

GLOBAL SANITATION FUND – OUTCOME SURVEY BRIEF

Kenya Sanitation and Hygiene Improvement Programme (K-SHIP)

February 2019

OBJECTIVE

In 2018, an independent programme outcome survey of the Kenya Sanitation and Hygiene Improvement Programme (K-SHIP) was conducted to describe the distribution of key sanitation and hygiene indicators in the program coverage areas, as the WSSCC's GSF country programme was completing implementation activities.

The specific objectives of the survey were:

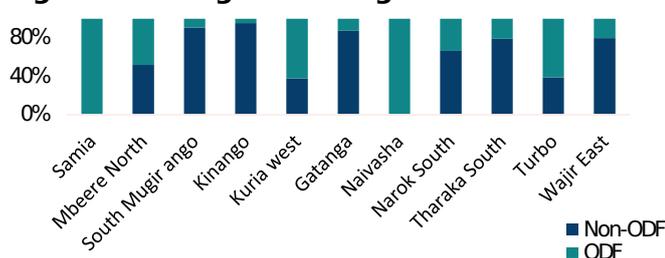
- To provide statistically reliable data on key sanitation and hygiene outcomes of the GSF programme in households and public facilities
- To document sustained ODF status among previously verified communities
- To assess integration of equity and non-discrimination and the needs of marginal and vulnerable households/population
- To describe emerging indicators of programmatic effect, including behavioral norms, habits, and satisfaction with available sanitation service

The survey was intended to provide consistent and representative estimates of key indicators in the program area for use in assessing programme effectiveness.

METHODS/SAMPLING

A representative multi-stage sampling methodology was adopted. The target population of the study comprised of project beneficiaries. There also was a comparative component using a sample of population in pre-intervention communities. The survey's primary sampling units (PSUs) were the intervened and the pre-intervened communities (hereinafter rural villages) while the households were the secondary sampling units (SSUs). The WSSCC GSF country program standard set of survey tools were customized to fit the Kenyan national context. The survey tools included: household questionnaire; the head of household questionnaire; the female (caregiver) questionnaire; the persons with a physical disability /persons over age 65 questionnaire; the school & health facility questionnaire; the structured observation guide for households; and the village ODF verification guide.

Figure 1: Percentage of ODF villages in 11 subcounties



CONTEXT



K-SHIP has been funded by the Water Supply and Sanitation Collaborative Council (WSSCC/ GSF) for 5 years (2014-2019).

The Kenyan government through the Ministry of Health supports the programme with policy guidance and formulation, resource mobilization and technical assistance. K-SHIP intends to accelerate sanitation

coverage to reach over 1.92 million people with appropriate sanitation and hygiene interventions using the Community Led Total Sanitation (CLTS) approach. This support will directly contribute to the achievements of the Open Defecation Free (ODF) road map goals and the national health sector goals. The programme is being implemented in 11 selected sub-counties in the 11 target counties.

National ODF Criteria (National ODF verification and 3rd Party Certification Guidelines): 1. No exposed human excreta within the community/households 2. All households have access to a latrine which should not facilitate faecal-oral transmission 3. The squat hole should be covered (except for VIP latrines) 4. The floor should be free of faeces and urine 5. Superstructure that provides privacy 6. All households have a handwashing facility near the latrine 7. Be in use 8. Evidence of soap/ ash and water.

Table 1: Sample allocation based on the multi-stage sampling strategy in the outcome survey, 2019

	Total Selected	Method
Primary Sampling Unit	123 villages in 11 subcounties	PPS (Probability proportional to size) & simple random
Households	1,968 households/16 households per village	Simple random
Structured Observation	492 observations	Simple random



KEY FINDINGS

Access to drinking water: Access to drinking water was rather low in the target population with the findings indicating that overall, about 3 in 10 households (29.6%) used surface water and more than 40% of sampled households reported that they do not “do anything extra” to make the drinking water safer.

Access to sanitation facilities: The overall distribution of access to sanitation across all program areas indicates that 77% of the households accessed basic sanitation facilities, 15.5% accessed limited sanitation facility, 1.0% use unimproved sanitation facility and 6.5% had no access to sanitation facility (open defecation).

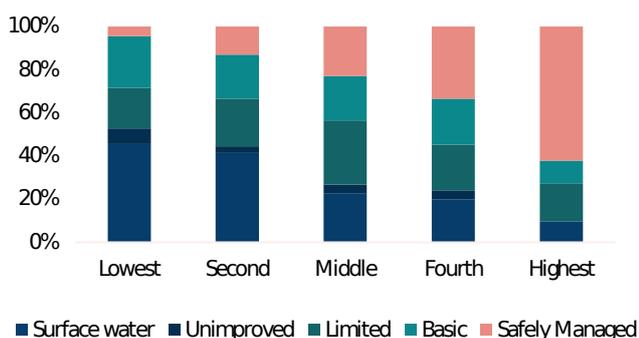
Access to handwashing facilities: According to the survey findings, 14.6% of the households in the programme area had no handwashing facility (no service), 37.9% had a facility but lacked water or soap (limited) and 47.5% had a handwashing facility with soap and water available on their premises (basic).

