ChildFund Kenya

ENDLINE EVALUATION/KAP SURVEY OF NAIROBI WASH (MAZINGIRA BORA) PROJECT IN MUKURU AND KASARANI INFORMAL SETTLEMENTS.

July 2020

Submitted By

HEFDC
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Abbreviations

BOM	Board of Management
CHVs	Community Health Volunteers
ECD	Early Childhood Development
FGDs	Focus Group Discussions
HEFDC	Health and Economic Finance Development Consortium
KAP	Knowledge, Attitude and Practices
M&E	Monitoring and Evaluation
MCO	Metropolitan Child Organization
NCWSC	Nairobi City Water and Sewerage Company
ToR	Terms of Reference
WASH	Water Sanitation and Hygiene
KII	Key Informant Interview

Executive Summary

On July 2018, ChildFund Kenya, with support from ChildFund Korea, rolled-out the Nairobi WASH (Mazingira Bora) project in Mukuru and Kasarani informal settlements. The project provided Water and Sanitation Hygiene (WASH) interventions aiming to improve management of waste disposal, increase access and use of safe water and improve hygiene practices to decrease water borne diseases among children between 0-14 years. The beneficiaries for this project were 700 households, 28 Community Health Volunteers (CHVs), and, 15 ECDs and primary schools covering a target population of approximately 22,500 people living in the Mukuru and Kasarani informal settlements.

HEFDC Group Limited has been contracted by ChildFund Kenya to conduct an independent, rigorous, assessment of the Mazingira Bora projects activities, which have been undertaken between July 2018 and March 2020. The geographic scope of the evaluation covered the Fuata Nyayo, Kayaba, Lunga Lunga, Gracious, Marurui, Mwiki, and, Njiru villages (also referred to as "zones"), which are located within the Mukuru and Kasarani sub-counties. The endline evaluation employed a mixed methods design which applied both qualitative and quantitative research study methods. The assessment sought to identify the changes brought about by the project and to establish extent to which the project has contributed to the identified changes through the analysis of the project outcomes against the project's Monitoring and Evaluation (M&E) matrix. The evaluation targeted several respondents who were interviewed through Focus Group Discussions (FGDs) and KAP survey interviews at the household level. The respondents included: Caregiver Focus Groups; Community Health Volunteers (CHVs); Representatives of the 700 households reached by CHVs with WASH messages; and, Representatives of schoolteachers from the 15 schools that benefited from the project. Key Informants Interviews were conducted with a variety of focal persons, key partners, and stakeholders who have been involved in the implementation of the Mazingira Bora project. These included: sub-county public health officers; Ward Administrators; Chiefs; Headteachers; local partners (including Metropolitan Childcare Organization); and ChildFund staff. Below we have provided a summary of key findings from the KAP survey.

Brief Summary of the Key Findings from the End line Evaluation

The key findings from the evaluation are captured in detail in section 3.0. The analysis is based on data and evidence collected during the evaluation.

Access and Use of Safe Water – this is measured by % of people who treated their water always before drinking.

In the surveyed area, water treatment, use of membrane filter and boiling of water showed marked improvement from the baseline. Use of micro-membrane filter increased from 1% to 76.20%. Protection of water systems from contamination increased from 38% to 41% at end line. Water accessibility to children increased from 77% at baseline to 89.7%. Functionality of water system decreased from 64% to 63% and use of chlorination decreased from 62% at baseline to 30 % at end.

Improved Management of Waste Disposal and Sanitation – open defecation practices in the community compared to baseline.

There was marked improvement in sanitation through the Mazingira Bora project compared to the situation observed at the baseline whereby the consultant observed/documented: Access to toilets increased from 91% to 98.9% at endline. Households with increased toilets that provided privacy increased from 70% to 93%.6 at end line. Households with slabs that were easy to clean increased from 77% to 94.80%. Presence of toilets for persons with special needs increased from 72% to 79.20% at end line. Presence of open defecation in the community decreased from 43% to 15%.

Hygiene Promotion Knowledge Attitudes and Practices – availability and use of soap for hand washing within the household and communities

There was a marked improvement on all the trainings on hygiene including caregivers who received training, presence of hand washing facilities, availability of water at the hand washing facility, availability of soap for hand washing, Level of hygiene in food preparation, the capacity of dustbin to hold waste and good presence of dustbin with the compound. Caregivers who received training increased from 35% to 81.10%. Presence of hand washing facilities increased from 36% to 54.90%. Availability of water at the hand washing facility increased from 29% to 83%. Availability of soap for hand washing increased from 21% to 86.50%. Level of hygiene in food preparation increased from Good at 28% to 47.4%. Good presence of dustbin with the compound improved from 26% to 49.7%. Average present on the other hand decreased from 72% at baseline to 49.1% at end line. The capacity of dustbin to hold waste improved from 44% at baseline to 86.10% at end line.

Lessons learnt

Mazingira Bora project demonstrated that access to water, sanitation and hygiene (WASH) in schools is integral to the well-being of children and to the quality of their education. Proper WASH programmes in schools can have a significant impact on school enrolment rates, girl/boy enrolment ratios, absenteeism and school performance. The use of football as a good vehicle for the promotion of advocacy for behavioral change contributed to the achievements made in hygiene practice. Inter-sectoral collaboration between Education, Public Health and Water in planning, implementing WASH interventions, has accelerated implementation rates and this is aimed at enhancing sustainability. Proper planning, keen follow ups and routine monitoring is key to ensure the project is successfully implemented. Timely disbursement of funds supported allocation of proper time to project activities and timely implementation

ChildFund Kenya, through this project has been able to demonstrate their presence and impact in WASH and waste management and has since been able to leverage resources from Private Partnership with Dow Chemical and other stakeholders. Together, ChildFund Kenya has been able to undertake successful clean-ups and support to women and youth in the informal settlement.

Best Practice

The uptake and adaptation of hand washing was a major behavior change especially for the mothers to the under-fives. The training and information given on the benefits of hand washing was quickly adapted and at the end of year one, the care givers did not need follow up reinforcements of the messages on the

same. The adaptation of the advocacy tool, a slogan, "*Maji bora, Maisha bora*" was successful in schools, was liked and used routinely, this was a great achievement. Sustainability has been instituted through equipping the community health volunteers to ensure continuity of the cleanups, regular cleanups in the community areas. There are ongoing discussions with the county public health office on the integration of community health volunteers to continue working in the same community and reporting to the sub county's office. The sustainability of the school program has been achieved through the training of patrons this will ensure continuity in terms of ensuring that the clubs are still active.

Challenges

Some households have been affected by recurrent slum fires which gutted down over 400 homes at the Mukuru informal settlement since January 2020. Many of the affected families lost basic commodities used to meet their basic WASH needs. A total of 275 households of the targeted 700 vulnerable populations did not receive water filters to promote safe water use; the households which did not receive the water filters have since been complaining with no reason given for why they were left out.

The COVID 19 interrupted the smooth finalization of the project period. However, due to the collaboration established between the project and the stakeholders, the sustainability of project activities would be ensured through advocacy for support of Community Health Volunteers (CHVs) to be absorbed into County Ministry of Health, so that they implement COVID 19 community intervention strategies and the continued Mazingira Bora project activities.

1.0 INTRODUCTION AND BACKGROUND

1.1 Inception Phase for the Endline Evaluation of the Mazingira Bora Project

At the beginning of the inception phase for the endline evaluation of the Mazingira Bora project, the consultant held initial consultation meetings with ChildFund staff. The ToR was discussed at length to ensure that ChildFund and the consultant created mutual understanding on the volume and quality of work expected. During the inception meeting, the team discussed evaluation protocols and the sample size, including the number of household surveys to be undertaken. The consultant and ChildFund agreed on reducing the number of visits in each of the target areas due to time constraint.

Following the initial consultation meetings, the consultant developed an inception report based on the terms of reference and a desk review of program proposal, mid-term evaluation, baseline data, and budget and program annual plans. The inception report was shared with ChildFund and became the management document for guiding delivery of the evaluation in accordance with the scope of the evaluation.

1.2 WASH Situational Analysis at time of inception of the WASH program

Before ChildFund started the Mazingira Bora project, a baseline survey was undertaken for Mazingira Bora between November 2018 and January 2019 which reached a total of 683 out of the 700 households targeted in the project. The survey based its findings on baseline information on the identified households.

1.3 Programme operations/administration

ChildFund implemented Mazingira Bora project in collaboration with its local partner, Metropolitan Childcare Organization at the start and other stakeholders including the National, County, sub county governments and other stakeholders to achieve the set objectives. The project implemented in Mukuru, Kasarani and Njiru informal settlements targeted to increase access and use of safe water, improve management of waste disposal and improve water related hygiene practices.

The implementation used a three-pronged-approach; interventions targeting the schools, interventions targeting the households and lastly interventions targeting improvement of environment within the slums and informal settlements. It worked with 3 Early Childhood Development centers (ECD) and 10 Primary schools with an approximate enrolment of 22,500 and 700 households within the target slums.

1.4 End line Evaluation objectives

The goal of the endline evaluation was **"***to provide an independent and rigorous assessment so as to identify the changes brought about by the project and establish extent to which project has contributed to the identified changes against its M&E matrix as encapsulated in the project proposal using the outcome harvesting approach."*

Key objectives of the endline evaluation included:

i. *Appraise the project's M&E matrix indicators to establish the extent to which the project met its targets specifically on water access increase, improvement on solid waste disposal and improvement in hygiene practices.*
ii. *Analyze the challenges and critical risks that the project may have encountered, and how these challenges and risks may have impacted the project.*
iii. *Identify good practices and lessons learnt related to the project operational contexts, actors engaged, strategies applied in the implementation, and changes observed.*

2.0 APPROACH AND METHODOLOGY

The endline evaluation employed a mixed methods design which applied both qualitative and quantitative research study methods. The evaluation sought to identify the changes brought about by the project and establish extent to which project has contributed to the identified changes assessed against the project M&E matrix using the outcome harvesting approach. The implementation period being evaluated is July 2018 to End of March 2020. The timeline for conducting the endline evaluation was June 30th 2020 to July 24th2020.

