

**SOCIO-ECONOMIC FACTORS THAT CONTRIBUTE TO LOW ACCESS
TO SANITATION FACILITIES: A CASE STUDY OF BULEGENI
SUB COUNTY BULAMBULI DISTRICT
– UGANDA**

**BY
KOSKEY WILLIAM MATILA
REG. NO: BEM/40175/91/DU**

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DECLARATION

I KOSKEY WILLIAM MATILA, hereby declare that this dissertation is my original work and has never been submitted in any academic institution or university for academic awards.

Student : KOSKEY WILLIAM MATILA

Signature : *Koskey W*

Date : *5th / 11 / 2012*

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ABBREVIATIONS OF KEY TERMS

NGOs	Non Governmental Organisations
PHC	Primary Health Care
HASs	Health Assistants
CDAs	Community Development Assistants
WHO	World Health Organisation
UNHCR	United Nations High Commission for Refugees
MWE	Ministry of Water and Environment
GoU	Government of Uganda
PHAST	Participatory Hygiene and Sanitation Transformation Programm.
EPA	Environmental Protection Agency.
RWSN	Rural Water Supply Network.
US	United States.
SUSANA	Sustainable Sanitation Alliance
UNICEF	United Nation International Children's Emergency Fund

ABSTRACT

The study was conducted in Bulegeni Sub-county which is located 35 Kilometers from the Eastern town of Mbale Uganda.

This study was conducted between the month of May and September 2012. The main objective of the study was to find out, the socio- economic factors influencing low access to sanitation facilities at different household level. The study used descriptive research methods to obtain data it included face to face interviews and questionnaires.

The research finds will help the community member of Bulegeni and other communities on how best they can improve on their sanitation facilities, great awareness on socio-economic factors limiting access to sanitation facility. The research will also enable future research to increase on the available literature for further studies.

According to the findings 80%of the respondents said that socio-economic factors plays major role in limiting access to sanitation facilities hence negative impacts on their health and livelihoods. They also called for government support to help construct latrines and also provide piped water as part of the initiatives to mitigate the socio-economic factors that influence sanitation accessibility.

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter consists of; background of the study, statement of the problem, purpose of the study, research objectives, and scope of the study and the significance of the study

1.1 Background of the study

The US National Sanitation Foundation, 2004 defines sanitation thus: “It is the quality of living expressed in clean homes, clean farms, clean neighbourhoods and clean community. Being a way of life, it must come from people, nourished as it is by knowledge and it grows as obligation and ideal in human relations”. Accordingly, environmental sanitation is viewed as “the control of all those factors in man’s physical environment which exercise a deleterious effect on his physical development, health and survival” (WHO, 1992). Environmental sanitation is vital for protecting the environment, improving health, alleviating poverty, enhancing quality of life and raising productivity.

Sanitation facilities, are constructions and installation that hygienically separates or prevents contamination for example human excreta from human contact and this includes ; water supply, safe disposal of human waste, waste water and solid waste management, control of vectors of diseases, domestic and personal hygiene, food, sanitation, housing etc. (WHO –UNICEF 2003).

Community health is a discipline that concerns itself with the study and betterment of the health characteristics of a biological community. Basic health relevant variables range from the proportion of a given age group, life expectancy and medical intervention aimed at improving health of the community range from access to medical care to public health communication campaigns. Community itself is a social group of any size whose members reside in a specific locality, share government, and have common cultural and historical heritage. (Journal of urban health ISSN 1468-2869).

Socio-economic factors, are the social and economic experiences and realities that helps molds one's personality, attitudes and life style (Merriam Webster, 2007).

At The Global Level

Highlighting the absence of rudimentary sanitation facilities in half the world, a UNICEF report (1997) has pointed out that about 2.2 million children die annually of diseases caused by unhygienic conditions. The report has underlined that the problem is most acute in rural areas where only 18 per cent of the people worldwide have access to a toilet. In urban areas of developing countries, 40% of the world's population lack basic sanitation facilities now. And even there, according to reports, Uganda, for example, claims adequate sanitation in about 80 per cent of households, but the figure shrinks to just three per cent if pit latrines are excluded. Considering that the cost of providing adequate toilets or latrines ranges from five to 60 dollars, the UN agency estimates that the problem can be solved in ten years if an amount equal to 10% of a year's global military spending is set aside for toilet construction programmes. But as WHO's rural health chief Dennis Warner notes, sanitation is not a priority issue and governments either do not have a political commitment or do not like to provide services to 'squatters'. They only hope the problem will just go away, but it doesn't; and lack of funds only aggravates it further.

