage and availability of ORS packets at the centres at the time of the survey was quite high, with almost four fifths of the respondents indicating so (79%). On an average it was found that around 514 packets of ORS were stored by the centres at the time of the survey. The medical college hospitals and the sub centre had more ORS packets in their stock compared to the other centres.



SECTION VII
DIARRHOEAL PREVENTION
PRACTICES





7.0 INTRODUCTION

Among the various causes of diarrhoeal diseases, a large number can be traced back to poor sanitation and unsafe drinking water.

This study aimed at assessing the sources and usage of drinking water by the respondent mothers or caregivers. Several questions were administered to elicit information on water related practices.

USE OF SAFE WATER

7.0.1 Households reporting use of safe water by purpose

The respondents were asked to specify the main source of drinking water for their household. For the household survey, the water sources were divided into two categories - private sources and community sources. The former comprised tap, handpump and sanitary well while the latter consisted of tap, handpump, sanitary well and open sources. The open sources included open wells, rivers, streams, canals, lakes and ponds.

Main source of drinking water

Base : All respondents (weighted)	All total	Rural	Urban	1-4	SEC			8
					5-6	7		
	782	303	479	55	238	194	295	
	%	%	%	%	%	%	%	%
<u>Private</u>								
Tap	29	55	12	68	38	27	15	
Handpump	8	19	2	10	13	6		
Sanitary well	*	*	-	-	*	-		
<u>Community</u>								
Tap	42	18	59	17	28	46	58	
Handpump	21	14	28	11	23	22	28	
Sanitary well	*	*	-	-	*	*		
Open sources	*	1	*	1	-	-		

* less than 0.5 percent

(Refer Watsan Table 1)

Across the households, the usage of the tap was reported to be high.

The usage of the private tap and handpump was higher amongst the rural respondents as compared to the urban respondents. The households in the urban areas (in case of Delhi, the slums) were using the community sources to a larger extent. It was also seen that with a decrease in the SEC category of the respondent, the usage of the private tap decreased while that of the community taps increased.

A higher proportion of the literate mothers (44%) as compared to the illiterate mothers (19%) used private sources. It has been noted that the usage of the tap is very high in Delhi district as compared to the rest of the districts covered for this study. Further rural Delhi enjoys a better situation regarding water sources as compared to urban Delhi. Finally the usage of open sources is almost negligible in Delhi district while it is quite high across other districts in this study.

7.0.2 Collection, storage and handling practices

The respondents across the households were asked to mention the sources of water that they used for performing different water-related activities. Responses by different activities are discussed below :

Cooking

Private taps (29%) and the community taps (43%) were the major sources of water for this activity.

A higher proportion of the rural households as compared to the urban households used the private sources for cooking (tap and handpump); a greater proportion of the latter used community sources.

The usage of the private sources decreased with a decline in the SEC category of the household, while the usage of the community sources increased. Literate mothers preferred to use the private sources for water for cooking as compared to the illiterate mothers (statistically significant difference), while the latter used the community sources to a larger extent (difference being statistically significant).

Bathing

Most of the respondents used the private (30%) and community (36%) taps for water for bathing. The usage of private sources for bathing water was more amongst the rural households as compared to the urban households (difference statistically significant).

As seen earlier use of private water sources was directly related with better SEC status. A greater proportion of the literate mothers used private sources, as compared to the illiterate mothers, a higher proportion of whom used the community sources.

Other activities : (Washing vessels and clothes, washing cattle and drinking water for cattle)

For washing of vessels and clothes, the private and community taps were used to a larger extent than the handpumps. The usage of the private water sources was more prevalent amongst the rural households, as compared to the urban households; more of the latter used the community sources. With declining SEC category of the household, the usage of private sources decreased. Also, a greater proportion of the literate mothers as compared to the illiterate mothers, used the private sources; more of the latter category used the community sources.

Four fifths of the respondents were unable to mention the sources used by them for washing cattle and for drinking water for cattle probably since they might not have had cattle. The rest generally used the private tap and handpump, as well as the community handpump and lake/pond.

Activities such as cooking, bathing, washing vessels and washing clothes, were mostly performed inside the house, either by using the private water source or by collecting water from outside and storing it. However, there were a tenth of the respondents who performed bathing and washing clothes outside the house without water being collected. It was also noted that the performance of the activities outside house without water being collected was more prevalent amongst the lower SEC households than the upper SEC households.

Those respondents who stored drinking water in the house, were asked to specify the position in which they stored the water container. There was an equal practice of storage of drinking water on the floor and on the platform.

Position of stored water

Base : All respondents (weighted)	All total	Rural	Urban	SEC			Literacy		
				1-4	5-6	7	8	Literate	Illiterate
	669	249	420	47	200	164	258	235	434
	%	%	%	%	%	%	%	%	%
On the floor	50	33	61	27	43	54	58	36	58
On a platform	50	67	39	73	57	46	42	64	42

(Refer Watsan Table 4b)

The incidence of storage on the floor was very high amongst the urban households, as compared to the rural households. More of the latter category respondents adopted the hygienic practice of storing on a platform. (Difference statistically significant). This can be understood well when we remember that urban households in this case were slums, usually comprising make shift constructions.

The proportion of SEC category 8 respondents using the floor was more as compared to the proportion of SEC category (1-4) respondents doing so. With a decrease in the SEC category of the respondent, more of them used the floor while the usage of the platform decreased. This could partly be explained by the fact that most of the urban households belonged to the lower SEC categories of 7 and 8 as discussed earlier in 'Respondent Profile'. The literacy level of the mothers also made a difference across the practice adopted for storage as indicated in the table.

It is also interesting to note that a higher proportion of the Hindu respondents, as compared to the respondents belonging to the other religions, stored water on a platform; the latter preferred to use the floor for this purpose as compared to the former. These differences are statistically significant. However, these are in contradiction to findings from other districts where in fact, the Muslim households reported more correct practices.

Those respondents who stored drinking water were asked about the practice of covering the vessel.

Almost all the respondents (95%) kept the vessel in which drinking water was stored, covered. The others left the vessel open. This practice of not covering the vessel was prevalent amongst the lower SEC category mothers, the illiterate mothers and the non-Hindu mothers.

The acceptance and adoption of safe water protection measures amongst the respondents was also evident from the fact that three quarters of those who stored drinking water used a narrow mouthed vessel (narrow being defined as less than or equal to the size of a saucer). The rest of them used a broad mouthed vessel. There are differences in the proportion of higher SEC (83%) and lower SEC (73%) categories respondents using the narrow mouthed vessel; however these differences are not statistically significant.

The method of taking out water from the container at the time of drinking differed across the classification variables.

How water taken out at time of drinking

	All Total	Rural	Urban	SEC				LITERACY	
				1-4	5-6	7	8	Lite- rate	Illi- terate
Base: all respondents who store drinking water (weighted)	669 %	249 %	420 %	47 %	200 %	164 %	258 %	235 %	434 %
A separate ladle used	10	7	13	12	13	9	9	12	10
A separate glass/ cup kept for this	32	34	30	23	33	34	31	34	31
Vessel tipped over and used	11	6	14	12	10	10	13	9	12
Any glass/cup dipped	47	53	43	54	44	48	47	44	48
Tap in pot/ vessel	1	1	1	-	2	1	2	1	1

(Refer WATSAN Table - 4e)

The predominant method being followed was that of dipping a glass or cup into the storage vessel.

As regards the use of specific vessels, a higher proportion of the urban respondents (43%) as compared to the rural respondents (41%) adopted this practice. Also the method of tipping over the vessel and using it was more prevalent amongst the urban respondents. Within our sample of respondents a higher proportion (47%) used any glass/cup rather than using a separate one for taking out drinking water (31%). This difference is statistically significant.



7.0.3 Water purification

The incidence of filtration and purification was very low in Delhi district.

Filtration of drinking water

Base: All respondents (weighted)	SEC						
	All Total	Rural	Urban	1-4	5-6	7	8
	782	303	479	55	238	194	295
	%	%	%	%	%	%	%
Something done to clean it	4	3	4	8	6	4	1
Used as is	96	97	96	92	94	96	99

(Refer Table WATSAN 5a)

Very few respondents did something to clean the water.

A higher proportion of the upper SEC category respondents (8%) did something to clean the water as compared to the lower SEC category respondents (1%).

The most common water purification method adopted was the use of a cloth filter (70%); 23% boiled the water while the rest used purification tablets or other filters. The usage of the cloth filter was higher amongst the urban households, the lower SEC category households and the illiterate respondents; the upper SEC category respondents and the literate respondents preferred to boil the water instead.

The respondents adoption of the practice of cleaning the drinking water may be linked to the main source of obtaining the water. A low proportion (4%) of those who used the tap and handpump as the major source of drinking water did something to clean the water; the rest used it as it was. By contrast, people using the sanitary well cleaned the water.

Cross analysis between the different water storage and purification methods, reveal the following points :

- Irrespective of whether water was stored on the floor or on the platform, very few respondents (around 4%) cleaned the water.
- All those respondents who did not cover the vessel in which drinking water was stored also used the water without cleaning it.

7.1 SANITARY PRACTICES

7.1.1 Household members reporting use of sanitary latrines .

For those households having a latrine or having accessibility to a community or mobile latrine, it was decided to find out the people who normally used the facility.

Household members normally using latrine

Base: all respondents (weighted)	SEC							
	All Total	Rural	Urban	1-4	5-6	7	8	
	359	93	266	30	106	86	137	
	%	%	%	%	%	%	%	%
All	25	49	16	37	31	23	19	
Only adults (male)	57	30	66	50	51	59	62	
Only adults (female)	63	33	74	55	56	64	71	
Only old/sick	6	7	5	13	7	5	3	
Only boys	30	13	36	36	27	32	29	
Only girls	28	12	34	26	25	37	25	
None	10	13	9	8	11	12	10	

(Refer Table Watsan 7d)

Slightly less than half of all the households (46%) had the facility of a latrine (either private or community). However in only a quarter of such households, all the household members used the latrine. Amongst the rural households enjoying the facility of a latrine, half of them had all the household members using the facility. This proportion was low for the urban households, at 16%.

Across the SEC categories of the respondents, there were some variations in the type of household where all/some members were using the latrine. The households where all the members were using the latrine were mostly in the upper SEC categories; by contrast, those households where only adults (both male and female) were using the latrine were in the lower SEC categories. Also, it was more of the lower SEC category households as compared to the upper SEC households where none of the members used the latrine.

There was a higher proportion of the Hindu households where all used the latrine (28%) as compared to the households which were non-Hindus (10%).



Those households where there were at least some members using the latrine were asked to mention the sex and age of the persons who used the facility.

It was reported that 81% of all the households using the latrine did not have a male, under five child, using the facility.

72% of all households having access to a latrine did not have any male between 6-14 years of age using it.

The percentage of usage of the latrine by males was high in the age group of 15 years and above (90%).

In the case of females, the non-usage percentage was the highest in the less than 5 years age category (82%).

In the 15 years and above category the usage percentage was higher for the females (95%) as compared to the males (90%).

7.1.2 Reasons for use and non-use of latrine

Most of the respondents, in whose households at least one person used the toilet for defecation, were unable to specify any particular reason for the usage of the toilet for this purpose. They felt that the facility was available and hence it was being used (82%). Around 8% felt that using a toilet was more hygienic than open air defecation. However, this opinion was more prevalent amongst the rural respondents than the urban respondents. In fact a higher proportion of the urban respondents as compared to the rural respondents stated the reason for usage as availability of facility. This difference is statistically significant.

It is also interesting to note that the concept of a latrine being more hygienic, was more prevalent amongst the non-Hindu respondents as compared to the Hindu respondents (difference being statistically significant).

Amongst the other usage were use of a toilet in conformity with status (1%), 'educated people prefer to use this method' (2%), and 'no place available outside' (2%).

Thus from the above, one can say that the use of a toilet was looked at more in terms of accessibility and convenience rather than from the viewpoint of a hygienic practice. A similar pattern was also observed in other districts covered for this study, with three quarters of the total respondents subscribing to this view.

In three quarters (75%) of the households where a private latrine was present or a community latrine was accessible there were at least one member each, who did not use this facility. It is also interesting to note that in 14% of such households, none of the members used the latrine inspite of its availability.

As regards reasons for not using a latrine, convenience emerged to be the major factor, with more than three fifths of the respondents finding the usage of a latrine inconvenient. Since this does not stand up to logical scrutiny and since common sense would dictate that latrine must be more convenient than outdoor defecation in crowded area such as Delhi, we would add that "inconvenience" was only a stated response that should not be taken at face value. It probably hides a range of difficulties and problems that would need more in depth research to resolve.

Reasons for not using latrine

Base : All respondents (Weighted)	All total	Rural	Urban	1-4	SEC 5-6	7	8
	271	47	224	19	74	67	111
	%	%	%	%	%	%	%
Not convenient	62	39	67	57	63	53	68
Open air is much better	9	28	5	12	14	8	6
Latrine is in bad condition	14	13	14	8	12	21	12
Toilet broken (walls/door)	4	2	5	4	2	7	4
Child is too small to use toilet	38	10	43	43	36	41	34

(Refer Table WATSAN 7g)

The inconvenience factor was reported more by the urban households as compared to the rural households (difference statistically significant). It has been indicated earlier that the prevalence of community latrines were more in the urban areas. Thus a lack of privacy, distance, untidiness and other factors could be the reasons behind the urban households reluctance to use the latrine.

Two fifths of the respondents felt that the child was too small to use the toilet. This feeling was higher amongst the urban respondents than amongst the rural respondents.

The usage of a latrine by members of the household, was to some extent dependent on the presence of a latrine in the household itself.

	People normally using latrine	
	Presence of a latrine in the household	
	Yes	No
	%	%
All members	42	15
Only adults (male)	40	67
Only adults (female)	50	71
Only old/sick	5	6
Only boys	27	31
Only girls	22	31

Across all those households where a latrine was present, despite the existence of the latrine not all members used it. The usage of latrines by adult males and females in households where a latrine was not present, was higher than in those households where latrines were present.

7.1.3 Disposal of child's excreta

All the respondents were asked to state the spot of disposal of faeces of the under five children. Responses received were as follows :

	Spot of disposal of faeces		
	All total	Rural	Urban
Base : All respondents (weighted)	782	303	479
	%	%	%
Near house, outside compound	49	41	53
Near house, on/at the drain	27	27	27
Near the house, outside the wall	10	11	9
At a place away from the village	13	17	10
In the latrine	4	5	2

(Refer WATSAN Table 9)

Faeces were mostly being disposed off near the house. However, such disposal was primarily being done outside the compound or at the drain. The usage of the latrine for disposal was very low



The practice of disposing the faeces near the house was prevalent amongst the lower SEC category 8, households. (88% of them did so) as compared to 76% of the upper SEC category (1-4) respondents. More of the upper SEC category respondents (1-4) preferred the usage of a latrine for this purpose (14% against 3% of the lower category 8 respondents).

The method of disposal of faeces. varied across the respondents. A set of questions pertaining to the method being adopted was administered to the respondents (n=772).

- (a) Do you leave around the faeces for a while before attending to them ?

88% of the respondents answered in the negative to this query. The rest of the respondents agreed to following this practice.

The habit of leaving the faeces around for a while before attending to them was more prevalent amongst the rural respondents (16%), and the upper SEC category respondents (14%) as compared to the urban respondents (19%) and lower SEC (12%) category respondents.

- (b) Do you wrap these faeces in some form before disposing them ?

57% of the respondents adopted this method. A higher proportion of the rural respondents (66%) as compared to the urban respondents (51%) adhered to this practices

- (c) Do you ever dig a hole and put the faeces inside ?

There was a virtual absence of this practice, with 99% of the respondents answering in the negative.

A cross analysis of the manner in which the faeces were disposed off and the spot of disposal, reveals that, when the spot of disposal, was away from the house, a higher proportion wrapped the faeces in some form.