The evaluation applied a variety of methods to collect and analyze data. Participatory methods were used to collect qualitative and quantitative data. The key methods included, but are not limited to:

- Household survey using survey questionnaires;
- Literature review of existing documents and review of context and project trends, including the project proposal and other documents, annual and quarterly reports, monitoring and evaluation reports.
- Field observation of the targeted community (-ies) and schools;
- Key informant interviews with ChildFund staff and relevant stakeholders;
- Review photos; and,
- Focus Group Discussions.

A representative sample size of about 176 households, out of the total 700 households that benefited from the project, were selected for the KAP survey. The following sample size formula was used in determination of the number of households to be interviewed:

$$\mathbf{n} = \{\frac{(z)^2(p)(q)}{(d)^2}\}\mathbf{D}$$

Consequently, below is the sample size calculation for the proposed sample size of households to be included in the KAP survey

$$\mathbf{n}= \{\frac{(1.96)^2(0.94)(0.06)}{(0.05)^2}\}\mathbf{2= 176\ households}$$

Where,

n= the sample size (when population is greater than 10,000)

z = the standard normal deviate, usually set at 1.96 which corresponds to the 95 percent confidence level

p= the proportion of the target population estimated to have a particular characteristic. {***The value of 'p' was 94 % of the population of Nairobi's' informal settlements do not have access to adequate sanitation***}

q = 1.0 – p

d= degree of accuracy desired, usually set at 0.05

D = we propose a design effect of 2 (Design effect can vary between 1-9 depending on the circumstances).

Samples were drawn from each of the two sub-counties of Mukuru and Kasarani. The computed sample was distributed proportionately according to the sizes of the populations for each of the areas/zones within the project implementation area. Table one (Table 1) below shows the number of households drawn from each of the areas/zones

Table 1: Number of Households sampled from each area/zone for the Household Knowledge Attitude and Practices Survey

Area/zone	Number of households in area/zone	Households sampled from area/zone
1.Mwiki	43	11
2. Fuata Nyayo	140	36
3. Kayaba	159	41
4. Njiru	48	12
5. Lunga Lunga	195	50
6. Marurui	49	13
7. Gracious	49	13
TOTAL	**683**	**176**

NB: We used 683 households as our sampling frame; this was the same number of households who participated in the baseline survey. However, the total number of households who benefitted from the project are 700 and an additional 60 households received water filter in July 2020

2.1 Sampling Frame

The survey's primary sampling units were the area/zones which served as the clusters while the households were the secondary sampling units. The sampling frame therefore consisted of the list of households that are within the project intervention area. From the constructed sampling frame, simple random sampling procedure was used to select the households.

2.2 Sampling Process for Selection of Households

Only areas/zones where the Mazingira bora project was implemented was included during the sampling. The survey sample size was proportionately allocated according to the number of households which were enrolled in the project. Eventually 176 households were randomly sampled for the end line survey.

2.3 Selection of Care Givers at the Households

The respondents were mainly caregivers within the households who happened to be in most cases mothers of the children within the households. In rare cases fathers were also interviewed especially when mothers were not found at the households at the time of the survey.

2.4 Recruitment and Training of Enumerators

Recruitment of enumerators for the end line evaluation was completed between the 30th June 2020 and 1st June 2020 by the HEFDC evaluation team. A total of ten (10) enumerators and two (2) supervisors were identified and recruited. Once the recruitment process was finalized, the enumerators and supervisors underwent a data collectors' orientation which was conducted on 3rd July 2020. A detailed program of activities undertaken during the data collector's orientation can be found in the Annex attached to this report.

2.5 Field data collection

Data collection was conducted over a duration of four days (7th -10th July 2020) with the enumerators covering a total of 176 households. The data collection team was required to cover a minimum of fourty households daily. Electronic questionnaires were used for the household data collection with each questionnaire (household visit) lasting between 15 – 20 minutes.

Additionally, Key Informants Interviews were conducted with a variety of focal persons, key partners, and stakeholders who have been involved in the implementation of the Mazingira Bora project. These included: sub-county public health officers; Ward Administrators; Chiefs; Head teachers; local partners (including Metropolitan Childcare Organization); and ChildFund staff. Focus Group Discussions (FGDs) were also conducted for a various of respondents including: Caregiver Focus Groups; Community Health Volunteers (CHVs); Representatives of the 700 households reached by CHVs with WASH messages; and, Representatives of schoolteachers from the 15 schools that benefited from the project. Table Two (Table 2) below if the list of Key Informant Interviews and Focus Group Discussions conducted by the evaluation team as part of the endline evaluation.

Table 2: List of Key Informant Interviews and Focus Group Discussions completed in Mukuru and Kasarani area/zones

Key Informant	Respondent/Designation (Mukuru)	Respondent/Designation (Kasarani)
Public Health, Education, WASH Officers	• Starehe Sub County WASH focal person • Mukuru Sub-County WASH Resource Person	• Kasarani Sub county WASH focal person
Ward Administrators, Headteachers	• Headteacher – Kasarani Primary School	• Mukuru Sub-county ward administrator
Village/Community Heads	• Chief Mukuru Nyayo	
ChildFund Project Coordinator	• ChildFund Nairobi WASH Project Officer • ChildFund Project M&E Officer	
Project Local Partner	• Project Coordinator, Metropolitan Childcare Organization (MCO)	
Focus Group Discussions held in Mukuru and Kasarani		
• Community Health Volunteers • Caregivers • Representatives of schoolteachers from the 15 schools that benefited from the project		

2.6 Field management

The recruitment of enumerators was done in collaboration with the ChildFund Kenya. To facilitate community entry process, ChildFund Kenya sent introductory letters to the relevant authorities, county government departments, the areas administration, and health facilities introducing the consultancy firm and the baseline study.

2.7 Ethical Protocols

The evaluation team maintained ethical standards while conducting the evaluation study, consent was sought from the interviewees before commencement of the interview and confidentiality of the obtained information was maintained.

2.8 Limitations to performance of the Evaluation

i. Conducting the evaluation study during the COVID-19 pandemic period and especially during partial lockdown measures (i.e. restriction of movement across counties, stay-at-home and school closures) placed by the Kenyan Government.
ii. There were time constraints in as far as implementation of the evaluation was concerned. Hence, very little time was available to engage the focal points during the Outcome Harvesting evaluation.

3.0 Results and Findings

Results below outline the key findings from the household KAP as well as the qualitative interviews (KII and FGDs) undertaken as part of the endline evaluation.

3.1. Demographic information

3.1.1 Number of people in the household

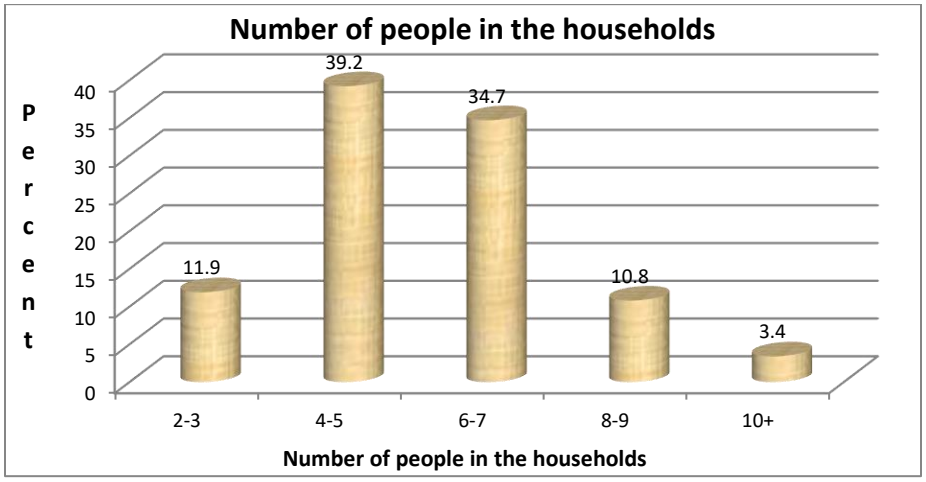

Figure 1: Number of persons per households (Mukuru and Kasarani)

Results from the household KAP data collection in Mukuru and Kasarani found that majority of the households interviewed had between 4-5 persons (39.2%) and 6-7 persons (34.7%) living under the same roof (Figure 1). Households that had between 2-3 persons made up at least 11.9% of the households

interviewed; in contrast, at least 10.8% of households interviewed had between 8-9 persons living under the same roof.

The results summarized above are quite similar to those observed during the baseline. A key observation here is that there is overcrowding, which is synonymous with households in informal settlements. Consequently, accessibility and use of water and sanitation facilities, as well as the practice of hygiene, is greatly hampered in households within these settlements which are forced to share meager water resources.

3.1.2 Number of Children Enrolled

With regard to the enrolled children, all 176 households interviewed had at least one child enrolled in the Mazingira Bora project. The frequency of children enrolled per household ranged from one child (101 households) to five children (5 households). Table 3 below shows the frequency distribution of the number of children enrolled per household.

Number of Children enrolled per household	Frequency
1	101
2	54
3	8
4	7
5	5
6	0

Table 3: Frequency distribution of the number of children enrolled per household

Figure 2 below shows the frequency (sum) of children enrolled in the project, disaggregated according to the zone/area where they reside.

