

Basic Sanitation Practice of Rural People of Selected Villages of Kishoreganj District

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Maintenance of proper sanitation is now crying need of our country. Its deviation is an obstacle for the development and may result in a long lasting effect in later life. Poor sanitation leads to a greater impact on health status and girls, children, adolescent, women and infants suffer most from it. Regarding sanitation status a cross-sectional study has been carried out at Austogram upazilla among 128 people to find out hazardous risk factors which leads to poor sanitation status. The main objective of the study was to find out the relation of several variables to poor sanitation status. Several important factors were identified and these are low socio-economic condition, poor housing condition, illiteracy, improper source of drinking water. Among the respondents highest number 40(31.25%) were in age group more than 50 years. Based on education status respondents were classified into 6 groups-illiterate, primary, secondary, SSC or equivalent, HSC or equivalent, graduate and above. As many as 49.22% respondents were found illiterate and highest numbers among literate 26.56% have educational status up to primary level. Concerning religion 115(89.84%) were Muslim and remaining 13(10.16%) were Hindu. Most of the female respondents 74(57.81%) were found housewife. Concerning monthly income highest number of respondents about 69.53% have monthly income up to 10000 Tk. And regarding sanitary status it's observed that among 128 respondents 121(94.53%) uses sanitary latrine and remaining 7(5.46) have not privilege of using sanitary latrine.

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Introduction

Around the world, poor sanitation remains a major threat to development, impacting countries' progress in health, education, gender equality and social and economic development.

Globally, 2.5 billion people including 840 million children do not use improved sanitation; 1.2 billion, almost a fifth of the world's population, practice open defecation in rural areas, this is the case for nearly 1 in 3 people.¹

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Open defecation and its public health social and economic impacts, can create a vicious cycle of illness, high expenditure on health care, lost work and school hours and poverty.

Poor sanitation and hygiene, cost for women and children. Women, adolescent, girls, children and infants suffer most from inadequate hygiene sanitation facilities. The two main causes of mortality among children under age five-acute respiratory infections and diarrhoeal diseases are closely linked to poor water, hygiene and sanitation; Of the 1.8 million people estimated to die each year from diarrhoea, 1.5 million are children.² Repeated diarrhoeal episodes are a significant underlying cause of malnutrition, leading to weakened immune systems and impaired growth and development.³

Girls and women are made more vulnerable by poor sanitation and hygiene. Lack of safe, Separate and private sanitation can inhibit girls from attending school and increase the burden of caring for the sick, as well as the likelihood of disease during pregnancy. Furthermore, these conditions can expose women and girls, who in some cultures are forced to defecate only in dark, to serious illness brought on by waiting and increased risk for harassment and assault during the night time walk to and from communal defecating fields.⁴

However, Bangladesh still has the diarrhoeal disease as second leading cause of child and infant morbidity, meaning that we have to go a long way to achieve health impacts through extensive health and hygiene education, enhanced knowledge and practice related to use of safe water and sanitation, and focusing on other aspects of environmental sanitation including solid waste management, household waste water and storm water disposal and indoor air pollution. Bangladesh is committed to achieve the millennium development Goals

(MDGs). This commitment is reflected in the poverty reduction strategy paper (2005) that envisages reducing IMR from the 2000 benchmark value of 66 of 37 by 2010 and 22 by 2015.⁵

Method

This was a descriptive, cross sectional study. Data were collected with semi structured questionnaire in January 2015. This study was carried in the villages-Sorailhati, Alam Dighipara, Hazipara of Austagram upazilla of Kishoregonj district. Study population included rural people of selected villages of Austagram Upazilla of Kishoregonj district. Head of the family was the unit of the study. Sample size was one hundred twenty eight (128).

Convenient type of non-probability sampling technique was followed. Data were analyzed through master sheet by using scientific calculator.

Result

Among the respondents 31.25% were in the group above 50 years, while 29.69% were in the group 31-40 years, 18.75% respondents were in the age 21-30 years, 17.19% in the age group 41-50 years, 3.21% in age group up to 20 years.