The global coverage of population with access to excreta disposal facilities has increased from 55% (2.9 billion people served) in 1990 to 60% (3.6 billion) in 2000. Still a total of 2.4 billion people in the world were without access to improved sanitation at the beginning of the year 2000. In India, the percentage coverage increased from 21 to 31 during the same period. Although there is an appreciable gain in the access to sanitation facilities by the population in absolute numbers, the percentage coverage appears to be modest due to high population growth.

The health implications for this state of affairs are appalling. Globally 10 millions children under age of five die every year; of which 1.5 million children perish from diarrheal disease each year. The majority are children under the age of five in developing countries. Improved hygiene and sanitation help reduce sickness from diarrhea considerably. Intestinal worms infect about 10% of the population of developing countries that can be controlled through better sanitation, hygiene and water supply. As per the WHO report globally 200 million people are infected with schistosomiasis, out of which 20 million suffer seriously. Basic sanitation facilities reduce the

disease by up to 77%. Sanitation facilities help check transmission of many faecal – oral diseases by preventing contamination of water and soil through human excreta. Epidemiological evidence suggests that sanitation is at least as effective in preventing diseases as improved water supply. Studies carried out in India and abroad indicate that human excreta are the cause of many enteric diseases: cholera, dysentery, typhoid, paratyphoid, infectious hepatitis, hookworm, diarrhea, etc. Over 50 infections can be transferred from a diseased person to a healthy one by various direct or indirect routes from human excreta and it causes nearly 80 per cent of the sickness.

According to the report submitted by Sustainable sanitation and water renewal systems Uganda. [NGO November 2008] stated that, the lack of access to improved sanitation together with malnutrition lead to increased mortality and morbidity which is higher in children under 5 years of age. On average each slum dweller in Kampala is spending 25000 shillings per month on water and sanitation related diseases (H. Plumm 2008). The mortality as a result of diarrhea was estimated to be 440 children per week in Uganda (National sanitation guidelines 2000), and evidence suggest that improving sanitation could reduce diarrheal diseases by 35-40% and child mortality by half. The latrine coverage in Uganda is estimated at 62.4%, the latrine coverage in Kampala is estimated at 94 % (NSWG/JSR 2008) however just like in any other region, rural and urban areas in Uganda, sanitation facilities are never uniformly distributed. Low latrine coverage is experienced in informal settlement where majority of the poor reside. Bulambuli district still face a major problem of sanitation facilities accessibility mostly in Bulegeni Sub County where population is rising and sanitation facilities are scarce. Most of the pit latrine are being shared by more than four households of which most of them are inaccessible because they are full and dislugging has not been done, most of them have leaking roofs, some are in risk of collapsing, the doors are reckless and made out of old iron sheets covered with rust and offers no privacy. Children and disabled people cannot access these latrines, during heavy rains runoff finds its way to the latrines because they are not raised hence they get filled up. The community also faces challenges on safe water accessibility as most of the piped water came to stand still due to poor management by the local authorities forcing them to fetch water on springs and river which is contaminated by people washing and bathing in it. Most homesteads also lack proper defined waste dumping sites like compost pits where leftovers can be dumped. And also on market days like Wednesdays and Saturdays a lot of wastes accumulate and are poorly managed because of lack of dumping sites these wastes are collected and burnt some are left and rot along the road hence causing nuisance smell unless it rains is when most of the solid wastes are

washed by run offs to the river. Notorious dirty drinking joints with very dirty latrines serving over fifty people on market days coupled with bad sanitation and lack of adequate sanitation facilities allow pathogens found in human faeces and wastes that are poorly managed which puts community at risk of epidemic diseases like diarrhea which has claimed lives of both adults and children. 1.8 million People die every year 90% are children under five years of age mostly in developing countries 88% of diarrhea diseases is attributed to unsafe water supply and inadequate sanitation and hygiene (WHO 2012).

