IRC

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Scaling-up Sanitation and Hygiene in Kabarole

A MONITORING REPORT OF THE HOME IMPROVEMENT CAMPAIGNS IN MUGUSU AND KASENDA SUB-COUNTIES, JUNE – JULY 2021

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Supporting water sanitation and hygiene services for life

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OD Open Defecation

ODF Open Defecation Free

DHI District Health Inspector

PHAST Participatory Hygiene and Sanitation

SDG Sustainable Development Goals

Introduction

Kabarole District Local Government and IRC have a collaborative commitment to improve WASH in two sub counties per year, an initiative that started in 2020. Specifically focusing on SDG6.2 target on sanitation and hygiene, intensive campaigns are carried in two select sub-counties reaching every village and household with information on and skills to maintain good standards of sanitation and hygiene in their homes. Thus, in February and March 2021 the home improvement campaigns were conducted in 49 villages of Mugusu and Kasenda sub-counties, and a monitoring exercise carried out in June-July to assess the levels of impact registered by the intervention.

The Sanitation campaign activities implemented in Mugusu and Kasenda included stakeholder engagement meetings, a baseline survey, home improvement Campaigns, health education, piloting of the Participatory Hygiene and Sanitation Transformation (PHAST) tools, celebration of the 2021 Sanitation week and rewarding the best homes, Sanitation and Hygiene home visits.

The monitoring exercise used a participatory approach that involved sub-country stakeholders in planning meetings, home visits and data collection, analysis and documentation of key findings.

(i) Planning meetings for follow up on home improvement campaigns.

The planning meetings for the follow up were conducted on 17th June 2021 in Kasenda at Iruhura Health Centre III premises and on 18th June 2021 in Mugusu at Mugusu Subcounty offices.

The objective of the follow up meetings was to convene stakeholders to discuss their engagement in monitoring progress of the implemented Sanitation and Hygiene activities.

The meetings were attended by 36 participants who included Subcounty Chiefs, Parish Chiefs, the Acting District Health Inspector (DHI), the Subcounty Health Inspectors, Health Assistants, the Local council (LC3) Chairpersons, the Community Development Officers (CDO), Mary Concepta from IRC, among others. (*See appendix 1 and 2*).

Key issues discussed were the monitoring tool and the WASH status quo in Kasenda and Mugusu sub counties.

The Household sanitation improvement monitoring tool

Mary Concepta Ayoreka, a facilitator from IRC guided the stakeholders on how to use the monitoring tool to capture information. A detailed description of what ideal and non-ideal latrine technologies, hand washing facilities, bath shelters, drying racks, Safe water chain management, environmental cleanliness entails as reflected in the national Sanitation Guidelines (2000) was done using a participatory approach. A detailed description of what open defaecation (OD) and what (ODF) entails was also done as

stipulated in the ODF guidelines (2012). This enabled all stakeholders to get familiar with key WASH standards and specific parameters to consider while inspecting homesteads.

The participants were cautioned to vigilantly confirm the presence of sanitary facilities on ground before filling the monitoring tool and to correctly fill the tools and ensure completeness.

Mr. Shedrach Asaba (the Acting DHI of Kabarole district) addressing the participants during the stakeholders' meeting in Kasenda.

Mary Concepta Ayoreka, the facilitator from IRC guides participants on how to fill the monitoring tool.

Participants in Mugusu internalize the monitoring tool

During the meeting, the data collection schedule was drawn, data collection teams constituted, and roles distributed. The stakeholders noted that the monitoring process was very timely to help them assess progress to inform planning and decisions on how to improve the WASH situation in their communities and appreciated IRC for the support, as reaffirmed by one of the participants,

> "*This monitoring process is very timely because it will help us to assess progress and to forge a way forward on what we can do differently, inform decisions and planning and to help us redirect more efforts on what the report points to in order to improve the WASH situation in Kasende subcounty*," [Kasenda Subcounty chief]

(ii) Data collection

Data collection commenced on 21st June 2021 and took 15 working days. The data was collected by 10 Health Assistants supported by 7 Parish Chiefs and 49 VHTs who guided the teams to the homes. During the data collection exercise, home visits, demonstrations and Focus Group Discussions were conducted. To ensure quality of the data collected and proper filling of the Sanitation and Hygiene Monitoring Tool, the data collection teams were supervised by the IRC Regional WASH Advisor, the Acting DHI and Mary Concepta Ayoreka the facilitator from IRC. Data entry was done in excel and exported to STATA for analysis by Mary Concepta Ayoreka from IRC.