Spot of disposal

	Near the house %	Away from the house %
Faeces left around for a while before attending	9	8
Wrapped in some form	53	77



7.1.4 Defecation practices of children below 5 years

All the respondents were asked to state whether the under five children went for defecation alone. 70% of the respondents indicated that the child was accompanied by someone on the way to defecate. The rest of the respondents mentioned that the child went alone.

Base : All respondents (weighted)	Infant accompanied during defecation				Sex of child	
	All total	Rural	Urban	Male	Female	
	782	303	479	392	390	
Go alone	30	30	29	30	29	
Accompanied by somebody	70	69	71	79	71	

(Refer Table Watsan 10)

A cross analysis of the spot of defecation for under five children and their being accompanied by someone indicates, that a higher proportion of the children who defecated at a place away from the house (both within and outside the village) were accompanied by someone.

7.1.5 Use of footwear by family members

The usage of footwear by the members of the households who went out for defecation, was significantly high. 98% of the respondents stated that this practice was being adopted by the household members either always or at times; the rest of the respondents stated that the household members went barefoot for defecation.

Base : All respondents (weighted)	Footwear used during defecation							
	All total	Rural	Urban	SEC				
	782	303	479	1-4	5-6	7	8	
				55	238	194	295	
	%	%	%	%	%	%	%	
Goes barefoot	1	4	1	3	2	1	2	
Goes wearing footwear	92	88	94	86	94	92	90	
Nothing fixed, varies from time to time	2	2	2	6	1	3	2	
Varies from person to person	4	6	4	6	3	4	6	

(Refer Table Watsan 11a)

All the respondents who stated that the footwear usage varied across persons were asked to state the sex and age of the members who used footwear

The footwear usage, broadly by age and sex, was as follows.

- a) the usage of footwear by under five children was more for female children than male children (25% of the households reporting for female children as against 17% of the households reporting for male children).
- b) in the 6-14 years age category, 39% of the households reported having female members of this age group using footwear; by contrast 28% of the households indicated the presence of such male members who used footwear.
- c) in the 15 years and above age group, the usage was high; 94% each of the households reported having male and female members who used footwear.

7.1.6 Handwashing practices

All the respondents were asked to recall the different activities where they might have washed their hands, in the last 24 hours, preceding the interview. The responses, mentioned spontaneously were first noted down followed by the responses which were prompted to them from a list of activities.

They were then asked to specify what they had used for washing their hands, if at all they washed, either before or after performing the activities. The results have been analysed below activity wise :



Activities for which hands washed

Base respondents (weighted)	All total		Rural		Urban	
	Spontaneous mention %	Total mention %	Spontaneous mention %	Total mention %	Spontaneous mention %	Total mention %
Before eating food	41	99	49	97	36	99
Before serving food	16	93	16	86	17	97
Before feeding child	4	70	5	59	4	77
Before cooking	44	96	43	92	44	99
After using latrine defecation	44	100	50	100	40	100
After cleaning child's stool	30	99	35	98	27	100
After disposing child's stools	20	98	25	97	16	99

(Refer Table watsan 14a & b)

- a) Before eating food : The differences in the spontaneous mentions across the rural and urban respondents are statistically significant. Across all the classification variables, more than 95% of the respondents recalled having washed their hands (both spontaneous and prompted) before eating food.

Three fourths of the respondents who washed their hands before eating food used water only while the rest used soap also.

- b) Before serving food . The top of the recall was low for this activity.

78% of the respondents used only water while the rest used soap for washing their hands before serving food



- c) Before feeding child :- It is significant to note that the top of the mind recall for washing hands for this activity was the lowest amongst all the activities.

80% of the respondents used only water for washing hands before feeding the child while the rest used soap.

- d) Before cooking :- The total mention was quite high (98%) though only 44% recalled spontaneously having washed their hands before cooking.

73% of such respondents used only water for washing hands while the rest used soap.

- e) After using latrine/defecation

All the respondents recalled having washed their hands after using the latrine/defecation. However, the top of the mind recall was low in this case (44%). The top of the mind recall was higher (50%) for the rural respondents as compared to the urban respondents (40%).

78% of the respondents who washed hands after using latrine/defecation, used soap, while 15% used ash/mud. The rest used only water.

- f) After cleaning child's stools :- Less than a third of the respondents recalled spontaneously having had washed their hands after performing this activity.

77% of such respondents used soap while 15% used ash/mud. The rest used only water.

- g) After disposing child's stools :- The top of the mind recall for having had washed hands after disposing the child's stools was only for one fifth of the respondents.

Soap was used by 78% of such respondents for washing hands after the activity; 14% used ash/mud while the rest used only water.

Amongst other activities, 8% recalled spontaneously having had washed their hands after cleaning utensils, 6% after cleaning/brooming house and 3% after cleaning cowshed/using cowdung.

For all the activities, the usage of soap for washing hands was higher amongst the rural and upper SEC respondents. The urban and lower SEC respondents used ash/mud for washing hands.



7.2 FEEDING PRACTICES AND IMMUNISATION

7.2.1 Households reporting breast-feeding

In Delhi district, a total of 6023 households were contacted, of which 81% had under five children.

Of these households which had a child in the under five age group, a total of 782 households were interviewed which had a child currently (i.e., in the preceding 24 hours) suffering from diarrhoea

On an average there were two children below five years of age, per household. Almost half (47%) of all the under five children were being breastfed at the time of the interview.

7.2.2 Children breastfed by sex and age

Of the children under five who were being breastfed at the time of the interview, 51% were males. The average age of the male children being breastfed was 13.2 months while for the female children it was 12.1 months.

7.2.3 Children breastfed exclusively by sex and age

It was decided to find out the prevalence of breastfeeding exclusively in the age group of 6-12 months.

Age of exclusive breastfeeding

Base : All children in the age group 6-12 months (weighted)	All total	Rural	Urban
	280	102	158
	%	%	%
Upto 3 months	15	17	13
3.1 - 6 months	44	42	45
6.1 - 8 months	25	20	30
8.1 - 10 months	9	9	9
10.1 - 11 months	1	1	1
Not specified	6	11	2
Average age of exclusive breastfeeding (months)	5.4	5.2	5.6

(Refer Table main 2a)

Almost three fifths of the children were exclusively breastfed till the age of six months. Within this category also, it was reported that 15% were breastfed exclusively till the age of 3 months. The average age of exclusive breastfeeding was slightly higher for the urban children as compared to the rural children.

2.4 Age for solid food

The respondents were asked to indicate any additional items that were being provided to the children during the time when they were being exclusively breastfed

Provision of additional items

Base : All children in the age group of 6-12 months (weighted)	SEC						
	All total	Rural	Urban	1-4	5-6	7	8
	200	102	158	14	82	61	103
	%	%	%	%	%	%	%
<u>Water</u>							
Yes	92	86	95	95	93	91	91
No	8	14	5	5	7	9	9
<u>Honey</u>							
Yes	25	25	26	14	33	21	24
No	75	75	74	86	67	79	76
<u>Janam Ghutti</u>							
Yes	57	65	53	84	70	63	40
No	43	35	47	16	30	37	60
<u>Gripe Water</u>							
Yes	34	39	31	33	46	35	24
No	66	61	69	67	54	65	76

(Refer Table Main 2b)

Almost all the respondents (92%) in Delhi gave water to a child who was being exclusively breastfed. In our sample in Delhi district, a greater proportion of the urban children were given water as compared to the proportion of rural children.

Only one fourth of the children in our sample were given honey. A greater proportion of the literate mothers (36%) as compared to the illiterate mothers (20%) adopted this practice.

There was a high degree of usage (57%) of Janam Ghutti for the children, alongwith breast milk.

More than twice the proportion of children in the highest SEC category of (1-4) as compared to those in the lowest category of 8, were given Janam Ghutti. Also, a higher proportion of the literate mothers as compared to the illiterate mothers provided Janam Ghutti to the child.

The usage of gripe water was more amongst the children belonging to the upper SEC categories.

The average age of introducing solid foods was reported at 4.6 months. However, 26% of the respondents could not specify this average age.

Age of introducing solid foods

Base : All children in the age group 6-12 months (weighted)	All total 280 %	Rural 102 %	Urban 158 %
Less than 4 months	6	9	4
4.1 - 7 months	46	46	46
7.1 - 10 months	22	20	23
10.1 - 11 months	1	1	1
Not specified	25	24	26

(Refer Main Table 2)

7.2.5 Immunisation status

Respondents who had children in the 12-24 month age group were also asked to about whether their child had received measles immunisation.

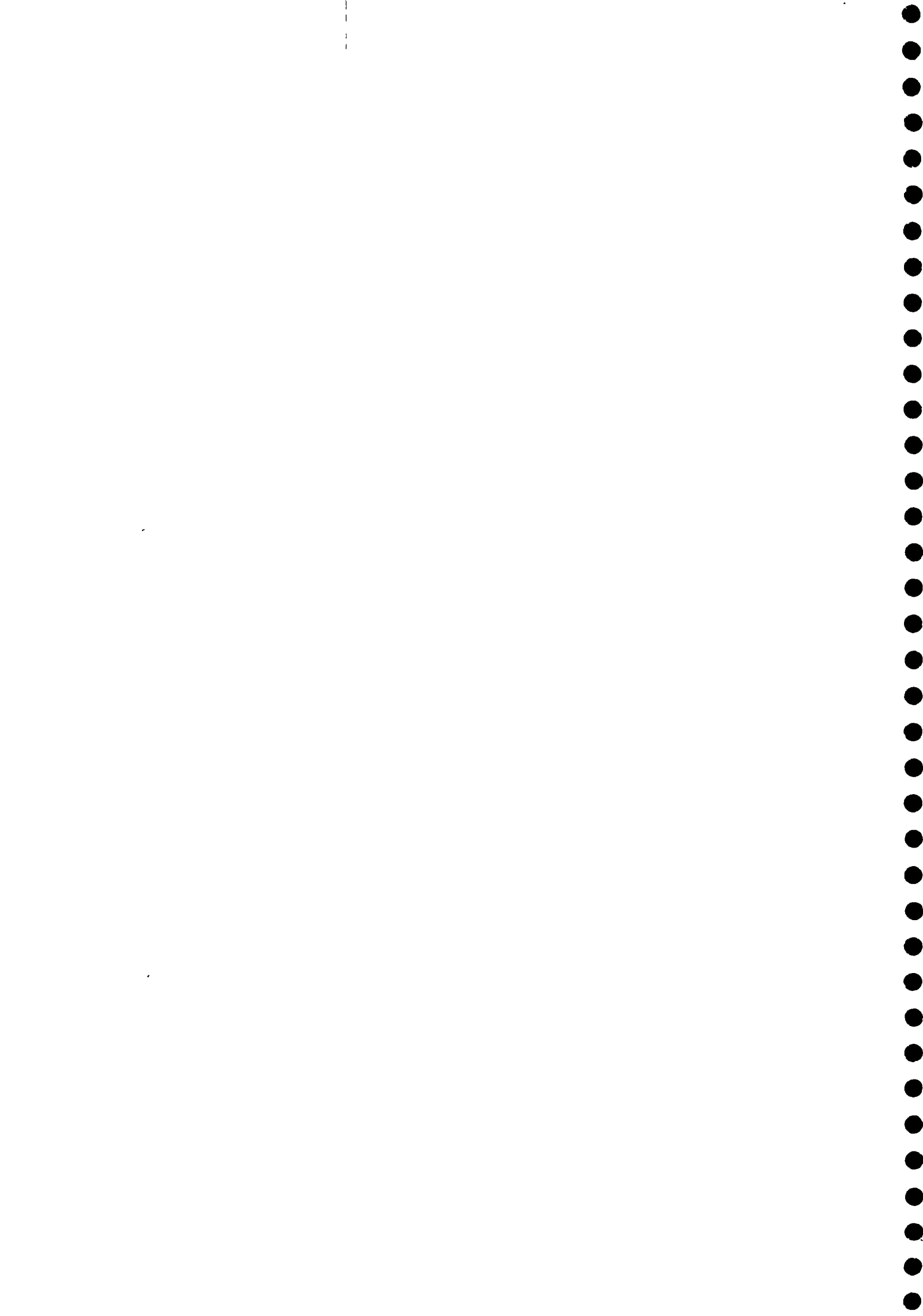
Almost three fifths of these children (57%) had been immunized against measles. The incidence of immunisation was more amongst the rural children as compared to the urban children. This practice was reported to a higher extent amongst the literate mothers as compared to the illiterate mothers.

It was also found that with a decrease in the SEC category of the children, the proportion who were immunised against measles also decreased.

It was also essential to find out the age at which immunisation was undertaken. For this the respondents whose children had been immunised, were asked to show the immunisation card. The immunisation card was available for only 42% of the children who had been immunised. For these cases, the average age of immunisation was reported to be 9.8 months. The average age of immunisation for those children in whose cases card could not be shown but they had been immunised, was reported at 8.7 months. Thus in both the cases the average age of immunisation was closer to the generally acceptable range of immunisation age at 9-12 months.

SECTION VIII
DIARRHOEA MANAGEMENT





8.0 INTRODUCTION

Correct diarrhoea management requires an increased fluid intake and continuation, if not, increase in solid foods. The following sections would examine the actual practices vis-a-vis these norms and the mothers showing an awareness towards ORS.

8.1 GENERAL FEEDING PRACTICES DURING DIARRHOEA

In order to understand the feeding practices adopted by mothers, questions were administered, to them separately about food and fluid giving habits. The respondents were asked to indicate the changes they had made, if any, in the quantity of food given to the diarrhoea affected child in the last 24 hours prior to the interview.

a) Same as normal quantity :-

Slightly more than half of the respondents (51%) provided the same quantity of food as normal.

The respondents were asked to specify the reasons for not altering the quantity of food.

Reasons for giving same as normal quantity of food to the child

Base . All respondents (weighted)	All total	Rural	Urban	1-4	5-6	7	8
	%	%	%	%	%	%	%
Believe it to be right	87	81	90	80	88	86	88
Suggested by doctor	7	10	5	8	5	4	9
Traditional practices	6	7	5	11	5	9	3

[Refer CDD Table 5(i)]

Majority of the respondents (87%) did not alter the quantity of food, believing it to be the right practice. This proportion was higher amongst the upper SEC category respondents as compared to the lower SEC respondents.

b) More than normal quantity of food :-

Only 5% of the respondents adopted this practice.

87% of the respondents who gave more than normal quantity of food did so as the child felt hungry and demanded more food.



c) Less than normal quantity of food :-

Three out of every ten respondents provided less than the normal quantity of food. A higher proportion of the literate mothers (36%) adhered to this practice as compared to the illiterate mothers (27%). This difference is statistically significant.

The reasons that emerged for this practice were : child not feeling hungry and rejecting food (85%), (n=235), food increases frequency of loose motions (7%) and believing it to be the right practice (4%).

d) Stopped all food :-

23 of the 782 respondents had stopped all food to the diarrhoea affected child. The reason that emerged for doing this was the child not feeling hungry and rejecting food (83%).

We may have a look at these two reasons i.e 'child not feeling hungry' and 'food making matters worse'.

	Base	Child not hungry	Food makes matters worse
		%	%
Gave less than normal quantity	235	85	7
Stopped all food	23	83	9

Some associations were observed across the feeding practices adopted by the respondents and their perception of the seriousness of diarrhoea.

Quantity of food given to child

Seriousness of diarrhoea

Base : All respondents (Weighted)	Very serious	Somewhat	Neither
	328	133	321
Same as normal	47	43	57
More than normal	5	8	4
Less than normal	36	34	23
Stopped all food	4	2	2
Milk only	5	11	11

There was a distinct shift in the quantity of food given from 'same as normal' to 'less than normal', as the



perception of the attack changed from something 'not serious/routine' to 'very serious'. With the concern for the attack increasing, a higher proportion of the respondents gave less than normal quantity of food. Also as the concern increased, the proportion giving milk alone decreased. There was also a marginal increase in the proportion of those who stopped food totally.