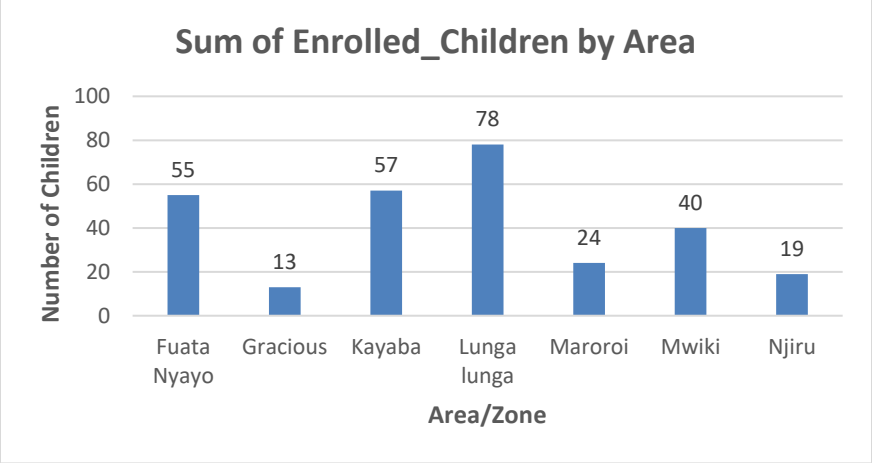

Figure 2: Number of Enrolled Children in each zone/area

From Figure 2 above, we observe that majority of children who were enrolled under the Mazingira Bora project were from the Mukuru area: Lunga, Kayaba, and Fuata Nyayo had seventy-eight (78), fifty-seven (57), and fifty-five (55) children enrolled. In contrast, the Kasarani area had fewer children enrolled under

the project: Mwiki, Marurui, Njiru, and Gracious had fourty (40), twenty-four (24), nineteen (19), and thirteen (13) enrolled children respectively.

3.1.3 Highest Level of Education attained by caregiver

Figure 3 below shows that slightly more than half (52%) of caregivers interviewed had only attained primary level education. A slightly lower proportion had attained secondary level education (32%) whilst an even a smaller percentage has managed to acquire college level education (3.4%).

About 13.7% of caregivers reported that they had received vocational education and training (VET) which granted them knowledge and skills to gain minimal wage employment, as well as open small businesses.

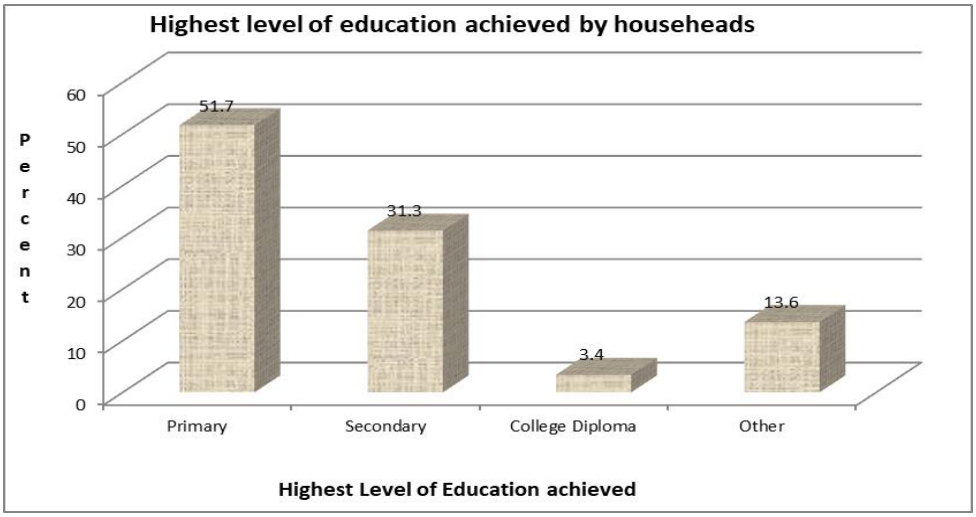

Figure 3: Level of Education of the Respondents

From the above results, we deduce that minimal levels of education amongst the caregivers has been a major challenge in behaviour change and demand creation for improvement of WASH facilities in the

> ***"It can be stated that Mazingira Bora project has been able to transform the lives of this community since it has provided them with health education on various aspects such as hand-washing, toilet/latrine use, use of safe drinking water thereby empowering them and consequently transforming their lives." – (KII, Public Health Officer)***

communities. The knowledge gap amongst community member is a great impediment in realization of WASH in the informal settlements. Therefore, the introduction of CHVs has greatly contributed towards the sensitization of the community on the importance of safeguarding their welfare and healthcare. Additionally, the CHVs have provided the caregivers with the tools and knowledge necessary to reduce the high incidence of water-borne illnesses in the community. The above was also confirmed during our interview with Kasarani Public Health Officer:

3.2 Access and use of safe water

The access and use of safe water is essential towards improvement of WASH within informal settlements which can be attributed towards reduction of water-borne illnesses in children. Results collected at the

endline sought to determine the extent and impact of the project towards diversification of water sources and improved methods of collection and storage of safe water.

3.2.1. Increased Access and use of safe water

Evaluation of the project outcome objective "increased access and use of safe water": the assessed change in access and use of safe water was through comparative analysis of the baseline status/values and the end line values/status.

3.2.1.1. Sources of Water

The major sources of water within the project area are piped water from Nairobi Water Services Company (NWSC). The community also accesses water from boreholes, water bourses from NWSC and/or private venders and springs. Some households especially in Kasarani area tap rainwater during the rainy season. Households from Mukuru reported that they do not harvest rain water since they live in close proximity to the industrial area and the environment is highly polluted thereby rendering the water unfit for human consumption.

Table 4: Household Respondents Sources of Water

Responses	Baseline (N=683)	End line (n=176)
Rain water collection	1 (0.1)	2 (1.1%)
Piped water	680 (99.6)	149 (85.1%%)
Vendors	1 (0.1)	41 (23.4%%)
Borehole	N/A	8 (4.6%)
No response	1 (0.1)	0 (0%)
Cumulative Total	**683**	**176**

As per Table 4 above, majority of the households rely on piped water (approximately 149 households or 85%); a significant number of those households also rely on water vendors to meet their daily water needs (about 41 households or 23%). A small proportion of the households also rely on rainwater and borehole water (about 10 households or 5.71%).

The increased number of households relying on and using rainwater and water vendors is an indication of decreased access to water; and there is a likelihood that these water sources could be less safe than piped water. During Focus Group discussions, it emerged that the Water from Nairobi City Water and Sewage Company (NCWSC) was not always available. This forced some households to store water and later sell it to other households. In addition, all the respondents reported that water from NCWSC was grossly inadequate since it was only available at times for three days in a week while, sometimes, it

was not available at all. During the time that the consultant conducted survey (July 2020), the taps were dry particularly in Mukuru.

> ***"There's another challenge, when NWSC water is not available, some people store water in large water-tanks, then sell to us at Kshs 20 per the twenty-liter jerry can".*** **[Focus Group Discussion]**

3.2.1.2. Protection of Water Systems from contamination

The number of households that had a water system protected from contamination increased from 38% at baseline to 41% at end line. Consequently, the number of households that did not have water system protected from contamination had decreased from 62% (baseline) to 50.90% (endline).

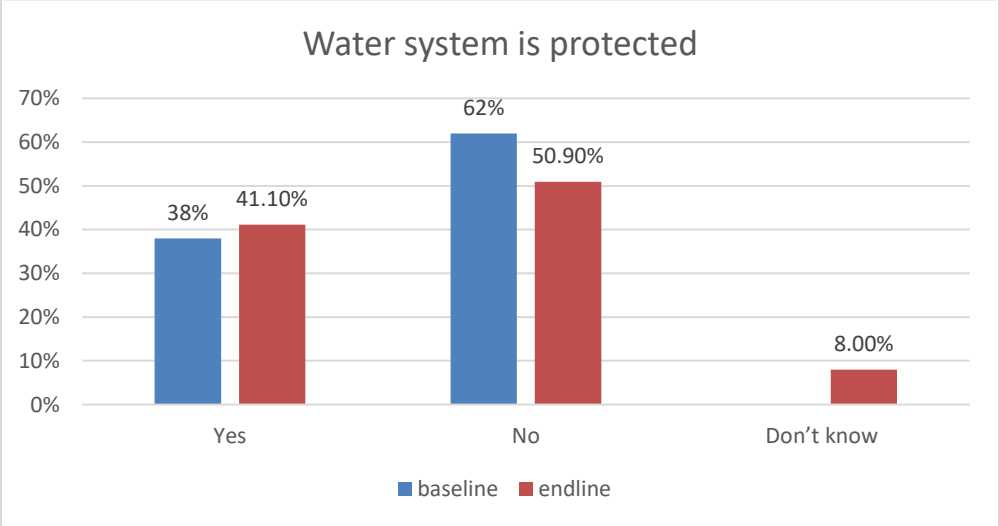

Figure 4: Availability of Protected Water System at the Household Level

Some of the interviewed respondents, however, indicated that they had some concerns regarding the contamination of the piped water as highlighted during one of the Key informant Interviews below:

> ***"The water that is available requires to be treated before it can be considered to be safe for use particularly for drinking. Some of the pipes pass through sewer-lines and there is a possibility of contamination".*** **[KII]**

The project has sensitized the community and as at the time of the evaluation, the community members had adopted some behaviour change practices where they could not drink water from whatever source including piped water from the NWSC without ensuring that it is either filtered, chlorinated, boiled to ensure that it is safe for drinking.

> ***"During the first meeting that we had there was a lot of feedback that there is poor practice. Like in water handling, people would just fetch water directly from the tanks and drink them with the belief that it's safe because it is coming from the city taps".*** **[KII]**

The achievement on the accessibility to protected water can be attributed to the project partnering with other key stakeholders (i.e. the national government and county government) who sensitized the community on all aspects of public health such as living and maintaining clean environments. In addition, ChildFund Kenya had distributed safe water storage vessels to trained caregivers across the 700 households targeted by the project. In addition, ChildFund had also distributed Safe Water System (SWS) kits to selected schools.