A Focus Group Discusion in Kasenda during data collection

(iii) Key findings

All the households in Mugusu and Kasenda were visited. A total of 5,626 households were visited, (2,992) in 21 villages of Mugusu and (2,634) in 28 villages of Kasenda. 5 Focus Group Discussions involving 8 - 12 people were also held in Kabagona, Kyezire, Nyabuswa, Burungu, Kasiriza villages.

Most people were living in houses that are in a good state, mostly built with mud and bricks [1](semi-permanent and permanent respectively) [Mugusu – 90.1% (2696/ 2991),

[1]Most of the permanent houses built with bricks were incomplete

Kasenda 89.2% (2349/2632). Only 9.9% (295/2991) and 10.8% (283/2632) in Mugusu and Kasenda respectively were in bad state and were mostly owned by the elderly.

Coverage of Sanitary facilities in Mugusu and Kasenda

12.7% (380/2992) of households in Mugusu and 8.7% (230/2634) in Kasenda had all basic sanitary facilities so were ideal homesteads.

Most of the rest of the households had some of the basic sanitary facilities. Kitchens and Latrines had the highest coverage. 84.2% (2519/2992) of households in Mugusu and 72.3% (1903/2632) in Kasenda had Kitchens. More than three quarters of households in Mugusu 83.9% (2510/2991) and Kasenda 76.3% (2010/2633) had latrines. Only 16.1% (481/2991) and 23.7% (623/2633) in Mugusu and Kasenda respectively had no latrines.

However, coverage other sanitary facilities (Bathshelters, drying racks, rubbish pits, Hand washing facilities, safe water chain management was still below average especially in Kasenda.

Only 47.5% (1250/2633) of households in Kasenda and 62.6% (1873/2992) in Mugusu had bath shelters. Only [43.4% (1142/ 2632) in Kasenda and 52.2% (1560/2991)] in Mugusu had no drying racks. Only 31.4% (827/ 2631) of households in Kasenda, and 31.4% (940/2992) in Mugusu – (31.4%)] had a rubbish pit.

Only 44.1% in Mugusu and 43.1% in Kasenda had hand washing facilities with soap. Majority of households [55.9% in Mugusu and 56.9% in Kasenda] did not have any hand washing facilities or those who were not using soap.

The Safe water chain was not well managed. Most of the jerricans and buckets used for water collection and storage were dirty, [59.3% (1562/2633) and 47.7% (1428/ 2992)] in Kasenda and Mugusu respectively. *(See details in table 3 below).*

Table 1: Showing the availability of Sanitary facilities in Mugusu and Kasenda S/Cs

Parameter		Mugusu		Kasenda	
		Frequency	Percentage (%)	Frequency	Percentage (%)
State of main house	Good	2696	90.1	2349	89.2
	Bad	295	9.9	283	10.8
Presence of Kitchen	Yes	2519	84.2	1903	72.3
	No	473	15.8	729	27.7
Presence of Latrine	Yes	2510	83.9	2010	76.3

	No	481	16.1	623	23.7
Presence of HWF with soap	Yes	1106	**44.1**	866	**43.1**
	No	1882	**55.9**	1765	**56.9**
Presence of Bath Shelter	Yes	1873	62.6	1250	47.5
	No	1119	37.4	1383	52.5
Presence of Drying rack	Yes	1560	52.2	1142	43.4
	No	1431	47.8	1490	56.6
Presence of Rubbish pit	Yes	940	31.4	827	31.4
	No	2052	68.6	1804	68.6
Presence of Safe water chain	Yes	142	52.3	1071	40.7
	No	1428	47.7	1562	59.3
Environmental Cleanliness	Yes	2142	71.6	1711	65.0
	No	850	28.4	922	35.0
Evidence of OD	Yes	176	5.9	581	22.1
	No	2816	94.1	2052	77.9

Bath shelters

Only 47.5% (1250/2633) in Kasenda and 62.6% (1873/2992) in Mugusu had bath shelters. The rest [52.5% (1383/2633) and 37.4% (1119/2992)] in Mugusu and Kasenda respectively had no bath shelters.

Some of the available bath shelters were not maintained to good hygiene standards and were found in a poor state, with rags surrounding the bathrooms, sponges placed on the ground, too short to provide privacy so some people opted to use their bath shelters during the night. This was evident in Isunga and Nyabweya parishes.