1.2 Problem statement

In Uganda 40% of the population still have no access to improved water sources and 57% have no improved sanitation (MWE, 2011). This has been a major problem mostly in rural areas where lack of clean water supply, inadequate health facilities has resulted into high infant mortality rate, multiple water borne diseases such as typhoid, dysentery and cholera, and this has made it difficult for people to improve on their livelihood (GoU, 2005). The impact has been experienced most by women and girls which makes them suffer increased work load as they have to fetch water from rivers which are not near (PHAST, 1995). Inadequate sanitation facilities also lead to poor performance at school due to lack of attendance of classes as a result of illness and also increased medical costs (Jones and Reed, 2005). In Bulegeni most house holds have inadequate sanitation facilities such as latrines, access to clean water supply and properly defined waste dumping site hence leading to pollution of water sources which puts the community health at risk of diseases like cholera and malaria (Sulton, 2007). However, few studies have been done to find out what factors influence accessibility of the sanitation facilities in this area. And that's why the researcher is interested in this area to try and find ways of solving these problems.

1.3 General objective

To find out the socio-economic factors influencing access to sanitation facilities at different households.

1.4 Specific objectives

- i) To identify the sanitation facilities available at house hold level?
- ii) To establish how these facilities are managed?
- iii) To find out the socio-economic factors that limit access to sanitation facilities?

1.5 Research questions.

- i) What are the sanitation facilities available at house hold level?
- ii) How are these sanitation facilities managed?
- iii) What are the effects of socio-economic factors to access to sanitation facilities?
- iv) To find out how this socio-economic factors limiting access to sanitation facilities can be addressed?

1.6 Purpose of the study

This study is being carried out to find ways of mitigating and minimizing threat that are caused by socio-economic factors to access to sanitation facilities on the community of Bulegeni Sub County.

1.7 Scope of the study.

This study will be conducted in Bulegeni sub county Bulambuli district located 45kms away from Mbale and it will cover socio-economic factors influencing access to sanitation facilities in Bulegeni.

1.8 Significance of the study

This study will help the community members of Bulegeni Sub County on how best they can maintain and improve on their sanitation facilities and also help them improve on hygiene, it will also raise environmental awareness to the people in Bulegeni sub county hence they will keep their environment clean. The study will be useful to the government of Uganda as it will contain useful information about health related issues caused from inadequate sanitation facilities, and it will provide room for further researches on sanitation within and outside Bulambuli district.

CHAPTER TWO

LITRATURE REVIEW

2.0 Introductions

The chapter reviewed related literature and scholars and researchers views and ideas, sanitation facilities available at house hold level, how these facilities are managed and socio-economic factors influencing access to sanitation facilities. It also reviewed Internet and other sources that may provide relevant information.

2.1 Sanitation facilities available at house hold level and their uses.

Kitchen,

Every dwelling must contain a kitchen, Space to store, prepare and serve food in a sanitary manner this is important because it keeps germs away that may cause diseases and deaths. In Bulegeni most house hold lack kitchen others share it with animals and smell from the droppings and urine may contaminate food during preparation leading to food poisoning.

(Universal class.com)

Bathroom and latrine

Bathroom and latrines should be sanitized to remove bacteria which can be responsible for disease transmission hence maintain healthy environment. By draining stagnant water even if one is having bathroom made of dry leaves from banana and stones used on floor destroys breeding ground for mosquitoes and other disease causing pathogens like bacteria. The problem is such shelters are used as urinal shelters thus favouring mosquitoes to breed on (Somnath and Yue, 2005).

Water supply

The United Nations General assembly in July 2010, recognized, “the right to safe and clean drinking water and sanitation as a human right that is essential for full enjoyment of life and all human rights. “.The international and national laws dealing with human rights should now recognize the right to water and sanitation as equal to other basic rights. Therefore every dwelling unit must be connected to a supply of drinkable water of sufficient quantity and

pressure to meet the ordinary needs of the occupants. Unfortunately in Bulegeni Sub County the piped gravity water to the community came to stand still due to lack of management and the community now fetch water in rivers, spring and rain water harvest. (Water and sanitation guide 2011).

Trash disposal

Trash should be first separated for collection and appropriate disposal by using separate bins so that wastes can be placed in their designated storage bins for composting or incinerating or taken to landfill. In most communities in developing countries such arrangements are not followed hence a great challenge in wastes management, creating breeding ground for disease causing vectors like rodents and insects (William P. Canningham and Marry Ann Canningham, 2002).

2.2 Management of sanitation facilities at house hold level.

Manufacturing processes can be used to recycle water or be redesigned to save water, Japan and Israel lead the world in conserving water through process of recycling, in U.S used water (gray water) from bathtubs, showers, bathrooms, sinks, and cloth washers can be collected, stored, treated and reused which is not common in Uganda, its only in urban areas where waste water is collected and treated (G. Tyler Miller jr, 2000). “Conserving water would have benefits including reduced burden on waste water plant, decreasing pollution of surface and ground water and saving energy and money needed to treat and distribute water” Mohamed El-Ashry.