Quantity of fluids given

During feeding the diarrhoea affected child the principle generally followed is 'least strain on the system but nutrition'. To achieve this end, fluids are recommended which apart from the functions of providing nutrition and strength and reducing weakness and of quenching thirst, combat dryness and dehydration. The respondents in our sample were asked to indicate the changes they had made (if any) in the quantity of fluids given to the child in the last 24 hours prior to the interview.

Quantity of fluids given to child

Base : All respondents (weighted)	All total	Rural	Urban	SEC			
				1-4	5-8	7	8
	782	303	479	55	238	194	29
	%	%	%	%	%	%	%
Yes, gave more fluids	10	13	7	9	9	11	
Yes, gave less fluids	17	18	16	19	20	16	1
Same quantity	73	68	76	71	72	72	7
Stopped altogether	1	1	*	-	-	1	

[Refer CDD Table 6a(i)]

* less than 0.5 percent

Almost three quarters (73%) of the respondents provided the same quantity of fluids to the child. However this practice was more prevalent amongst the urban mothers (76%) as compared to the rural mothers (68%). This difference is statistically significant. A higher proportion of the illiterate mothers (77%) provided the same quantity of fluids as compared to the literate mothers (65%).

More of the rural respondents (13%) increased the quantity of fluids being given as compared to the urban respondents (7%). A higher proportion of the upper SEC category respondents provided less fluids as compared to the lower SEC respondents.

There were five respondents who had stopped fluids altogether for the diarrhoea affected child. Yet two out of these five respondents indicated the use of ORS during the attack.



B.2 HOUSEHOLDS REPORTING HOME AVAILABLE FLUIDS BY TYPE

It was also felt essential to determine the types of fluids given to the child during the diarrhoeal attack. For this only those respondents who had stated that they changed the quantity of fluids or retained the same, were asked to specify the fluids administered to the child. Their spontaneous responses were first noted down.

Fluids given to diarrhoea patient - spontaneous

Base : All respondents (weighted)	All total	Rural	Urban	SEC				Literacy	
				1-4	5-8	7	8	Literate	Illiterate
	777	501	478	55	298	181	243	282	495
	%	%	%	%	%	%	%	%	%
Breastmilk	56	59	58	51	58	52	58	55	57
Milk/cow's milk	47	58	41	59	58	45	38	55	42
Water	31	23	38	29	38	26	31	28	31
Tea	25	22	26	14	21	26	28	22	26
Dal water	7	7	7	8	9	5	7	9	8
SSS	8	10	7	8	7	9	8	9	8
ORS	3	4	2	2	3	2	4	4	2

(Refer Table CDD 6b)

Breast milk and cow's milk was recalled immediately by majority of the respondents. The top of the mind recall for ORS was very low (3%) for the respondents. This recall for ORS was marginally higher amongst the rural respondents and literate respondents.

A cross analysis of the total fluids ever given for diarrhoea by the seriousness of the attack as perceived by the respondents, revealed that with an increasing concern for the attack, the usage of lemon water with salt, lassi/butter milk, milk/cow's milk, SSS and ORS increased. This was possibly done to compensate for the fluid loss and check subsequent dehydration.

Total fluids ever given for diarrhoea

Seriousness of the attack

	Very serious	Causes some concern	Not serious
	%	%	%
Lemon water with salt	38	34	33
Lassi/butter milk	22	17	14
Milk/cow's milk	62	61	58
SSS	42	32	28
ORS	23	9	21

The mothers while deciding on the feeding practices for the diarrhoea affected child, also took into consideration the age of the child. The changes made if any, in the quantity of food and fluids, appeared to be linked with the child's age.

Quantity of food given according to age of child

	Upto 6 months	7-12 months	13-18 months	19-24 months	25-36 months	37-48 months	49-60 months
	%	%	%	%	%	%	%
More food	2	3	3	8	6	8	12
Same food	30	49	48	51	63	60	49
Less food	7	27	44	39	29	28	39
Stopped all food	1	5	4	3	2	3	-
Milk	41	14	1	-	-	-	-
Not specified	18	3	-	-	-	-	-

The practice of giving less food or stopping all food, was adopted for the younger children (below 18 months); for the children above 18 months, the trend seems to have been to maintain the same quantity of food.

Quantity of fluids given according to age of child

	Upto 6 months	7-12 months	13-18 months	19-24 months	25-36 months	37-48 months	49-60 months
	%	%	%	%	%	%	%
More	6	11	11	8	9	10	7
Less	13	19	22	19	20	9	5
Same	78	69	67	73	70	81	88
Stopped	2	1	1	-	-	-	-



Also, with an increase in the age of the child, mothers tended to maintain the same quantity of fluids, if not give more. The incidence of providing less fluid was restricted to children upto one and half years of age.

8.3 HOUSEHOLDS REPORTING ORS AND BY BRAND

A total of 51 respondents had given ORS to the child during the recent diarrhoeal attack.

67% of such respondents were able to show the ORS packets being used by them.

Half of the respondents stated the brand name of ORS provided as 'ORS' itself, while almost one third (32%), indicated 'Electral'. The rest were unable to specify. The usage of 'Electral' was higher amongst the upper SEC category (1-4) respondents as compared to the lowest SEC category 8 respondents; also a greater proportion of the literate mothers as compared to the illiterate mothers spoke of 'ORS' as a brand name.

8.4 HOUSEHOLDS REPORTING ORS IN THE LAST 24 HOURS

All the respondents who stated that they had given ORS to the child during the attack were asked if they had given ORS to the child in past 24 hours prior to the interview. 77% of the respondents (n=51), indicated having done so.

All the upper SEC category respondents as compared to 69% of the lower SEC category 8 respondents, indicated having given ORS to the child in the last 24 hours. This proportion was also higher for the literate mothers (83%) as compared to the illiterate mothers (72%).

8.5 PLACE OF PROCUREMENT

In order to find out the usage of ORS, sources of procurement, methods of preparation of the solution and time over which used, questions were administered to those respondents who had used ORS during the attack prevailing at the time of the interview (n=51).

Almost four fifths of such respondents (77%) had used ORS in the last 24 hours prior to the interview. The rest had not used ORS during this time.

The chemist shop was the main source of procurement (78%) followed by the PHC/sub-centre (24%) and health worker (19%)



8.6 PERSON PREPARING THE ORS

Almost nine tenths of the respondents had prepared the ORS solution on their own, with the rest depending on other family members.

A higher proportion of the urban respondents (95%) prepared the solution on their own as compared to the rural respondents (80%).

8.7 METHOD OF ORS PREPARATION

The respondents who had mentioned the use of ORS during the diarrhoeal attack at the time of the interview, were asked to state the quantity of powder used by them for preparing the solution (n=51).

15% of the respondents indicated the usage of the whole pack of ORS, while 82% stated that the powder was taken out as needed.

The usage of the whole pack of ORS was more amongst the urban respondents (12%) as compared to the rural respondents (4%).

Those respondents who indicated the usage of the whole pack of ORS, were asked to mention the quantity of water used by them for preparing the solution. The interviewer was then required to pour this water into his own measuring jar and note the quantity used.

The average quantity of water used was reported at 800 ml. with 68% of the respondents (n=8) using between 751-1000 ml. of water.

8.8 RETENTION OF PREPARED ORS

It was also decided to find out the time over which the ORS solution was used by the respondents during the attack at the time of the interview.

71% of the respondents used the ORS solution for half day (n=51).

19% of the respondents used the solution over a full day. This proportion was higher in the urban sample (26%) as compared to the rural sample (13%). More of the upper SEC category respondents (24%) used the solution for a full day as compared to the lower SEC respondents (14%).

6% of the total respondents used the solution in the next day also.

8.9 WHEN TO SEEK TREATMENT

All respondents were asked to state the symptoms that would indicate to them the necessity to seek treatment for the diarrhoea affected child.

There were a variety of symptoms that indicated to the mother that the condition of the child warranted consultation for treatment.

Symptoms indicating need to seek treatment

Base : All respondents total (weighted)	All	Rural	Urban	SEC			Literacy		
				1-4	5-6	7	8	Literate	Illiterate
	782	303	479	55	238	194	295	284	498
	%	%	%	%	%	%	%	%	%
Does not get better in two days	24	24	23	17	22	23	26	23	24
Starts passing many stools	79	78	79	87	81	80	74	82	77
Has repeated vomiting	4	8	1	5	6	4	2	5	4
Is eating and drinking poorly	3	2	3	3	3	3	2	1	3
Develops fever	19	16	21	25	17	25	16	20	19

(Refer Table CDD 12)

Mothers took notice when the child started passing many stools. This symptom was a danger signal to a higher proportion of the upper SEC category (1-4) mothers as compared to the lower SEC category (8) mothers. This difference is statistically significant.

Both literate and illiterate respondents treated various symptoms with almost equal concern and felt the need to consult someone for treatment.

8.10 HOUSEHOLDS REPORTING CONSULTATION BY SOURCE

In order to understand the mother's practices with regard to diarrhoea, all respondents were asked to mention the sources they had consulted for treatment of the diarrhoea affected child.



Half of our respondents had consulted someone for treatment of the present diarrhoeal attack of the child. Almost half (48% - 55%) of the respondents across the different classification variables reported having sought consultation for treatment.

A typical mother in our sample used a variety of practitioners in her quest for curing her child of diarrhoea.

Persons consulted for diarrhoea treatment

Base : All respondents (weighted)	All total 394	Rural 163	Urban 231	1-4 31	SEC		
					5-6 116	7 90	8 157
	%	%	%	%	%	%	%
Allopathic doctor - government.	25	22	28	40	26	19	25
Allopathic doctor - private	69	73	66	58	68	76	68
Non allopathic doctor	3	2	4	-	6	1	3
Pharmacist/chemist	1	2	1	3	2	1	1
Sub-centre/Health worker	3	5	2	3	-	4	5
Others†	1	1	1	-	1	1	1

(Refer CDD Table 10)

† (others include tantrik/witch doctors)

Almost all the mothers depended on allopathic doctor - both government and private, with the latter kind being more in demand. A higher proportion of the upper SEC categories respondents (1-6) as compared to the lower SEC respondents (7 and 8) contacted the government allopathic doctor; the latter respondents relied more upon the private allopathic doctor. The use of the government facilities like the sub-centre, health worker, as referral sources, was very low. The private doctor had made a successful inroad into the rural areas - in fact more than in the urban areas. This could be partially explained in terms of the fact that the rural areas in our sample were very close to urban centres, and only slums were covered in the urban areas.



As would be expected the perception of the seriousness of the attack influenced the mother's decision to seek treatment. With increasing concern for the attack, mothers felt inclined to consult someone for treatment. This is revealed in the cross analysis below :

Seriousness of diarrhoea			
Consulted for treatment	Very serious	Somewhat serious	Not serious/routine
	%	%	%
Yes	65	51	35
No	35	49	64

Type of doctor

	72	72	68
1) Private			
2) Government	25	24	22

It is also interesting to note that with an increasing concern for the attack, more people reposed their confidence on the private doctor - both allopathic and non-allopathic and on pharmacists/chemists. This possibly could be the result of the people's belief in modern medicines and quicker remedies as compared to traditional remedies.

8.11 TYPE OF PRESCRIPTION RECEIVED

All those respondents who sought advice from different people for treatment of diarrhoea as discussed in the previous section, were also asked to state what had been prescribed/given by their referral persons.

Items prescribed/given by advisor			
Base : All who sought advice from others (weighted)	All total	Rural	Urban
	%	%	%
Pills/tablets	36	47	29
Injections	13	17	10
Powder (non ORS)	11	13	10
ORS	7	9	5
Syrup/mixture/tonic	61	46	72
Purias	12	13	12

(Refer Table CDD 11)

There was a high usage of syrup/mixture or tonic, with three fifths of the respondents reporting having been advised so.

In our sample, pills/tablets were prescribed for a greater proportion of the rural respondents as compared to the urban respondents; on the other hand the usage of syrup/mixture/tonic was more amongst the latter as compared to the former. These differences are statistically significant. The high incidence of prescribing modern remedies such as syrups, pills, injections etc. should be looked at in light of the fact that most of the respondents approached the private doctors for consultation. ORS usage was quite low, while purias and other such 'quack' medicines were also prescribed.

The items prescribed varied across the age of the child suffering from diarrhoea. While syrup, tonics, pills, tablets were being randomly prescribed irrespective of the age of the patient, the advisors restricted the usage of injections, ORS and non-ORS powder to younger children aged upto two and half to three years. The older children (4 and 5 years ones) were not prescribed these items.

The indiscriminate usage of pills and tablets could also be gauged from the fact that more than four fifths of the respondents who had stated that pills/tablets were prescribed, were unable to state the names of such medicines.

An analysis of the type of medicine prescribed to the respondent according to the type of person consulted reveals the following :

Things prescribed/given by the consultant

Things prescribed	Allopathic doctor		Non allopathic doctor	Chemist	Sub centre	Health/anganwadi worker
	Government	Private				
	%	%	%	%	%	%
Pills/tablets	31	37	55	76	58	16
Injections	12	14	9	-	21	-
Powder (non ORS)	9	11	45	-	-	16
Tonic	14	2	9	39	-	51
Syrup/mixture	62	65	18	-	42	32

The prescription of pills /tablets was high amongst the non allopathic doctors, chemists, and sub centres. Syrup and mixture were more widely prescribed by the allopathic doctor both government and private.



The health worker/anganwadi worker and the chemist were in favour of ORS. This is interesting as it reveals the need for greater emphasis on promotion of ORS to chemists, now that ORS has been put into the category of OTC drugs, chemists may be motivated to promote ORS because of good margins. We have no data on this but it is a hypothesis. Whatever their motivations, they have the potential to play a useful role and this should be fully exploited.

8.12 GENERAL PERCEPTION ON DIARRHOEA MANAGEMENT

In order to assess the perceptions of the respondents on different issues pertaining to diarrhoea management, a set of statements were read out to them. They were then asked to specify whether in their opinion, the statement was true.