With regard to occupation of the respondents, highest number of respondents 74(57.81%) were housewives, while 6(4.69%) were service holder and labourer. 2(1.56%) were students and businessman and 38(22.69%) were from other occupations.

Based on educational status, 63(49.22%) respondents were illiterate, while 65(50.78%) were literate, Of the literate, highest number 34(26.56%) had educational status upto primary level, whereas 13(10.16%) had upto secondary, 6(4.68) upto S.S.C, 5(3.91%) up to HSC, and 7((5.46%) were graduate or higher.

All the respondents 128(100%) had their drinking water from tube well. Regarding sanitary status, highest number of respondents 12(94.53%) used sanitary latrine and 7(5.47%) used kacha latrine.

Table I: Distribution of age of the respondents

Age in years	Frequency	%
Up to 20	4	3.12
21-30	24	18.75
31-40	38	29.69
41-50	22	17.19
>50	40	31.25
Total	128	

Highest number of respondents 40(31.25%) were in the group above 50 years, while 38(29.69%) were in the group 31-40 years, 24(18.75%) respondents were in the group 21-30 years, 22(17.19%) in the age group 41-

50 years, and 4(3.12%) in age group up to 20 years.

Table II: Distribution of respondents according to occupation

Occupation	Frequency	%
Housewife	74	57.81
Student	2	1.56
Service holder	6	4.69
Labour	6	4.69
Business	2	1.56
Others	38	22.69
Total	128	

With regard to occupation of the respondents, it was observed that highest number of respondents 74(57.81%) were housewife, while 6(4.69%) were service holder and labour, 2(1.56%) were students and businessman and 38(22.69%) were from other occupations.

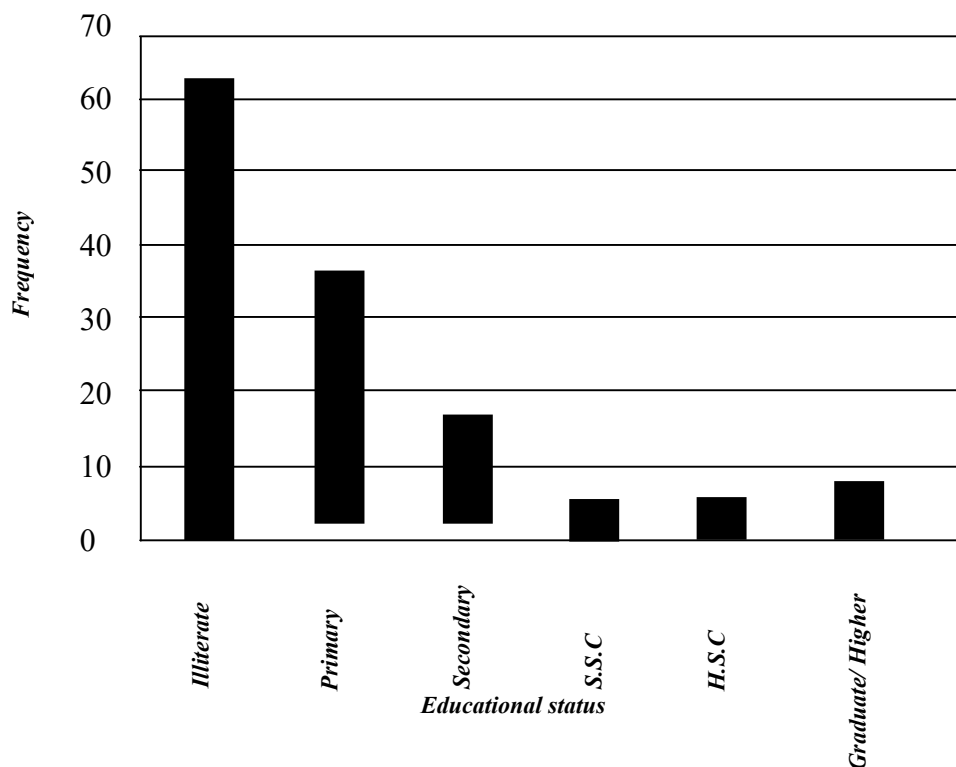


Figure I. Simple bar diagram showing educational status of respondents

Based on educational status, respondents were arranged into six classes like illiterate, primary education, secondary education, SSC/equivalent and HSC/equivalent, graduation/higher. As many as 63(49.22%) respondents were illiterate, while 65(50.78%) were literate, Of the literate, highest number 34(26.56%) had educational status upto primary level, whereas 13(10.16%) had up to secondary, 6(4.68%) up to S.S.C., 5(3.19%) H.S.C. and 7(5.46%) were graduate or higher.

