FACTORS AFFECTING HYGIENE AND SANITATION PRACTICES IN THE FAMILIES IN OBALANGA SUB-COUNTY,

AMURIA DISTRICT

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DEDICATION

I dedicate this research work to my dear loved parents and my dear husband for their tireless efforts in nurturing and making me the person I am today.

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ABBREVIATIONS / ACRONYMS

CDO	Community Development Officer
FGD	Focus group Discussions
HH	Households
LC	Local Council
NGO	Non Governmental Organisations
VHTs	Village health teams
WASH	Water and sanitation Hygiene

DEFINITION OF THE KEY CONCEPTS

Defecation - It is the practice of passing out excreta (Mahasneh, 2001)

Environmental sanitation - is a package of measures that eliminate factors that encourage the proliferation of flies and the spread of disease. Some of these interventions include the provision of safe water, toilets and health education programmes to improve the personal and environmental hygienic practices of a population (Rabiu, et.al 2012).

Good hygienic practice - includes actions people take to stay healthy, like washing hands thoroughly and often, taking a shower every day, wearing clean cloths and keeping homes clean (Auger, et.al 2005).

Good sanitation - is defined by safe, private and hygienic defecation and the maintenance of adequate, accessible facilities for this purpose (Fawcett, 2011).

Health - is a state of general physical, mental, and social well-being and not merely the absence of disease or infirmity (WHO, 2010).

Hygiene - is the practice of keeping yourself and your surroundings clean, especially to avoid illness or the spread of preventable diseases (Nordberg, and Winblad, 2004)

Hygiene Education - Prevent sickness and promote good health. It enables people to understand their situation, empowers them to plan and act to prevent diseases (Morga, 2001)

Hygiene is more than just being clean. It is defined as the combined practices that help people to stay healthy (Advameg, Inc, 2009).

Hygiene Promotion -This is the process of changing hygiene behaviour using systems and messages on what people know, do and want. It involves working with people to understand their beliefs, practices, taboos and building on this to achieve the desired hygiene behaviour (Mara, 2002)

Hygienic practice - means that a person frequently engages in activities or behaviour that serves to promote or preserve health (Answers.Com, 2010).

Open Defecation - It is the practice of passing out excreta in open field and indiscriminately. These excreta often find its way into sources of drinking water and food and may lead to disease (Environ Health Res. (2006)

Personal hygiene - may be described as the practice of maintaining cleanliness and grooming of the physical body. In common vernacular it is described by the phrase "looking after yourself" (Hygiene Expert (UK), 2000-2009).

Sanitation - is the process of preventing human, animal and insect contact with excreta to avoid the spread of disease (Global Education, 2010).

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ABSTRACT

This study focused on factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County, Amuria District. The Objectives of the study were to establish whether cultural practices, poverty, and literacy levels affects hygiene and sanitation practices, and strategies of improving in the families in Obalanga Sub-County.

The researcher used a case-study research design with a qualitative approach. The population of the research constituted the CDO, LC I & III, Sub-County chief, Sub-County health Assistant, NGOS and households. In this study in-depth interviews with key informants were conducted and FGD with the Households. The researcher used interview guides and focus group discussions to collect data about the three specific objectives and their corresponding questions.

According to the study findings and discussions it is clear that different cultural practices affects hygiene and sanitation practices in the families in Obalanga Sub-County. The cultural practices include; defecating in the bush instead of latrines; Habits of not washing hands and utensils before and after eating of visiting latrine/helping one's self or doing any dirty work***;*** and communities sharing most of the things like water sources or containers with animals as this transmits diseases. The findings confirm that in an attempt to adopt hygiene and sanitation practices in the families, poverty has always interfered a lot and this makes many households to concentrate on how to earn a living more especially improve on food security. The findings show that literate households find it hard to adapt to hygiene and sanitation practices in the families irrespective of its effects. The identified strategies include; Giving information about communicable diseases; Promotion of hand hygiene practices through providing education on proper sanitation and hygiene, campaign of construction of community public latrines; Construction of affordable health facilities in the community can help improve hygiene and sanitation practices in the families in Obalanga Sub-County, improvement of Network system within the villages; and encouraging the formation and active involvement in developmental community group meetings may also help improve hygiene and sanitation practices in the families in Obalanga Sub-County.

The researcher recommends that the Government and the Civil Society organizations should work jointly to support the adaption hygiene and sanitation practices. The district leaders should through the Health vote and department should budget funds to sensitize the public on the values of adaption of hygiene and sanitation practices, through organizing Radio talk shows, village outreaches visits.

CHAPTER ONE

1.0 Introduction

This study was about the factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County, Amuria district. The researcher for a long time observed that In Uganda, lack of sanitation exposes women and girls to security risks. Where there are no latrines, girls and women have to wait until darkness arises, for them to look for a place to defecate. Sometimes they need to walk long distances and are raped or mugged (UNDP 2006). In Amuria district, lack of sanitation facilities is a big problem for the people of Obalanga Sub-County.

Lack of high personal hygiene standards and enough pit latrines to be used by everyone always triggers sanitation and hygiene problems in villages of Obalanga Sub-County because all infections, diseases and poor conditions of living are as a result of poor sanitation. There is no hygiene in households since there is inadequacy of clean water and poor sanitation and unsafe hygiene practices have claimed more lives than anything else. People living in the villages of Obalanga Sub-County are more vulnerable to communicable diseases and malnutrition. Many families are not safe for children due to neglect of the operation and maintenance of facilities. This prompted the researcher to carry out a research to establish the factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County, Amuria District.

This dissertation comprises of five chapters. Chapter one consist of the background of the study, the statement of the problem to the study, the objectives of the study, Significance of the study, justification of the study and the scope of the study. And the conceptual frame work of the study. Chapter two presents a review of related literature on the study subject and this was accessed from various sources including research reports, newspapers, text books and internet and Chapter three presents the research design, the area of study, the study population, Sample population, Sample size and sampling techniques, data collection methods and instruments, data analysis, ethical considerations, quality control methods limitations of the study. Chapter four presents data from the field, interpretation, and discussion of the research findings Chapter five presents the summary of findings in line with

the study objectives and the researchers derived conclusions, recommendations and suggestions for further research.

1.1 Background of the study

Access to clean water, sanitation and hygiene is critical for the survival, development and well-being of family and community members. Sanitation literally means measures necessary for improving and protecting health and well-being of the people. Sanitation is any system that promotes proper disposal of human and animal wastes, proper use of toilet and avoiding open space defecation. Sanitation means the prevention of human contact with wastes, for hygienic purposes. It also means promoting health through the prevention of human contact with the hazards associated with the lack of healthy food, clean water and healthful housing, the control of vectors (living organisms that transmit diseases), and a clean environment. It focuses on management of waste produced by human activities (Danida Report, 2000).

There are different types of sanitation relating to particular situations, such as:Basic sanitation: refers to the management of human faeces at the household level. It means access to a toilet or latrine. Onsite sanitation: the collection and treatment of waste at the place where it is deposited. Food sanitation: refers to the hygienic measures for ensuring food safety. Food hygiene is similar to food sanitation. Housing sanitation: refers to safeguarding the home environment (the dwelling and its immediate environment).Environmental sanitation: the control of environmental factors that form links in disease transmission. This category includes solid waste management, water and wastewater treatment, industrial waste treatment and noise and pollution control. Ecological sanitation: the concept of recycling the nutrients from human and animal wastes to the environment (Duncker, 2001).

Sanitation is any system that promotes sanitary, or healthy, living conditions. It includes systems to manage waste water, storm water, solid waste, and household refuse and it also includes ensuring that people have safe drinking water and enough water for washing. Sanitation includes both the ‘software’ of understanding why health problems exist and what steps people can take to address these problems, and ‘hardware’ such as toilets, sewers and hand-washing facilities. Together, they combine to break the cycle of diseases that spread when human excreta and waste are not managed properly (Elliot, et al., 2014).

Good sanitation refers to the appropriate behaviour and practices of the people living in a specific environment. The people know to avoid contact with human excreta and to hygienically dispose of human waste. The people's behaviour displays a responsible attitude towards the hygiene of their families, the community, and the environment. By being a responsible and hygienic individual you make sure that you do not spread diseases (Bapat, and Desai, 2003).

Good sanitation is an essential part of primary and preventative health care, and hygiene promotion is just one aspect of health promotion. All health programmes use the same approach of research, education and advocacy. Poor sanitation promotes the spread of health problems - including chronic diarrhea, intestinal worms, bilharzia, hepatitis, and scabies - that can lead to malnutrition and stunting, especially in small children, places extra stress on the weakened immune systems of HIV positive people, accelerating the shift to full-blown AIDS, has a major impact on the quality of life of people with AIDS, and the quality of life of those around them. Sanitation matters for a range of other reasons too: privacy, dignity, convenience and safety for individuals, pollution impacts, especially on water sources, poverty reduction, through reducing vulnerability to disease and allowing low-income people to make better uses of their resources. For all these reasons good sanitation is an essential part of community development.