Trash management

Waste is everyone's business, we all produce unwanted by-products and residue in nearly everything we do. According to Environmental Protection Agency (EPA), The United States produces 11 Billion tones of solid waste each year, nearly half consist of agricultural waste such as crop residues and animal manure which are generally recycled into the soil, but they also contribute to largest source of non point pollution of air and water which lead to diseases like cholera, Trachoma, and massive dysentery, this much of the waste is stored near the source of production, proper disposal practices is also carried out hence control wide spread pollution which lead to massive health effects. Most of them are recycled or disposed to landfills. The management is also done to avoid giant of wastes which attract scavengers, minimize exposure

from rain, wind and flies through composting, incinerating and re-use (William P. Cunningham and Marry Ann Cunningham, 2002).

2.3 Socio-economic factors influencing access to sanitation facilities.

Low Demand for improved sanitation

There is little demand for improved sanitation. People have many other priorities, which are viewed as more pressing than latrines. Unlike water which is viewed as a survival need, people don't see latrines or hygiene as part of basic survival. Sanitation is perceived as an individual, not a communal responsibility so it has been difficult to get the community and its management committees interested in sanitation.

Lack of Awareness of the Risks involved

Many people don't see anything wrong with open defecation in the bush. They don't understand that this is a health hazard to themselves and other people. There are no immediate negative effects to make them question this behaviour. There may have heard from the radio or extension workers that these practices are harmful, but they don't believe it or see its relevance to their 'gives. No one has taken the trouble to discuss sanitation in terms they could understand and do something about. Hygiene promotion campaigns have tended to be short term and not sufficiently supported by local government and education sectors for them to have long term meaningful impact.

No Sense of Ownership

People view sanitation as something imposed by outsiders - extension workers rather than something they want to do. It is seen, as a set of rules to be blindly followed, not a set of actions that people have planned themselves.

So, sanitation is not seriously considered as part of the planning of a safe household and environment. They may worry whether the roof of their house is strong enough, but they won't worry whether they have a safe latrine. A latrine is not seen as a basic part of the household.

Low Prestige and Recognition

Sanitation has been given low status and recognition within the civil service. Professionals in this field (Environmental Health staff) have relatively low status and in the past have received lower levels of training (i.e.) diplomas rather than degrees). As a result it has been difficult for these

professionals to play a strong coordinating role and persuade other officials to give sanitation more attention and priority.

Lack of political Will

In the past there has been a lack of political will behind sanitation. Many politicians viewed sanitation as the health workers' job, and took little responsibility for it. They neglected sanitation in their budgets and depended on donors to fund sanitation. They showed more interest in hardware than software, since they didn't understand the importance of software. Some politicians were reluctant to enforce Council bye-laws (e.g. closing down dirty markets) for fear of losing votes; and some were not exemplary in behaviour - they 'preached but did not practice' (i.e. build their own latrine).

Lack of legislation and Supportive Policies

There has been inadequate attention given to the development of sanitation policies. The Public Health Act (1964) and other laws are outdated. For example the fines for failure to build a household latrine are no longer effective deterrents. Sanitation remains a low priority within Primary Health Care and the Five-year Health Plans do not give sufficient emphasis to sanitation. The National Health Policy makes little reference to sanitation - the policy is based towards curative rather than preventive health, even though the top ten causes of morbidity and mortality are linked to poor sanitation. Policies tend to favour water supply over sanitation and hardware over software.

Poor institutional Framework and Coordination

The institutional framework in the past fragmented responsibility among different government departments and ignored the role that community organisations, NGOs, and the private sector could play. There was limited co-ordination and a lack of clarity about the roles of different players at different levels. Each project worked largely in isolation and produced its own guidelines.

Inadequate and Poorly Used Resources

Sanitation has not attracted the resources needed to do the job. It is as important for health as water supply and a far more demanding problem, yet sanitation receives far fewer resources.

Where resources are available, far too much goes into hardware and not enough into mobilisation and education.

Poor planning, budgeting and priority setting

Sanitation is marginalized in planning, budgeting, and resource allocation. At the national level sanitation marginalized within the PHC budget - it is only given 5% of the budget. In terms of implementation it is treated as an adjunct to water supply, rather than a legitimate activity in its own right, it is slotted into the water project cycle even though sanitation behaviour takes much longer to change.