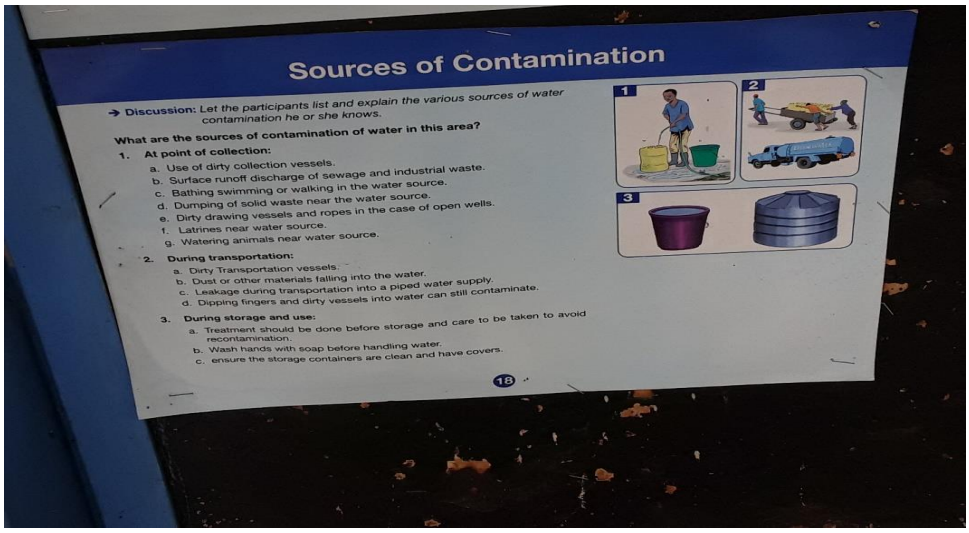

Figure 5: WASH Information Education and Communication (IEC) materials on Source of Water Contamination have been displayed at Kasarani Primary School

3.2.1.3. Functionality of the Water Systems

Households with functional water system remained the same only going down slightly from 64% at baseline to 63% at end line. The challenges encountered with functionality of the water system are highlighted as follows:

> ***"Sometime we find that, as I said the water is from different people, some may have water that is near them but you find that the cost is not favourable to them that they cannot afford, so they try to fetch the one that is cheaper according to them, so they might leave that is near them".*** [KII]

Functionality of the water system		
Responses	**Baseline (N=683)**	**Endline (n=176)**
Yes	434 (64%)	111 (63.4%)
No	43 (6%)	32 (18.3%)
Partially	205 (30%)	32 (18.3%)
No response	1 (0%)	0 (0%)
Total	**683**	**176**

Table 5: Endline findings on the number of households with functional water system

Figure 6: Caregivers demonstrate use of water filter within the homestead

3.2.1.4. Water Treatment

Households treating water increased from 22% at Baseline to 69.70% at end line. Those who never treat water decreased from 25% to 8.6%. Those who sometimes treat water decreased from 53% to 21.7%. This achievement is attributed to the project as it distributed water purification commodities such as aqua-tabs, water guard, and advice community members on the importance of ensuring that they should ensure that their drinking water is safe amongst others.

> ***"Uhh…. We encourage them to treat their water before consumption, whether they have the treatment chemicals or not. They have other options of boiling the water because sometimes we don't have the chemicals so just boil the water, but if you have chemicals just use them".*** **[FGD with CHVs]**

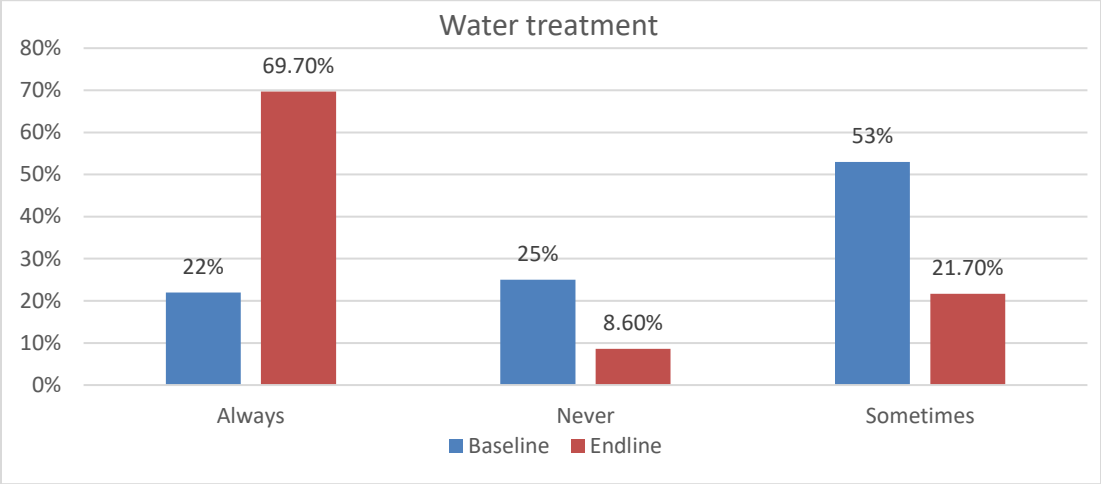

Figure 7: Percentage of households that frequently treat water used at the household level

3.2.1.5. Methods of Water Treatment

Households using chlorination as a water treatment method decreased from 62% at baseline to 30 % at end line. Those who used micro-membrane filter as increased from 1% to 76.20% at end line. Ceramic filter use increased slightly from 0% to 0.60% at end line. Boiling of water increased from 11% at baseline to 35% at end line. Those who did not use any method decreased from 25% to 1.90 %.

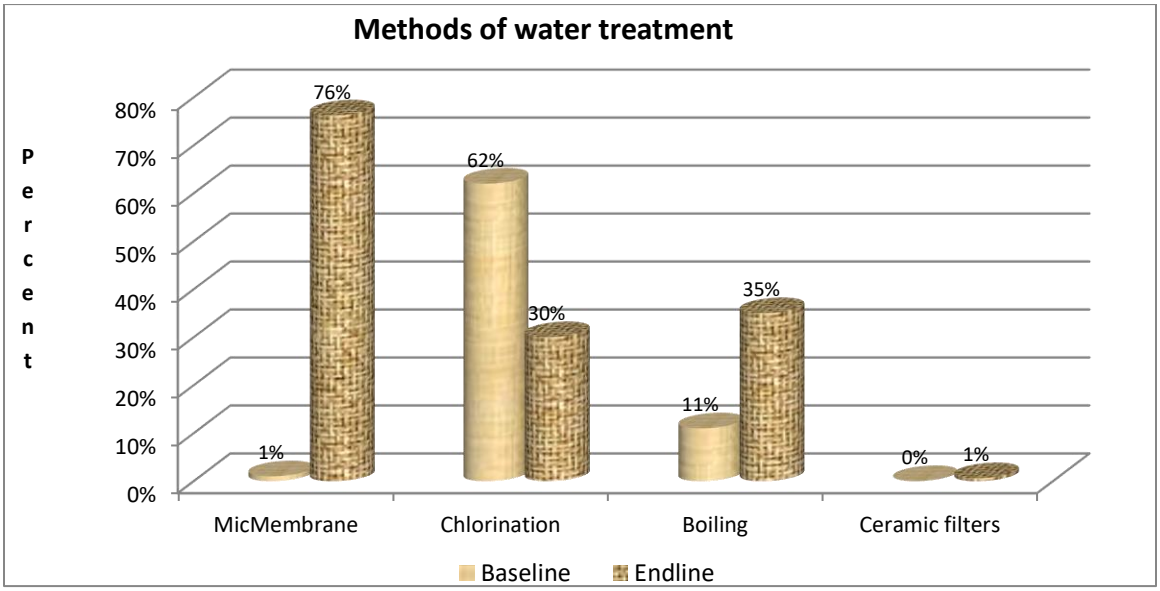

Figure 8: Distribution of households disaggregated by the preferred method of water treatment

Mazingira Bora project has provided water filters to households as well as to schools to enhance their easier access to safe drinking water. Through the project, ChildFund provided water filtration equipment which are commonly referred to as *Waterguard* to target household in order to encourage uptake of safe water at the community level. CHVs educated and sensitized the communities about the dangers of consuming unsafe water. It can be stated that Mazingira Bora project has not facilitated the acquisition of water but has educated/sensitized the community against consuming dirty water. It was noted from

the interviews with the community, the level of awareness in relation to water related hygiene practices was extremely low at the onset of the project.

> ***"A lot of sensitization and also the CHV's visiting these households every now and then and reminding the caregivers and also children on good practices"*** **(FGD, CHVs)**

3.2.1.6. Accessibility of Drinking Water to Children and Persons with Disabilities

Water accessibility to children and those with disabilities increased from 77% at baseline to 89.7% at end line. This improvement could be attributed to Mazingira Bora project's provision of four storage tanks to four schools out of the fifteen existing schools in Kasarani sub-county.

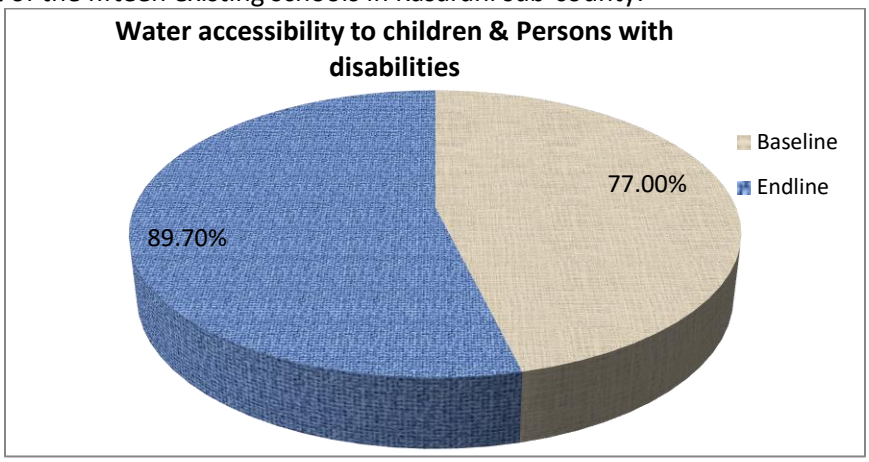

Figure 9: Percentage of children and persons with disabilities who have access to water under Mazingira Bora project

3.3 Management sanitation and waste disposal

3.3.1. Improved Management of Waste Disposal

The end line evaluation of the project outcome objective "Improved management of waste disposal", assessed the change in management of waste disposal through comparative analysis of the baseline status/values and the end line values/status. There are no set targets for the outcome indicators, hence this evaluation will only determine the change that has taken place during the project evaluation period.