Those who had no bathrooms claimed that the ones they previously had were eaten up by goats since they usually use plants. Indeed, most households for instance in Kyezire parish were using bathrooms made of plant material.

Drying racks

Majority of households [56.6% (1490/ 2632) in Kasenda and 47.8% (1431/2991)] had no drying racks. Only 52.2% (1560/ 2991) and 43.4% (1142/ 2632) in Mugusu and Kasenda respectively had Drying racks. Some of them were made of reeds and timber.

Most of the available drying racks were not of required standard. Some had one step (only for drying utensils) while lacking another step for washing and drying of saucepans. This forces people to wash from the ground which is unhygienic. Most of them were dirty and short, had no stones below to facilitate water filtration and no trenches for drainage. Those with no racks attributed it to lack of materials (reeds) within their vicinity.

Safe water chain management

The Safe water chain was not well managed. Most of the jerricans and buckets used for water collection and storage were dirty, [59.3% (1562/2633) and 40.7% (1428/ 2992)] in Kasenda and Mugusu respectively. Only 52.3% (1564/ 2992) in Mugusu and 40.7% (1071/2633) in Kasenda were clean. Some households have access to clean water, some fetch water from streams and crater lakes around but most people don't boil drinking water neither do they use chemicals.

Rubbish pits

Although the compounds of most premises were clean [Kasenda 65.0% (1711/2633), Mugusu 71.6% (2142/ 2992)], Only 31.4% (827/ 2631) of households in Kasenda, and 31.4% (940/2992) in Mugusu – (31.4%)] had a rubbish pit. Among those with pits, most were found with only one pit where all waste is collected without sorting. Most of the community members disposed of their wastes in the gardens and to those with filled up pits do not take up steps to empty them.

Kitchens

Most homes have kitchens [Mugusu 84.2% (2519/2992) and Kasenda 72.3% (1903/2632)] Only15.8 % (473/2992) in Mugusu, and 27.7% (729/ 2632) in Kasenda had no kitchens.

Most Kitchens were not meeting the standards: they are in bad state, with a poor substructure while some households share the kitchen with animals.

Latrines

More than three quarters of households [83.9% (2510/2991) in Mugusu, and 76.3% (2010/ 2633 in Kasenda] had a latrine. Only 16.1% (481/2991) and 23.7% (623/2633) in Mugusu and Kasenda respectively had no latrines. Households whose latrines were almost full (Contents less than 3 meters deep) or were dilapidated were considered absent.

Over 99% of these latrines were traditional pit latrine type, made of local materials (a pit, wooden slab and a superstructure made of mud and wattle or grass). In some homes, the timber slabs were not completely closing the pits which is a good entrance and exit to flies. Most of the latrine doors were made of local materials like banana fibers and some latrines were not clean.

Trading centers with rentals still lack enough facilities, so tenants use one latrine. Some households which are close to each other share latrines with other families especially relatives and others use communal latrines for instance those households in Nyabweya parish near sub county headquarters use latrines at the sub county. Some family's reason for lack of sanitary facilities in Nyahanga village was that they had just relocated to the area, as confirmed by their newly constructed house.

Most homes had no evidence of Open Defecation. [Mugusu (94.1%), Kasenda (78.1%)]. In addition to the two villages which had already been declared Open Defecation Free by the Health Inspectorate team (Magunga 100% and Karwoma 100%), the follow up reveals that 15 more villages in Mugusu and 12 out of the 28 villages in Kasenda had more than 89% of their households without any evidence of OD. These include; Baranga, Nyeri, Kinyankende, Kyakijara, Nyahanga, Kabagona, Butimange, Kasiriza, Nyabuswa, Kyezire, Nyakasojo, Rukooko, Kanyamutwale, Bubandi, Burungu in Migusu. Kibuga B, Kitojo, Nyabweya A, Nyabweya B, Kihumuro, Muhwezi, Isunga Central, Nyabinyonyi, Rwenkuba, Mutukura, Bugangama and Kirombe in Kasenda, *(See details in table 4 and 5 in Appendix)*

Hand washing facilities with soap

Only 37.0% (1106/2988) and 32.9% (866/ 2631) in Mugusu and Kasenda respectively had handwashing facilities with soap. Majority of households [63.0% (1882/ 2988) in Mugusu and 67.1% (1765/ 2631) in Kasenda] did not have any handwashing facilities or those who were not using soap.