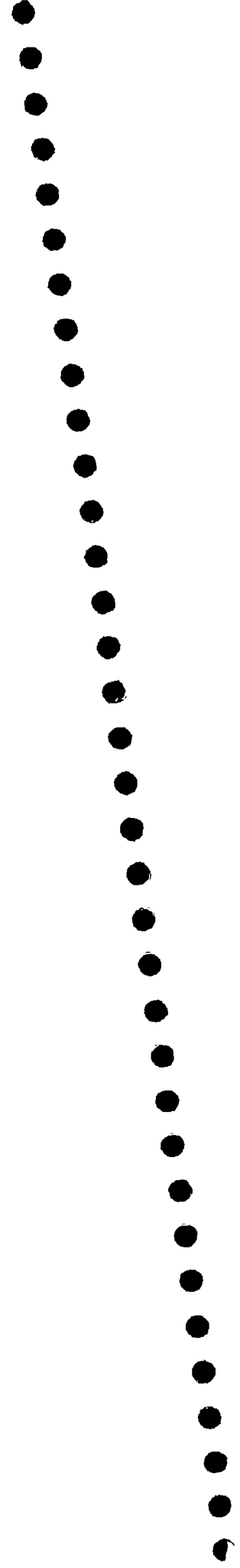
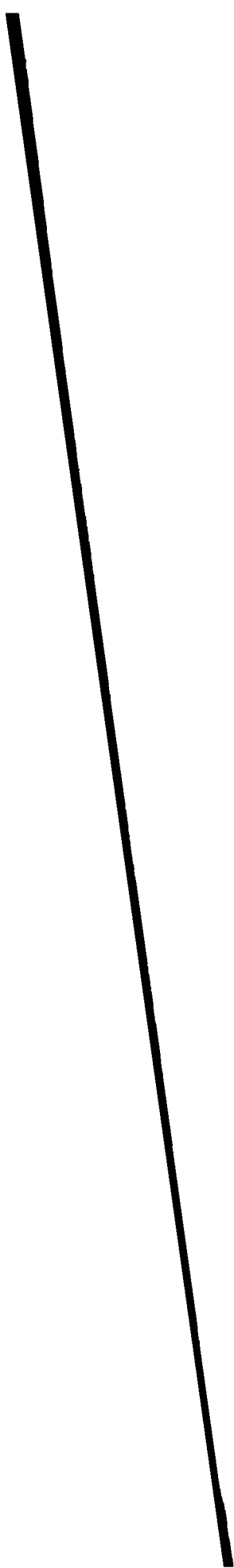
Respondents who agreed with the statement

Base : All respondents (weighted)	All total 782	Rural 303	Urban 479	Literacy	
				Literate 284	Illiterate 498
	%	%	%	%	%
Diarrhoea is only caused by contaminated water	59	59	59	65	55
During diarrhoea fluid intake should be increased	79	77	79	85	75
During diarrhoea all solid foods should be stopped	40	38	41	42	39
Dehydration is an extremely dangerous situation	93	95	91	95	91
If a child is breastfed the mother should continue so during diarrhoea	85	80	87	80	87

(Refer CDD Table 13)

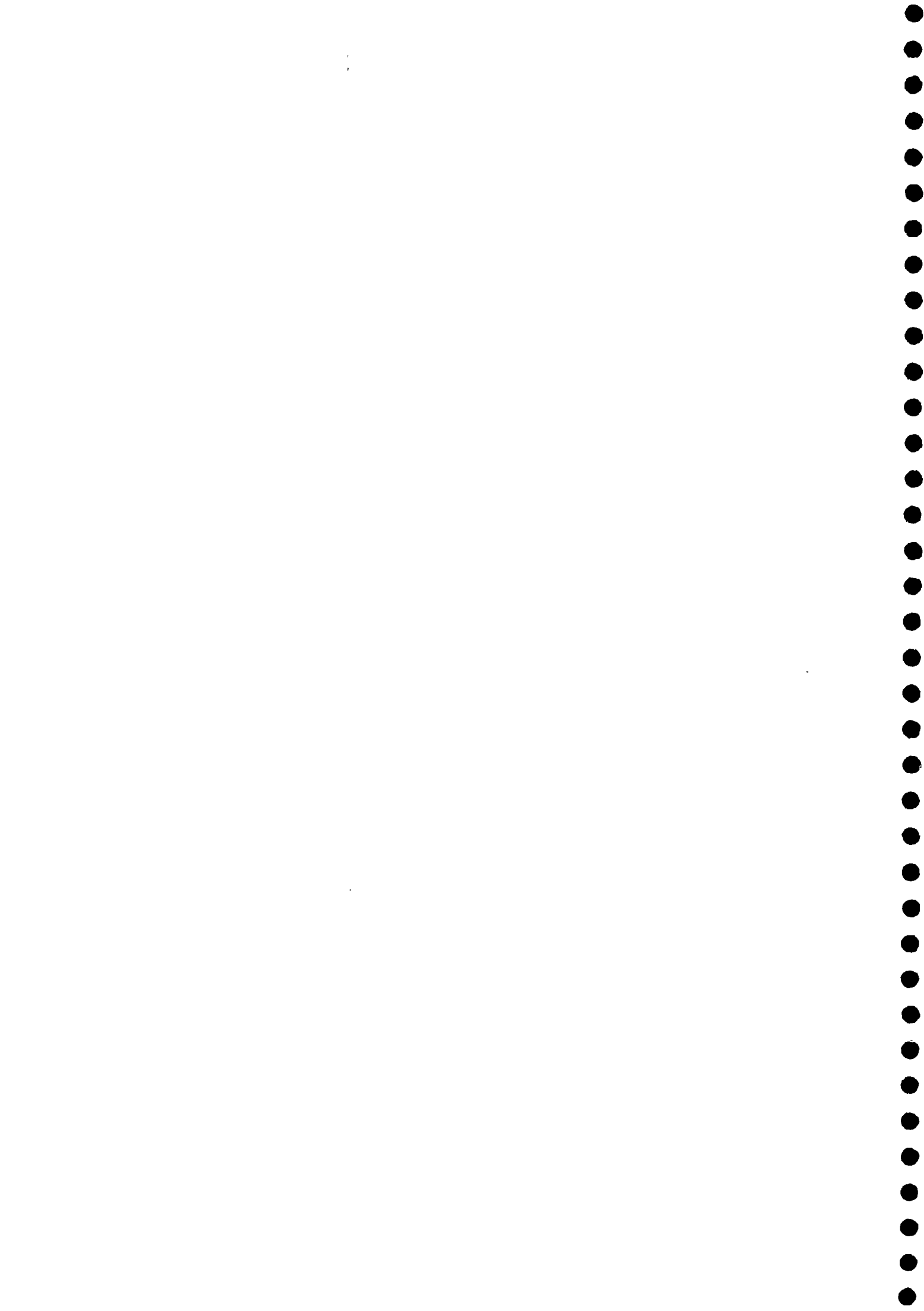
To establish the knowledge level of the respondents on the above issues, a pattern of scoring was adopted where a score of one was given to each respondent who had given correct answers vis, who had mentioned false for statement 1 and 3 and 'true' for statement 2,4 and 5. Thus a scale of five points was obtained on which the knowledge level was indicated.





SECTION IX
ADEQUACY AND EFFECTIVENESS
OF REPORTING SYSTEM





9.2 FREQUENCY OF SENDING REPORTS ON DIARRHOEAL INCIDENCE

Respondents reporting the incidence of diarrhoea to their higher authorities were asked to indicate the frequency at which they did so.

The findings have been analysed separately for the rural and urban health units.

Frequency of sending diarrhoeal disease report at normal circumstances (Rural)

Base : All respondents	Rural 29	CHC 3	PHC 7	Sub-centre 19
	Number of respondents	Number of respondents	Number of respondents	Number of respondents
Once in a week	7	-	2	5
Once in a month	20	3	3	14
Almost daily	2	-	2	-

(Refer HS Table 1c)

In 69% of the cases, reporting was done on a monthly basis.

Frequency of sending diarrhoeal disease report at normal circumstances (Urban)

Base : All respondents	Urban total 5	Medical college 1	hospital	Dispensary 4
	Number of respondents	Number of respondents		Number of respondents
Once in a week	-	-		-
Once in a month	4	-		4
Almost daily	1	1		-

(Refer HS Table 1c)

None of the urban health units reported on a weekly basis.

Thus under normal circumstances, a monthly reporting system was followed by both the rural and urban health units (70%, n=34).

9.0 INTRODUCTION

One of the objectives of the integrated CDD/WATSAN study is to look at the adequacy and effectiveness of the present reporting system on diarrhoeal diseases and deaths through the existing health infrastructure such as sub-centres, PHC's, Urban Health Centres etc.

The health system questionnaire was administered to the health functionaries at the above mentioned centres to obtain information on the system of reporting and to gauge their knowledge pertaining to case management of diarrhoea.

A total of 38 such health functionaries were interviewed in Delhi district. Of these 33 were in the rural areas and the rest were in the urban areas.

There was a high prevalence of subcentres in the rural areas (25 of them). There were 7 PHCs, 3 Community Health Centres, and one district hospital in the rural areas. In the urban areas there were four dispensaries and one medical college hospital.

9.1 PRESENT REPORTING SYSTEM BY DISEASE

The incidence of reporting childhood diseases to higher authorities varied across the type of centres and type of diseases. The responses recorded were spontaneous.

Number reporting childhood disease to higher authorities

	All total	Rural	Urban
Base : All respondents	38	33	5
	Number	Number	Number
Tetanus	22	19	3
Polio	26	23	3
Pertussis	15	14	1
Diarrhoea	28	23	5
Cholera	21	19	2
Fever	7	6	1

(Refer HS Table 1a)

Diarrhoea was reported on a large scale with 74% of the respondents indicating so.

While 70% of the rural health units reported diarrhoeal diseases, all the urban units in our sample did so

9.3 FREQUENCY OF SENDING REPORTS ON DIARRHOEAL DEATHS

All the respondents were asked to recall the number of childhood deaths due to diarrhoea in the past one year from the last monsoon to the present one.

Almost all of them stated that there had been no such death in the time period mentioned (92%) (n=38). The rest of them reported the occurrence of upto 10 deaths. All of them were from the rural health units.

The average number of cases where death occurred due to diarrhoea over the time period as mentioned above, was reported to be 2.3 cases for all the respondents.

Only 19 respondents (i.e.50%) were sending out separate reports on diarrhoeal deaths. Of these 15 were from the rural areas.

Actual frequency of reporting diarrhoeal death

Base : All respondents	All total 19	Rural 15	Urban 4
	Number of respon- dents	Number of respon- dents	Number of respon- dents
Once a month	11	9	2
Once a week	3	3	-
Immediately/Once a day	4	2	2

(Refer Table HS 2b-2)

One respondent mentioned that the reporting was done once in six months. Respondents who mentioned that diarrhoeal deaths were being reported by them (n=19) were asked whether any special report was sent for this purpose or if it was part of a regular report. 47% of such respondents mentioned the practice of sending a special report. For the rest, it was just part of a regular report.



9.4 AVERAGE DIARRHOEAL CASES REPORTED IN A WEEK/MONTH

All the respondents were asked to mention the number of cases of diarrhoea reported to them in a week, and in a month.

Average number of diarrhoea cases reported

Base: all respondents	All Total	Rural respondents	Urban respondents
	38 Numbers	33 Numbers	5 Numbers
In a week	43	39	68
In a month	152	121	344

(Refer HS Table 3a-1, 3a-2)

The reported prevalence of diarrhoea was more in the urban areas as compared to the rural areas.

9.5 AVERAGE NUMBER OF CASES SIGNIFYING DIARRHOEAL OUT BREAK

However, all the respondents felt that the number of cases being seen by them in a week or in a month, were not high enough for them to treat the situation as an outbreak. This threshold level of worry was much higher for the urban respondents as compared to the rural respondents.

Average number of cases which would indicate a diarrhoeal outbreak

Base : All respondents	All total	Rural	Urban
	38	33	5
	Number	Number	Number
In a week	123	98	318
In a month	482	339	1339

(Refer Health System Tables 36-1, 36-2)

Most respondents (82%) had not faced an outbreak of diarrhoea, such an occurrence being defined in terms of the number of cases as indicated in the above table.

9.6 FREQUENCY OF REPORTING DIARRHOEA OUTBREAK

In case of an outbreak the frequency of reporting diarrhoeal diseases increased from what it was during normal circumstances.

Frequency of reporting diarrhoeal disease during an outbreak

Base : All respondents	All total 34	Rural 29	Urban 5
	Number of respondents	Number of respondents	Number of respondents
Once <u>in</u> a week	18	16	2
Once <u>in</u> a month	8	6	2
Almost daily	8	7	1

(Refer HS Table 1c)

It should be noted that while in the cases of an outbreak, 25% reported almost on a daily basis, 9% did so during normal circumstances.

53% followed a weekly reporting during an outbreak.

9.7 ACTION TAKEN DURING THE LAST OUTBREAK

Information was also sought on the incidence of diarrhoeal outbreak in the district. Only 7 of the 33 respondents mentioned the outbreak of diarrhoea in their areas. However, it should be noted that 34 respondents had indicated the frequency with which they sent out reports on diarrhoeal outbreak.

The need was felt to comprehend the steps/actions needed in case of an outbreak of diarrhoea. Those respondents who had mentioned having experienced diarrhoeal outbreak were asked on the actions they had initiated during such an event. Their spontaneous and prompted responses were both noted down.



Base : Total number of respondents having faced on outbreak
(n=7)

Actions initiated	Spontaneous Number of respondents	Prompted Number of respondents
Increase medicine stock	3	3
Increases I/V fluids stock	2	3
Increase indent for ORS packets	6	-
Give cholera vaccination	1	1
Report to higher authority	1	4
Organise a mother's meeting	1	3

(Refer HS Table 3d i, ii)

The spontaneous responses were in terms of increased indent for ORS packets, increased medicine stock and increased I/V fluids stock.

Respondents who had not faced an outbreak were asked to spell out the actions they would initiate if such an outbreak were to occur.

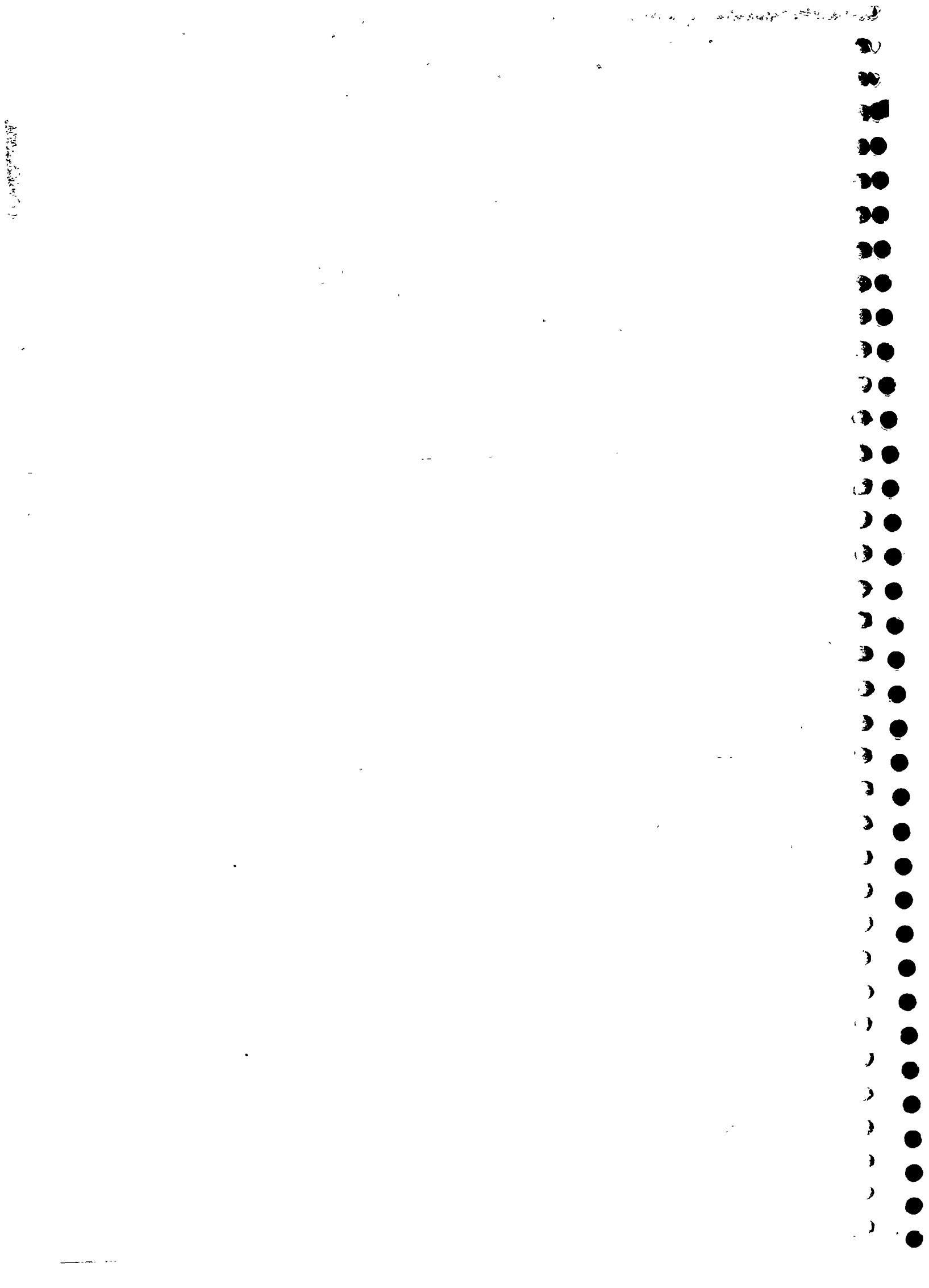
On a spontaneous basis, 65% of them said that they would increase the indent for ORS packets, almost three fifths of them stated that they would report to higher authorities (58%), two fifths mentioned that they would increase the medicine stock (39%). On being prompted, 52% said that they would organise a mothers meeting.