3.3.1.1 Access to a toilet

Access to toilets increased from 91% at baseline to 98.9% at end line. Households who did not access toilets decreased from 7% at baseline to 1.1% at end line.

Access to a toilet		
Responses	**Baseline**	**End line**
Yes	624 (91%)	173 (98.9%)
No	49 (7%)	2 (1.1%)
No response	10 (1%)	0 (0%)
Total	683	176

Table 6: Percentage of households with access to a toilet

According to the community beneficiaries, Mazingira Bora project has enabled households to improve hygiene standard and waste management. This is because they have provided education and sensitization about the use of clean toilets/latrines to the community, and also eliminate existence of stagnant waste water in the drainages surrounding the homestead.

> ***"So, the principle that we started with, we told everyone to clear your area, make sure the water is flowing next to your house. So, over time now, you see everyone clearing, especially the houses we sensitized. The first time we went, they always had water around there but now it's cleared. So, it's cleaner. Then about cleaning the environment, we have seen a lot of change".*** [FGD]

Figure 10: Toilet located within proximity of household, Kasarani

Figure 11: Boys toilet block constructed by ChildFund at Kasarani Primary School

3.3.1.2. Toilets Provide Privacy and Security

Households with toilets that provided privacy increased from 70% at baseline to 93.6%at end line. Those with toilets that did not provide privacy decreased from 29% to 6.4%.

According to the community beneficiaries, the project has enabled households to improve hygiene standard and waste management. This is because they have provided education and sensitization about the use of clean toilets/latrines to the community. It can therefore be said without any fear of contradiction that the community has been empowered through education for the long term about this practice.

> ***"It's long term because the practises that know the community has owned, they have owned the practises, so it's not something they do because child fund has said you do that. They know it's for their own good, so it's a long term".*** [FGD]

Table 7: Percentage of respondents who indicated that they have access to a toilet that has both privacy and security

Do toilets provide privacy and security?		
Responses	**Baseline (N=683)**	**End line (n=173)**
Yes	480 (70%)	162 (93.6%)
No	196 (29%)	11 (6.4%)
No response	7 (1%)	
Total	**683**	

3.3.1.3. Slab is Easy to Clean

Households with slabs that were easy to clean increased from 77% at baseline to 94.80 % at end line. Those without slabs that were easy to clean decreased from 21% to 5.2%.

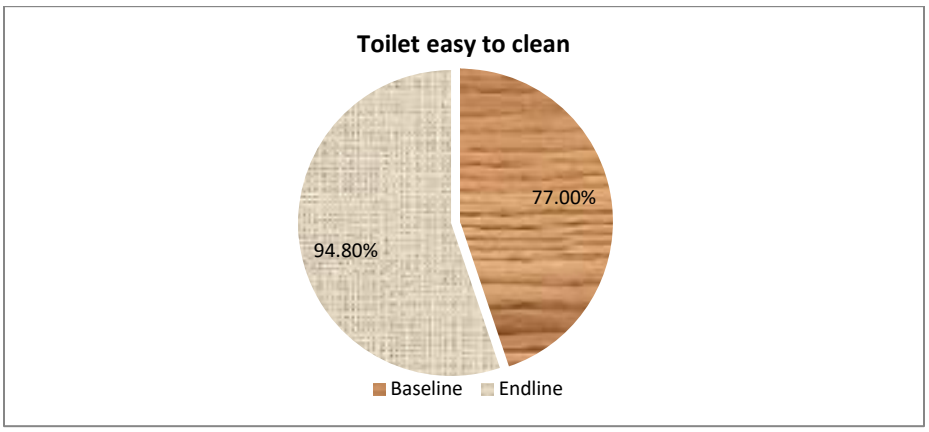

Figure 12: Percentage of caregivers who indicated that the toilet was easy to clean

This is attributed to Mazingira project. It should be noted that according to the project design, most of the project interventions were more of behaviour-change as compared to infrastructure development. The level of awareness in relation to water related hygiene practices was extremely low at the onset of the project. However, after the project-initiated education/sensitization interventions, the community's perceptions changed for the better.

Figure 13: A slab toilet constructed within proximity of target households in Mukuru

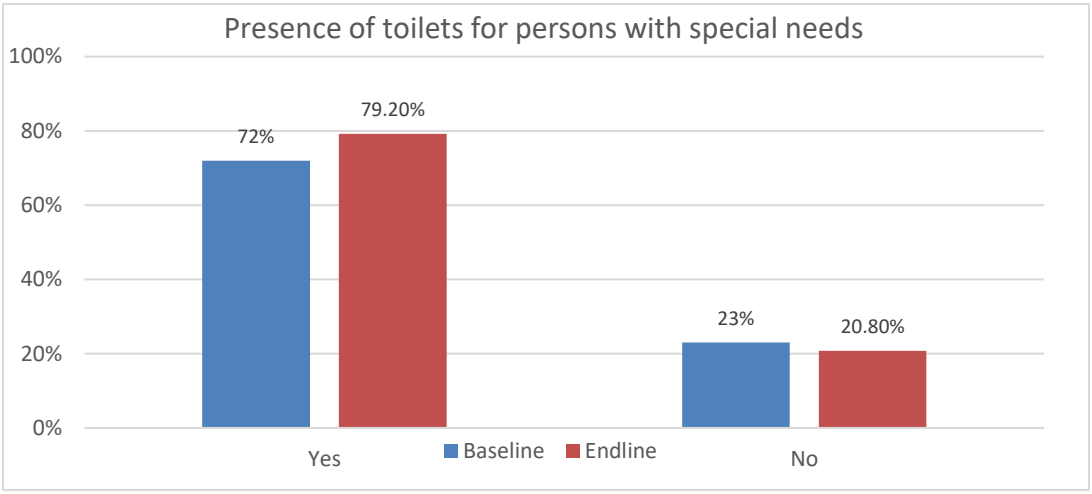

Figure 14: Percentage of toilets which can be accessed by persons with disabilities and/or special needs

3.3.1.4. Presence of Toilets for People with Special Needs

Presence of toilets for persons with special needs increased from 72% at baseline to 79.20%at end line, while absence of toilets for persons with special needs decreased from 23% to 20.8%
This could be attributed to Mazingira Bora project which has built a block of toilets in Kasarani Primary school comprising of ten latrines for boys but none in Mukuru. However, it has built the capacity of Community Health Volunteers. To achieve this, the project has employed some strategies in an effort to influence behaviour change. It reached out to the communities through the "Nyumba Kumi" chairpersons, sports such as football, chief's barazas, through regular face to face meetings amongst others. It also used teaching aids such as pamphlets, leaflets, banners, have erected murals in schools and in the community not to mention that it also uses megaphones within the community to make announcements and to reach out to the community with key messages when the need arises.

> ***"So, we opted to do football, because uhm… So, when we integrated football, let's say we had a healthy interactive practice session and through it all, we were able to share information about water, sanitation and hygiene. And because Child Fund is a child-based organization, child protection should have to come out in any conversation. So, during all that we were able to—like, for example when we score…. The game was very interesting, one side was the germs and the other side was the water and soap. So, towards half time, the water and soap become this side and they try to win a goal by ensuring that they score. So, when they score, it means a good practice has been enhanced".*** *[FGD]*

3.3.1.5. Signs of Open Defecation

Presence of open defecation in the community decreased from 43% at baseline to 15% at end line. Those who reported they did not see any signs of open defecation increased from 52% at baseline to 85% at end line.

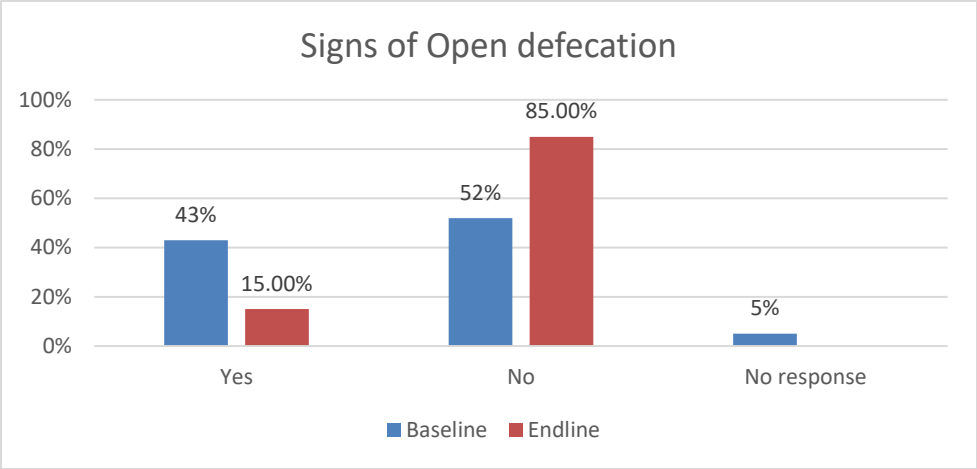

Figure 15: Percentage of households observed to have signs of open defecation within compound

The project has enabled households to improve their hygiene standards through training of the Community Health Volunteers (CHVs) who have also trained the households in the areas of ensuring that they practice hand-washing practices, maintaining clean environments, using toilets/latrines for waste disposal, ensuring that there are hand-washing stations in almost all the schools as well as waste-bins in almost all the areas in the sub-county for solid waste disposal. When asked their comment concerning flying toilets in Mukuru, community members reported that now is a thing of the past.