Good sanitation is achieved when everyone in a community understands the health importance of safe excreta disposal, and takes the necessary practical steps to promote good personal hygiene and public health. This includes access to, and consistent use of, a safe and hygienic toilet. Good sanitation behaviour increases life expectancy with reduced morbidity and child mortality, savings in health care costs, reduces sick leave and higher worker productivity, betters learning capacities among schoolchildren - increased school attendance, especially by girls, it promotes national pride and strengthened tourism and reduces water treatment costs (Greene, 2001).

Hygiene generally refers to the set of practices associated with the preservation of health and healthy living. The focus is mainly on personal hygiene that looks at cleanliness of the hair, body, hands, fingers, feet and clothing, and menstrual hygiene. Hygiene is related to personal cleanliness, such as personal hygiene (body, clothing). Sanitation refers to waste management, particularly management of human waste. Improvements in personal

knowledge; skill and practice that modify an individual's behaviour towards healthy practice are the focus of hygiene promotion. Safe hygiene practice includes a broad range of healthy behaviours, such as hand washing before eating and after cleaning a child's bottom, and safe faeces disposal. When you carry out hygiene education and promotion the aim is to transfer knowledge and understanding of hygiene and associated health risks in order to help people change their behaviour to use better hygiene practices (Hogrewe et.al 2001).

There are no safe hygiene practices, health benefits from better water and sanitation services are limited. Hygiene promotion has a positive impact on health even without improvements in water and sanitation services. Hygiene promotion is mostly about changing people's hygiene behaviour, a difficult and often slow process. It begins with working with local residents to understand their beliefs, practices, and problems, and raising awareness of the impacts of poor sanitation. Residents work with support teams to devise appropriate remedies. Hygiene behaviours can be divided into five main areas: Safe disposal of human faeces, Protection and use of water sources, Home and environmental hygiene, Water and personal hygiene, and Food hygiene (World Health Organization, 2008).

At the World Summit on Sustainable Development at Johannesburg in September 2002 the World Community committed itself to halve by 2015 the proportion of people without access to safe sanitation. Since 1990 an estimated 747 million people have gained access to sanitation facilities (equivalent to 205,000 people every day).Despite this huge achievement, a further 1,089 million rural and 1,085 million urban dwellers will need to gain access in the coming 15 years if the 2015 target is to be realized. Today, sixty percent of people living in developing countries, amounting to some 2.4 billion people, have no access to hygienic means of personal sanitation (World Health Organization, 2008).

Globally, an estimated one in four children under age 5 suffer from stunting, a form of malnutrition in which children are shorter than normal for their age.[1] In India, almost 62 million children (48 percent) across all income groups are stunted. Stunting, or chronic malnutrition, is accompanied by a host of problems weak immune systems, risk of sickness and disease, arrested cognitive and physical development, and a greater risk of dying before age 5. Stunting happens over time and can be caused by inadequate maternal nutrition, poor feeding practices, or substandard food quality as well as frequent infections. The high rate of stunting in India is surprising given its economic growth, especially in contrast to sub-

Saharan Africa where GDP is lower. A recent case in the New York Times explored the link between high rates of child malnutrition in India and the country's poor sanitation, shedding light on a potential cause of a protracted problem. For India, the issue is not a lack of food, but rather a lack of toilets for its population one-half of India's population, at least 620 million people, defecates outside. The interaction between diarrheal disease and malnutrition is well established. Diarrhea is often caused by a lack of clean water for proper hand-washing. A lack of toilets further exacerbates the problem as feces on the ground contribute to contaminated drinking water and water resources in general (UNICEF, 2013 and Heidi, W. 2014).

The World Health Organization estimates that 50 percent of malnutrition is associated with repeated diarrhea or intestinal worm infections from unsafe water or poor sanitation or hygiene. Children who are exposed to open defecation or who don't have a clean water supply may ingest bacteria, viruses, fungi, or parasites that cause intestinal infection; chronic inflammation in a child's gastrointestinal track is linked to stunting and anemia, and puts children at risk for poor early childhood development (WHO, 2008).

Many organizations have adopted an integrated approach to improve water, sanitation, and hygiene, known as WASH programs. One of the United Nation's Millennium Development Goals is to halve by 2015 the proportion of the population without sustainable access to safe drinking water and basic sanitation. However, despite progress, 2.5 billion people in developing countries still lack access to improved sanitation facilities. Unfortunately, the toilets that have been built in have sometimes gone unused or have been used to store tools, grain, or building materials. Changes in social norms and behaviors must change too. "Open defecation is everybody's problem. It is the quintessential 'public bad' with negative spillover effects even on households that do not practice it" (United Nations, 2014).

In Uganda, the lack of sanitation poses to security risks for women and girls. Where there are no latrines, girls and women have to wait until darkness arises, for them to look for a place to defecate. Sometimes they need to walk long distances and are raped or mugged (UNDP 2006).

In Amuria district, lack of sanitation facilities is considered a big problem for the people of Obalanga Sub-County but it is very difficult to improve the situation because of several related issues. First, there are floods which always destroy latrines; secondly, latrines are considered the responsibility of the government and Non-Government Organisations in this area. Lack of toilet facilities may trigger sanitation and hygiene problems in villages of Obalanga Sub-County because all infections, diseases and poor conditions of living are as a result of poor sanitation.

People living in the villages of Obalanga Sub-County are more vulnerable to communicable diseases and malnutrition. Women and children are particularly at risk. The risk factors for diseases in the villages of Obalanga Sub-County are water, sanitation and hygiene practices. They act in competing and complementing transmission pathways for causing diseases. Faecal- oral diseases are a major burden. Human and animal excretion products can affect human health through various transmissions pathways which include transmission through ingestion of water for example, through drinking, transmission caused by lack of water linked to inadequate personal hygiene, transmission caused by poor personal and domestic hygiene, transmission through contact with water containing organisms and transmission through contaminated aerosols from poorly managed water and drainage systems (Prusset el, 2002).

Communicable diseases are spread through physical contact with infected individuals, liquids, food, body fluids, contaminated objects, airborne inhalation, or through vector borne spread. Most of the diseases in villages of Obalanga Sub-County are a result of the lack of high personal hygiene standards and poor use of pit latrines by the people. The spread of infections from one person to another are frequent because of the overcrowding and congestion situation in villages. Women face the hustle of communicable diseases related to the unsanitary living environments, the lack of water and inadequate nutrition. The most common communicable diseases in villages of Obalanga Sub-County are cholera, malaria, and diarrhea (WHO, 2008). It is upon this back ground that the research study on factors affecting the hygiene and sanitation practices is incited.

1.2 The problem statement

Despite of many organizations adopting an integrated approach to improving water, sanitation, and hygiene, known as WASH programs, many households more especially in Obalanga Sub-County in Amuria District have not adopted hygiene and sanitation practices. Unfortunately, the toilets that have been built in have sometimes gone unused or have been used to store tools, grain, or building materials. Changes in social norms and behaviors must change too. People living in the villages of Obalanga Sub-County are more vulnerable to communicable diseases and malnutrition. Women and children are particularly at risk. In some areas of Uganda, a step forward to improve on sanitation is made except in some areas such as Obalanga Sub-County. This prompted me to carry out a research so as to find out the factors affecting the hygiene and sanitation practices in families, case study Obalanga Sub-County in Amuria district.

1.3 Objectives of the study

To establish the factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County, Amuria District.

1.3.2 Specific objectives

i. To establish whether cultural practices affects hygiene and sanitation practices in the families in Obalanga Sub-County.

ii. To find out whether poverty affects hygiene and sanitation practices in the families in Obalanga Sub-County.

iii. To establish whether literacy levels affect hygiene and sanitation practices in the families in Obalanga Sub-County.

iv. To identify strategies for the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County.

1.4 Research questions

i. Do cultural practices do affect hygiene and sanitation practices in the families in Obalanga Sub-County?

ii. Does poverty affect hygiene and sanitation practices in the families in Obalanga Sub-County?

iii. Does literacy level affect hygiene and sanitation practices in the families in Obalanga Sub-County?

iv. What strategies can be put in place for the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County?

1.5 Scope of the study

This section explained the geographical, content and the time scope of the study as indicated:

1.5.1 Geographical scope

The study was carried out among people in families in Obalanga Sub-County, Amuria District in eastern Uganda. Amuria district is bordered by Abim in the North, Katakwi in the East, Soroti in the south and Kabermaido district in the west. Amuria was selected for the study for the reason that there are so many case of death case registered in the Amuria Hospital due to poor hygiene and sanitation practices.The researcher felt there was need to carry out this study because hygiene and sanitation practices in the families in Obalanga Sub-County are very poor. As a result there many cases of cholera, dysentery, worms among others.