We can have a look at the responses obtained, both spontaneously and prompted, in events of a diarrhoeal outbreak having taken place and if such an outbreak was to occur.

	Diarrhoeal outbreak taken place (n=7)		In case of outbreak (n=31)	
	Spontaneous	Prompted	Spontaneous	Prompted
	Number of respond- ents	Number of respond- ents	Number of respond- ents	Number of respond- ents
Increase medicine stock	3	3	12	15
Increase I/V fluids stock	2	3	5	13
Give cholera vaccination	1	1	2	14
Report to higher authority	1	4	18	11
Increase indent for ORS packets	6	-	20	10
Organise a mother's meeting	1	3	5	16

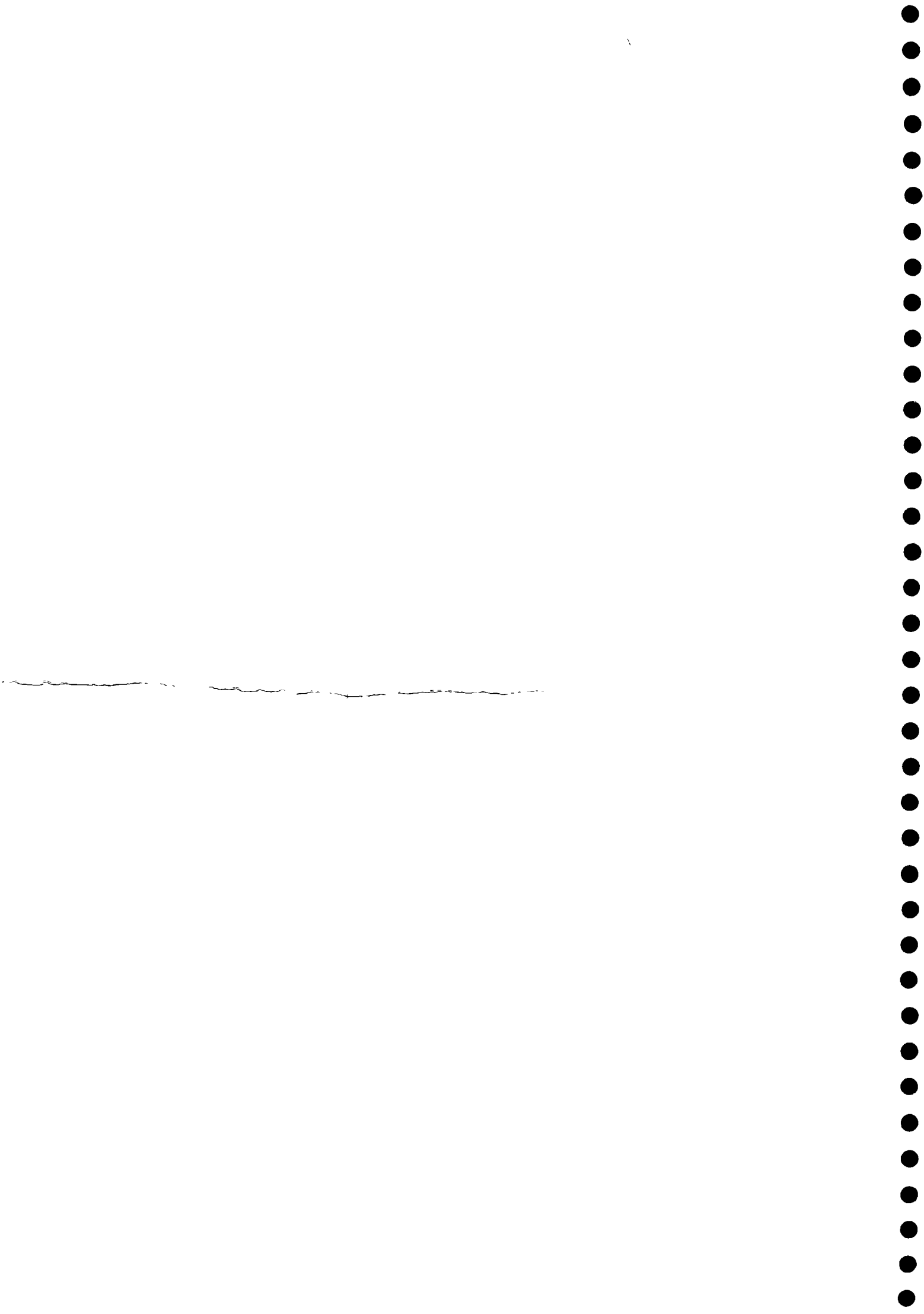
The top of the mind recall for increasing indent for ORS packets was quite high in both the situations.





SECTION X
APPENDICES





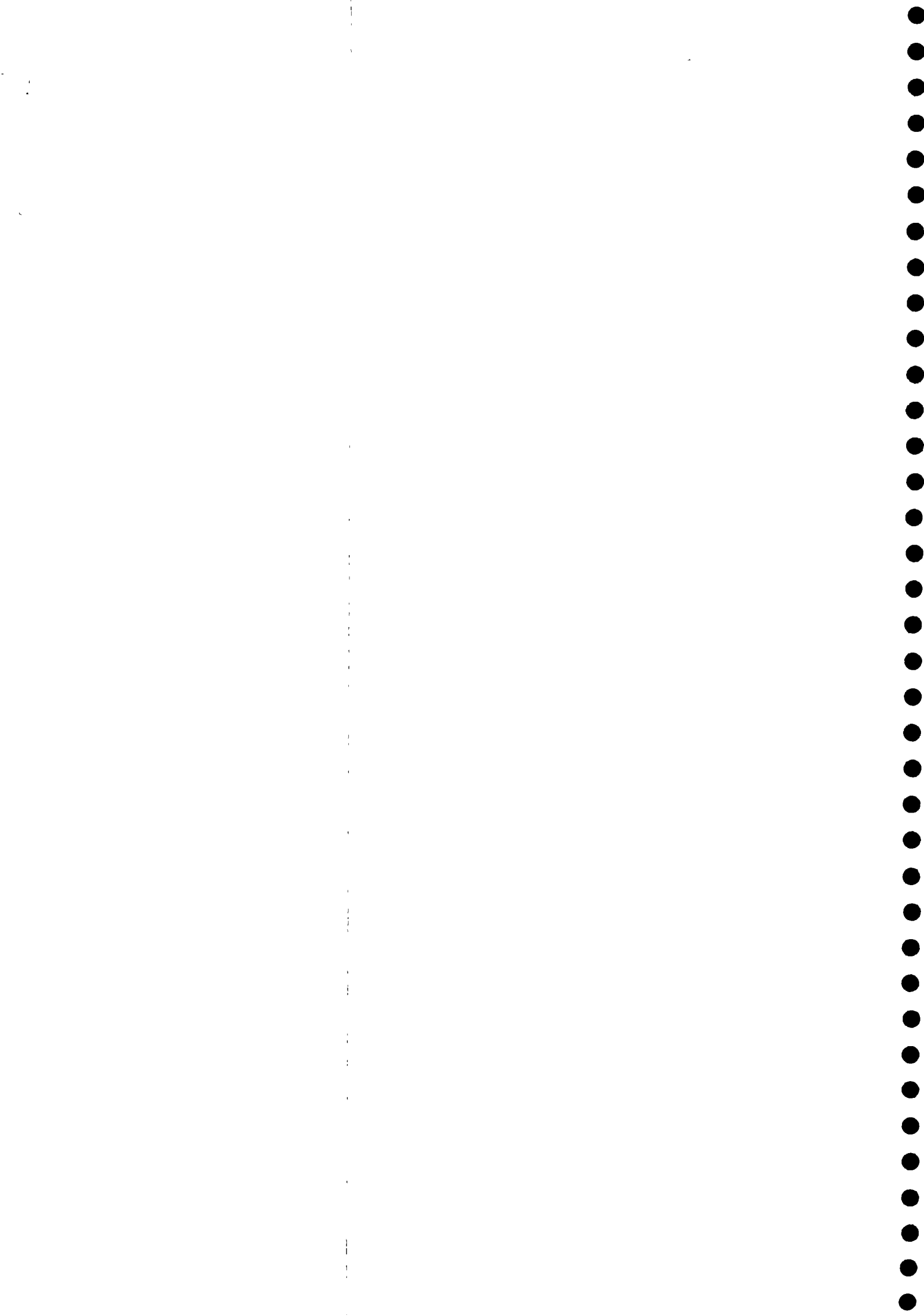
APPENDIX - I

List of scheduled castes in Delhi:-

Adi Dharmi; Agarria; Aheria; Balai; Banjara;
Bawara; Bazigar; Bhangi; Bhil; Chanar;
Chanwar; Gatav Chamar; Chohra; Chuhra; Dhanak;
Dhobi; Dom; Gharrame; Jallaha; Kabirpanthi;
Kachhanda; Kangar; Khalik; Koli; Latfegi;
Madari; Mallah; Mazhabi; Meghwal; Naribut;
Nat; Pasi; Perna; Sansi; Sajera; Sikligar;
Singiwala; Sirkiband.

(Source : District Census Handbook, 1981)





APPENDIX II

Socio economic classification:-

In the past, income data was used by market researchers as a variable to discriminate between individuals and between households. However income was an unreliable means of classification, namely for 3 reasons:- (i) Frequent understating of income. (ii) Income data getting outdated rapidly. (iii) Non-responses to questions about income. These problems necessitated the development of a new variable that was relatively stable over time and did not have the problems inherently associated with income. Socio-economic classification uses the occupation and education of the chief wage earner of the household. This system of classification has been evolved, tested and standardised by the Market Research Society of India.

The Socio-economic grid appears as follows:-

	Illiterate.	School upto 4 years	School Upto 5-8 years	SSC/ HSC	Some college (inc.dip.)but not graduate	Graduate. Post/graduate General	Graduate Post/graduate Prof.
Unskilled worker (Farm labour)	8	8	7	6	6	6	6
Skilled workers (Owner farmer 5 acres)	8	8	7	6	5	4	4
Petty traders (Owner farmer 6-20 acres)	8	7	7	6	6	6	6
Shop owners (Owner farmer 20 + acres)	7	6	5	4	3	2	2
Businessmen/Industrialists	5	5	5	5	3	2	1
Self employed/professionals	6	6	6	5	4	2	1
Clerical/Salesman	6	6	6	5	4	2	1
Supervisory level	6	6	6	5	4	3	2
Officer/Executives Junior.	5	3	3	3	3	2	1
Officer/Executives Middle/Senior	2	2	2	2	2	1	1



A brief explanation of the different socio-economic classes is provided below:-

SEC. 1 & 2 :- Would typically comprise households where the chief wage is a graduate / post graduate and is working in the managerial capacity.

SEC 3 & 4 :- Would typically comprise households where the chief wage earner has at least some education, normally upto college but not a graduate. Typically he/she would be working as a junior executive or in the supervisory capacity.

SEC 5 & 6 :- Normally comprise households where the chief wage earner has attended school upto certificate level and is running his own business/industry and is self-employed.

SEC 7 & 8 :- These are the lowest socio-economic classes and would typically comprise households where the chief wage earner who had only minimal education (or none at all) and is involved in fairly menial activity which does not require much skill.

The SEC scale is very flexible and gives due weightage to a high educational qualification or occupation. For example a person who is working as clerk but who has a professional post-graduate degree would come under SEC 1 while the same clerk/salesman would fall under SEC 5 if he had studied only upto certificate level.



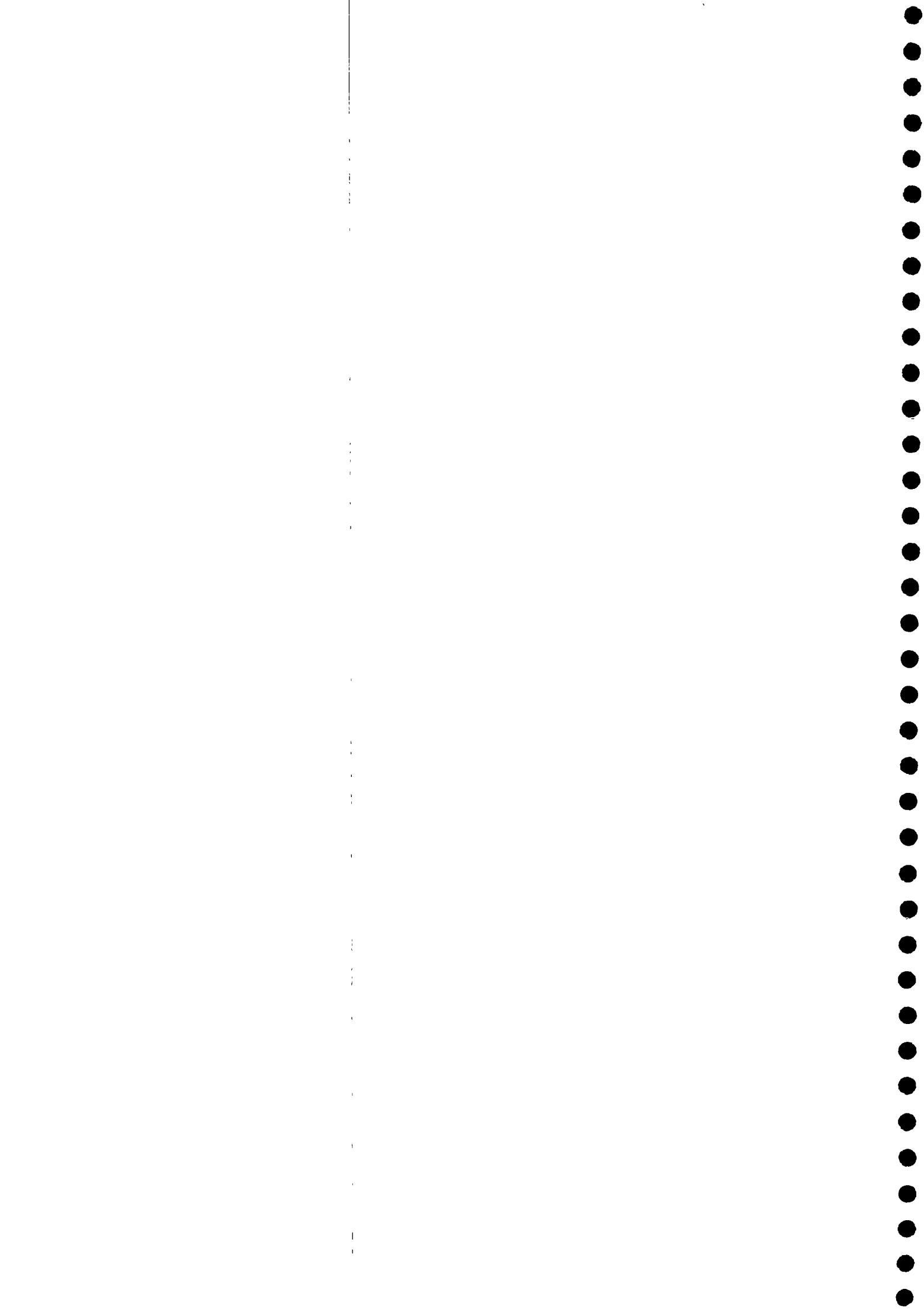
APPENDIX - III

Distribution of villages by population range. (Delhi District)

<u>Population.</u>	<u>No. of villages.</u>
Less than 200	9
200 - 499	9
500 - 1999	110
2000 - 4999	71
5000 - 9999	15
10000 +	-

(Source : District Census Handbook 1981)