Declining Coverage, Inadequate Facilitation, and Lack of Skills

The coverage of extension workers has significantly dropped. Many field staff lost their jobs due to public service reform and at present only half of the posts of HAs and CDAs are filled. Extension workers are demoralized by low salaries, inadequate allowances and transport, and insufficient supervision. The low coverage severely limits the amount of direct contact with communities and households. At the same time many extension workers are conditioned to using the old approaches (i.e. telling people what to do) and lack the skills to use the new, participatory methods.

Inappropriate Approaches

The approaches used in promoting sanitation have depended too much on coercion and one-way communication of generalised messages, and not enough on discussion, peer group learning, the fostering of commitment, and practical action planning.

Promotion of Health Benefits Only

In the past sanitation has been promoted on the basis of health benefits only, and neglected the reasons which motivate most people to build latrines e.g. convenience, privacy, status, and for visitors or in-laws.

Lack of Clearly Defined Technical Options for Different Areas and Groups

There has been a lack of clearly defined and accessible technical options suited to different soil conditions (e.g. rocky or water logged), different target groups (e.g. disabled, elderly, infants,

low income groups, etc), or different contexts (e.g. pen-urban areas, mobile populations, fishing villages, etc)

Income and occupation

One's income and occupation corresponds to the factor that contribute to low access to sanitation facilities since many community managed supply systems have fallen into disrepair for technical, financial and management reasons. Since most of the rural populations are subsistence farmers who grow food crop for home consumption and hence lack money to construct suitable sanitation facilities (Susana 2007).

Culture and ethnicity

Many interventions fail to appreciate prevailing social, cultural and religious norms and preferences that affect their acceptance and understanding by beneficiaries, such factors can also prevent vulnerable groups from participating in projects or restrict them voice less and unlikely to benefit (Sulton S, 2007).

Women Marginalised

Women have the most to gain from sanitation and are more receptive to its benefits than men; but women have been given a backseat in household decision-making and have been largely ignored as managers and potential agents of change in promoting sanitation. Women's dependency on men to finance latrines and dig pits has not been addressed as part of the programme design. (National Sanitation Guidelines produced for the ministry of health - Uganda by the water and sanitation programme – Africa region [WSP - AF])

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter will describe the methods and materials that will be used in the study to collect, analyse and present data. It will include the description of the area, study population research design sample size and sample techniques, data collection methods and instruments, data analysis and presentation, study limitations and ethical issues.

3.2.1 Description of the study area

Bulegeni Sub County is found in Bulambuli district, a district created by act of the Ugandan parliament in 2009, become operational on 1st July 2010. Prior to that the district was part of Sironko district coordinates 01⁰ 130460N and 34⁰140530E. They speak Lumasaba language called Lugisu. Bulegeni Sub County is located approximately 35 kilometers by road from Mbale town.

3.2.2 Population

The national census in 2002 estimated the population of Bulambuli is at about 97,560; people including men, women and children.

3.2.3 The Population of Bulambuli and its economic activities

Subsistence agriculture is the main economic activity carried out in Bulegeni Sub County and small scale trade. People cultivate crops like banana, groundnuts, beans, maize, and others like tomatoes for consumptions cash like coffee is also grown for selling purposes. Animal rearing is also practiced, animals kept are goats, cattle and pigs hence provide farmers with milk, meat and manure hence they earn some income through selling their produce on market days that is every Wednesday and Saturday other activities like local brewing is also being carried out by some community members as the way of earning their living.

3.3 Research design

The study will use descriptive research design. This will enable the researcher to describe the state of sanitation facilities in Bulegeni Sub County, by examining the existing facilities. He will

also determine the socio-economic challenges and constraints faced by the community, of Bulegeni Sub County on sanitation facilities accessibility. He will also identify the health problems and diseases caused by poor access to sanitation facilities and he will establish effective measures to solve the challenges faced by the community. The study will be carried out basing on the research objectives and research questions and will use descriptive research method.

3.4 Sample size and sampling techniques

3.4.1 Sample size

The study intends to use a total of 60 respondents, in which 10 respondents will include the local community leaders, government officials like district officer, district environmental officer religious leaders, teachers and NGO's representatives. The rest of the 50 respondents will be community residents.