Some of the hand washing facilities were not designed with touch tech as tippy taps and most of the foot pedestal system were not working- either the string is cut, or foot pedal is missing. There was no water in the tippy tap and the support system was not working.

The reason why some households did not have tippy taps is that they were stolen, some claimed not to have the materials (sisal) to use. Some do not afford the soap while others were just reluctant and lazy, as one of the FGD participants affirms,

> *"Some of our community members are just lazy to erect a simple tippy tap because they were taught how to make them and the materials required are very cheap"….* [FGD participant, Male, Kabagona Village]

Comparison of follow up findings with baseline findings

A comparison of statistics at baseline and after implementation of the sanitation campaign indicates that the sanitation and hygiene in some households has improved and the improvement is more evident in Mugusu sub county. (*See figure below 1 and 2 below*).

Figure 1: Showing latrine coverage in Mugusu and Kasenda before and after implementation

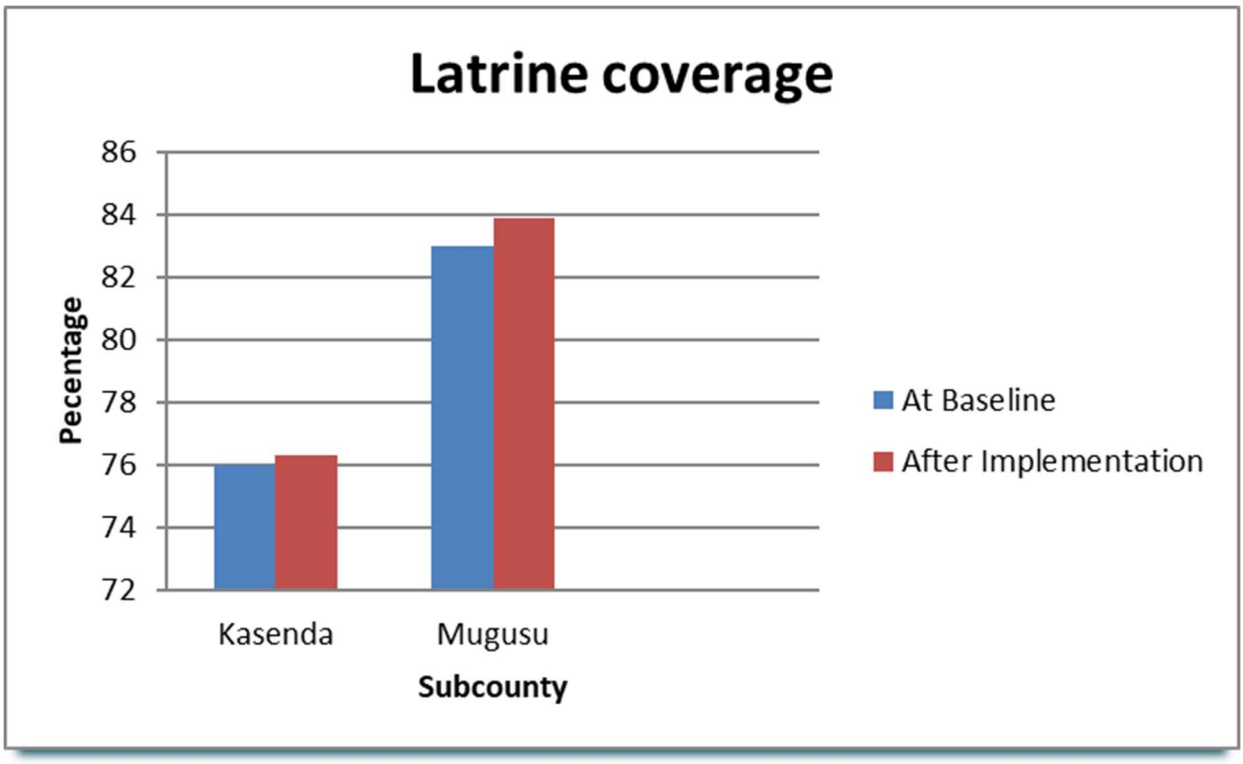
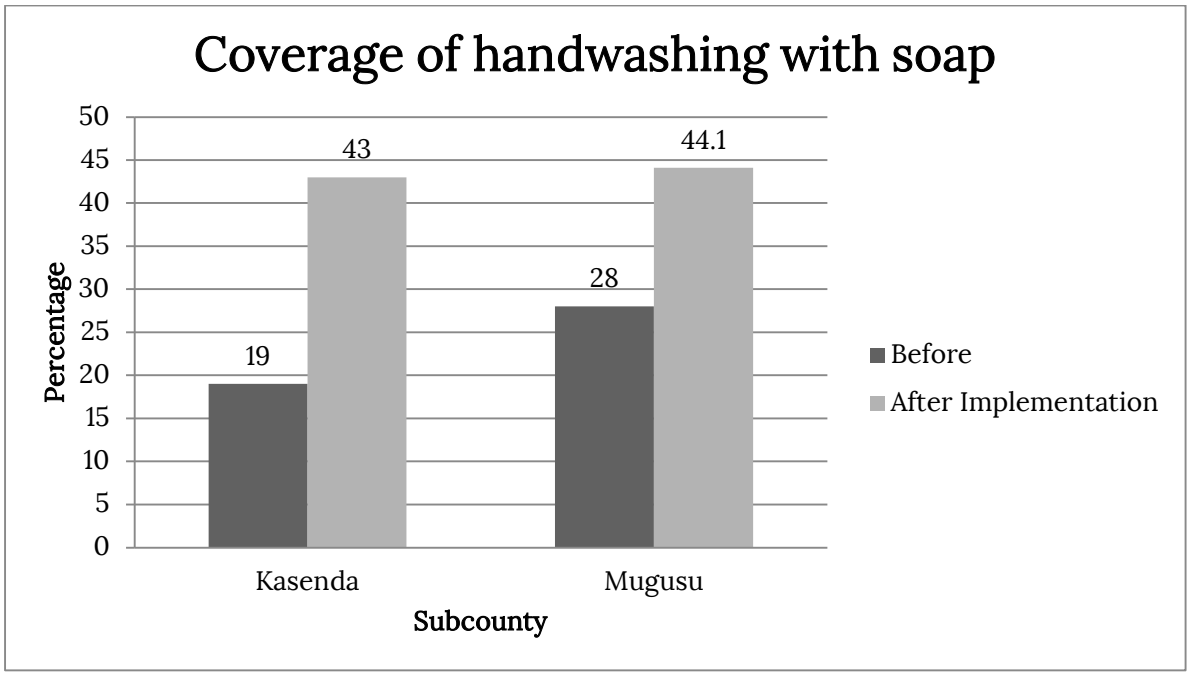