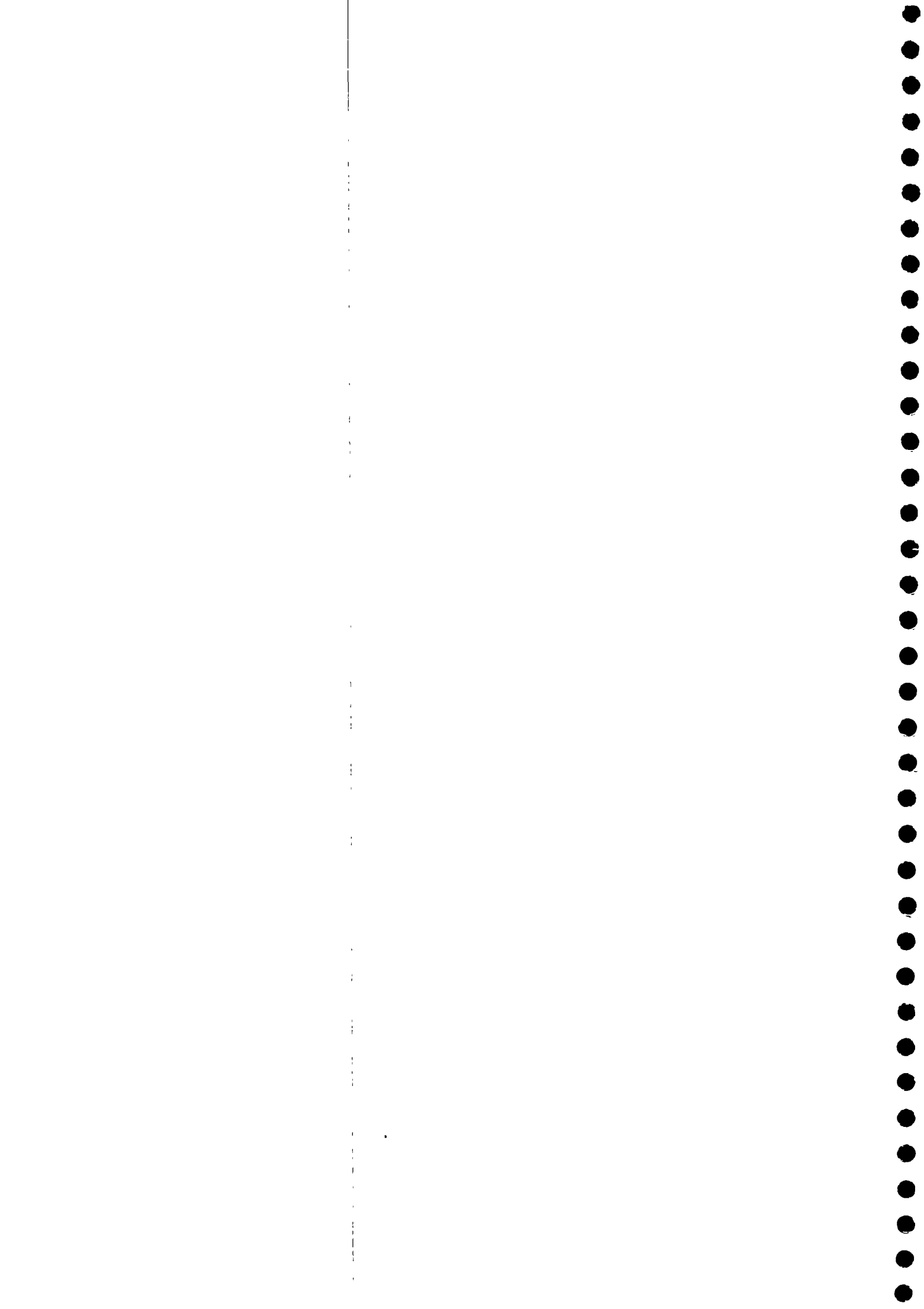
District Name: _____ Village Name: _____ City Name: _____

Ward Name: _____ Cluster Name: _____ Date: _____

CONTACT NO.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 11-14	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 43-46	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 75-78	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 11-14	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 43-46
Q 1 <5 year old present : (Y=1, N=2)	<input type="text"/> <input type="text"/> 15	<input type="text"/> <input type="text"/> 47	<input type="text"/> <input type="text"/> 79	<input type="text"/> <input type="text"/> 15	<input type="text"/> <input type="text"/> 47
Q 2 No of <5 year olds present	<input type="text"/> <input type="text"/> 16-17	<input type="text"/> <input type="text"/> 48-49	<input type="text"/> <input type="text"/> 80-81	<input type="text"/> <input type="text"/> 16-17	<input type="text"/> <input type="text"/> 48-49
Q 3 Sex of Children <5 years (M=1, F=2)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 18-25	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 50-57	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 82-89	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 18-25	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 50-57
Q 4 Diarrhoea started in past 2 weeks (Y=1, N=2)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 26-33	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 58-65	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 90-97	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 26-33	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 58-65
Q 5 Diarrhoea in past 24 hours (Y=1, N=2)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 34-41	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 66-73	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 98-105	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 34-41	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 66-73

CONTACT NO.	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 11-14	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 43-46	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 75-78	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 11-14	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 43-46
Q 1 <5 year old present : (Y=1, N=2)	<input type="text"/> <input type="text"/> 15	<input type="text"/> <input type="text"/> 47	<input type="text"/> <input type="text"/> 79	<input type="text"/> <input type="text"/> 15	<input type="text"/> <input type="text"/> 47
Q 2 No of <5 year olds present	<input type="text"/> <input type="text"/> 16-17	<input type="text"/> <input type="text"/> 48-49	<input type="text"/> <input type="text"/> 80-81	<input type="text"/> <input type="text"/> 16-17	<input type="text"/> <input type="text"/> 48-49
Q 3 Sex of Children <5 years (M=1, F=2)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 18-25	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 50-57	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 82-89	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 18-25	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 50-57
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Q 5 Diarrhoea in past 24 hours (Y=1, N=2)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 34-41	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 66-73	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 98-105	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 34-41	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 66-73

Q3. - Q5 ARE FIXED PLACE BOXES



APPENDIX

SRI/90033/JULY 1992

1				3					
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1-10

VILLAGE OBSERVATION SHEET

Name of village : _____

Census code No : _____

Block name : _____ Grampanchayat :

--	--	--	--	--

11-18

District : _____ State : _____

Post Office Present :

Yes	1	No	2
-----	---	----	---

Pin-code

--	--	--	--	--	--

20-25

Name of supervisor .

19

Name of Field Executive :

TO BE FILLED IN CONSULTATION WITH THE CHIEF OF THE VILLAGE PANCHAYAT OR REVENUE OFFICE ETC. - ALSO REFER TO ANY FORMAL RECORDS MAINTAINED IN THE VILLAGE.

Q1 Village population (as per 1991 census) : _____

--	--	--	--

26-29

Q2 Total number of households _____

--	--	--	--

Q3. Break up by religion and caste * _____

--	--	--	--

30-33

Name of religion	Population - %	Households (Number)						
Hindu	<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>				
Muslim	<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>				
Sikh	<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>				
Christian	<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>				
Jain	<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>				
Buddhist	<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>				
Others (Specify)	<table border="1"><tr><td></td><td></td></tr></table>			<table border="1"><tr><td></td><td></td><td></td><td></td></tr></table>				

No of household*

SC _____

--	--	--	--

 69-71

ST _____

--	--	--	--

 72-74

Other castes _____

Total . _____

--	--	--	--

 75-78

34-47

48-68

4a Is the village electrified ?

Yes

1

%age of households electrified

--	--

 80-81

No

2

 79

Q 4b) What is the average duration of time for which power is available per day ?

_____ hours/day

--	--

 82-83

Q 4c) Is there a functioning streetlight in the village?

Yes

1

No

2

 84

Q 5 Transport and communication

Yes No

Is there a bus coming upto the village ?

1	2
---	---

 85

IF NO, How far is the nearest bus connection _____ Kms

--	--

 86-87

How many times do buses stop here in a day _____ Times

--	--

 88 89

Q 6 Is there a railway station
 Attached to the village ?
 IF NO Within 5 Kms. of the village ?
 IF NO, Within 15 Kms. of the village
 IF NO, How far is the nearest station? _____ Kms

Yes No

Name of railway station (WHEN YES CODED)

1	2
1	2
1	2

90-91

TRADE & INDUSTRY

--	--

92-93

Q 7a Which of the following shops exist in this village?

Q 7b FOR EACH ONE CODED, How many such shops are there in this village ?

Type of shops/establishment	7a	7b
	Existing in the village	Number
Paan/cigarette/bidi	1	
Tea stall	2	
Groceries/Provisions	3	
Vegetables	4	
Medicine/Chemist	5	
Ration/Fair price	6	
Agricultural items (Seeds/Fertilisers)	7	
Agricultural implements (Tools)	8	
Textiles/Cloth/Tailoring	9	

94-102

103-120

Q 7c Does the village have a weekly market? Yes : 1 No : 2 121

Q.8 Is there a bank in the village ? Yes 1 No 2 122

IF YES, Name(s) of bank(s) _____

123-126

Q.9 Are there any cooperatives/societies in the village? Yes . 1 No . 2 127

2				3					
---	--	--	--	---	--	--	--	--	--

1-10

IF YES What type of society is present in the village ? (Note as per list below)

- Type
- Agricultural credit
 - Agricultural credit cum Marketing
 - Consumer credit
 - Industrial cooperative
 - Others (SPECIFY)

1
2
3
4
5

11-15

Q.10a Are there any clubs/Mandals,associations in the village ?

Yes : 1 No . 2 16

IF YES, What are their areas of activity?

Association

1/ _____
 2/ _____
 3/ _____
 4/ _____
 5/ _____

17-26

IF MAHILA MANDAL/WOMEN'S GROUP NOT MENTIONED SPONTANEOUSLY IN Q.10a, ASK

Q 10b Is there any Mahila-Mandal or women's group in your village ?

Yes 1
 No 2

27

Q.11a Water and Sanitation

What is the main source of drinking water for the village? What other?

What is the main source of water for general use ? What other ?

(FOR EACH AND EVERY SOURCE MENTIONED, SPECIFY THE NUMBER AVAILABLE).

Drinking water Main Others No. General purpose Main Others No (SINGLE CODE)

Tap (within house)

1	2
1	2
1	2
1	2
1	2
1	2
1	2
1	2

1	2
1	2
1	2
1	2
1	2
1	2
1	2
1	2

Others (SPECIFY)

28 36

37-54

55 63

64-81

Q 11b Could you tell me that on an average for how many hours in a day, the following water sources are used by the households ?

Water source

Number of hours/day

Taps (within house)

Taps (outside house/community)

Handpumps

Sanitary wells

Gravity feed/Protected spring

82-91

Q.12a Are there any private latrines, in the village ? Approximately how many ?

12b Are there any community latrines in the village ? Approximately how many ?

	Yes	No	Number
Private latrines	1	2	_____
Community latrines	1	2	_____

92-93 94-97

12c. Can you indicate to me which of the following institutions are present in your village? FOR EACH OF THESE INSTITUTIONS PRESENT ASK Q.12d & Q.12e

Q.12d Does _____ have a latrine ? Is it functioning?

Q.12e Does _____ have a urinal? Is it functioning ?

INSTITUTIONS

School

Anganwadi

Health-Centre

Panchayat office

DWCRA - Multi - purpose centre

Q.12c	Q.12d				Q.12e			
	Latrine				Urinal			
	Present		Functioning		Present		Functioning	
Yes	No	Yes	No	Yes	No	Yes	No	
School	1	2	1	2	1	2	1	2
Anganwadi	1	2	1	2	1	2	1	2
Health-Centre	1	2	1	2	1	2	1	2
Panchayat office	1	2	1	2	1	2	1	2
DWCRA - Multi - purpose centre	1	2	1	2	1	2	1	2

98-122

Q.13 Does the village have any centre/shop from where ORS can be obtained ?

Yes 1

No 2 123

IF '1' CODED, SPECIFY SOURCE(S)

PHC/Dispensary/Hospital

Sub-centre

Anganwadi centre

Chemist - private

General stores

Others (SPECIFY)

1
2
3
4
5
6

124-127

Q 17b Why do you go to (READ OUT AS MENTIONED IN 18a) for advice on
 (READ OUT BASED ON WHETHER INFORMATION SOUGHT ON Low cost sanitation or
 Diarrhoea or Maintenance of water sources)?NOTE REASON VERBATIM

Low cost sanitation :

71-76

Diarrhoea

77-82

Maintenance of
 water sources :

83-88

Q.18a Who repairs the hand-pumps in the village when it breaks down?

89-92

Q.18b Who maintains the handpump in the village ?

93-96

Q.18c Who reports the breakdown of the handpump in the village?

97-100

Q.18d To whom is the breakdown reported?

101-104

Q.18e Normally, how much time does it take to repair the handpump?

_____ hours / days 105-106

Q.18f At present in your village, how many handpumps are out of order? 107-108

None : 1

_____ (Enter number as stated)

Q.19a Is there any source of flowing water present in the village?

Yes : No : 109

Q 20a What proportion of the village households are involved in farming ?

- | | | | |
|----------|---|----------------------|---|
| <25% | : | <input type="text"/> | 1 |
| 26 - 50% | : | <input type="text"/> | 2 |
| 51 - 75% | : | <input type="text"/> | 3 |
| 76%+ | : | <input type="text"/> | 4 |
| DK/CS | : | <input type="text"/> | 5 |
- 110

Q 20b Do most farmers grow only one crop or more than one crop?

One crop

1

More than one crop

2

111

Q.20c What percentage of the total cropped area would be irrigated?

_____ % (SPECIFY AS STATED)

--	--

 112-113

Q 21 Is there any forest near the village?

Yes : 1

No : 1

114

Q 22 Description of the village (Based on observation)

Yes

No

Is there drain water flowing/stagnating on the roads/open spaces?

1

2

Are houses crowded together ?

1

2

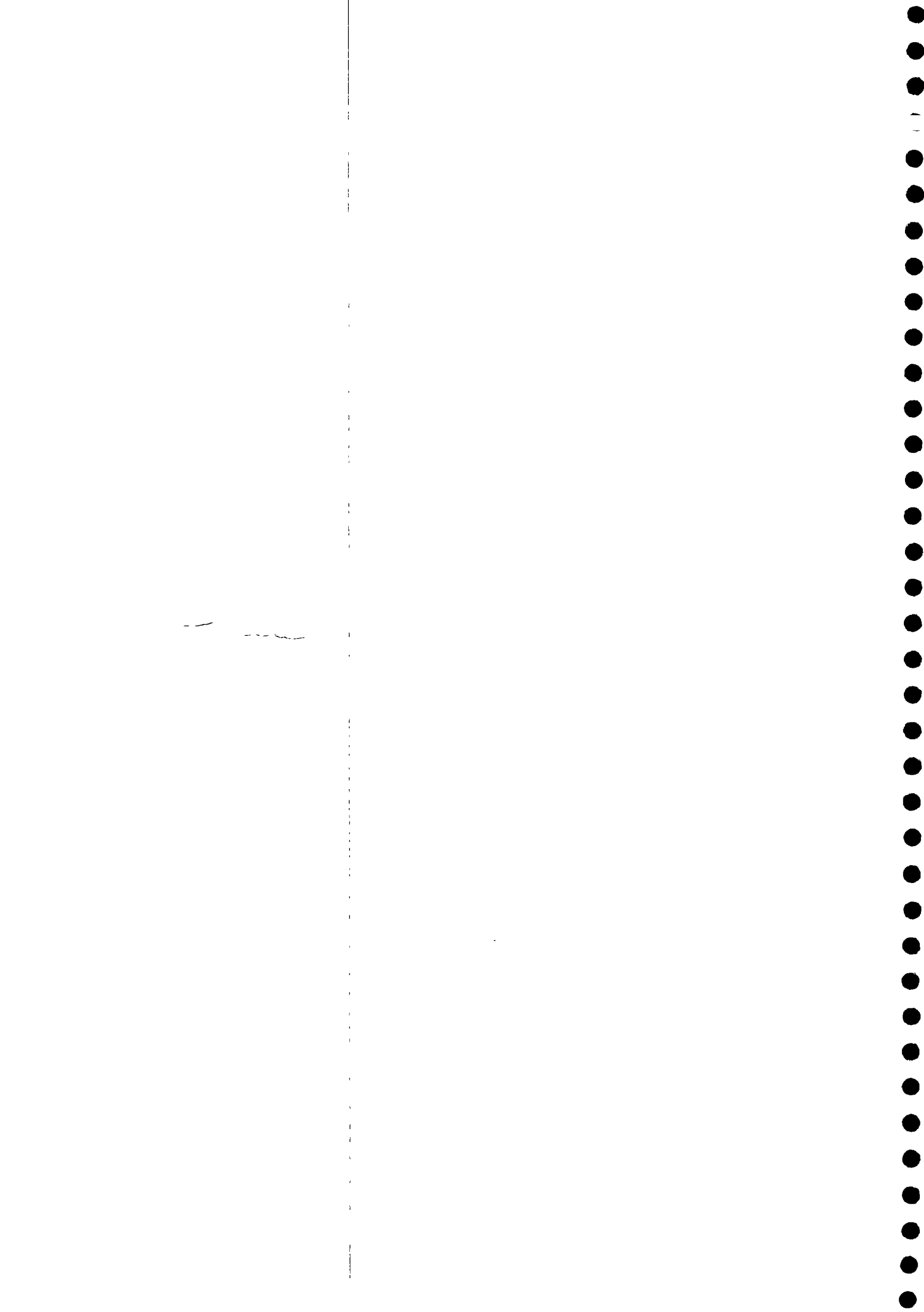
Is there garbage lying around, visible ?