3.4.2 Sampling techniques

The study will use both random and non random sampling techniques in selecting the sample size (respondents). Simple random sampling will be used to select 50 respondents among community members in which sampling frame will be prepared and 50 respondents will be randomly selected from the community. Simple random sampling will be used to avoid biasness and give respondents an equal chance to be in the sample. Such as use of lottery method each member of the population is assigning number, each number is placed in a bowl and mixed thoroughly. The blind folded researcher then picks numbered tags from the bowl, all individuals bearing the numbers picked by the researcher are the subject of the study.

3.5 Data collection methods and instruments

Primary data will be acquired through interviews, questionnaire, focus group discussion, and participatory observations, whereas secondary data will be obtained from documentary reviews. Focus group discussions with small respondents will be used.

3.5.1 Questionnaires

These will be composed of both closed and open ended questions. This will look at some of the challenges like lack of clean water supply, diseases like malaria information about sanitation facility accessibility and also will help to answer the research and objectives.

3.5.2 Interview

Interview will be conducted to collect information from key respondents like district health officer and others. An interview guide will help the researcher to collect information through interactions and hence gather detailed data.

3.5.3 Focus group discussions

Discussion will be held in groups of about 8 participants, 3 women 5 men, which will help the researcher to obtain relevant information on how best sanitation facilities can be improved to control diseases outbreak in Bulegeni Sub County.

3.5.4 Participatory observation

It will be used to obtain first hand information in which a researcher will observe the sanitation facilities and note their conditions and challenges faced by the community accessing them. This will be done by help of an observation checklist.

3.6 Data analysis and presentation

Descriptive analysis will be used to analyze the data obtained from the field by relating them to study objectives. Tables, charts, and pie charts will be used to present the field results.

3.7 Ethical issues

The permission to conduct the research "socio-economic factors that contribute to low access to sanitation facilities in Bulegeni sub county" will be obtained from District health officer Bulambuli district. Questionnaires will be administered to selected community members in the sub county as scheduled. Required data will be obtained through in-depth interviews, participant observation, and documentary review and focus group discussions. With the help of community leaders I will select the respondents to include in my study and also help the respondents answer the questionnaire, interview the key respondents, observing the sanitation facilities and

reviewing literature materials. I will thank the community members and other stakeholders for their cooperation as it will be a successful one.

CHAPTER FOUR

PRESENTATION OF RESEARCH FINDINGS AND DISCUSION

4.1 Socio-demographic characteristics of the population.

Table 1: showing socio-demographic characteristics of the respondents

Sex	Frequency	Percentage%
Female	24	40
Male	36	60
Age of respondents		
15-25	16	27
26-35	28	47
36-45	12	20
46 and above	4	6
Marital status		
Single	21	35
Married	39	65
Divorced	-	-
Others	-	-
Education levels		
Primary	12	20
Secondary	30	50
Tertiary	18	30
Others	-	-
Number of people in a household		
<5	17	28
5-10	37	62
11>	6	10

Source: Primary Data 2012

Analysis of the above table shows that, 40% of the respondents were female while 60% were male and females were also part of the study. The table also shows that 27% of the respondents were between the ages of 15-25 years, 47% were between the age of 26-35 years while 20% of the respondents were between the age of 36-45 years and 6% were above 46 years. This shows that majority of the of the respondents were between the age of 26-35 years and 36-45 years which means they had much responsibility in managing sanitation facilities and energetic to move to a nearby river to fetch water. The above table also shows that 65% of the respondents are married while 35% of the respondents are single. This is as a result of early marriages and the single are the ones still in school. The table above shows that 20% of the respondents attended primary school, 50% of the respondents studied until secondary school and 30% were of tertiary education. This shows that most of them could not attain higher levels of education. Finally the table also shows that most household in Bulegeni had 5-10 people with 62% then followed by those with less than 5 people with 28% and more than 11 people with 10%.

4.2 Sanitation facilities at household level.

4.2.1 TABLE 2: Responses on the available sanitation facilities available in their community.

No	Sanitation facilities	Frequency	Percentage %
1	Latrines	13	22
2	Bathroom	17	28
3	Access to clean water	-	-
4	Dust bins	-	-
5	Bathrooms	8	13
6	Kitchen	22	37
	Total	60	100

Source: Primary Data 2012

According to table 2 above, 22% of the respondents had latrines, 28% had bathrooms, the respondents also lacked access to clean water and dust bins, 13% of their bathrooms offered privacy while most of them had a kitchen. This means that majority had latrines and bathrooms and those that did not have bathrooms in good shape mentioned bathing at night or at the river because their bathrooms had no sound doors hence could not offer privacy due to lack of maintenance and repair. Water was not safe for drinking mostly water fetched from the river, which is a clear indication that they lacked access to clean drinking water.

