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Draft

NMIS Cycle 3

Diarrhoea, Water & Sanitation

Key Points for Discussion and Action

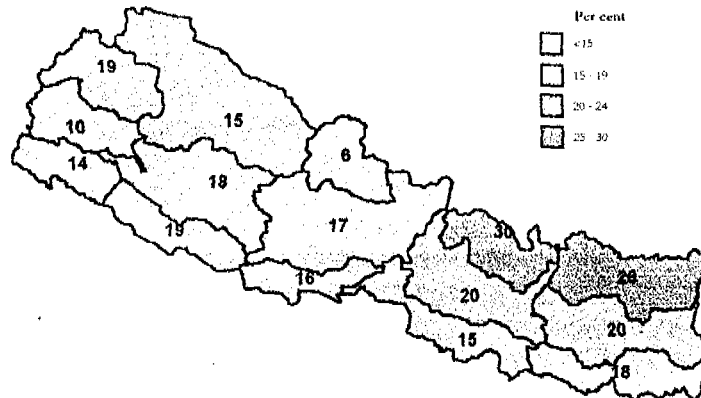
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Key Findings

Diarrhoea incidence and duration

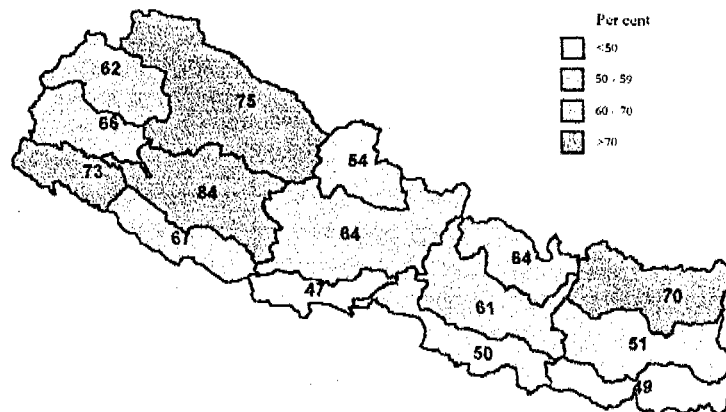
- ❑ 17% of children under five years old have had diarrhoea in the last two weeks (in the dry season). The peak age of diarrhoea is in children 7-18 months.
- ❑ The incidence of diarrhoea varies between different parts of the country

Incidence of diarrhoea



- ❑ Many people have misconceptions about the causes and prevention of diarrhoea; for example, they think it is due to hot or cold weather or certain foods.
- ❑ Just over half the episodes of diarrhoea last more than three days. The proportion of episodes that last more than three days varies between different parts of the country.

Episodes of diarrhoea

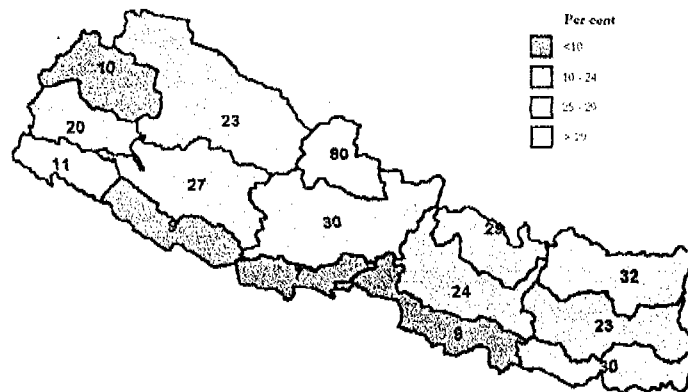


Key Findings

Diarrhoea management

- One third of children with diarrhoea are given Jeevan Jal.
- More than half the households know that they should give children with diarrhoea more fluid to drink than usual. But only one in five (20%) children are actually given the correct Oral Rehydration Therapy (ORT) of increased fluids and increased feeding. This is a little lower than the 1996 goal of 25% for this indicator in the Nepal National Programme of Action. The most common reason given in focus groups for not giving extra fluids is that the mother is too busy working to spare time for the sick child.
- The proportion of children with diarrhoea given correct ORT varies between different parts of the country