1.5.2 Content scope

The focus was basically to establish the factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County.

1.5.3 Time scope

The researcher collected relevant primary data from the field and secondary data was reviewed from 2000 to 2015 mainly from journals, magazines, reports of various authors. The study focused on six years, so as to establish the factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County. This is because a majority of NGOs came in with their WASH programmes and implemented them and they were targeting the household in the communities within Amuria district which was previously affected by floods.

1.6 Significance of the study

The study will help to create awareness among commonly leaders and service providers of the current situation status and may be need to improve hygiene and sanitation practices in the families in Obalanga Sub-County.

The study will help to inform persons responsible for formulating and implementing policies with the views of improving hygiene and sanitation practices in the families in Obalanga Sub-County.

The study will help to open another further research and study to better programming of hygiene and sanitation practices in the families in Obalanga Sub-County.

1.7 Justification of the study

The researcher felt there was need to carry out this study because hygiene and sanitation practices in the families in Obalanga Sub-County are very poor. As a result there are many cases of cholera, dysentery, worms among others. When sanitation systems fail or are inadequate the impacts on the health of the community, on the health of others and on the environment can be extremely serious. The researcher also carried out this research as a requirement for award of a bachelor's degree.

1.8 Conceptual framework

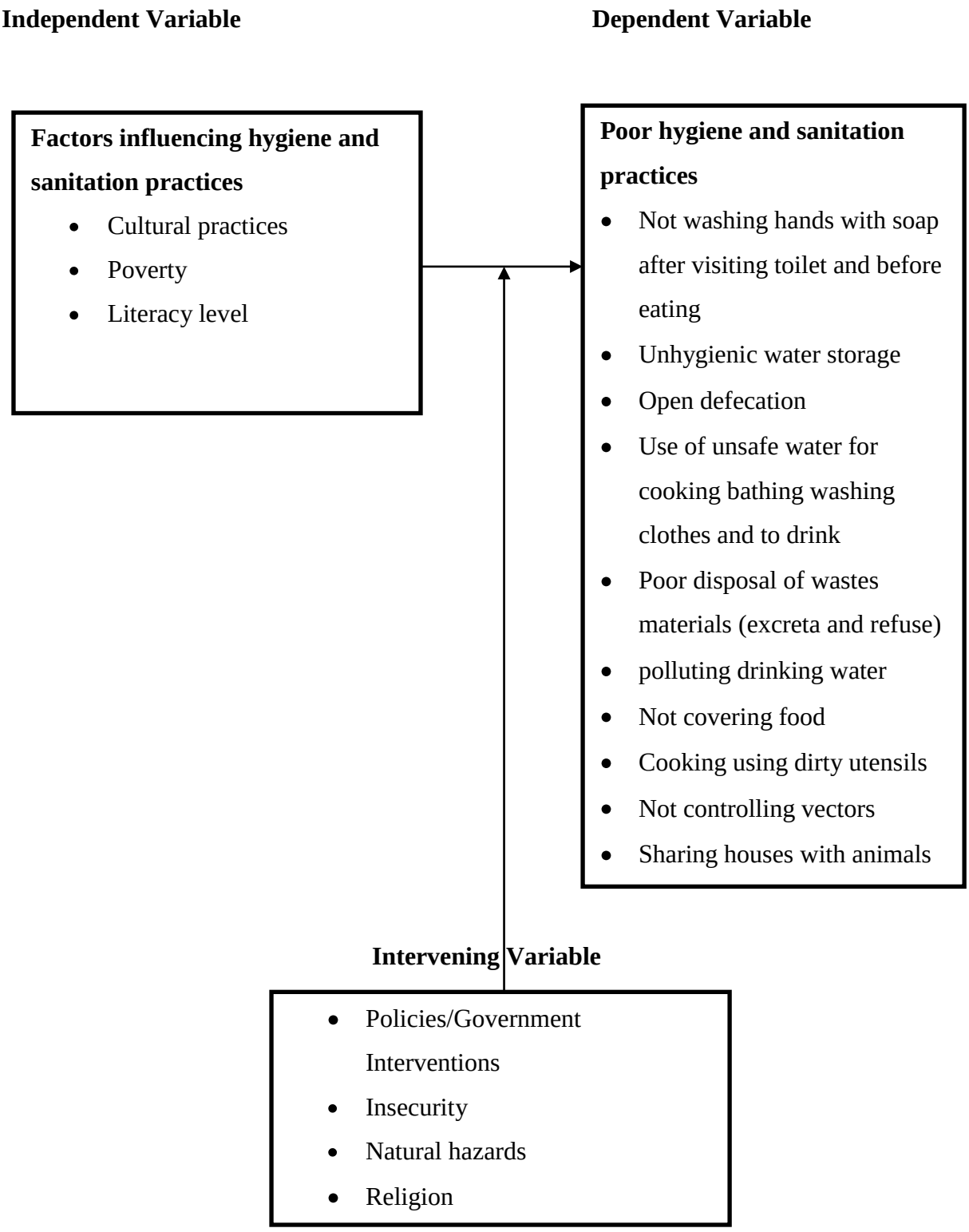

Figure 1: The Conceptual framework

1.8.1 Description of the conceptual framework

The above diagram shows that the independent variable Factors affecting(characterized by Cultural practices, Poverty, Literacy level) determines the dependent variable the Poor hygiene and sanitation practices (Characterized by not washing hands with soap or unhygienic water storage, Open defecation, Use of unsafe water for cooking bathing washing clothes and to drink) Cultural practices such as open defecation results to poor disposal of waste materials which also make people use unsafe water and unclean utensils/facilities. Poverty denies households to use clean utensils and facilities as there will be little or no money for replacing old utensils /facilities and purchase of soap and construction of latrines among others. Literacy makes households not to be aware and to use good hygiene practices such as washing hands with soap after visiting the latrine, before eating and use of clean utensils and facilities at home. The intervening variable (Characterized by Policies/Government Interventions, Insecurity, Natural hazards and Religion) also influences the relationship between the independent and dependent variables. Policies/government interventions which are not implemented will result to households to continue using cultural practices, living in poverty and having uneducated communities, hence poor hygiene and sanitation practices.

Insecurity will deny households from accessing clean water and opportunity to purchase soap, utensils among others hence poor hygiene and sanitation practices will continue.

Natural hazards like floods will collapse household latrines leading to open defecation hence poor hygiene and sanitation practices.

Religion like Muslim practice of washing their body parts after visiting the latrine is not well handled or it is done without soap and clean water hence still resulting to poor hygiene and sanitation practices.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature that was gathered from other sources that was related with the topic. The study reviewed different authors that wrote topics related to factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County, Amuria District. Under this chapter, views, articles, thoughts that explains how the research topics are presented. This information was obtained from the journals, magazines, text, books, internet, and newspapers.

2.2 Whether cultural practices do affect hygiene and sanitation practices in the families

The factors will vary from place to place depending on the local context. Behavioral, demographic, climatic, social, and cultural reasons can deter families from hygiene and sanitation practices in the families. For example, elderly people in rural areas may find it difficult to get used to new technologies such as use of latrines, boiling of water and may resist the adoption of new behaviours. In some local cultures, people may not want to share latrines with others; for example, women may not want to share the same facility with their father-in-law and there are some cultural practices that inhibit the use of one latrine by both the husband and wife. Children's faeces are often mistakenly considered not to be a potential health hazard and it may be considered unimportant for children to use the latrine. Household members may be discouraged from using the latrine at night because of the fear that 'evil' or 'devils' inhabit the latrine during that time.

Another factor is the misconception that prevails among some families that using the 'cat-system' (i.e. burying excreta or leaving it open in a field) will improve the soil condition (Bhatia , and Falkenmark ,2003).

Key issues are poor hygiene practices, such as open defecation; contamination of water sources; malnutrition caused by worms or ongoing diarrhea, lack of safe and hygienic toilet facilities, lack of facilities for hand Washing and inadequate refuse removal. It is crucial to

promote understanding of the linkages between water, sanitation, hygiene and health (Birongo, and Le, 2005).

Generally, communities adopt unsafe hygiene practices as residents do not wash hands after changing babies' nappies, before handling food, before eating, after a visit to the toilet, after house cleaning and after work or rubbish disposal, due to irregular water supply. Others do not wash food before eating, especially fruits. Men in most cases do not wash their hands after urinating and they urinated in open spaces (for example behind the house, on the street, next to the car). There is poor disposal of children faeces and solid waste because of the lack of essential services for waste disposal. Most mothers who use disposable nappies throw them in the grassland (Mulumba, Kakosova, and Juma, 2004).