> ***"We don't have, what we used to have before was the, before the sensitization was the flying toilet and that was mtu anaenda choo kwa nyumba anafunga anarusha ambapo inaenda kuangukia anywhere, lakini that is long gone and forgotten we don't have that any more".*** *[FGD]*

Although there is a remarkable improvement on toilet use, there is still 15% of households who still defecate openly. In Kasarani, there is one village which is a showcase in the whole city particularly in the informal sector. According to the community health workers it is just a question of time before it is formally declared as having the Open Defecation Free status. This will be possible after plans which are under way to construct a pit-latrine for the public at the edge of the village is completed. This will help curb the spread of water borne illnesses which were common amongst children and residents of the community.

> ***"Gituamba village, which was originally notorious for diarrheal diseases in the past, is just about to be declared, Open-Defecation-Free. This has been occasioned by the enviable working relationship between the Community Health Volunteers and members of the village"*** *[KII]*

3.3.1.6. Person Responsible for Maintaining Cleanliness of the Toilets

Responsibility of cleaning the toilets was shared among different entities including with caretakers 37% followed by tenants at 30%, the others were landlords 14%, owners at 6%, and Family members at 2%.

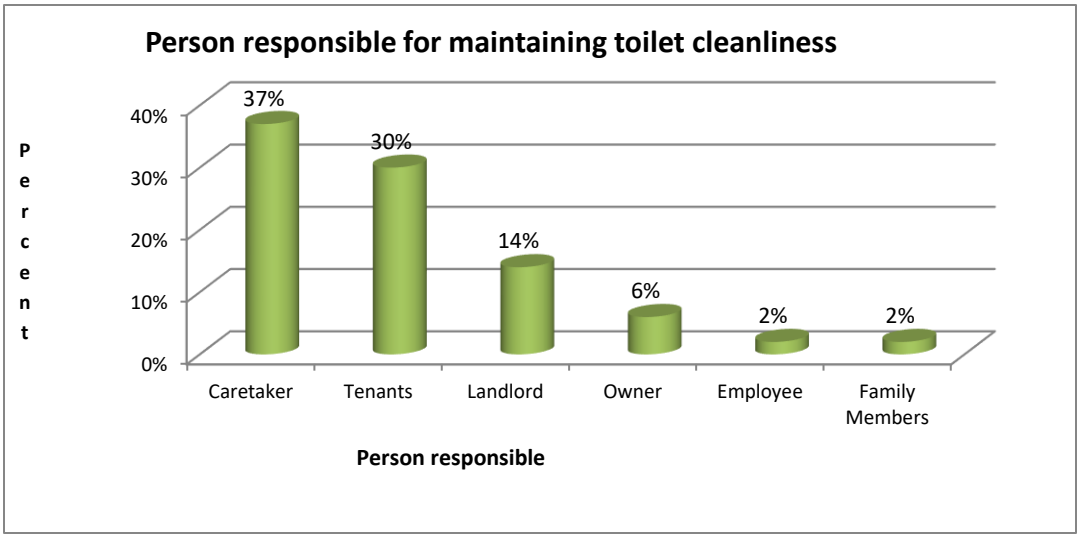

Figure 16: Distribution showing the persons responsible for maintaining toilet cleanliness at household level

3.4 Hygiene promotion knowledge attitudes and practices

3.4.1. Improved water related hygiene practices

The end line evaluation of the project outcome objective "Improved water related hygiene practices", assessed the change in hygiene promotion knowledge attitudes and practices through comparative analysis of the baseline status/values and the end line values/status. There are no set targets for the outcome indicators, hence this evaluation will only determine the change that has taken place during the project evaluation period.

The Mazingira Bora project has achieved behavior change through the trained CHVs as highlighted by the following quote:

> ***"I would say they have transformed the community because you can see behaviour change, before we used to have open waste like whatever has been used in the household, that has been used, you could find it everywhere, but now if you walk within the household, you will find that almost all the household has a place to put their waste"*** *[KII]*

3.4.1.1. Caregiver Training on Hygiene Education

Caregivers who had received training on increased from 35% to 81.10% whereas those who had not received training decreased from 63% to 18.90%.

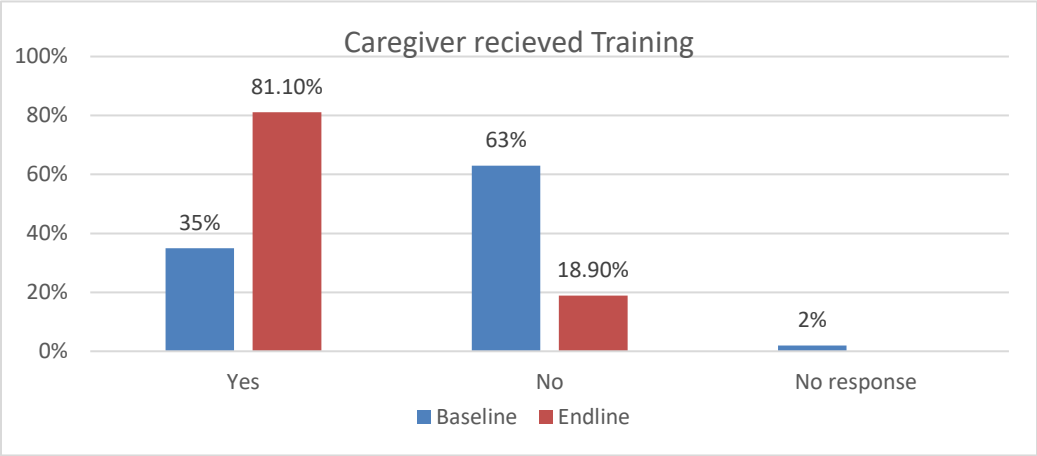

Figure 17: Percentage of caregivers who reported to have received training from CHVs

The project has enabled households to improve their hygiene standards through the trained CHVs:

> ***"We have the CHVs who are assigned to different units. And each unit has a number of households that the CHVs normally report to. And any WASH activity going on or any other program related to health that is going on within the community is supposed to reach the households. We have those units and assigned to the CHVs reporting to those units, who help us now track the progress of the health systems and whatever is going on"*** [KII]

3.4.1.2. Presence of Hand washing Facility in the Household

Presence of hand washing facilities increased from 36% at baseline to 54.90% at end line whereas absence of hand washing facilities decreased from 63% to 45.10%

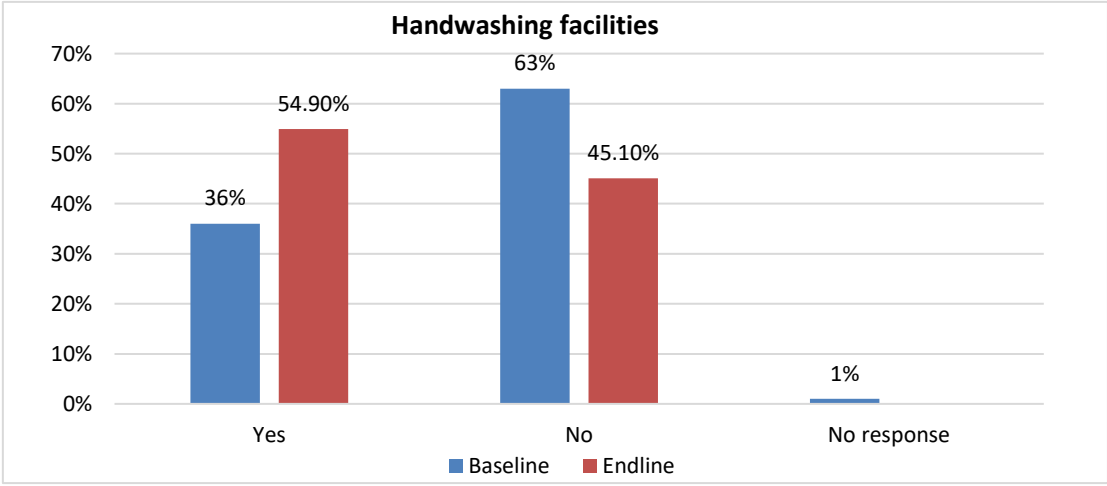

Figure 18: Percentage of households reported to have handwashing facilities

The project trained Community Health Volunteers (CHV), these were charged with specific activities to undertake within the areas they were assigned. Each CHV was assigned a minimum of twenty-five households. They were supposed to ensure that each of these households were trained in basic hygiene practices such as hand-washing, maintenance of clean households/environments, use and maintenance

of clean toilets/latrines, ensuring that households drink clean and safe water, ensuring that households

> ***"Like the- we have the proper way of hand washing, the steps on how to do hand washing, I make sure that they do it the right way, so that-it not only washing hands that they wash it in the proper way and also use clean safe running water, also when it comes in terms of hygiene I make sure that the caregivers wherever they live, wherever they are they make the place clean and the environment. The environment that is inside the houses and also outside".*** [FGD]

3.4.1.3. Presence of Water in the Hand Washing Facility at the Time of Assessment

Availability of water at the hand washing facility increased from 29% at baseline to 83% at end line while unavailability of water at the hand washing facility decreased from 49% at baseline to 17% at end line.