Per cent of children given extra fluids and any food during diarrhoea



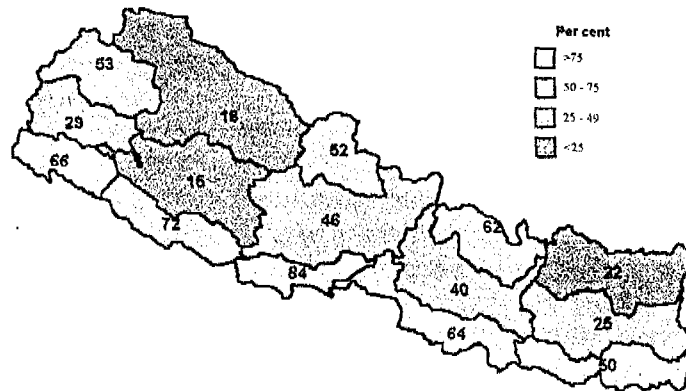
- Outside medical help is sought for just over half the children with diarrhoea. Help may not always be sought at the right time. Help is sought for nearly half the children who have short duration diarrhoea without any blood in the stool, probably unnecessarily. But help is sought for only two-thirds of those who have blood in the diarrhoea, for whom help should nearly always be sought.

Key Findings

Water access and quality

- In this survey, access to safe water within a reasonable distance is defined as access to safe water from a tap, pipe, borehole, handpump or spring within 10 minutes (return journey). 44% of households have reasonable access to safe water in the dry season (a little higher in the wet season). This is below the 1996 goal of 53% for this indicator. The access in urban sites (77%) is much better than in the rural sites (42%).
- Timely access to safe water varies between different parts of the country.

Water access (Per cent pump/tap within 10 minutes; wet season)



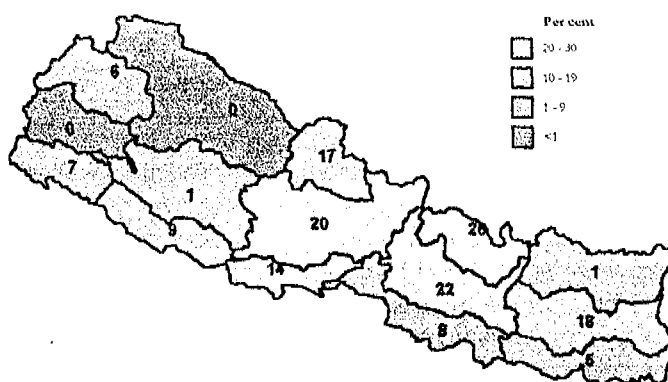
- Less than one in ten households treat their drinking water in any way before use and three out of four households think their water quality is 'good'.
- The most common complaints about water supply from households are about distance of the source and insufficient water supply. In focus group discussions, the particular difficulties of access for poor people were emphasized.

Key Findings

Latrines and sanitation

- ❑ Most households (85%) do not have a latrine and most of those without a latrine see no need to have one.
- ❑ Latrine coverage is 15% nationally: 12% in rural sites and 63% in urban sites. There is variation in latrine coverage between different parts of the country.

Per cent of households with adequate sanitation facilities



- ❑ Most households believe that cattle excreta are less hazardous than human excreta and a third report smearing the walls and floor of the house with cattle excreta.

Literacy of mothers

- ❑ About one in five (21%) of mothers of children under five years old are literate (able to read and write a simple letter).
- ❑ Literacy of the mother is protective. A child whose mother is literate has only three quarters the risk of recent diarrhoea of a child whose mother is illiterate; and when a child of a literate mother does get diarrhoea, she or he has only three-quarters the risk of prolonged diarrhoea compared with a child of an illiterate mother.

