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LOCAL ACTION WITH INTERNATIONAL COOPERATION TO IMPROVE AND SUSTAIN WATER, SANITATION AND HYGIENE SERVICES

Water sanitation and hygiene status in the neighbourhood of Bangladeshi Islamic schools and mosques


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Faith based interventions have been underutilized to improve water, sanitation and hygiene status and offers promise to promote behaviour in the community. Prior to delivering a faith based WASH intervention, we conducted a survey among the neighbouring households of eight Bangladeshi Islamic schools and associated mosques. We randomly selected 192 families from where any male attend mosque and interviewed adult women from that family. At baseline, almost all households used improved water sources and improved toilets. However, toilet cleanliness was poor. Faecal matter was disposed into the environment after emptying the pit/septic tank. Defecation and disposal among children <3years mostly occurred directly in the open which should be improved using behaviour change recommendations. Presence of hand washing agent in the hand washing place was low. Islamic faith based intervention should be designed and delivered in way that can promote hand washing, safe sanitation practices and safe disposal of child faeces.

Background

Worldwide there are approximately 2,200 children are dying every day due to diarrheal disease [1]; inadequate water, sanitation and hygiene contributes to 88% of these deaths [2]. While an improvement in water and sanitation infrastructures collectively reduces the diarrhea prevalence by 6% [3], hand washing intervention alone reduces the risk of diarrhoeal disease by 23% [4]. A well designed behaviour change intervention along with water, sanitation and hygiene (WASH) infrastructural improvements could reduce the disease burden. An intervention based on emotional drivers, focusing on school-based events among school children aged 8–13 years demonstrated a 31% (p=0.02) improvement in hand washing with soap in the intervention schools compared to the controls [5]. Although faith is considered a powerful tool for attitudinal change to engage with members of the community [6-9], faith based approaches have largely been underutilized in contemporary WASH projects.

Studies show that faith-based programmes can improve health outcomes, when delivered through churches in African American communities [10-12]. Most faith based programmes focused on primary prevention (51%), general health maintenance (26%), cardiovascular health (21%), or cancer (19%) and the reported significant effects include reductions in cholesterol and blood pressure levels, weight, and disease symptoms [13]. Therefore, an intervention based on emotional drivers, specifically a faith based one and deliver that through institutions, will likely change people’s behaviour greater than infrastructure development interventions.

Global One UK and icddr,b has conducted a baseline survey to develop an Islamic faith based intervention which will be delivered through mosques and Islamic schools to improve the water, sanitation and hygiene status within the community. We have described the results from the pre-intervention survey here, which will help to design the intervention.
Methods

Study design and sites
As part of a cluster randomized trial of an intervention in Bangladesh, Pakistan, Nepal and Indonesia, we randomly selected 20 clusters from all countries. The results from baseline survey in eight Bangladeshi clusters are included in this report. We selected Moulavibazar, Sunamganj, Sylhet (Zakiganj), Sylhet (Bishawnath) from Bangladesh as the study area. We selected eight Islamic schools and their associated mosques in these four areas. All of the selected Islamic schools were located at least 500 meters away from each other.

Selection of survey respondents
To identify the respondents for the survey, the team visited mosques associated with the Islamic schools on a Friday. A list of adults who attended for Friday prayer and listened to the lectures on regular basis was prepared with the help of the Imam (Preacher). Those listed were informed verbally about the study objectives. After that a random number was generated to select respondents from the list. The team then visited households, took written informed consent and interviewed a female adult member. The team selected mother of the youngest child, if there were more than one adult female in the household. In case of refusal, another household was randomly chosen from the list. Thus the team completed the required 24 interviews from each Islamic school area. In total, we have interviewed 192 respondents.

Data collection
A structured questionnaire was used for the baseline data collection to determine current hygiene practices, facilities and knowledge. The data collector conducted three main tasks to determine hygiene practices, (1) face-to-face interviews (2) spot checks (3) hand washing demonstrations. The data collector also recorded self reported diarrheal and respiratory disease symptoms for children under three years of age. The face-to-face interview provides information on practices, facilities and knowledge; environmental spot checks were used to determine household WASH facilities and hand washing demonstrations were used as a proxy for current practices.

Data analysis
After completing data collection, the team further checked data validation. Data were analyzed using STATA (version 13). We performed descriptive analysis to determine respondents’ characteristics, WASH facilities, practices and knowledge. We calculated means and standard deviations for continuous variables that were normally distributed. We used the WHO/UNICEF Joint Monitoring Program (JMP) definitions for improved water source and improved toilet [14].

Results
All respondents were adult females with a mean age of 32 years. Among them, 16% had no formal education, 46% completed education from grade one to five and another 32% completed grade six to ten. Among them, 92% were homemakers. Average monthly household income was around 188 USD per month.

Almost all households (93%) had an improved water source for drinking. However, only 37% households had their own water source, the remainder used shared/neighbouring/public sources. The average distance to water source was 24 meter from households and to the nearest toilet was 17 meter. Each household spent around six minutes to collect water from the water source for each water collection. Among them, 77% households stored water for drinking.

Among the households, 75% of them used their own toilet and 51% had an improved toilet. On average, eight persons used one toilet. Twenty percent of toilets had visible faeces on the floor and 36% had visible faeces on the pan. Thirty three percent of toilet’s pipes that were connected to a pit or septic tank were visibly broken and stool is visible. When pit/septic tanks filled up, 97% of those households disposed faecal matter into the nearby environment: beside house, river and lake. Moreover, 18% of these households discarded faecal matter within 200 meters of the toilet. Only 12% of <3 years old children were reported to defecated in the toilet, whereas 28% used a potty and another 24% defecated inside the house or into a rag/nappy/diaper. Those who used potty and nappy/rag/diaper, 53% of caregivers discarded faeces outside the house openly nearby bushes, river, pond or any other general water body.
Almost all (98%) households had a hand washing place, but only 46% of them had soap placed there. Hand washing places were on average 9 meters away from the kitchen and 10 meters from the toilet. When we asked our respondents to show how they usually wash their hands, 58% used soap and washed both hands, but only 21% used a visibly clean cloth to dry their hands.

Knowledge about benefits of hand washing were high (96%), 98% knew the benefits of using sanitary toilets, and 97% knew about the using improved drinking water sources, suggesting that describing benefits alone will not be effective. However, only a few respondents mentioned as Imams or religious leaders as a source of information: 3% mentioned as a source of safe water knowledge, 5% mentioned as a source of hand washing knowledge, and 4% mentioned as a source of sanitary latrine use and faeces disposal knowledge.

**Conclusion**

Knowledge among the respondents was high about water, sanitation and hand washing but practices were poor. Islamic faith based intervention should be designed and delivered in way that can promote presence of soap at hand washing place, faecal sludge management, and safe disposal of child faeces. Presence of hand washing facilities in a convenient place should be emphasized in future intervention which could improve the practices. Faecal sludge disposal need urgent attention as almost all of the faecal matter went to the environment. Islamic faith based intervention should be designed and delivered in way that could promote hygiene practices and safe faeces disposal. Under three years aged child defecation practice was not hygienically managed and faeces disposed in the environment. Delivering interventions through mosques and Islamic schools could be an alternative solution to improve these behaviours as people usually didn’t get information from Imams or religious leaders on WASH facilities and practices.

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