4.2.2 Management of sanitation facilities

Table 3: showing management of sanitation facilities

No	Management of sanitation facilities	Frequency	Percentage %
1	Dispose of excreta in latrines	25	42
2	Storage of water	21	35
3	Separation of trash before disposal	-	-
4	Water treatment	7	12
5	Repair	2	3
6	Hygiene maintenance	5	8
Total		60	100

Source: Primary Data 2012

From the study it was found out that sewage management was proper because excreta was disposed off in the latrines even those that did not have personal latrines were able to access latrines from their neighbors, and also those that had theirs full or at a risk of collapsing also went at neighbors though others locked their latrines to maintain hygiene. Their storage of water was in drums and pots. Most of them did not separate trash before disposal which indicated that trash was poorly managed; it was only banana peelings that were put aside for the animals as other kitchen remains were disposed in the open. The above table also shows that 12% treat their water before drinking and most of them just take it without treatment putting their lives at risk of diseases. 3% of the respondents carry out repair on their facilities by replacing worn out iron sheets on doors, kitchens, latrines and bathroom. 8% of the respondents maintain their hygiene by sweeping, boiling water and locking their latrines with padlocks to avoid other community members from messing them up.

The respondents agree that they experience safe water shortage. This proves that they have no access to clean water. The respondents mentioned that they access water from the river, gravity

water and harvest rain water as a way of overcoming safe water shortage. Most of them mentioned that their latrines are suitable for disabled and children and. This proves that most latrines are in good conditions and the ones that could not be accessed by disabled were not hygienically maintained, others were at risk of collapsing hence not accessible.

Most of the respondents mentioned that limited access to latrines and clean safe water were the major cause of diseases in the community while. And from the interviews held respondents mentioned children as the most the most affected. The respondents mentioned; diarrhea, typhoid, malaria and hook worm diseases that affect the community.

4.2.3 Challenges limiting access to sanitation facilities.

Table 4: Challenges limiting access to sanitation facilities

No	Challenges	Frequency	Percentage
1	Income	6	10
2	Government support	17	28
3	Lack of legislation	19	32
4	Campaigns and mobilisation	10	17
5	Women marginalised	8	13
Total		60	100

Source: Primary Data 2012

According to table 4 above, most of the respondents agree that they face challenges in accessing sanitation facilities. This means that they lack clean water, waste collection services and limited access to latrines. The respondents were required to mention the factors that make it difficult for them to access bathrooms, latrines, water and kitchen most of them mentioned; 10% of the respondents mentioned inadequate income to buy materials used in construction of latrines. This could be attributed to the fact that most of them are not employed so they have no source of income to enable them improve on their livelihood. 28% of the respondents mentioned lack of government support in sanitation projects. 32% of the respondents mentioned lack of legislation as factor limiting access to sanitation facilities, this shows that inadequate attention has been given to the development of sanitation policies, people who fail to construct household latrines are no longer penalized. Majority of them also mentioned lack of campaigns and mobilisations from extension workers to help create awareness on sanitation facilities crisis like it is done on agricultural sector. 15% of the respondents mentioned women being marginalized in house hold decision making and have been ignored as managers and potential agents in promoting sanitation.

The respondents also mentioned that lack of sanitation facilities have impact on their health.

Lastly, the respondents were required to give their own views on what measures should be taken to minimize the socio economic factors contributing to limited access to sanitation facilities and they mentioned that they need support from the government, Non Governmental organizations and massive sensitization to help solve the challenges.

CHAPTER FIVE

5.0 CONCLUSIONS AND RECOMANDATIONS

5.2 Conclusions

In conclusion the researcher found out that most of the community members of Bulegeni Sub County have access to a kitchen, latrine bathroom but lack access to clean safe water and they also do not use dust bins as a way of waste management. Most of them also lock their latrines with padlocks to keep strangers away. The researcher also found out that low income and lack of government support are some of the challenges that limits them from accessing sanitation facilities.

5.3 Recommendations.

The researcher recommends the following to alleviate socio-economic factors limiting access to sanitation facilities.

Sanitation facilities coverage should be increased to coupe up with the increasing population to reduce on disease out break that may come as a result of households sharing facilities like latrines.