Water containers are sometimes left uncovered or half-covered so as to ensure that they capture rainwater. The communities share water with animals because of lack of demarcation areas around households. They also drink untreated water from unprotected streams, due to lack of money to buy disinfectants. A number of communities use the “bush” for defecation due to the lack of toilets. This habit also stems from poor technical awareness in communities, a lack of maintenance and cleaning of public toilets and facilities, cultural norms and beliefs regarding certain practices as well as poor designs in public facilities. The following expressions highlight some of the cultural hygiene practices: “Most houses are not fenced; domestic animals come in the yard to drink water from the containers”.

“During some traditional ceremonies, people do not wash meat in order to retain its nutrients”. “It is sometimes perceived as a disgrace for the father in law to use a toilet used by the daughter in law”. “Sometimes community members would not use the toilet because they are afraid that there could “be juju” on the toilet seat to bewitch them” (Mulumba, Kakosova, and Juma, 2004).

There are myths, attitudes, beliefs and distorted perceptions. For example, most communities do not perceive children's faeces as harmful. They touch children's stools and say “ikoku” which literally means “this is a child” giving the impression that children's stools are clean. Some people perceive safe hygienic practices as a rich people's affair and people prefer to defecate in the bush because they are afraid to share toilets to avoid being bewitched. Other expressions can be as follows: “It is sometimes perceived as a disgrace for the father in law

to use a toilet used by the daughter in law". "Sometimes one has to defecate outside in order to examine the faeces to see if s/he has been bewitched or not". This makes it difficult for the adoption of safe hygienic practices (Klaassen, 2007).

2.3 Whether poverty and hygiene does affects sanitation practices in the families

Poverty is a state of not having enough money to meet your basic needs such as water, food and shelter. Poverty is prevalent in Kenya. In 2003, 56 % of the population was below the poverty line, and it is expected to become 65.9% by 2015 (Government of Kenya, 2005).

Despite the health benefits, some family members in rural households may not practice proper hand washing. Why do you think that some people in your village don't wash their hands properly? Possible reasons include they can't afford to buy soap, they have a poor attitude to hand washing and can't be bothered to do it, they lack the utensils and equipment, the inappropriate placement of the hand washing facility or lack of water, but other reasons are also possible (Global Health Action (2015).

Poverty in rural is more pronounced and has always led to poor hygiene and sanitation, increase in diseases and infections, lack of proper nutrition, security and safety. The most significant general needs of every human being are housing, employment, food, toilet availability and water accessibility; unfortunately these are not available for rural dwellers due to poverty (Dalrymple et al 2002).

Poverty in Kibera slums is evident through the structures of the houses the residents live in which are often constructed of cardboard, corrugated tins, mud, thatch and plastics. They are mostly single rooms which are about six feet by nine feet and are partitioned by only a curtain. This single room is used as a living room, kitchen, bathroom as well as a bedroom where both parents and children share. People living in poverty are the most overcrowded because of the cost of housing and the large family sizes (UNECOSOC 1997). Lack of jobs is the main reason why poverty in Kibera slums is highly increasing. Men usually get part time jobs such as plumbing, building, cutting grass, carrying water, driving buses but women are the most disadvantaged when it comes to getting a source of income. In addition to poverty, the lack of employment also leads to the lack of education for the children, robbery, insecurity, diseases and other things (Dalrymple et al 2002).

Poverty in rural areas has led to poor hygiene and sanitation, increase in diseases and infections, lack of proper nutrition, security and safety. Women are mostly affected by poverty in rural areas because being as housewives, they are responsible for the upkeep of the

family, taking care of the children, determining the nutritional status of the family, observed .In order for women to fulfill their roles in the family such as child bearing, maintaining the family, bringing up the children, they should maintain their health status and practice good health behaviours as it affects themselves as well as their families and community at large (Mahasneh 2001). The income level of women aged between 18-45 years is beyond poverty line. This makes it next to impossible for a woman to be able to meet the needs of her household in Kibera slums as well as maintain good health.

Poverty has also lead spread of diseases because of lack of money to access treatment as well as to purchase medicine and facilitate the construction of a separate house for animals. Mulumba et al (2004) argues that the lack of employment opportunities in the rural, has always led to poverty. It is the main reason why there is a lot of informal trading manifested in the form of randomly distributed kiosks some of which are licensed by the Town Council but the majority of which operate without a valid license (Wag staff, 2002).

Good income is considered as one of the key motivating factors for adoption of safe hygienic practices. Further, provision of affordable sanitation products and services, with more equitable distribution so as to reach the low-income groups and to enhance access to and demand for goods and services is viewed as critical. Unemployment, low incomes, poor living conditions, low literacy levels and lack of recreational facilities are perceived as de-motivating factors towards the adoption of safe hygienic practices.

Similarly the high cost of water and sanitation to families of low income and the shortage of capital for investment are also cited as de-motivating factors (Pruss, et.al 2002). While even the lowest-income families can usually afford potable water as it is delivered, the provision of indoor connections close to the house can become unaffordable because of attendant costs that are not taken into account in project feasibility studies. People are always willing to pay for the type of service they want. It should be ensured that that the method of payment is the preferred one which best suit their circumstances. Special provision may have to be made for the poorest individuals and families (Sclar, and Northridge, 2003).

Issues relating to economic efficiency and resource scarcity should be taken into consideration when price for services are made and issues concerning the right to what is often considered basic level of service. Programmes should emphasize poverty and related problems rather than solely focusing on sanitation (UNICEF, 2013).

2.4 Whether literacy level does affect of hygiene/sanitation practices in the families

The factors vary from place to place depending on the local context. Behavioral, demographic, geographic, climatic, social, cultural and economic reasons can deter families from using latrines. For example, elderly or uneducated people in rural areas may find it difficult to get used to new technologies and may resist the adoption of new behaviours. There are other more practical reasons such as the use of inappropriate materials for latrine use, construction, and maintenance due to once education level (Kagiri, 2007).

Educational factors include training, advocacy; capacity building, social mobilization, access to information and information exchange. There is always unhygienic practice, certain cultural beliefs in relation to hygiene, fears and perceptions of hygienic practices would have to be changed through raising awareness and education. Ineffective promotion and low public awareness, ignorance of people, lack of capacity building, lack of hygiene education and training, negligence of people always de-motivate the adoption of safe hygienic practices (African Health Sciences 2005).

Due to lack of education and training, this is why most communities look at education as a necessity of a hygiene awareness workshop and it should address cleanliness, collection of waste, safe disposal of faeces, food storage, disease prevention, sanitation facilities and erection of toilets. The Ill-health of people living in the rural is largely due to ignorance (Henrique 2005).

2.5 Strategies for improvement of hygiene and sanitation practices in families

There is need to identify the factors affecting the use of latrines that are relevant in your community. Once these are defined, then one can discuss them in a transparent way. Open discussion of these issues within the community will ease the construction and use of latrines (Hilfinger, 2001).

To improve on hygiene and sanitation practices in families one should focus on individual and communal communication to change the attitude of people towards the direct (health) and the indirect (economic) benefits of hand washing. One can recommend the use of locally available materials such as ash for detergent purposes, and tin cans or jerry cans as hand washing devices .One can later check that the hand washing facility is conveniently placed near latrines and that the water is clean to avoid further contamination (Hiruma, 2007).

Health education is frequently delivered by someone lecturing about hygiene and sanitation in health facilities and community gatherings. However, such an approach is not recommended as the sole means to achieve individual behaviour change. Because human behaviour is influenced by the surrounding environment and social context, specific messages instead of universal messages of hygiene and sanitation are more important. Hygiene messages must be contextually and culturally suitable, and comfortable, for your community. If one are trying to change behaviour by targeting individuals, one need to consider not only their prior experience but also their learned behaviours (Camdessus, 2003).

Education about how to maintain and care for toilets is often part of hygiene education. Key elements of a good hygiene promotion programme include: Close interaction between local residents and support teams to identify a specific local problem or behaviour as the priority target, Household participation in identifying problems and needs and in finding solutions for those problems and needs, development of an effective communication or education campaign, local level advocacy work and Evaluating the impact of the programme (Stren, 2002).

Good sanitation is an essential part of primary and preventative health care, and hygiene promotion is just one aspect of health promotion. All health programmes use the same approach of research, education and advocacy. One method of strengthening both a hygiene

and sanitation promotion programme is to link it with other health promotion projects (Samantha, and Wijk, 2008).

Access to improved water and sanitation facilities does not, on its own, necessarily lead to improved health. There is now very clear evidence showing the importance of hygienic behaviour, in particular hand-washing with soap at critical times: after defecating and before eating or preparing food. Hand-washing with soap can significantly reduce the incidence of diarrhea, which is the second leading cause of death amongst children under five years old. In fact, recent studies suggest that regular hand-washing with soap at critical times can reduce the number of diarrhea bouts by almost 50 per cent (Sheth, and Obrah, 2004).

Good hand-washing practices have also been shown to increase the incidence of other diseases, notably pneumonia, trachoma, scabies, skin and eye infections and diarrhea-related diseases like cholera and dysentery. The promotion of hand-washing with soap is also a key strategy for controlling the spread of Avian Influenza (bird flu)(UNICEF/WHO2009).