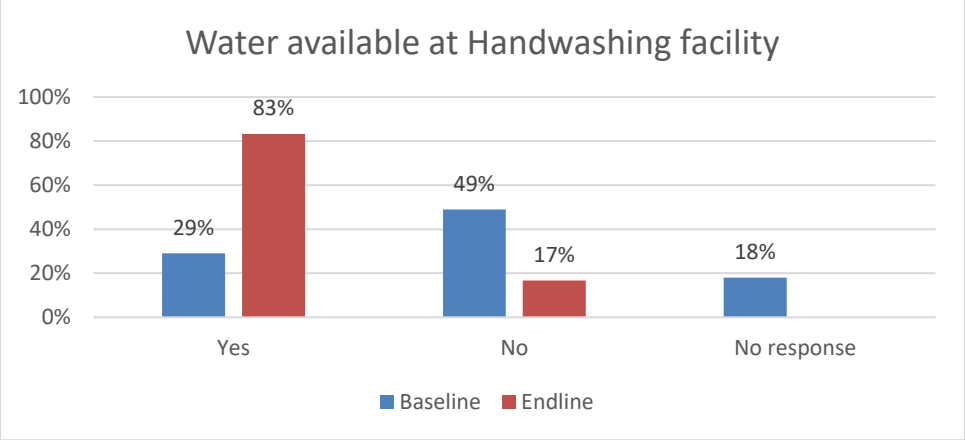

Figure 19: Percentage of households reported to have handwashing facilities

The increase in availability of water at the hand washing facility is attributed to hygiene training offered to the caregivers. As a result of sensitization from the Mazingira Bora project, most of the households made sure that they have available sources of water. The evaluation team saw some of the households buying water from the vendor.

Figure 20: Household member demonstrates use of handwashing facilities

3.4.1.4. Proximity of Hand washing Facilities to Latrines/toilets

> ***'Okay, so I would start by saying, first and foremost, by the very nature of the project, the ultimate goal was more behavior change. Because, most of the work was more behavior-related compared to infrastructure. Yeah, so I believe that there has been a very big change because when we started off with the 28 community health volunteers doing household visits to the 700 houses. There was a lot of feedback that there are poor practices.''*** [KII]

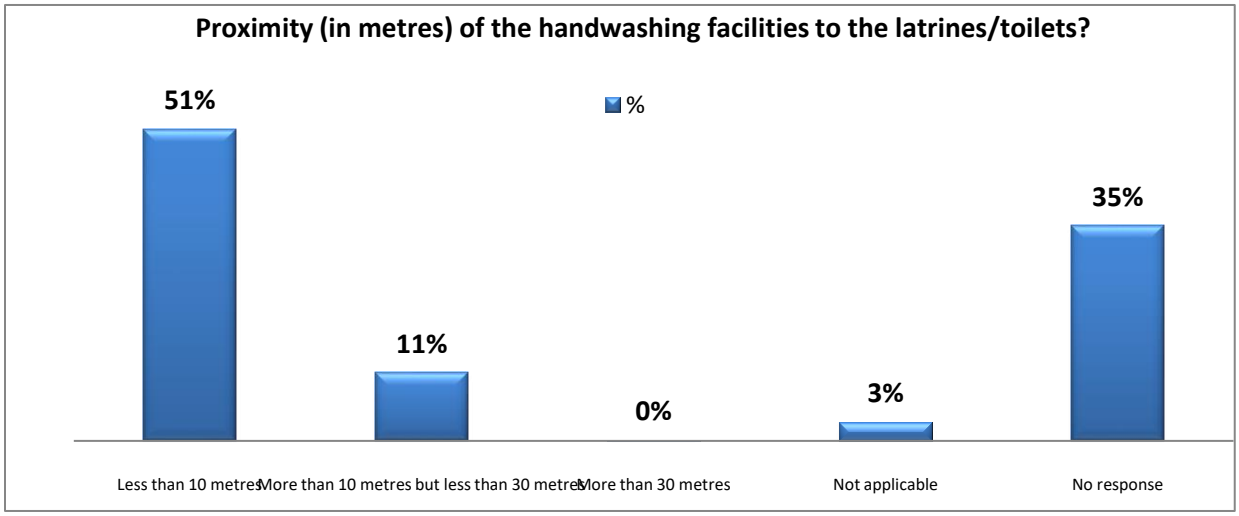

Figure 21: Percentage of households reported to have handwashing facilities within proximity of latrines

3.4.1.5. Availability of Soap for Hand Washing

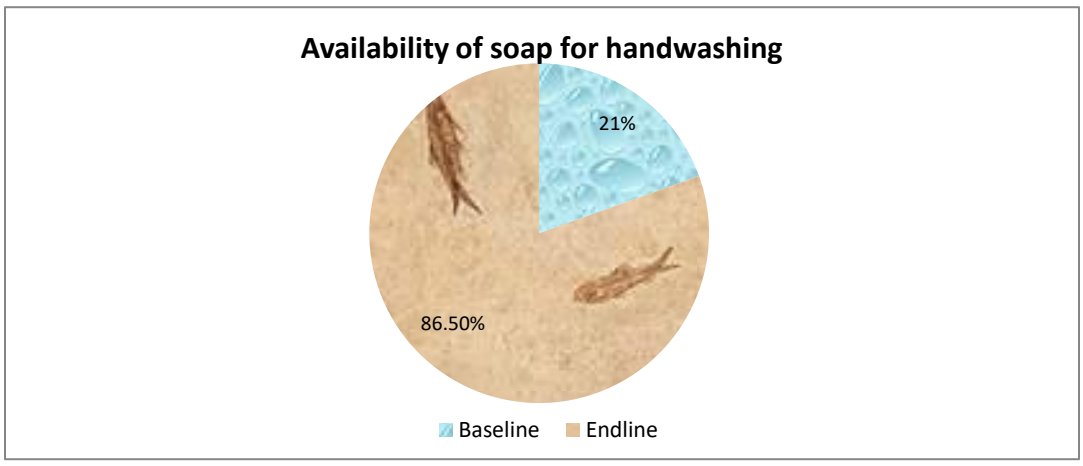

Figure 22: Percentage of households that had soap available for handwashing

Availability of soap for hand washing increased from 21% at baseline to 86.50% at end line. Unavailability deceased from 63% at baseline to 13.5% at end Line. This positive change could be attributed to the hygiene training and sensitizations offered by the CHVs to caregivers.

> ***"A lot of sensitization and also the CHV's visiting these households every now and then and reminding the caregivers and also children on good practices"*** (FGD)

3.4.1.6. Hygiene of the Food Preparation Area

Level of hygiene in food preparation increased from 'Good' at 28% at baseline to 47.4% at end line. It decreases from 'Average' at 70% at baseline to 49% at end line and increased from 'Bad' from 1%at baseline to 3.4% at end line. The following is a best practice highlighted by the teachers;

> ***"There was a challenge, I teach the young children, ECD. We have a big population in our school and at times it is very hard. You want them to wash their hands; most of them don't know how to do it. And maybe they want to go and take meals, so it forces you to wash each and every child`s hands. So, that was a challenge to me. Like in my class, I have 40, age four, and imagine its lunch time, that time is limited and you want to start washing hands one by one until you finish the last one".*** [FGD]

How hygienic is the food preparation area?		
Reponses	**Baseline (N=683)**	**End line (n=176)**
Good	190 (28%)	83 (47.4%)
Average	479 (70%)	86 (49.1%)
Bad	6 (1%)	6 (3.4%)
No response	8 (1%)	

3.4.1.7. Personal Hygiene of care givers

The achievement of 'Good' practice with personal hygiene of caregivers improved from 26% at baseline to 49.7% at end line. The 'Average presence' on the other hand decreased from 72% at baseline to 49.1% at end line.

> ***"I make sure that the caregivers wherever they live; wherever they are they make the place clean and…"*** [KII]

Personal hygiene of caregiver		
Responses	**Baseline (N=683)**	**end line (n=176)**
Good	178 (26%)	87 (49.7%)
Average	490 (72%)	86 (49.1%)
Bad	8 (1%)	2 (1.1%)
No response	7 (1%)	
Total	**683**	

3.4.1.8. Capacity of Dustbin to Hold Waste Generated in the Household

The capacity of dustbin to hold waste improved from 44% at baseline to 86.10% at end line. Lack of capacity of the dust bin to hold waste generated decreased from 49% to 13.90%. This achievement can be attributed to the Mazingira Bora Project which procured and distributed 30 receptacles and distributed to 15 schools. The project has enabled households to improve their hygiene standards through training of the Community Health Volunteers who have also trained the households in the areas of ensuring that

they practice hand-washing practices, maintaining clean environments, using toilets/latrines for waste disposal, ensuring that there are hand-washing stations in almost all the schools as well as waste-bins in almost all the areas in the sub-county for solid waste disposal.

Figure 23: Waste bins were provided by ChildFund to the beneficiary schools

3.5 CHALLENGES, LESSONS LEARNED AND BEST PRACTICES

The evaluation team observed that there is an inadequate number of trained CHVs within the community. Through the Mazingira Bora Project, ChildFund managed to train 28 CHVs who were able to reach 700 households which had been selected for WASH interventions under the project. The number of households reached by the project is a small coverage compared to over 80,000 households living in the slums. Majority of the CHVs interviewed indicated that they were understaffed and overworked.

Inadequate and irregular water supply from NWSC is another serious challenge facing the project implementation. The demand for toilets/latrines in schools, in households, as well as all other inputs such as water storage tanks, water purification chemicals, water filters among others cannot be gainsaid. However, resources are always limited for any given project.

3.5.1 Key project challenges, Best Practices, Lessons Learnt

The following are best practices and lessons learned highlighted from key informant interviews:

Challenges

- Some households have been affected by recurrent slum fires which gutted down over 400 homes in Mukuru informal settlement since January. Many of the affected families lost basic commodities used to meet their basic WASH needs.
- Perennial water shortages, accompanied by water scarcity have affected the uptake of WASH in the informal settlements. Residents are forced to pay a high premium to access water.
- It has been claimed that unscrupulous water vendors have colluded with county officials to drive water shortages in the communities.

- The threats of COVID 19 when the first case was reported in early March in Kenya interrupted the smooth completion of the project activities.

Lessons Learned:

The quarterly review of the project identified the following lessons learned:

- The use of popular sports, such as football, are a good vehicle for the promotion of advocacy for behavioural change contributed to the achievements made in hygiene practice.
- Inter-sectoral collaboration between Education, Public Health and Water in planning, implementing WASH interventions, has accelerated implementation rates and this is aimed at enhancing sustainability.
- Proper planning, keen follow ups and routine monitoring is key to ensure the project is successfully implemented.
- Timely disbursement of funds supported allocation of proper time to project activities and timely implementation
- ChildFund Kenya, through this project has been able to demonstrate their presence and impact in WASH and waste management and has since been able to leverage resources from Private Partnership with Dow Chemical and other stakeholders. Together, ChildFund Kenya has been able to undertake successful clean-ups and support to women and youth in the informal settlement.