Figure 2: Showing Hand washing facility coverage in Mugusu and Kasenda before and after implementation



Why minimal latrine percentage increase?

0.9% increase in latrine coverage equates to approximately 27 new latrines constructed in Mugusu sub county in this period of time. There is also an increased number of households constructing V.I.P latrines, a success that is attributable to this project.

A good number of ordinary latrines are being improved through the installation of SatoPans to scale up washable latrines. For instance, over 30 latrine facilities, were transformed to washable floors by installation of Sato pans as found in Isunga parish. In addition, Some Ecosan toilets were also found, which would partly be attributable to AMREF that is engaging in sanitation marketing.

The increase in latrine coverage seems minimal because the time between implementation of the sanitation campaign and follow up i.e., 3 months is small. As a result, several new developments still underway at the time of follow up for instance Excavation and construction of new pit latrines is not part of the reported 0.9%.

Greater outcomes from the sanitation campaign supported by IRC are still being realized since some community members were found sinking new pits for latrines, erecting drying racks, tippy taps with clean water and soap in use, during the time of follow up.

The photos below show some of the new developments in Mugusu and Kasenda

Excavation of a new latrine at the home of the LC1 chairman of Nyaruhanga village in Kasenda S/C

A latrine under construction in Nyakasojo Village in Mugusu S/C

An improved pit latrine under construction in Kyantambara zone, Kasenda.

This is a resident of Kyangabukama zone who had no latrine but committed himself to construct one after the sanitation campaign.

Kyaringabira Aidah, A VHT – Iruhura B exhibiting exemplary leadership with her improved pit latrine with a SatoPan

The acting DHI inspecting an improved pit latrine of Mr. Sande Vicent with an ideal homestead who narrated his story of change.

"*After attending the sanitation improvement campaign that was conducted in this village, I committed myself to improve my latrine. I decided to put a SatoPan. My latrine is now free from the smell and flies. I have inspired other community members to replicate my example of using locally available materials.*

Below are photos showing some of the newly erected tippy taps

More tippy taps erected in Kyantambara parish

Newly constructed three steps drying racks in Isunga parish, Kasenda Subcounty.