The key to increasing the practice of hand-washing with soap is to promote behavioral change through motivation, information and education. There are a variety of ways to do these including high-profile national media campaigns, peer-to-peer education techniques, hygiene lessons for children in schools and the encouragement of children to demonstrate good hygiene to their families and communities. See the hygiene promotion page [link: Hygiene promotion page] for more information (United Nations Habitat 2005).

In order to have an impact on health, any change in health practice needs to be adopted by many individuals in the community. Shared behaviour is only achieved when the community's members themselves feel there is a problem, and are motivated to solve the problem by jointly taking actions that would permanently improve health conditions (United Nations Habitat 2006).

The following the two particular approaches to community motivation that are becoming increasingly popular throughout the developing world for communal behaviour change: Participatory Hygiene and Sanitation Transformation (PHAST) and Community-Led Total Sanitation (CLTS) are among the CATS techniques used to achieve total sanitation. These methods introduce community mobilization and behaviour change as their core principles to

improve sanitation and integrate hygienic practices. Traditional methods of sanitation and hygiene promotion were teacher-driven, that is to say the educator taught by lecture and the community listened passively. CATS approaches are demand-driven, community-led and emphasize the sustainable use of user-friendly, affordable and safe sanitation.

The following sections outline the basic principles of PHAST and CLTS but to be a facilitator of these techniques requires further study and training to develop the skills required. Such training might be sought from NGOs involved in water and sanitation (also known as WASH) projects. The other is Participatory Hygiene and Sanitation Transformation (PHAST) is a widely used community approach to hygiene promotion. It uses participatory techniques to promote good hygiene behaviours, sanitation improvements and community management of water supply and sanitation facilities. It is derived from a community appraisal method of health practice that, in the process, empowers community members (participants) to be able to identify their community problems. Community appraisal is a process for analysing the existing community health problems by mapping water and sanitation, and identifying good and bad hygiene behaviour in relation to community hygiene practices and the spread of diseases (World Health Organisation, 2003).

School-Led Total Sanitation (SLTS) is a related form of community approach to total sanitation. You can engage school teachers and students in similar sanitation activities with the aim to clean up the school environment and promote hygiene among school children and staff. School sanitation clubs can be actively engaged in SLTS. Though the targets are slightly different, the techniques are similar to the CLTS approach. In CLTS, it is very important for you to consider and understand the cultural and contextual differences between communities. There might be incidences when the community members may be angry or sensitive to discussions at times of triggering and when they are ignited. You must know how to handle these events in order to get back on track. So instead of adopting the whole practice of CLTS applied elsewhere, you may need to adapt it to fit your community's cultural and social conditions (World Health Organisation, 2003).

The Ill-health of people living in the rural areas is largely due to ignorance and over population. Nurses have the primary responsibility to influence the health care pattern in a community. Individuals see nurses as experts in advising communities on wellbeing. Nurses can serve as educators as a link between the Ministry of Health leaders, authority leaders and

the community. Nurses should inform all community members and especially women that communicable diseases can be basically prevented by boiling water and by cooking food properly and that washing hands with soap and water helps get rid of germs (WHO. 2001) (Nyamongo et.al 2004).

The government should ensure that the languages used are understandable by the community members of Kibera. Since women are mostly involved in sanitation and hygiene situations, they should be encouraged to participate in community groups, drama sessions, dances, songs and poems which are all involved in communicating developmental messages. By doing so, information was effectively spread in the slum areas and the problems facing them was curbed (Keraka and Wamicha 2003).

According to UN-Habitat and Gender Water Alliance (2005), community participation is becoming a central issue in modern times. It should have its own initiative, planning and management of people's quality of life. This requires a change in thinking and action of community based projects. Working with the community, requires nurses, therefore, to start at the level of households, working upwards from there to the community and even higher levels. This ensures that projects meet people's needs. Government and organisations can then come in to help in sustainability of the projects (World Health Organisation, 2003).

Health promotion in the community involves nurses focusing on places where people spend most of their days. Nurses need to meet people in these areas to and interact with them, for example, in market places, health care Centres and religious Centres. Working with the community helps the communities identify their problems and how to overcome these problems. "The church as a major social institution is a powerful resource for health care programming" (Miner, 2003: 7). Many Africans are church goers. Hence the church is an effective institution and it reaches high percentage of people. Therefore, the church is able to identify people's needs in different surroundings and to provide a good environment for nurses to educate various groups, for example, women.

The church is also able to organise people into various groups to mobilize community in the implementation of new health promotion. Miner (2003) notes that nurses can use pastors, teachers, local politicians and community elders as an instrument for the success of any

implemented health programs Education programs in churches have the greatest potential to reduce health problems.

The Church and other religious institutions can influence people's behaviour and change to certain behaviour. Health care providers should work in collaboration with churches to utilize the principles of community-based programs. Nurse researchers should include churches as participants in their research, and involve the church in the implementation and evaluation of research recommendations. Churches often offer a good setting for the sustainability of a program.

Developing education programs that are implemented in education curriculum for school goers is an effective way for nurses to promote hygiene and sanitation practices at home in the present and in the future when children grow. Working with schools may fail to reach those children who do not attend school and especially girls who mainly do the household chores. In addition to visiting schools and teaching children on the ways and means of good sanitation and hygiene, nurses should also encourage school teachers to introduce sanitation and hygiene lessons in the school curriculum. By doing this, the children would grow up having acquired knowledge on the ways and means of disease prevention and sanitation and hygiene maintenance (Keraka and Wamicha et al 2003).

This chapter presented a review of related literature on the study topic and this was accessed from various sources such as research reports, text books and internet. The study focused on the following themes: cultural practices, poverty and literacy in relation to hygiene and sanitation practices in households. Despite the health benefits of good hygiene and sanitation practices, some households in rural areas will not have good hygiene and sanitation due to cultural practices such as open defecation, poverty which makes households to continue using old utensils and facilities and finally literacy which makes households not to be able to wash hands after visiting the latrine and before eating using soap.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This section presents the methodology that was used by the researcher to carry out the study. It describes researcher design, study population, sample size and sampling techniques, research instruments, validity and reliability of the research instruments, procedure of data collections, data analysis, ethical considerations and limitations of the study.

3.1 Study design

The researcher only employed qualitative approach with a case study research design. It is a survey because it gathered data from large number of respondents at the same time so as to describe the nature of factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County. It is cross-sectional in that the researcher used different categories of respondents (Sub-County chief, Sub-County Health officer, Community Development Officer, Non -Government Organisations, Village Health Teams, Households, Chairperson LC III and I at the same time. This reduced costs in terms of money and time. The qualitative approach was used for data collection, presentation and analysis. Qualitative research approach helps the researcher to gain an insight and understanding of the phenomenon through intensive collection of narrative data.

3.2 Study population

The target population composed of Sub-County chief, Sub-County Health Assistant, Community Development Officer, Village Health Teams, Households, Chairperson LC III and I. The total population for the study was 736 respondents and this is where the sample size was got from. This population was targeted because they are the right categories to provide the study with the required information on factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County.

3.3 Sample techniques

Purposive sampling technique was used for selecting the Sub-County chief, Sub-County Health officer, Community Development Officer, Village Health Teams, Non-Government Organisations, Chairperson LC III and I. This was because they are few and are the technical personnel in the area of education in primary schools. The researcher believes that they are the right people who can give the right information on teachers' involvement in Decision making and teachers' performance. The researcher had in mind that these categories of respondents had information required for the study. This sampling technique was employed because it is simple and helps to avoid cases of biasness in sampling. Stratified random sampling techniques were used in this study to select Households because they are the ones directly affected by the poor hygiene and sanitation practices. This method is very economical, effective, reports accurate results and a high degree of representativeness and is very useful (Amin 2005).

3.4 Sample size

Table 3.1: Shows sample size

Category of Respondents	**Population**	**Sample Size**	**Adjusted sample size**	**Sampling Strategy**
Sub-County chief	01	01	01	Purposive
Chairperson LC III, I,	36	32	06	Purposive
Sub-County Health Assistant	02	02	02	Purposive
Community Development Officer	02	02	02	Purposive
Village Health Teams	26	24	06	Purposive
Non-Government Organisations	03	03	03	Purposive
Households	667	60	30	simple random sampling
Total	**736**	**124**	**50**	

The sample size was calculated using the Krejcie and Morgan table (1970) as quoted by Amin (2005:454) for determining sample size and this gave a practical ratio according to the population size. The study used a sample size of fifty (50) respondents reason being that with qualitative research you should not exceed the number of respondents beyond fifty and also because of the limited time but those respondents represented the majority.

3.5 Source of data

3.5.1 Primary source

The researcher obtained the data mainly from the study respondents (Sub-County chief, Chairperson LC V, Sub-county Health Assistant, Community Development Officer, Village Health Teams, Households, Chairperson LC III and I).