Sanitation projects should be accelerated like water projects which may help solve problem of water shortage and also community can earn income and maintain their facilities as they will be part of the projects.

Growing political recognition of the need to give sanitation more emphasis in government list of priorities to enhance development and also individual responsibility for maintaining a safe environment is encouraged.

Environment Health Division should bring together stakeholders together to work on sanitation policies and guidelines the importance of this is that it will help protect the national development strategies that may help to be used in advocating for sanitation commitment at all levels by political leaders from all districts and representative from NGOs and donor agencies to maintain sanitation in the region.

Finally the researcher concluded that in Bulegeni Sub County the community can benefit much on sanitation projects like provision of piped treated water through repair of the existing network that collapsed because of poor management and sensitization by extension environment and health workers thus improving community health.

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APENDICES
APENDIX A
QUESTIONNAIRE

Dear Respondent,

I am KOSKEY WILLIAM MATILA, a student of Environmental Management from Kampala International University, am doing a research on 'Socio-economic factors that contribute to low access to sanitation facilities in Bulegeni sub county'. This research is for academic purpose, am requesting you to help me in answering these questions and all the information obtained will be of great confidentiality.

Questionnaire aimed at studying the socio-economic factors that contribute to low access to sanitation facilities in Bulegeni sub county, Uganda.

INSTRUCTION

Please fill in the space provided or tick the correct answer for multiple choice questions.

GENERAL HOUSE HOLD INFORMATION

1. (a) Sex: Female ☐ Male ☐
- (b) Age: 15-25 years ☐ 26-35 years ☐ 35-45 ☐ 46 above ☐
2. Marital status: Single ☐ Married ☐ Divorced ☐ Others
3. Education level: Primary ☐ Secondary ☐ Tertiary ☐ Others
4. Number of people in the house hold: <5 ☐ 6-10 ☐ >11 ☐

Part 1

5. List down the sanitation facilities that you have in your area
- a)
- b)
- c)

d)

e)

6.

a) Where do you fetch water from?

b) Is it safe for drinking? Yes / no

c) If no, how do you treat it?

7.

a) Does your bathroom offer privacy? Yes / no

b) If no, then how do you bath without inconveniencing other people?

.....

8. Do you think most households have kitchen?

Yes ☐ No ☐

Part 2:

9. How do you dispose of your excreta?

10. How do you store water?

.....

11. Do you separate your trash before disposal?

.....

12. What other ways do you use to manage the sanitation facilities in your community?

a)

b)

c)

d)

13.

a) Do you think limited access to latrines and clean safe water is the major cause of diseases in your community? Yes / No

b) If yes, mention the diseases,

.....
.....
.....
.....

14. Do you think the latrines are suitable for disabled and children?

Yes ☐ No ☐

Part 3

15.

a) Do you have any challenges in accessing sanitation facilities? Yes / No

b) If yes, which ones?

.....
.....
.....

16. What factors make it difficult for your household to access bathroom, latrine, water and kitchen?

.....
.....
.....

17. What other factors do you think make it difficult for other people to access sanitation facilities?

.....

.....
.....
.....

18.

a) Does lack of sanitation facilities have any impact on your health?

Yes ☐ No ☐

b) If yes, which ones?

.....
.....
.....

19.

a) Do you experience safe water shortage?

Yes ☐ No ☐

b) If yes, what do you do when that happens?

.....
.....
.....

20. In your own view what measures do you think should be put in place to minimise this socio-economic factors contributing to low access to sanitation facilities?

.....
.....
.....

Thank you so much, may God bless you.

APENDIX B

INTERVIEW GUIDE

1. Does your community have adequate sanitation facilities?
2. Which criteria do you follow to educate community members to use their sanitation facilities?
3. Is the livelihood of the community affected by inadequate access to sanitation facilities?
4. Briefly how do you manage the available sanitation facilities?
5. What are the socio-economic factors that contribute to low access to sanitation facilities in your community?
6. Do you think most of the diseases in your community are as a result of lack of sanitation facilities?
7. Who are the most affected?
8. What are the strategies that have been put in place to address the socio-economic factors that contribute to low access to sanitation facilities in your community?

APPENDIX C

Observation checklist

The following criteria were used to determine whether latrines are good, fair, or poor.

1. Access to dislodging.
2. Availability of non leaking roof.
3. Risk of collapsing.
4. Sufficient ventilation.
5. Structure in sound conditions that offer privacy.
6. Sufficient hand broom.