Mrs. Mugisa posing for photos near her newly constructed drying rack

Residents posing for photos near their newly dug rubbish pits (Below)

Challenges

- Some community members consider farming and other activities more important than sanitation in villages.
- Limited turn up of community members to participate in activities geared towards improving sanitation in the villages, an individual commented,

  "There is lack of full community participation, some community members have a tendency of taking off after seeing us, knowing that we are going to arrest them" …. [Male, Health Assistant]
- Some village leaders with homes still lacking basic sanitary Facilities are not exemplary which limits their advocacy for Ideal homes in their communities.
- Limited commitment of some stakeholders who no longer care to enforce local byelaws in relation to sanitation and hygiene of the villages.
- Very big villages that are not feasible for LCI chairpersons to visit all households at once.

- Increased theft of hand washing Facilities, by passersby which has complicated hanging them at latrines.
- Limited facilitation for the Health inspectors, Assistants and VHTs to conduct follow ups.
- Poor management of SaTo pans due to lack of enough water for flushing and cleaning. This was evident in Isunga zone, Isunga central and Iruhura B.

Best practices used during implementation of the sanitation campaign.

- *Using PHAST tools* - They have the potential of promoting community participation for more significant behavioral change if extensively promoted.
- *Promoting the use of locally available materials.*
- *Identifying and rewarding model homes with Certificates*
- *Mapping out leaders so that they be exemplary.* The Acting DHI mapped out 60 homesteads of leaders who include the local council team, the secretary for health, VHTs, among others. These were mobilized and are expected to at least have exemplary homesteads. It is envisaged that if these all transform into model homesteads in all areas, they would constitute a good proportion of households with improved sanitation and hygiene.
- *Team building sessions* among the implementers and their communities were held. For instance, a football match was held between Kasenda and Mugusu. This has helped in building synergies and creating a good working relationship.

Key lessons learnt.

- Behavioral change is a process and requires time, the impact of the sanitation campaign can be observed later than the three months after implementation.
- Although resources used to construct most of the sanitary facilities are within community reach, defiance is evident.
- Mobilization of some community members is hard, which would be attributed to fear of being arrested.
- Sustainability of the fragile gains still remains a dilemma.
- More trainings and follow ups can yield more sanitation improvements
- Open Defecation is still evident even in some premises of some households with latrines, which implies that Installation does not mean total behavioural change.

What can be done differently?

Most stakeholders are pointing at enforcement [silent enforcement or arresting] as their next step of dealing with individuals who have deliberately remained adamant and refused to improve the sanitation of their households. Although enforcement would yield compliance particularly in regard to installing the sanitary facilities, this will be done to please the health inspectorate team and actual usage of the installed facilities may be

poor. That explains why OD is still evident even in some homesteads with latrines and why some hand washing facilities are not functional. This also explains why mobilization of community members for WASH is not easy. This report thus recommends enforcement to be used as a last resort.

More follow ups and blending different approaches should be emphasized. For instance, the use of PHAST tools beyond the Health Assistants to the community members and promoting community led total sanitation using tools like "the walk of shame" and adopting the household cluster approach (UMOJA plus) that embraces togetherness so as to promote inclusive participation are better strategies of influencing behaviour change.

Existing farmers revolution groups could be another opportunity to influence behaviour change at household level.

Mobilization strategy: Mostly using participatory approaches described above other than enforcement can also improve mobilization, having realized that some community members without sanitary facilities often run away when any WASH team arrives. Besides, this project should start engaging LC1s and community resource persons since they are keys stakeholders at grassroot level to improve mobilization.

Recommendations

- Instead of only one sanitation campaign, two or more campaigns should be conducted in each subcounty to realize greater impact.
- Intensifying health education sessions and trainings using PHAST tools so as to build the capacity of more community members. This requires facilitating the trained Health Assistants to reach out to more communities.
- More strategies that promote competition among Health Assistants and motivation should be initiated. The Health Assistant of the Sub-counties with high improvement can be recognized, awarded with a certificate or any present. This might increase regular follow ups of the health inspectorate team.
- Work with the District Health Inspectors office to ensure strictness on the follow-up of the communities by Health Assistants to ensure that they do not relapse thus increasing compliance and sustainability.
- Lobby policy and decision makers to make byelaws for communities to have standard sanitary facilities that influence policy for sustainability.
- Train Environmental Health Workers and VHTs on new technologies such as installation of SaTo pans such that information can be passed to community level to improve their sanitation.
- Continue engaging the leaders for change of attitude and mind set so as to yield a critical mass of stakeholders who can influence the rest in communities to ensure sustainable behavioral change.