3.5.2 Secondary source

In this study, the main sources of secondary data were from the text books, journals, and websites (Internet).

3.6 Data collection methods and instruments

The researcher used interview guides and focus group discussions to collect data about the three specific objectives and their corresponding questions. This study did not involve use of questionnaires because it was not looking at quantitative approach and also this was because most of the respondents did not know how to read and write and the officials who could read and write were too busy to fill the questionnaires hence prompting me to use only interviews and focus group discussion methods.

3.6.1 Interview guide

The detailed interviews of this research work focused on; the community women group activities taking place, challenges hindering women active participation in community women group activities, and practical strategies of improving women active participation in community women group activities. The interviews were conducted with the Sub-County

chief, Chairperson LCV, Sub-County Health Assistants, Community Development Officer, Village Health Teams, Chairperson LC III and as these were the key informants. Since this research study required soliciting information on individual or personal experiences encountered on water hygiene and sanitation in families, in-depth interviews will aid the researcher to understand individuals' views on what they consider reasons for women Heading Households low active participation of women/men heading household, beliefs and the cultural context in which this problem is occurring.

Similarly, interview guide was suitable for this research work since it is appropriate for venturing into sensitive issues. It also helped the researcher to know the individuals' feelings and emotions about the topic under study. The questions used were open-ended questions so as attain detailed explanations and insights about the study topic. Most importantly by employing this research method, the hidden emotions individuals attach to their experiences were brought to the surface easily. Under the guidance of interview guide, semi-structured interview guides were used as data collection instrument.

3.6.2 Focus group discussions

Focus group discussions were used in this research because it is very instrumental in gaining a broad range of views on a research topic; in three sessions of interaction with the selected respondents. Only Women were engaged in the discussion (women heading households whereby they was 10 per group) because it is mostly women who stay at home and probably they know more on what is in their homes and community at large. It is suitable for; exploring topics about which, where is faint information, thus generating a range of views about the study issue in a single event of data collection, and enabling vast data collection in a short period of time.

In this research, focus group discussion method aims at assessing the hidden factors that are deterring good hygiene and sanitation practices in families, while at the same time identifying ways in which these problems could be defused. The focus group discussion was conducted with the households. However, the researcher used focus group discussions for collecting data since the study was qualitative research.

3.7 Validity and reliability of the research instruments

To ensure methodological reliability and validity, the study instruments were made in line with the research objectives. The study instruments were subjected into pretesting to ensure the reliability and validity before the actual data collection in the selected area of study and respondents. The researcher will personally collected information from the field and follow the research ethics. To ensure reliability and efficiency of the data collected, the interview guides and focus group discussion guides was structured according to themes to enable the correlation between themes and data collected for easy follow-up. The researcher designed the instruments and requested the supervisor and other research experts in the university to verify them by rating each item on the instrument.

3.8 Ethical considerations

The following ethical considerations were ensured during the course of this study;

The researcher got permission from the relevant authorities before carrying out this study.

Acknowledgement of authors and scholars whose works are reviewed in this study was done. This was done so as to avoid cases of plagiarism in this study. This was done by citations and referencing.

Researcher also ensured confidentiality of respondents as ethical measure. Confidentiality of respondents especially after research in connection to information they provided for this study. This was done through presenting information provided by respondents without revealing their true identity.

Further still, respondents consent was sought before they embark on this study. This was done so as to allow respondents to participate in this study freely and at their own will. Informed consent was established through asking respondents to sign in the Informed Consent Form.

3.9 Research procedure

Upon the approval of the proposal, the researcher obtained an introductory letter from the Uganda Martyrs University Authorities. This letter introduces the researcher to District Authorities so as to be allowed to carry out a research on factors affecting hygiene and sanitation practices in the families in Obalanga Sub-County. The collected data was edited, coded, analyzed, interpreted and presented using frequency tables, and percentages. Thereafter, conclusions and recommendations were made and a final report written.

3.10 Data analysis

The qualitative data collected through interviews and focus group discussion were analyzed manually as they were categorized, cleaned, interpreted and analyzed under their respective themes. The analysis steps were systematically and consistently done for each one of the four objectives, from objective one to four.

3.11 Limitation and delimitation of the study

Unwillingness to participate in the interactions; some respondents were unwilling to share information about Staff Appraisal Systems and teachers' performance. The researcher however, endeavored to emphasize that it is a purely academic research and confidentiality was uphold.

Sensitivity of information; some respondents felt that the information required were sensitive and could affect their working environment if revealed. The researcher however made an effort to convince respondents that the information exchanged was very confidential.

Interpretation of the questions affected the meaning as some respondents had difficulty in interpreting the questions correctly. However, the researcher interpreted the questions for the respondents.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND DISCUSSIONS

4.1 Introduction

This chapter presents the findings of the study. The chapter deals with data presentation, interpretation, and discussion of the research findings from in Obalanga Sub-County, Amuria district, regarding cultural practices, poverty, literacy levels affects hygiene and sanitation practices in the families and strategies for the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County. The researcher presents the views of the respondents, analysis and discussion of the research findings in light of the literature reviewed in chapter two. The methods, instruments of data collection and the nature of data was qualitative, as a result the findings were as well presented, analyzed, interpreted and discussed thematically.

4.2 Whether cultural practices do affect hygiene and sanitation practices in the families in Obalanga Sub-County

According to the Focus Group Discussion and interviews findings, the following were highlighted. The respondents agreed that different cultural practices affects hygiene and sanitation practices in the families in Obalanga Sub-County. They include:

- **Using the bush for defecation**

  "Poor disposal of children faeces and solid waste" (Sub-County chief during interviews); "Not sharing latrines with in Laws" (Chairperson LC I during interviews); "Pregnant women no using toilets" (Sub-County Health Assistant during interviews); and "Sometimes community members would not use the toilet because they are afraid that there could be *juju* on the toilet seat to be witching those (VHTS during interview sessions).

The findings are in agreement with Bhatia, and Falkenmark, (2003) who observed that Behavioral, demographic, climatic, social, and cultural reasons can deter families from hygiene and sanitation practices in the families. For example, elderly people in rural areas may find it difficult to get used to new technologies such as use of latrines, boiling of water and may resist the adoption of new behaviours. In some local cultures, people do not want to share latrines with others; for example, women do not want to share the same facility with their father-in-law and there are some cultural practices that inhibit the use of one latrine by both the husband and wife. Children's faeces are often mistakenly considered not to be a potential health hazard and it was considered unimportant for children to use the latrine. Household members may be discouraged from using the latrine at night because of the fear that 'evil' or 'devils' inhabit the latrine during that time.

Key issues are poor hygiene practices, such as open defecation; contamination of water sources; malnutrition caused by worms or ongoing diarrhea, lack of safe and hygienic toilet facilities, lack of facilities for hand Washing and inadequate refuse removal as found in (Birongo, and Le, 2005) seen in the literature review.

- **Habits of not washing hands and utensils**

  "Not wash hands after before handling food, before eating, after a visit to the toilet, after house cleaning and after rubbish disposal (Sub-County Health Assistant during interview sessions)"Not covering water containers and utensils" (NGO staff du. ring the interviews). "Not washing meat in order to retain its nutrients during some traditional ceremonies"(CDO during interview session).

The findings are in agreement with Mulumba, Kakosova, and Juma, 2004) who observed that generally, communities adopt unsafe hygiene practices as residents do not wash hands after changing babies' nappies, before handling food, before eating, after a visit to the toilet, after house cleaning and after work or rubbish disposal, due to irregular water supply. Others do not wash food before eating, especially fruits. Men in most cases do not wash their hands after urinating and they urinated in open spaces (for example behind the house, on the street, next to the car). There is poor disposal of children faeces and solid waste because of the lack

of essential services for waste disposal. Most mothers who use disposable nappies throw them in the grassland.

- **Communities shared most of the things with animals**

  "We share the same water source with our animals"(One HH member during FGD). "I share containers with my animals such as pigs, goats, sheep and cows more especially when drinking water" (Another HH member during FGD). "In our village most families even share houses with their animals. It is worse when wild animals come and begin eating our goats, sheep" (Chairperson LC I during interviews).

The findings are in agreement with Mulumba, Kakosova, and Juma, (2004) who observed that Water containers are sometimes left uncovered or half-covered so as to ensure that they capture rainwater. The communities share water with animals because of lack of demarcation areas around households. They also drink untreated water from unprotected streams, due to lack of money to buy disinfectants. A number of communities use the "bush" for defecation due to the lack of toilets. This habit also stems from poor technical awareness in communities, a lack of maintenance and cleaning of public toilets and facilities, cultural norms and beliefs regarding certain practices as well as poor designs in public facilities. The following expressions highlight some of the cultural hygiene practices: "Most houses are not fenced; domestic animals come in the yard to drink water from the containers". "During some traditional ceremonies, people do not wash meat in order to retain its nutrients". "It is sometimes perceived as a disgrace for the father in law to use a toilet used by the daughter in law". "Sometimes community members would not use the toilet because they are afraid that there could "be juju" on the toilet seat to bewitch them".