1

2

115-117

THANK AND TERMINATE



APPENDIX

1					1				
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SRI/90033/1992 JULY

DIARRHOEA STUDY - RURAL & URBAN

Name of respondent : _____

District Name : _____ City Name : _____

Village Name : _____ Ward Name _____

Name of interviewer : _____ Date _____

Name of Supervisor : _____

Accompanied : 1	Backchecked : 2	Neither : 3	11
-----------------	-----------------	-------------	----

Contact sheet No :

--	--	--	--	--	--

 12 - 17

Household No. :

--	--	--	--

 18 - 21 (as given in contact sheet)

PROCEED WITH MAIN INTERVIEW ONLY IF '1' IS CODED FOR ANY CHILD FOR THE QUESTION PERTAINING TO DIARRHOEA IN THE PAST 24 HOURS. IF THERE ARE TWO OR MORE CHILDREN SATISFYING THIS CRITERION, MULTIPLE INTERVIEWS IN ONE HOUSEHOLD ARE POSSIBLE AS LONG AS THE CARE GIVERS OF THESE CHILDREN ARE NOT THE SAME

Q.1 IS ONLY TO BE ASKED FOR CHILDREN < 5 YEARS OLD

Q 1a You said that there are _____ children aged below 5 years in your household. Could you please tell me the name, age and whether boy or girl for each child. START WITH YOUNGEST AND MOVE UP UNTIL ALL BELOW FIVES COVERED.

CODE IN COL 1a.

For each one of these children, ask Q.1b

Q.1b Of these, which children are currently breastfed ? (CODE IN COL 1b)

Serial No	Child Name	1a		Age		1b	
		Male	Female	Years	Months	Yes	No
Youngest 1		1	2			1	2
2		1	2			1	2
3		1	2			1	2
4		1	2			1	2
5		1	2			1	2
6		1	2			1	2
7		1	2			1	2
Oldest 8		1	2			1	2

Q.2a-Q.2c WILL BE ASKED ONLY FOR CHILDREN IN THE AGE GROUP 6 MONTHS - 12 MONTHS - FOR EACH OF THESE CHILDREN, ASK :

Q 2a Till what age (months) was (name of child) fed only on breastmilk and given no other food items or any other form of milk

Youngest	1	_____	Months	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>									
	2	_____	Months										
	3	_____	Months										
Oldest	4	_____	Months		54 - 61								

Q 2b During this period of time, when the child was fed only on breastmilk, was this child given any of the following items?

ASK FOR EACH CHILD RECORDED ABOVE

	Youngest		Next		Next		Oldest		
	Yes	No	Yes	No	Yes	No	Yes	No	
Water	1	2	1	2	1	2	1	2	62 - 65
Honey	1	2	1	2	1	2	1	2	66 - 69
Janam-Ghutti	1	2	1	2	1	2	1	2	70 - 73
Gripe water	1	2	1	2	1	2	1	2	74 - 77

Q 2c At what age did you introduce solid foods for your children ?

Youngest	1	_____	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>									
	2	_____										
	3	_____										
Oldest	4	_____		78 - 85								

Q.3a & Q.3b WILL BE ASKED ONLY FOR CHILDREN IN THE AGE GROUP 12 - 24 MONTHS

Q 3a Has (Name of Child) been immunised against measles?

FOR EACH CHILD FOR WHOM '1' CODED IN Q.3a, ASK TO SEE IMMUNISATION CARD - IF CARD AVAILABLE, SEE IT AND NOTE DOWN EXACT AGE OF IMMUNISATION IN COL '3b'. IF NOT AVAILABLE ASK Q.3b. (NOTE UNDER "CARD SHOWN" AS APPROPRIATE)

Q 3b Can you tell me the exact age at which this child was immunised (enter in col '3b' below)

Name	3a		3b		Age at Immunisation								
	Immunised	Card shown											
	Yes	No	Yes	No									
1)	1	2	1	2	<table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr><tr><td> </td><td> </td></tr></table>								
2)	1	2	1	2									
3)	1	2	1	2									
4)	1	2	1	2									
5)	1	2	1	2									

86 90

91 95

96 - 105

IF '2' CODED FOR ALL ABOVE, ASK

Q.3b Would you say your child's behaviour is as normal?

- Yes 1
- No 2 16

IF NO,

Q.3c In what way is the child's behaviour different?
(RECORD VERBATIM)

17 - 22

4a During the past 24 hours, was the quantity of food given to the child suffering from diarrhoea
(READ, ROTATE ORDER)

- Same as normal 1
 - More than normal 2
 - Less than normal 3
 - Stopped all food 4
 - DK/CS 5
- CONTINUE
- 23 MOVE TO Q 6a

5 Why did you feed the child more/less/same or why did you stop ?

General answers

Suggested by doctor

- 1
- 2
- 3

24 - 26

More

- 1 Child hungrier/
demanded more
- 2 To make up for
child losing food
- 3 Food tightens stools

To give energy/counter
weakness

27 - 30

Less/stopped

- 1 Child not hungry/
rejected food
- 2 Food not retained
in any case
- 3 Food increases freq.
of loose motions/makes it
worse
- 4 Solids should not be given
- 5 Important to give only fluids

31 - 35

Others (SPECIFY) _____

6a (i) During the past 24 hours, did you make any change in the quantity of fluids normally given to the child, i.e. increased or decreased or stopped any fluid ?

- Yes, gave more fluids 1
 - Yes, gave less fluids 2
 - No same quantity given 3
 - Yes stopped fluids altogether 4
 - DK/CS 5
- 42 CONTINUE

IF '1', '2' OR '3' CODED IN Q 6a (i) ASK Q.6b, Q.6c & 6d

IF 4 OR 5 CODED IN Q 6a(i), CONTINUE

(ii) During the attack have you used any powder from packs such as these

- Yes 1 No 2

IF YES, GO TO 6F IF NO, GO TO Q9.

6b During this attack, what were the fluids that you gave the child ? (CODE ALL ITEMS MENTIONED SPONTANEOUSLY UNDER COL 6b)

Q.6c Of the fluids given, which fluids would you say you are giving the most frequently ? (SINGLE CODE - CODE UNDER COL 6c)

FOR EACH FLUID NOT MENTIONED IN Q.6b, ASK

Q.6d I have with me a list of fluids here. Can you tell me which of these fluids you have given this time to the child suffering from diarrhoea ? (Code under 'This time')

FOR EACH FLUID NOT GIVEN THIS TIME, ASK

6e) Have you ever given any of these fluids for a child with diarrhoea ?

	6b Spontaneous	6c Most frequent	6d Given This time	6e Ever Given
Breastmilk	1	1	1	1
Lemon water with salt	2	2	2	2
Lassi/Buttermilk	3	3	3	3
Kanji	4	4	4	4
Coconut water	5	5	5	5
Dal water	6	6	6	6
Rice water	7	7	7	7
Vegetable soup	8	8	8	8
Milk/Cows milk	9	9	9	9
SSS	10	10	10	10
ORS	11	11	11	11
DK/CS	12	12	12	12
Others (SPECIFY)				44 - 58

59 - 60

IF '11' CODED IN Q 6b, Q 6c or 6d ASK TO SEE THE PACKETS. IF AVAILABLE, NOTE DOWN THE CONSTITUTION OF THE ORS AND ITS BRAND NAME IF NOT AVAILABLE, SHOW RESPONDENTS DIFFERENT PACKETS AND ASK HER TO POINT OUT THE PACK USED NOTE BRAND NAME AS POINTED OUT.

6f NOTE BRAND BELOW

BRAND NAME _____

61 - 62

CODE Whether pack shown by her .

Identified from pack shown to her .

Neither stated nor identified

1
 2
 3 63

Note the pack ingredients as follow :

Ingredients	Amount
Packet weight (grams)	_____ grams
Glucose (a form of sugar)	_____ grams
Sodium nitrate	_____ grams
Sodium bicarbonate	_____ grams
Potassium chlorite	_____ grams

64 - 81

PLEASE NOTE THIS INSTRUCTION VERY CAREFULLY

Q7. WILL BE ASKED ONLY IF ORS HAS BEEN GIVEN DURING THIS ATTACK

Q8. WILL BE ASKED TO ALL WHO EVER GIVEN ORS

Q 7a Have you given ORS to the child in the past 24 hours?

Yes	1	
No	2	82

Q 7b From where did you procure it ?

SPECIFY SOURCE

Within the village	1	
Outside the village	2	83

Health worker
 Anganwadi worker
 PHC/Sub-centre
 Chemist shop
 Others (SPECIFY)

1
2
3
4
5

84 - 87

Q 7c Who prepared the ORS solution ?

Self	1	
Other family members	2	
Neighbours	3	
Health worker	4	
Other (SPECIFY)	5	88 - 91

Q 7d Over how much time did you use this solution ?

..... hours (ENTER AS STATED AND THEN POST-CODE)

For a half day (upto 12 hrs)	1	
For a full day (13- 24 hrs)	2	
For the next day (> 25 hrs)	3	
DK/CS	4	97

--

92-96

ASK ALL WHO HAVE GIVEN ORS (i.e. '1' coded in 6a (ii) or '11' coded in 6b,c,d)

Q.8a This time when you used ORS, did you use all the powder (the whole pack) at a time or did you take out powder as needed?

Whole pack used	1	CONTINUE
Powder taken as needed	2	
DK/CS	3	98

IF '1' CODED ASK 8b

IF 2 OR 3 CODED GO TO Q9

Q.8b For this quantity of powder, can you show me how much water you used? (ASK THE RESPONDENT TO BRING A CONTAINER AND INDICATE THE QUANTITY OF WATER USED - POUR THIS INTO YOUR OWN MEASURING JAR AND NOTE THE QUANTITY USED).

_____ ml

--	--	--	--

 99 - 102

ASK ALL

Q.9 For your child's present attack of diarrhoea, have you consulted anybody for treatment ?

Yes	1	CONTINUE
No	2	MOVE TO Q 12
DK	3	103

IF '1' CODED ASK

Q.10 Whom did you consult for treatment ? Any other? Any other ? MULTI - CODE OKAY

Allopathic doctor - government	01
Allopathic doctor - private	02
Non-allopathic doctor - government	03
Non allopathic doctor - private	04
Pharmacist /chemist - commercial	05
Sub-centre	06
Health worker/Anganwadi worker	07
Village health guide	08
Tantrik/Witch-doctor	09
Other (SPECIFY) _____	10

104 - 109

SECTION B : WATSAN

Q1. What is the main source of drinking water for your household ?

	Private	Community
Tap	01	02
Handpump	03	04
Sanitary well	05	06
Open well	07	08
Protected spring/Gravity feed		09
River / stream /canal		10
Lake/Pond		11
OTHERS (SPECIFY)	_____	_____

P V T		
C O M M		

28 - 37

Q2. Approximately what distance do you have to travel to get drinking water ? _____ Km
How much time does it take to walk till the source (one way)? _____ Minutes

Distance

< 0.5 Km	1
0.5 - 1.0 Km	2
1.1 to 1.5 Km	3
1.6 - 3.0 Km	4
> 3 Km	5
DK/CS	6

38

Time taken

< 5 minutes	1
6 - 10 minutes	2
11 - 15 minutes	3
16 - 20 minutes	4
20 + minutes	5

39

Q3. How often in a day do you go to collect drinking water ?

Nothing fixed, any number of times	1
1 - 3 times	2
4 - 6 times	3
7 times or more	4
DK/CS	5

40- 43

Other (SPECIFY) _____

Q4a. Is drinking water stored in your house or is it not stored ?

Not stored at all	1
Is stored	2

44

IF '2' CODED IN Q4a, CONTINUE

IF '1' CODED GO TO Q.5a

Q4b. Where (in terms of position) do you store the water ?

On the floor	1
On a platform	2

45

Q4c. Is the vessel in which drinking water is stored normally kept covered or is it not covered ?

- Kept covered 1
- Not kept covered 2
- DK/CS 3
- Other (SPECIFY) 4 46

Q4d. Does the vessel in which water is stored have a narrow mouth or a broad mouth ? (Narrow-means less than or equal to the size of a saucer)

- Narrow : 1
- Broad : 2 47

Q4e. How is water taken out from the container at the time of drinking ?

- A separate ladle used 1
- A separate glass/cup kept only for this 2
- Tap in pot / vessel 3
- Vessel tipped over and used 4
- Any glass/cup dipped into the water 5
- Others (SPECIFY) 6 48 - 51

Q5a Do you do anything to make the drinking water clean or do you use it as is ?

- Something done to clean 1
- Used as is 2
- DK/CS 3 52

IF '1' CODED, ASK 5b; ELSE GO TO Q.6

Q5b What are the water purification methods employed (MULTI CODING OKAY)

- Cloth filter 1
- Purification tablets 2
- Candle filter 3
- Aquaguard type 4
- Boiling of water 5
- Others (SPECIFY) _____ 6 53-56

Q6a) For each of the following activities can you tell me where you obtain the water? (ENTER CODE IN COL 6a - SOURCE CODE IS TO BE TAKEN FROM IN Q1 WATSAN SECTION OR THE CARD GIVEN TO YOU THEN ASK Q6b) AND THEN MOVE ON TO THE NEXT ACTIVITY)

Q6b) Can you tell me where _____ is performed (CODE WHETHER THE ACTIVITY IS PERFORMED AT HOME WITH PRIVATE WATER SOURCE OR WITH STORED WATER OR AT THE WATER SOURCE ITSELF)

Activity	6a		6b		
	Source (CODES FROM Q1)		In house (pvt. water source)	Performed	
			In house (Water collected from outside and stored)	Out of house (water not collected)	
Cooking	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Bathing	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Washing vessels	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Washing clothes	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Washing cattle	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Drinking water (Cattle)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	57 - 68		69 - 74	75 - 80	81 - 86

IF '2' CODED AT ALL IN Q 6b, OR IF 2 CODED IN Q4a, ASK

Q6c) What is the container that you usually (mainly, mostly) use for collecting water for different activities
Can you please show it to me?

PLEASE NOTE

IF CONTAINER CAPACITY PREVIOUSLY MEASURED (IN EARLIER INTERVIEWS) I.E A STANDARD SIZED CONTAINER NORMALLY USED IN VILLAGE NOTE CAPACITY BELOW.