Table II: Distribution of respondents according to source of drinking water

Source	Frequency	%
Tube well	128	100
Supplied water	0	0
Others	0	0
Total	128	

Based on source of drinking water, respondents were arranged into three classes like tube well, supplied water and others. All the respondents 128(100%) had their drinking water from tube well.

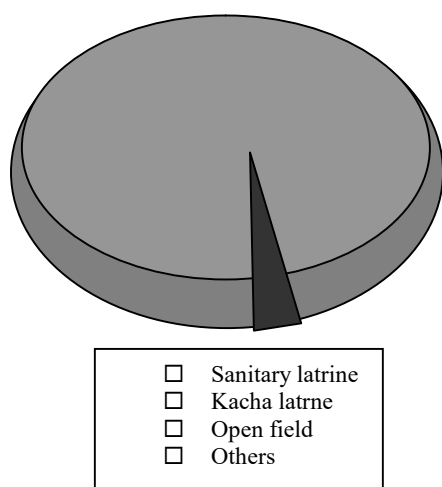


Figure 2. Pie diagram showing sanitary status of the respondents about their basic situation.

Regarding sanitary status, it was observed that highest number of respondents 121(94.53%) used sanitary latrine and 7(5.47%) used kacha latrine, none of them used open field.

Discussion

A descriptive, cross-sectional study was carried in Shaheed Syed Nazrul Islam Medical College Hospital, Kishoreganj to find out the basic sanitation practices of rural people of selected villages of Kishoreganj District.

Regarding age distribution, highest number of respondents, 40(31.25%) were in the age group >50 years.

It was observed that highest number of respondents 63.53% have monthly income up to 10,000 TK. As many 49.22% respondents were illiterate. Among the literate highest number 26.56% have educational status up to primary level.

Regarding religion of respondents, highest number of respondents 115(89.84%) is Muslim and remaining 13(10.16%) represents Hindu.

The preferences to female respondents were based on the fact that they had knowledge of her households day to day activities related to water, sanitation and usually responsible for collecting and storing water and for maintenance of latrine an household cleanliness. Most of the female respondents 74(57.81%) were housewife.

It was observed that out of 128 respondents 121(94.53%) used sanitary latrine, remaining 7(4.56) had not privilege of using sanitary latrine they used kacha latrine.

In the study of Jahangirnagar University Environmental Bulletin, Vol.2, 50-60, 2013 it was found that 98% people used sanitary

latrine which is more or less consistence with this study finding.⁷

But in some studies, Exploring the Current Status of Sanitary Latrine Use in Shibpur Upazila, Narsingdi District. Web: www.brac.net/research it was observed that near 85% household owned the latrine of nay type and among them only 30% used sanitary latrine.⁸

Concerning source of drinking water, it revealed a satisfactory study. Out of 128(100%) all respondents irrespective of any group used to drink tube well water.

The study of Exploring the Current Status of Sanitary Latrine use in Shibpur Upazila, Narsingdi District. Web: www.brac.net/research shows that almost 99.7% respondents use tube well water which is similar to this study.⁹

Considering housing condition of respondents' highest number of respondents 69(5.91%) resides in kacha house.

Present study shows that a satisfactory level of basic sanitation has been achieved even in this remote are due to public health awareness.¹⁰

Conclusion

The finding of study emphasize the need for proper maintenance and utilization of sanitary latrine, tube well and improve the sanitary coverage of the community where it is deficient. This can be achieved by providing health education about basic sanitation practices and make community people being able to realize is as 'felt need' fir them. In remotest areas like this can be achieved by

existing schools, primary health care provider and service approach provided by both government and non-government organization.

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