However, the findings answered the research questions one as stated in chapter one and confirmed that cultural practices affected hygiene and sanitation practices in the families in Obalanga Sub-County.

4.3 Whether poverty does affect hygiene and sanitation practices in the families in Obalanga Sub-County

According to the Focus Group Discussion and interviews findings, the following were highlighted. The respondents agreed that in an attempt to adopt hygiene and sanitation practices in the families, poverty has always interfered a lot and this makes many households to concentrate on how to earn a living more especially improve on food security.

> "Continuous use of old utensils/water containers such as jerry cans, pots, source pans plates, cups among others do not promote hygiene and sanitation practices in the families more especially in Obalanga Sub-County" (VHTS during interview sessions).

Closely related,

> "Due to poverty, a majority of the people in Obalanga Sub-County, have ended up sharing water containers with their animals for drinking water and even some times for feeding for example sheep, goats, pigs, and cows. This includes even sharing water sources like boreholes and spring wells with animals which does not promote hygiene and sanitation practices" (CDO during interview session).

In support,

> "Whenever, there are home visits and health facility visits by clients, it is discovered that personal and home hygiene is very poor. When asked what the problem was , most clients and HH we interacted with associated the problem or cause to poverty as they have to spend much of the time look for food to eat with the family members" (Sub-County Health Assistant)

Similarly,

> "Due to poverty problems, most NGOs operating in the area have discovered poverty to be interfering with the successful implementation of hygiene and sanitation practices among the HH in Obalanga Sub-County" (NGO staff during the interviews).

The findings are in agreement with Mulumba, Kakosova, and Juma, (2004) who observed that Water containers are sometimes left uncovered or half-covered so as to ensure that they capture rainwater. The communities share water with animals because of lack of demarcation areas around households and funds for construction of separate houses for animals. They also drink untreated water from unprotected streams, due to lack of money to buy disinfectants. A number of communities use the "bush" for defecation due to the lack of toilets. This habit also stems from poor technical awareness in communities, a lack of maintenance and cleaning of public toilets and facilities, cultural norms and beliefs regarding certain practices as well as poor designs in public facilities. The following expressions highlight some of the cultural hygiene practices: "Most houses are not fenced; domestic animals come in the yard to drink water from the containers".

> "Our leaders together with Some NGO who have ever supported our sub county have always encouraged and trained the community members on ways of promoting health practices at home and in the community. Because of poverty my husband cannot even afford to construct even good houses for us neither can he construct a latrine at home" (Another HH member during FGD).

Similarly,

> "Most families even share houses with their domestic animals such as goats, sheep, chicken, pigs as they cannot afford to construct house for their animals" (Chairperson LCIII during interviews).

In addition,

> "In most families, the HH regard poverty to be a big problem than hygiene and sanitation practices. Due to this believe, most HH cannot bother to practice even after being trained on water and sanitation skills and knowledge" (Sub-County chief during interviews).

The findings are in agreement with Dalrymple et al (2002) who observed that poverty in rural is more pronounced and has always led to poor hygiene and sanitation, increase in diseases and infections, lack of proper nutrition, security and safety. The most significant general needs of every human being are housing, employment, food, toilet availability and water accessibility; unfortunately these are not available for rural dwellers due to poverty.

In support, Mulumba et al (2004) observed that poverty has also lead spread of diseases because of lack of money to access treatment as well as to purchase medicine and facilitate the construction of a separate house for animals.

> "I was some time back stopped by the water committee from accessing water from the borehole though very near my home just because I failed to pay Shs. 1000 which is to be paid on monthly. So since then I rely on rain water, getting sometimes from the local spring well where animals also drink from" (Another HH member during FGD).

Closely related,

> "Sometimes I have failed to afford soap, and because this my family members always bath, wash utensils without soap. In a way I cannot catch up with hygiene and sanitation practices my families" (One HH during FGD).

The findings are in agreement with Global Health Action (2015) who observed that despite the health benefits, some family members in rural households may not practice proper hand washing. Why do you think that some people in your village don't wash their hands properly? Possible reasons include they can't afford to buy soap, they have a poor attitude to hand washing and can't be bothered to do it, they lack the utensils and equipment, the

inappropriate placement of the hand washing facility or lack of water, but other reasons are also possible.

According to the researcher, issues relating to economic efficiency and resource scarcity should be taken into consideration when price for services are made and issues concerning the right to what is often considered basic level of service. This is in line with UNICEF (2013) who recommends that Programmes should emphasize poverty and related problems rather than solely focusing on sanitation.

However, the findings answered the research question two as stated in chapter one and confirmed that poverty affected hygiene and sanitation practices in the families in Obalanga Sub-County.

4.4 Whether literacy levels affect hygiene and sanitation practices in the families in Obalanga Sub-County

According to the Focus Group Discussion and interviews findings, the following were highlighted. The respondents agreed that literate households find it hard to adapt to hygiene and sanitation practices in the families irrespective of its effects. The following were the respondents' responses:

> "My home members defecate in the nearby bushes. This is why some times bushes near homes are never cleared/ slashed. This can also act as local manure and our culture supports the practice. I our village we do not even have latrines and there is no money for digging it" (One HH during the FGD).

Closely related,

> "It is a miracle to have latrines, rubbish pits or dustbins in a family of illiterate households" (NGO during the interviews).

The findings are in agreement with Kagiri, (2007) who observed that behavioral, demographic, geographic, climatic, social, cultural and economic reasons can deter families from using latrines. For example, elderly or uneducated people in rural areas may find it difficult to get used to new technologies and may resist the adoption of new behaviours. There are other more practical reasons such as the use of inappropriate materials for latrine use, construction, and maintenance due to once education level.

> "Concerning beddings and clothing, more especially those of the children are rarely washed instead they are only put under the sun to dry and in the night they are used. This is common for the cases of those children who urinate" (LC I during interviews). "In the villages, in some families, children including elderly people rarely brush teeth and sometimes they do not even wash their faces. It is even commonly seen with men who drink, as they wake and begin looking for the homes with local beer 'Ajon' so as to drink" (Sub-County Health assistant during the interviews)."All village households rarely boil drinking water irrespective of where it was fetching from. The water containers and utensils in most cases are dirty. Sometimes they practice dry cleaning. In such families, if you ask for drinking water and see the container used and the hands of the person who has brought it , you may not want to drink" (VHTS during the interviews).

The findings are in agreement with Henrique (2005) who observed that due to lack of education and training, this is why most communities look at education as a necessity of a hygiene awareness workshop and it should address cleanliness, collection of waste, safe disposal of faeces, food storage, disease prevention, sanitation facilities and erection of toilets. The Ill-health of people living in the rural is largely due to ignorance.

> "The water containers used such as pots and jerry cans are never washed from year to year until they get broken/damaged" (Sub-County chief during the interviews)."People in this Sub-County share water sources with their animals being a borehole or spring well" (Another HH during the FGD).

In support,

> "Most people more especially women and the youth prefer bathing, washing their legs from the well after garden work and in a process they even end up urinating in the water and defecating near the water sources" *(LC III during the interviews).*

The findings are in agreement with African Health Sciences (2005) who observed that there is an always unhygienic practice, certain cultural beliefs in relation to hygiene, fears and perceptions of hygienic practices would have to be changed through raising awareness and

education. Ineffective promotion and low public awareness, ignorance of people, lack of capacity building, lack of hygiene education and training, negligence of people always de-motivate the adoption of safe hygienic practices.

However, the findings answered the research question three as stated in chapter one and confirmed that literacy level affected hygiene and sanitation practices in the families in Obalanga Sub-County.

4.5 To identify strategies for the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County

The following strategies can help in the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County:

> "Promotion of hand hygiene practices through providing education on proper sanitation and hygiene, campaign of construction of community public latrines" (CDO during interviews),"Giving information about communicable diseases" (Sub –county Health Assistant during interviews), and Availability of proper and available means of communication" (VHTS during the interviews)

The findings are in agreement with Hiruma, (2007) suggests that to improve on hygiene and sanitation practices in families one should focus on individual and communal communication to change the attitude of people towards the direct (health) and the indirect (economic) benefits of hand washing. One can recommend the use of locally available materials such as ash for detergent purposes, and tin cans or jerry cans as hand washing devices .One can later check that the hand washing facility is conveniently placed near latrines and that the water is clean to avoid further contamination.

In addition, Samantha, and Wijk, (2008) suggests that good sanitation is an essential part of primary and preventative health care, and hygiene promotion is just one aspect of health promotion. All health programmes use the same approach of research, education and advocacy. One method of strengthening both a hygiene and sanitation promotion programme is to link it with other health promotion projects.