- Inclusion of a component on menstrual hygiene. This may involve educating girls and women in the communities on the usage and making of washable sanitary towels which are more environmentally friendly, yet cheaper than the disposable ones.
- During monitoring and evaluation, consider reviewing records in health facilities to ascertain the prevalence of diarrhoeal diseases at baseline line and after the process.
- Using an Evidence Based approach of implementation which involves comparing and evaluating the effectiveness of individual or a cocktail of strategies so that IRC can document and use the most effective ones.

Conclusion.

The home improvement campaigns conducted in the two sub-counties of Kasenda and Mugusu yielded visible improvements in household sanitation and hygiene. There is need for IRC to continue supporting Kabarole district local government to promote Sanitation and Hygiene.

Appendices

Table 1: Attendance list for the planning meeting for the follow up in Kasenda

No.	Name	Designation	Telephone contact
1.	Muyonga Richard	Health Inspector	0778825094
2.	Biingi Isaac	Health Inspector	0785003836
3.	Bwambale Saul	Health Assistant	0775940675
4.	Bwaruhanga Nicola	Parish Chief	0778901980
5.	Turyagyenda Wilberforce	Health Inspector	0772377557
6.	Musinguzi Peter	Parish Chief	0772/0702945913
7.	Batalingaya Tossy	Secretary for Education/Health	07822710876
8.	Mugume Dancan	Parish Chief Nyabweya	0776924056
9.	Kemigisa Ritah	CDO	0776360821
10.	Mugarra Marvin	SAS, Kasenda Subcounty	0774062172
11.	Nyamazarwa Francis	VHT Coordinator	0774451810
12.	Betty Kamuli	VHT Coordinator	0771052244

13.	Kyojo Wilber K	VHT Coordinator	0772840047
14.	Kweyamba Godfrey	VHT Coordinator	0773159226
15.	Asiimwe Godfrey	VC/person LCIII	0782710816
16.	Tusiime Ronald	Health Assistant	0787395029
17.	Asaba Shadrach	Health Assistant/Acting DHI	07886061270
18.	Ayoreka Mary Concepta	IRC	0776416371

Table 2: Attendence list for the planning meeting for the follow up in Mugusu

No.	Name	Designation	Telephone contact
1.	Tumusiime Christopher	Environmental Health Officer	0753498398
2.	Birungi Zuura	Health Inspector	0776179462
3.	Bwambale Amiri	Health Assistant	0781734782
4.	Katungi Godfrey	Health Assistant	0779115777
5.	Muhenda Simon. R.	Health Assistant	0775316254
6.	Kabarokole Mary	Parish Chief Kiraaro	0782951437
7.	Hon. Mugabo David Nedved	Secretary for Finance & Works	0786793445
8.	Birungi Zuura	Health Assistant	0776179462
9.	Karungi Josephine	SAS	0775461896
10.	Muhairwe Sam	Parish Chief	0773757153
11.	Grace Agaba	VHT Coordinator	0782093886
12.	Sabiiti Yuster	VHT Coordinator	0705003454
13.	Christine Katalibaabo	VHT Coordinator	0779079399
14.	Katusabe Veronica	Sec for Gender, Health & Educ	0785150817

15.	Kusemererwa T. Vicent	VC/person LCIII	0772843868
16.	Mpairwe Harold	Health Inspector	0772 959832
17.	Asaba Shadrach	Health Assistant/Acting DHI	07886061270
18.	Ayoreka Mary Concepta	IRC	0776416371

Table 4: Showing evidence of Open Defecation in Mugusu

No.	Village	Evidence of OD	Frequency	Percentage (%)
1.	**Balanga**	Yes	7	8.4
		No	76	**91.6**
			(n = 83)	
2.	**Nyeri**	Yes	12	7.3
		No	153	**92.7**
			(n = 165)	
3.	**Kinyankende**	Yes	12	4.2
		No	277	**95.8**
			(n = 289)	
4.	Karundo	Yes	24	17.3
		No	115	82.7
			(n = 139)	
5.	**Kyakijara**	Yes	3	3.9
		No	74	**96.1**
			(n = 77)	
6.	**Nyahanga**	Yes	2	2.1
		No	94	**97.9**