IF NOT EARLIER MEASURED (I.E STANDARD CONTAINER NOT USED) THE MEASURE THE CAPACITY AND NOTE BELOW:

Container capacity _____ litres (a)

How many such containers are collected in a day (drinking + others) ? _____ containers (b)
87-90

Total water collected (litres) a x b _____ litres
91-94

FOR EACH ACTIVITY WHERE '1' OR '3' CODED IN Q 6b, OR IF '1' CODED IN Q4a ASK

Q6d) If you had to store water for (READ OUT EACH ACTIVITY FOR WHICH WATER NOT STORED ONE BY ONE), how many such containers would you need? (Refer to container most frequently used).

Activity	Number of containers
Drinking	<input type="text"/>
Cooking	<input type="text"/>
Bathing	<input type="text"/>
Washing vessels	<input type="text"/>
Washing clothes	<input type="text"/>
Washing cattle	<input type="text"/>
Drinking water (cattle)	<input type="text"/>
	95-108
	<input type="text"/>
	109-112

Q.7a Does your household have a latrine?

Yes 1
No 2

CONTINUE
MOVE TO Q.7c

113

IF '1' CODED IN Q.7a. ASK

Q.7b What type of latrine is it?

Service 1
Septic tank 2
Flush system 3
Single pit 4
Dual pit 5
DK/CS 6
Others (SPECIFY) 7 114-117

IF '2' CODED IN Q.7a, ASK

Q.7c Is there any community latrine or mobile latrine accessible to you?

	Yes	No
Community latrine	1	2
Mobile latrine	1	2

 118-119

IF '2' CODED IN BOTH, MOVE TO Q.8

IF '1' CODED IN 7a/7c ASK

Q.7d In your household who are the people who normally use the latrine ?

All 1
Only adults (Male) 2
Only adults (Female) 3 CONTINUE
Only old/sick 4
Only boys 5
Only girls 6
None 7 GO TO Q 7g

120-123

IF AT LEAST ONE PERSON FROM THE HOUSEHOLD IS USING THE LATRINE, ASK :

Q7e Can you tell me the sex and age of each of the persons who make use of the latrine for defecation?

S.No.	Sex		Age (Years)
	Male	Female	
1	1	2	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%; border-bottom: 1px solid black;"></div> <div style="width: 35%; border-bottom: 1px solid black;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%; border-bottom: 1px solid black;"></div> <div style="width: 35%; border-bottom: 1px solid black;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%; border-bottom: 1px solid black;"></div> <div style="width: 35%; border-bottom: 1px solid black;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%; border-bottom: 1px solid black;"></div> <div style="width: 35%; border-bottom: 1px solid black;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%; border-bottom: 1px solid black;"></div> <div style="width: 35%; border-bottom: 1px solid black;"></div> </div>
2	1	2	
3	1	2	
4	1	2	
5	1	2	

11-15 16-25

Q7f Why do some (all) of your household members use a toilet for defecation?

More hygienic/open air defecation is unhygienic	1	SPECIFY ILLNESS <hr/> <hr/> <hr/>	<div style="display: flex; justify-content: space-between;"> <div style="width: 60%; border-bottom: 1px solid black;"></div> <div style="width: 35%; border-bottom: 1px solid black;"></div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="width: 60%; border-bottom: 1px solid black;"></div> <div style="width: 35%; border-bottom: 1px solid black;"></div> </div>
Using a toilet is in keeping with status	2		
Facility is available and so is used	3		
Person is ill	4		
Educated people prefer to use this method	5		
DK/CS	6		
Others (SPECIFY) _____	7		

26-31 32-37

In Q.7d IF '1' NOT CODED ASK

Q7g Why do some of your household members not use a latrine for defecation ? OR Why do none of your household members use the latrine ?

Not convenient	01
Open air is much better	02
Latrine is clogged up/blocked	03
Latrine is in bad conditions/smells bad	04
Tradition	05
Water problem/ water not available	06
Toilet broken (walls/floor/door)	07
Not accessible	08
DK/CS	09
Others (SPECIFY) _____	10

38-47

IF NONE USE OUTDOORS, GO TO Q.9

IF SOME OR ALL MEMBERS DEFECATE OUTDOORS (DO NOT USE A LATRINE), ASK Q 8

Q 8 Where do the members (who do not use any latrine) go for open-air defecation ? Please tell me for all children first (by sex), then youngsters and then older persons

Place of defecation	< 5 year		6-14 years		15+ years	
	Male	Female	Male	Female	Male	Female
Just near the house	1	1	1	1	1	1
Near house, outside compound	2	2	2	2	2	2
Near house, on/at the drain	3	3	3	3	3	3
At a place away from the house, in the village	4	4	4	4	4	4
At a place away from the house, away from the village	5	5	5	5	5	5
	18-51	52-55	56-59	60-63	64-67	68-71

ASK ALL

Q 9 In case of children (< 5 years old), can you tell me where the faeces are disposed-off?

Near the house, outside the wall	1
Near the house, outside the compound	2
Near the house, on/at the drain	3
In the latrine	4
At a place away from the village	5
Not disposed of at all	7
DK/CS	8
Others (SPECIFY) _____	9 72-75

ASK ALL

Q 10 Normally in your household do the children below the age of 5 go alone for defecation or do they go accompanied by someone ?

Go alone	1
Accompanied by somebody	2
DK/CS	3
Others (SPECIFY) _____	4 76-77

Q 11a When a person from your household goes for defecation does he/she go barefoot or does he/she go wearing some footwear ?

Goes barefoot	1
Goes wearing footwear	2
Nothing fixed varies from time to time	3
Varies from person to person	4
DK/CS	5
Others (SPECIFY) _____	6 78-81

IF '4' CODED IN Q 11a, ASK;

Q11b. Can you tell me who in your household uses footwear at time of defecation ? (by sex and age)

Male	Female	Age (years)
1	2	
1	2	
1	2	
1	2	
1	2	

82-86

87-96

REFER Q. 9 IF 1-5 CODED IN Q9, ASK,

Q12) You said that you normally dispose the infants faeces in some way I shall now read out some questions to you. Please answer these questions with a Yes or No (ROTATE ORDER IN WHICH QUESTIONS ARE READ)

	Yes	No	Sometimes	Never
Do you ever leave these faeces around for a while before you attend to them?	1	2	3	4
Do you ever wrap these in some form?	1	2	3	4
Do you ever dig a hole and put the faeces inside?	1	2	3	4
Do you ever cover the hole with mud/soot/leaves ?	1	2	3	4

97-100

IF OPEN - AIR DEFECACTION MENTIONED FOR ANY OF THE HOUSEHOLD MEMBERS, THEN ASK, Q .13 a; IF NOT, GO TO Q.14

Q13a) You said that some of your household members go for open air defecation. Can you tell me how far this spot is : (READ OUT LOCATION, ENTER RESPONSE AND THEN ASK Q.13b - THEN READ OUT NEXT LOCATION)

Location	Distance (Meters/Km)	Minutes	
i) From any person's home or place of human inhabitation	_____	_____	101-105
ii) From nearest playground	_____	_____	106-110
iii) From any drinking water source	_____	_____	111-115

ASK ALL

Q14a) Please think back over the last 24 hours and the occasions on which you may have washed your hands. Can you tell me what these occasions were? (CODE SPONTANEOUS RESPONSES UNDER 14a)

FOR EACH RESPONSE NOT MENTIONED, ASK

Q14b) I have with me a list of activities here. Could you tell me for which of these in the past 24 hours, you washed your hands?

FOR EACH RESPONSE MENTIONED IN Q 14a/14b FOR WHICH HANDS WASHED, ASK,

Q14c) With what did you wash your hands?

Activity	14a Spontaneous	14b Washed hands (Prompted)		Water only	14c		Other (SPECIFY)
		Yes	No		Water + Soap	Water + ash/ mud	
Before eating food	1	1	2	1	2	3	_____
Before serving food	1	1	2	1	2	3	_____
Before feeding child	1	1	2	1	2	3	_____
Before cooking	1	1	2	1	2	3	_____
After using the latrine/defecation	1	1	2	1	2	3	_____
After cleaning child's stools	1	1	2	1	2	3	_____
After disposing child's stools	1	1	2	1	2	3	_____
Others (SPECIFY)	_____						_____

11 - 40

41-58

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59

CLASSIFICATION DATA

1 **Age of respondent**

_____ years	Stated	Sex
< 15 years	1	Male 1
16 - 25 years	2	Female 2 60
26 - 35 years	3	
36 - 45 years	4	
46 + years	5	
DK/CS	6 61	

2a **Type of family**

Joint	1
Nuclear	2 62

(Joint = different family units/generations other than nuclear family sharing the kitchen)

2b **Total number of family members living together :** _____ 63-64

3. **Could you tell me your average monthly household income (Please include income from all sources)**

< Rs. 350	1	
Rs 351 - 500	2	Rs _____ per month
Rs 501 - 750	3	
Rs 751 - 1000	4	
Rs 1001 - 1500	5	
Rs 1501 - 2000	6	66-69
Rs 2001 - 2500	7	
2501 +	8 65	

4a **Religion of respondent**

Hindu	1	Jain	4
Muslim	2	Sikh	5 70
Christian	3	Other (SPECIFY)	

4b. **Caste of respondent** _____

71-72

5a. **Have you ever been to school ?**

Yes	1
No	2

MOVE TO Q 5c

73

5b. Upto what level have you studied ?

- | | | |
|---|---|----------|
| Less than 4 years | 1 | CONTINUE |
| 5 - 9 years | 2 | |
| > 10 yrs (SSC/HSC) | 3 | |
| Some college (including diploma but not graduate) | 4 | |
| Graduate/Post graduate (general) | 5 | |
| Graduate/Post graduate (Professional) | 6 | 74 |

ASK IF '2' CODED IN 5a OR '1' CODED IN 5b

5c. Can you read any language ?

- | | | |
|-----|---|----|
| Yes | 1 | |
| No | 2 | 75 |

6 I would like to know something about the person who makes the biggest contribution to the family budget. What is his occupation ? (If Retired : What was his occupation before he retired ?)

6a. What is the highest level to which he has studied ?

1	2	3	4	5	6	7	76
---	---	---	---	---	---	---	----

	School upto 4 years	School upto 5-8 years	SSC/HSC	Some college (inc. dip.) but not graduate	Graduate Post/Graduate General	Graduate Post/Graduate Prof
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01. Unskilled worker Farm labour	8	8	7	6	6	6	6
02. Skilled workers (Owner farmer - 5 acres)	8	8	7	6	5	4	4
03. Petty traders (Owner farmer 6-20 acres)	8	7	7	6	6	6	6
04. Shop owners (Owner farmer 20+ acres)	7	6	5	4	3	2	2
05. Businessmen/ Industrialists	5	5	5	3	3	2	1
06. Self-employed professionals	6	6	6	5	4	2	1
07. Clerical/Salesman	6	6	6	5	4	2	1
08. Supervisory level	6	6	6	5	4	3	2
09. Officer/Executives - Junior	5	3	3	3	3	2	1
10. Officer/Executives Middle/Senior	2	2	2	2	2	1	1

77-78

7. BASED ON OBSERVATION

NOTE CONSTRUCTION OF DWELLING AND CODE BELOW

- | | | |
|--|---|-------------|
| Mud walls thatched roof | 1 | SINGLE CODE |
| Mud walls roof of shingles tin asbestos | 2 | |
| Brick walls tin asbestos roof | 3 | |
| Brick walls concrete or cemented ceiling | 4 | SINGLE CODE |

THANK AND TERMINATE.

79/80

APPENDIX

QUESTIONNAIRE - HEALTH SYSTEM

Name of town : _____

Name of village : _____ Tehsil _____

District : _____ State _____

Name of interviewer _____

Name of supervisor : _____

Accompanied :

1

 Date : _____

Backchecked :

2

Neither :

3

 11

Type of centre :

Rural

Urban

District hospital

1

Medical college hospital

1

Community health centre

2

Government hospital

2

PHC

3

Dispensary

3

Sub-centre

4

 12

Others (SPECIFY)

4

 13

ASK ALL

Q.1a Which are the childhood diseases for which you report to your higher authorities?

Tetanus

1

Polio

2

Pertussis

3

Diarrhoea

4

MOVE TO Q.1c

Cholera

5

Others (SPECIFY)

6

 13-18

19-22

IF DIARRHOEA NOT MENTIONED IN Q.1a, ASK

Q.1b Do you ever send out any reports on diarrhoeal disease cases ?

Yes

1

 CONTINUE

No

2

 MOVE TO Q.2

IF '4' CODED IN Q.1a OR '1' CODED IN Q.1b, ASK

Q.1c How frequently do you send out reports on diarrhoeal diseases during normal circumstances? And during an outbreak?

	Normal	Outbreak
Once in a week	1	1
Once in a fortnight	2	2
Once in a month	3	3
Less frequently	4	4
DK/CS	5	5
Others (SPECIFY)	6	6
_____	24-25	26-27

ASK ALL

Q.2a In this past one year, from the last monsoon to this one, how many childhood deaths occurred due to diarrhoea in your area?

_____ ENTER AS STATED 28-31

ASK ALL

Q.2b How frequently do you report on deaths due to diarrhoeal disease?

Once in _____ (time period) 1

No separate reports on death due to diarrhoeal disease 2

Others (SPECIFY) _____ 3 32

7 33-35

IF '1' CODED IN Q.2b, ASK

Q.2c Is this a special report or does it go as part of a regular report?

Special 1

Regular 2

SPECIFY NAME OF REGULAR

REPORT: _____ 37-38

ASK ALL

Q.3a On an average, how many cases of diarrhoea are reported to you in a week?

And in a month?

_____ (Cases per week) 39-41

_____ (Cases per month) 42-45

Q.3b And how many cases per week, would indicate to you the occurrence of a diarrhoeal outbreak? And per month?

_____ (Cases per week) 46-48

_____ (Cases per month) 49-52

Q.3c In your experience here, have you ever faced such an outbreak of diarrhoea?

Yes 1
 No 2 53

IF '1' CODED IN Q.3c, ASK

Q.3d The last time that there was an outbreak of diarrhoea, what actions did you (if sub-centre)/your centre (in other cases i.e. PHC/district hospital etc.) initiate? (CODE UNDER SPONTANEOUS)

FOR EACH ITEM NOT MENTIONED SPONTANEOUSLY, ASK

Did you (READ ITEM) during the outbreak?

IF '2' CODED IN Q.3c, ASK

Q.3e If there was to be an outbreak of diarrhoea here, what actions would you initiate?

FOR EACH ITEM NOT MENTIONED SPONTANEOUSLY IN Q.3e, ASK

Would you do (READ ITEM) if there was an outbreak of diarrhoea?

ITEMS	Q.3d			Q.3e		
	Spontaneous	Prompted Yes	No	Spontaneous	Prompted Yes	No
Increase medicine stock	1	2	3	1	2	3
Increase IV fluids stock	1	2	3	1	2	3
Give cholera vaccination	1	2	3	1	2	3
Report to higher authority	1	2	3	1	2	3
Organise a mother's meeting	1	2	3	1	2	3
Increase indent for ORS packets	1	2	3	1	2	3
Initiate well chlorination	1	2	3	1	2	3
<u>ONLY FOR PHCs AND HOSPITALS</u>						
Conduct training of health/medical workers	1	2	3	1	2	3
Fill up vacancies/increased staffing	1	2	3	1	2	3

54-62

54-62

Q.4 IS TO BE ASKED ONLY IN CASE OF PHCs AND CHCs

Q.4a Do you have an ORT corner in this centre?

Yes 1
 No 2
 Sometimes 3 63

64-65

(SPECIFY) Only during _____

IF YES, ASK

Q.4b Is it a permanent corner ?

Yes No

1	2
1	2

Q.4c Is it operational just now ?

66-67

ASK ALL

Q.5a Do you have any stock of ORS packets at present?

Yes

1

No

2

68

IF '1' CODED IN Q.5a, ASK

Q.5b Approximately how many ORS packets do you currently have in stock?

_____ ORS packets

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67-92

THANK AND TERMINATE