Points for discussion and action

At household level

- A child in a house where the drinking water is treated has only three quarters the risk of diarrhoea of a child in a house where the drinking water is not treated, even though most treatment is simple filtration and very few households boil their drinking water. Households could reduce the risk of diarrhoea in children by treating their drinking water.
- The presence of a latrine in itself does not reduce the risk of diarrhoea in children. But using the latrine when there is one does reduce the risk by about half. This is probably because this reflects generally better hygiene practices in the household. Households can reduce the risk of diarrhoea in children by good hygiene practices and by teaching these to their children.
- Giving fluids to a child with diarrhoea *on the first day of illness* reduces the child's risk of diarrhoea lasting more than three days by two and a half times and giving Jeevan Jal as part of the fluid regime reduces the risk by nearly one and half times. Mothers can greatly improve the outcome of their child's diarrhoea by making the effort to give the child extra fluids the first day; an important message for mothers is that the time they spend giving fluids early on can save them much more time and expense later.
- Many children with simple diarrhoea that can be easily treated at home are taken for outside help, costing time and money. Households should rather take for care only those children who are more ill, for example those who have blood in their diarrhoea.

Points for discussion and action

At community level

- A child in a house with 'safe' water supply has only three quarters the risk of diarrhoea of a child in a house with an unsafe water supply. There is a higher incidence of diarrhoea in communities which mentioned difficult access to water in focus group discussions. Communities can organize to try to ensure that they have access to safe water sources and maintain them well, for example through creating Water Use Committees.

- Attitudes towards women's literacy among community leaders can influence the setting up of women's literacy classes in that community and the participation rate of women. So community leaders need to be convinced of the benefits to children's health (in this case in relation to diarrhoeal diseases) of women's literacy.

Points for discussion and action

Among service providers and NGOs

- Programmes of latrine provision need to place more emphasis on community participation and to recognize the lack of perceived need for latrines in many communities. It is likely to be the programmes of education that accompany latrine provision that have a beneficial effect on the rate of diarrhoeal diseases, if there is such a benefit, rather than the actual provision of latrines. Communities particularly dislike simple pit latrines, which they see as smelly and bringing infection risk near the house.
- Continued efforts to bring 'safe' water to all households are worthwhile. Even though the actual safety of 'safe' water can be questioned, the results here indicate that 4% of cases of diarrhoea could be prevented by universal provision of 'safe' water.
- Government services and NGOs providing literacy classes for women can be encouraged by these findings. The effect of mothers' literacy on diarrhoea incidence and duration is not explained by other factors examined; and literacy for all mothers could be expected to prevent 4% of cases of childhood diarrhoea. Literacy classes are an opportunity to educate mothers about good hygiene practices and good home management of diarrhoea. The classes can also educate mothers about when to seek help for children with diarrhoea, as many mothers seek help when it is not needed while some do not seek when it is needed.

At Policy level

- Efforts to support adult literacy among women should be strengthened and the curriculum should be reviewed to ensure it covers hygiene practices.
- Programmes providing latrines only should be discouraged. Programmes providing water and latrines and with a strong emphasis on community participation should be encouraged.

Brief Description of NMIS Methodology

The Nepal Multiple Indicator Surveillance (NMIS) is a reiterative process designed to gather data on key problems in the country, provide this information to planners in a timely manner and help establish an operational framework for decentralization. A key feature of this approach is the national representation for the data, while permitting district level conclusions for at least 20 districts.

The surveys were coordinated by the steering committee under the National Planning Commission and funded by UNICEF Nepal. The statistically valid sample was developed by the Central Bureau of Statistics. All survey instruments were developed in consultation and approved by a technical committee under the steering committee. The field work of NMIS cycle 1-4 were carried out by New Era, a national NGO; and Central Bureau of Statistics from cycle 5. The technical assistance was provided by CIETinternational. A total of 144 clusters were randomly selected to represent the urban/rural balance in the 15 eco-development regions. Each cluster or site was made up of approximately 120 contiguous households. In each site in addition to the household survey, focus group discussion, institutional review and key informant interview were also carried out in each site to allow both quantitative and qualitative analysis. The qualitative survey results provided a opportunity to look behind the quantitative indicators. Key results of the previous cycle were feedback to the survey communities during the successive cycle.

NMIS cycle one data were collected between January and March 1995 from 18,772 households, including 102,008 people, 9,537 of them children under the age of three years.

So far 5 cycles of NMIS have been carried out. They are:

Cycle one:	Health and Nutrition.	January-March 1995
Cycle two:	Education	April-June 1995
Cycle three:	Water and Sanitation	March-May 1996
Cycle four:	Caring, feeding and disability	August-November 1996
Cycle five:	Pregnancy and delivery	March-June 1997