> "Construction of affordable health facilities in the community can help improve hygiene and sanitation practices in the families in Obalanga Sub-County" (Sub-County chief during interviews), "The government should help us construct good houses, latrines, more water sources especially for the animals" (One HH during the FGD), and "Introduction of sanitation and hygiene lessons in the school curriculum" (CDO during interviews).

The findings are in agreement with Keraka and Wamicha et al (2003) suggests that developing education programs that are implemented in education curriculum for school goers is an effective way for nurses to promote hygiene and sanitation practices at home in the present and in the future when children grow. Working with schools may fail to reach those children who do not attend school and especially girls who mainly do the household chores. In addition to visiting schools and teaching children on the ways and means of good sanitation and hygiene, nurses should also encourage school teachers to introduce sanitation and hygiene lessons in the school curriculum. By doing this, the children would grow up having acquired knowledge on the ways and means of disease prevention and sanitation and hygiene maintenance.

> "Encouraging the formation and active involvement in developmental community group meetings may also help improve hygiene and sanitation practices in the families in Obalanga Sub-County " LC III during the interviews).

The findings are in agreement with World Health Organisation, (2003)suggests that the following are the two particular approaches to community motivation that are becoming increasingly popular throughout the developing world for communal behaviour change: Participatory Hygiene and Sanitation Transformation (PHAST) and Community-Led Total Sanitation (CLTS) are among the CATS techniques used to achieve total sanitation. These methods introduce community mobilization and behaviour change as their core principles to improve sanitation and integrate hygienic practices. Traditional methods of sanitation and hygiene promotion were teacher-driven, that is to say the educator taught by lecture and the community listened passively. CATS approaches are demand-driven, community-led and emphasize the sustainable use of user-friendly, affordable and safe sanitation.

The following sections outline the basic principles of PHAST and CLTS but to be a facilitator of these techniques requires further study and training to develop the skills required. Such training might be sought from NGOs involved in water and sanitation (also known as WASH) projects. The other is Participatory Hygiene and Sanitation Transformation (PHAST) is a widely used community approach to hygiene promotion. It uses participatory techniques to promote good hygiene behaviours, sanitation improvements and community management of water supply and sanitation facilities. It is derived from a community

appraisal method of health practice that, in the process, empowers community members (participants) to be able to identify their community problems. Community appraisal is a process for analysing the existing community health problems by mapping water and sanitation, and identifying good and bad hygiene behaviour in relation to community hygiene practices and the spread of diseases.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of findings in line with the study objectives and the researchers derived conclusions, recommendations and suggestions for further research. The study establishes the factors affecting the hygiene and sanitation practices in households in Obalanga Sub-County.

5.2 Summary of findings

According to the study findings and discussions it is clear that different cultural practices affects hygiene and sanitation practices in the families in Obalanga Sub-County. The cultural practices include; defecating in the bush instead of latrines; Habits of not washing hands and utensils before and after eating of visiting latrine/helping one's self or doing any dirty work*;* and communities sharing most of the things like water sources or containers with animals as this transmits diseases. Therefore this responded to research question one which was that do cultural practices affect hygiene and sanitation?

The findings confirm that hygiene and sanitation practices in the families are affected by poverty. This is because poverty has always interfered a lot and this makes many households to concentrate on how to earn a living more especially improve on food security. This is seen when most Household Continue using old utensils/water containers such as jerry cans, pots, source pans plates, cups among others. This is why even NGOs have remarked that most NGOs operating in the area have discovered poverty to be interfering with the successful implementation of hygiene and sanitation practices among the HH in Obalanga Sub-County. In most families, the HH regard poverty to be a big problem than hygiene and sanitation practices. The aspect of using old utensils confirms the research question two which is does poverty affect hygiene and sanitation practices in the families in Obalanga Sub-County?

The findings show that an illiterate household affects hygiene and sanitation practices in the families irrespective of its effects. This is clearly explained by household members defecate in the nearby bushes. Households are not thinking of having latrines, rubbish pits or dustbins in a family, beddings/clothing in most cases are never washed especially when children urinate on them instead they are always dried without washing. Households rarely brush teeth or wash their faces and households drink un-boiled water and use of old/unwashed containers. This responded to question three which was that, assess whether literacy levels does affect hygiene and sanitation practices in the families in Obalanga Sub-County. Therefore this responded to question three which was that, does literacy level affect hygiene and sanitation practices in the families in Obalanga Sub-County?

The following strategies can help in the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County; Giving information about communicable diseases; Promotion of hand hygiene practices through providing education on proper sanitation and hygiene, campaign of construction of community public latrines; Construction of affordable health facilities in the community can help improve hygiene and sanitation practices in the families in Obalanga Sub-County,; improvement of Network system within the villages; and encouraging the formation and active involvement in developmental community group meetings may also help improve hygiene and sanitation practices in the families in Obalanga Sub-County. This responded to the research question four which was that what strategies can be put in place for the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County?

5.3 Conclusions

From the data collected and discussed above, the researcher concluded that: different cultural practices Such as defecating in the bush instead of latrines; Habits of not washing hands and utensils before and after eating of visiting latrine/helping one's self or doing any dirty work***;*** and communities sharing most of the things like water sources or containers with animals as this transmits diseases affects hygiene and sanitation practices in the families in Obalanga Sub-County.

The findings confirm that hygiene and sanitation practices in the families are affected by poverty. This is because poverty has always interfered a lot and this makes many households to concentrate on how to earn a living more especially improve on food security. This is seen when most Household Continue using old utensils/water containers such as jerry cans, pots, source pans plates, cups among others.

The findings show that an illiterate household affects hygiene and sanitation practices in the families irrespective of its effects. This is clearly explained by household members defecate in the nearby bushes. Households are not thinking of having latrines, rubbish pits or dustbins in a family, beddings/clothing in most cases are never washed especially when children urinate on them instead they are always dried without washing. Households rarely brush teeth or wash their faces and households drink un-boiled water and use of old/unwashed containers.

5.4 Recommendations

The researcher recommends that the Government and the Civil Society organisations should work jointly to support the adaption hygiene and sanitation practices.

The district leaders should through the Health vote and department should budget funds to sensitize the public on the values of adaption of hygiene and sanitation practices, through organizing Radio talk shows, village outreaches visits.

Health service providers should always liaise with other stakeholders such as the counselors, NGOs, Local council, Community elders and church leaders to always support with spiritual guidance and counseling on adaption of hygiene and sanitation practices.

The Government should make sure that legislation is in place to modify cultural practices so as to improve on the adaption hygiene and sanitation practices.

5.5 Areas for further research

An assessment on the impact of VCT on adaption of hygiene and sanitation practices

An assessment on the men's perception on hygiene and sanitation programmes.

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APPENDICES

APPENDIX I

FOCUS GROUP DISCUSSION

Dear respondent,

I am Amuge Everlyn, a student of Uganda Martyrs University under taking a degree in Democracy and Development studies. Currently am carrying out a research study on factors affecting hygiene and sanitation practices in the families in Obalanga Sub County, as part of the requirement for award of the bachelor's degree.

This information is intended for academic purpose and all responses provided will be handled with maximum confidentiality. You are kindly requested to take part or participate in proving information required.

Thank you

1. In your opinion, what cultural practices are in place that affects hygiene and sanitation practices in the families in Obalanga Sub-County?

2. According to you, how do cultural practices affect hygiene and sanitation practices in the families in Obalanga Sub-County?

3. In your view, how does poverty affect hygiene and sanitation practices in the families in Obalanga Sub-County?

4. Do you think that literacy level affects hygiene and sanitation practices in the families in Obalanga Sub-County?

5. In your opinion, what strategies can be put in place for the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County?

6. Do you have any other information about hygiene and sanitation problem in Amuria?

APPENDIX II

INTERVIEW GUIDE WTH THE KEY INFORMANTS

Dear respondent,

I am Amuge Everlyn, a student of Uganda Martyrs University under taking a degree in Democracy and Development studies. Currently am carrying out a research study on factors affecting hygiene and sanitation practices in the families in Obalanga Sub County, as part of the requirement for award of the bachelor's degree.

This information is intended for academic purpose and all responses provided will be handled with maximum confidentiality. You are kindly requested to take part or participate in proving information required.

Thank you.

1. In your opinion, what cultural practices are in place that affects hygiene and sanitation practices in the families in Obalanga Sub-County?

2. According to you what is your opinion on cultural practices that affects hygiene and sanitation practices in the families in Obalanga Sub-County?

3. In your view how does poverty affect hygiene and sanitation practices in the families in Obalanga Sub-County?

4. What is your view on how literacy level affects hygiene and sanitation practices in the families in Obalanga Sub-County?

5. In your opinion, what strategies can be put in place for the improvement of hygiene and sanitation practices in the families in Obalanga Sub-County?