			(n = 96)	
7.	**Kabagona**	Yes	1	0.7
		No	139	**99.3**
			(n = 140)	
8.	**Butimange**	Yes	5	4.0
		No	121	**96.0**
			(n = 126)	
9.	**Kasiriza**	Yes	9	8.4
		No	98	**91.6**
			(n = 107)	
10.	Kigaya	Yes	19	16.5
		No	96	83.5
			(n = 115)	
11.	**Nyabuswa**	Yes	10	7.7
		No	120	**92.3**
			(n = 130)	
12.	Katuru	Yes	32	16.8
		No	158	83.2
			(n = 190)	
13.	**Burungi**	Yes	5	3.0
		No	163	**97.0**
			(n = 168)	
14.	**Kyezire**	Yes	11	1.9
		No	582	**98.1**
			(n = 593)	

15.	**Nyakasojo**	Yes	2	2.5
		No	79	**97.5**
			(n = 81)	
16.	**Rukooko**	Yes	4	1.4
		No	292	**98.6**
			(n = 296)	
17.	**Kanyamutwale**	Yes	1	1.4
		No	69	**98.6**
			(n = 70)	
18.	**Karuwoma**	Yes	0	0
		No	146	**100**
			(n = 146)	
19.	**Magunga**	Yes	0	0
		No	180	**100**
			(n = 180)	
20.	**Budandi**	Yes	7	4.0
		No	170	**96.0**
			(n = 177)	
21	Kyakihira	Yes	39	27.3
		No	104	72.7
			(n = 143)	

Table 5: Open Defecation in Kasenda

No.	Village	Evidence of OD	Frequency	Percentage (%)
1.	Kibuga A	Yes	62	61.4

		No	39	38.6
			(n =101)	
2.	**Kibuga B**	Yes	10	10
		No	90	**90**
			(n =100)	
3.	**Kitojo**	Yes	5	10
		No	45	**90**
			(n =50)	
4.	Nyabweya C	Yes	32	24.8
		No	97	75.2
			(n = 129)	
5.	**Nyabweya B**	Yes	7	6.6
		No	99	**93.4**
			(n = 106)	
6.	Nyakashojwa	Yes	33	43.4
		No	43	56.6
			(n = 76)	
7.	**Kihumuro**	Yes	7	9.2
		No	69	**90.8**
			(n = 76)	
8.	**Muhwezi**	Yes	2	2
		No	98	**98**
			(n = 100)	
9.	Kyantambara A	Yes	63	41.2
		No	90	58.8

			(n = 153)	
10.	Kyantambara B	Yes	47	37.6
		No	78	62.4
			(n = 125)	
11.	Kinyangabo	Yes	23	17.0
		No	112	83.0
			(n = 135)	
12.	**Nyabweya A**	Yes	6	6.5
		No	86	**93.5**
			(n = 92)	
13.	Rwigo	Yes	42	51.9
		No	39	48.1
			(n = 81)	
14.	Kyakakwanzi	Yes	22	24.4
		No	68	75.6
			(n = 90)	
15.	Nyangabukama	Yes	47	44.3
		No	59	55.7
			(n = 106)	
16.	Iruhura A	Yes	26	24.3
		No	81	75.7
			(n = 107)	
17.	Iruhura B	Yes	16	12.6
		No	111	87.4
			(n = 127)	

18.	Isunga	Yes	14	11.8
		No	105	88.2
			(n = 119)	
19.	**Isunga Central**	Yes	3	2.2
		No	135	**97.8**
			(n = 138)	
20.	**Nyabinyonyi**	Yes	6	6.9
		No	81	**93.1**
			(n = 87)	
21	Nyaruhanga	Yes	16	27.1
		No	43	72.9
			(n = 59)	
22.	Kanyante	Yes	20	29.4
		No	48	70.6
			(n = 68)	
23.	**Rwenkuba**	Yes	8	10.1
		No	71	**89.9**
			(n = 79)	
24.	**Mutukura**	Yes	3	4.3
		No	66	**95.7**
			(n = 69)	
25.	Rweraza B	Yes	21	37.5
		No	35	62.5
			(n = 56)	
26.	Rweraza A	Yes	31	52.5

		No	28	47.5
			(n = 59)	
27.	**Bugangama**	Yes	7	10
		No	63	**90**
			(n = 70)	
28.	**Kirombe**	Yes	2	2.7
		No	72	**97.3**
			(n = 74)	

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