Best Practice:

- Through the project, ChildFund was able to procure 770 water filters for ALL of the targeted households; there was therefore a 100% coverage of the target households, a notable achievement
- The household survey recorded that handwashing was a major behavior change among targeted households. This was corroborated by existence of handwashing facilities and soap for handwashing, as well as the training and information given by CHVs on the benefits of handwashing was quickly adapted and at the end of year one, the care givers did not need follow up reinforcements of the messages on the same.
- The adaptation of the advocacy tool, a slogan, "*Maji bora, Maisha bora*" was successful in schools, was liked and used routinely, this was a great achievement.
- Sustainability has been instituted through equipping the community health volunteers to ensure continuity of the cleanups, regular cleanups in the community areas. There are ongoing discussions with the county public health office on the integration of community health volunteers to continue working in the same community and reporting to the sub county's office.
- The sustainability of the school program has been achieved through the training of patrons this will ensure continuity in terms of ensuring that the clubs are still active.

What could have been done differently

- The project focused more on behavior change and very minimal infrastructure. For example, many children have learned how to use a latrine, however access to good and safe latrines remain a challenge in most of the schools, many of which have high children population. If

funds can be available to improve more sanitation facilities in both the schools and community to complement the behaviour change education provided

- Many households live from hand to mouth due to the meagre wages received from manual jobs undertaken in the nearby industries, hence many prioritize to ensure families access food. If the project can integrate with activities that promote improvement of livelihoods, it will promote uptake of WASH.
- Due to the dense population and poor infrastructure in the slums many children become victims to child abuse and sexual harassment. If the project can also integrate aspects of Child protection so they CHVs can educate the households on issues of Child protection, gender-based violence and such ills in the community

3.6 APPRAISAL OF THE PROJECT'S M&E OUTCOME INDICATORS TO ESTABLISH EXTENT TO WHICH PROJECT MET ITS TARGETS

Goal: Safe and healthy Environment for Children in Mukuru, Kasarani and Njiru Informal settlements by June 2020.		**Goal Indicator:** The prevalence rate of waterborne diseases among children in project target community (%) _female, male						
Outcome	**Indicator**	**Baseline**	**Target**	**Endline**	**Source of Data**	**Method of Gathering Data**	**Frequency of Gathering Data**	**Data Gatherer**
1. Increased access and use of safe water	**% of people who have access to safe water** *Definition:* The people to access safe water will include the children both at the target schools and households and the caregivers who will be the participants in SWS. The numerator will be the actual number of people accessing safe water and the denominator will be the project target.	22% always treated their water before drinking	Children in school and Households	70% always treat water before drinking	Baseline and End of project Reports	Survey	at the beginning and end of project	Project Officer/ M&E team
2. Improved management of waste disposal in Mukuru, Kasarani and Njiru Informal settlements	**% of people disposing waste safely.** *Definition:* Management of waste disposal will involve solid waste collection and handling in schools and at community level, safe disposal of human feaces and community clean ups The numerator will be the actual number of people disposing wastes safely and the denominator will be the project target.	52% open defecation free	Children, Caregivers, environmental groups	85% open defection free	Baseline and End of project Reports	Survey	at the beginning and end of project	Project Officer/ M&E team
3. Improved water related hygiene practices.	**% of people applying knowledge on proper hygiene and put it into practice regularly** *Definition:* The people applying knowledge on proper hygiene will include the children both at the target schools and households and the caregivers who will be the participants *The numerator will be the actual number of people applying knowledge on proper hygiene and put it into practice regularly and the denominator will be the project target.*	21% use soap for handwashing	Children, Caregivers, environmental groups	87% use soap for handwashing	Baseline and End of project Reports	Survey	at the beginning and end of project	Project Officer/ M&E team

3.7 APPRAISAL OF THE PROJECT'S M&E OUTPUT INDICATORS TO ESTABLISH EXTENT TO WHICH PROJECT MET ITS TARGETS

Output Indicators	Expected Time for Results	Indicator	Baseline	Target	End line	Achievement Rate	Comments / Achievement
1.1. 28 CHVs trained to reach 700 households with WASH messages	*All quarters yr1 &2*	# of CHVs trained to reach households with WASH messages. # of Households reached with WASH messages	0 0	28 700	28 700	100% 100%	A total of 28 CHVs (26 females and 2 males) were supported with stipends to follow up a total of 700 households to ensure water sanitation and hygiene issues have improved in the targeted households.[1]
1.2. 15 Schools supported to implement Safe Water System activities	Quarter 1 Yr1	# of schools supported to implement the SWS activity # of teachers trained on safe water systems disaggregated by gender # of stakeholders trained on safe water systems disaggregated by gender	0 0 0	15 30 90	15 30 90	100%	• A total of 21 vessels against a target of 15 (140%) were procured and distributed to schools. • 6 schools with very high school population received additional 50-liter water vessels to ensure more water drawing points for the children. • 30 teachers (patrons) from the 15 schools trained on safe water systems • Sensitization of 90 stakeholders (BOM, GOK, Head teachers, Min Education, School Health department) on project objectives took place.
1.3. Support 15 Health club activities	Quarter 2 through to Yr2	# of Health clubs supported # of children participating in health clubs disaggregated by gender	0 0	15 22,500	15 21,000	100%	• 360 school health club members have been trained on WASH and effective club management • WASH Essential Package (EP) has been developed, printed and distributed as a guide/ IEC for implementing WASH in schools.

[1] Reference: Quarterly Progress Report Q1 January – March 2020

Output Indicators	Expected Time for Results	Indicator	Baseline	Target	End line	Achievement Rate	Comments / Achievement
							• Support participation in relevant International Days celebration • a total of 21,000 children during school assemblies and established school health clubs
2.1. Support Management of solid waste in 15 school	Quarter 2 in YR1 to Quarter 1 YR2	# of schools supported with solid waste management	0	15	15	100%	• 15 schools supported with waste bins to help in management of waste. • 10 disposal sites were identified and a firm engaged to fabricate the garbage collection facilities. • The boys' toilet block in Kasarani Primary School been constructed • Set up of mobile toilets for 10 schools (4 primary schools in Kasarani and 6 ECD centers in Mukuru:
2.2. Facilitate 2 Community Engagements in waste management	3RD quarter YR1 and 3rd Quarter YR2	# of community engagements conducted	0	2	2	100%	• Cleaning materials procured and distributed to the CHVs, schools and selected community members for use in Kasarani and Njiru sites. • 20 CHVS with support of the community supported to conduct monthly clean up as opposed to bi-annual clean ups in the neighborhoods.
3.1 Promote behavior change towards WASH	Quarter 2 YR1 through to 4th quarter YR2	# of behavior change messages shared # of PET performances supported # of pupils practicing positive hygienic behavior	0 0 0	2 24 22500	2 24 TBD	100% 100% TBD	• Support 2 football Tournament (MAJI CUP) conducted in order to celebrate the World Water week • 10 schools provided with school badges to motivate school health club members and other pupils to practice good hygiene in school and at home • 10 Primary schools provided with murals

Output Indicators	Expected Time for Results	Indicator	Baseline	Target	End line	Achievement Rate	Comments / Achievement
							• 24 PET performances to promote uptake of hygienic practices introduced/

CONCLUSION

The end-line evaluation of Mazingira Bora Project which was implemented by ChildFund provides very important information for the school WASH (Water, Sanitation and Hygiene) issues. The information gathered through Focus Group Discussions (FGDs), Key informant interviews (FII), household survey questionnaires, literature review and Field observation of the targeted household and schools has been authenticated by the consultant. According to the project design, most of the project interventions were more of behaviour-change as compared to infrastructure development. The level of awareness in relation to water and hygiene practices was extremely low at the onset of the project. However, after the project-initiated education/sensitization interventions, the community's perceptions changed for the better.

While project output performance varied, it is clear it had a positive impact on transforming the community and school experience for children by enhancing access and use of safe water, improved management of waste disposal and sanitation and hygiene promotion knowledge attitudes and practices. The project was buoyed by a sound implementation framework that was fully driven by the communities themselves. This framework supported efficient delivery of activities and enhanced prospects of the project being sustainable in the medium to long term.

RECOMMENDATIONS

The key recommendations that emanate from the findings of the evaluation are as follows:

i. It is evident the project increased access and use of safe water, improved management of waste disposal, as well as created demand for sanitation and hygiene promotion knowledge attitudes and practices. However, the project duration was too short (1.5 years) to ensure sustainability in the long term; the WASH problems in the informal settlements and Nairobi in General is too complex for a one-off project support. Hence, the need for consideration of the continuation of the project for an additional three and half (3.5) years, to give a complete 5-year period for the program impact to be realized and the necessary sustainability to be instituted through advocacy for local resource mobilization.
ii. The project collaborated with the schools and teachers who took the lead in the implementation of project activities i.e. school health clubs, which are well documented in success stories on: use of football to promote hygiene, adaptation of hygiene advocacy slogans in schools. It is recommended that the County Ministry of Education who were partners to the Mazingira Bora Project, to identify financial resources that will support continuation of the implementation of these intervention strategies. Working in collaboration with key stakeholders in the community has been a good strategy.
iii. The Community Health Volunteers working under the Mazingira Bora Project have been capacity built through training and on the job. The CHVs have contributed greatly to the documented achievements. The CHVs need to be supported to continue with the work they have been conducting under Mazingira Bora Project. We recommend the County Ministry of Health through the sub-county Public Health office to consider absorbing these CHVs and support them to continue with the project activities; their role can be expanded to cover the COVID 19 community interventions.