Sustainability of ODF: The findings show that overall, 78.3% of the households reported continued access to basic sanitation and hygiene facilities in previously declared ODF villages.

Access to Water

Access to water among households in the programme area, according to the JMP water ladder, was rather low with the findings indicating that overall, about 3 in 10 households (29.6%) used surface water. In regard to drinking water treatment, a majority of the sampled households (42.2%) reported that they do not “do anything extra” to make the drinking water safer. Over, 43.7% of the households in the programme area for Kenya failed to access sufficient quantity of drinking water in the past one month preceding the survey (July 2018). This was largely due to the prevailing dry season in some counties while others had experienced prolonged periods without rainfall throughout year 2018.

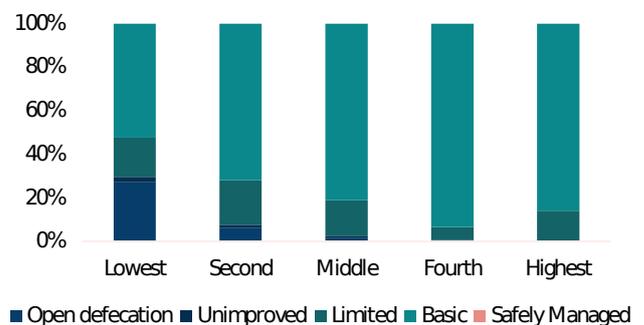
Figure 3: Access to water by wealth quintile



Access to Sanitation Facilities

The overall distribution of access to sanitation across all program areas indicates that 77% of the households accessed basic sanitation facilities, 15.5% accessed limited sanitation facility, 1.0% use unimproved sanitation facility and 6.5% had no access to sanitation facility (open defecation). County wise, more than 50% of households in 9 out of the targeted 11 subcounties in the programme area had access to basic sanitation facilities. Gatanga and Tharaka North subcounties reported the highest percentage of households with access to basic sanitation with 96% and 91.7% respectively. Factors found to have a correlation to the level of access to sanitation included: access to an improved water source; level of education of the household head; and whether the community was ODF verified or not.

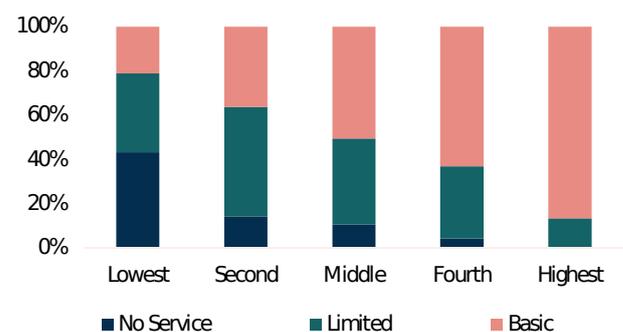
Figure 2: Access to sanitation facilities by wealth quintile



Access to Handwashing Facilities

According to the survey findings, 14.6% of the households in the programme area had no handwashing facility (no service), 37.9% had a facility but lacked water or soap (limited) and 47.5% had a handwashing facility with soap and water available on their premises (basic). Factors that were found to influence the practice of handwashing with soap at the household level included: nature of the drinking water source (whether improved or not); level of education of the household head (Household heads with university and post primary level of education had the highest proportion of households with a basic handwashing facility); and the socio-economic status of the household (wealth index).

Figure 4: Access to handwashing facilities by wealth quintile



Social Norms on Hygiene and Sanitation

Regarding social norms on hygiene and sanitation, 64.2% was the weighted percentage of survey population reporting strong social norms favoring latrine use; while 65.4% was the weighted percentage of survey population reporting strong social norms favoring hand washing.

Figure 5: Comparison in level of social norms of latrine use between pre- and post- intervention communities

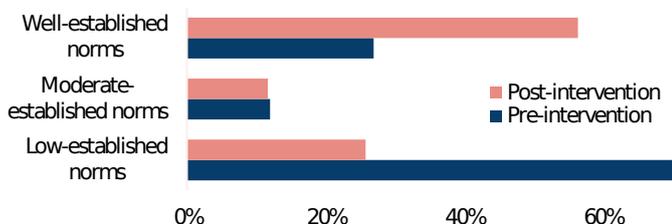
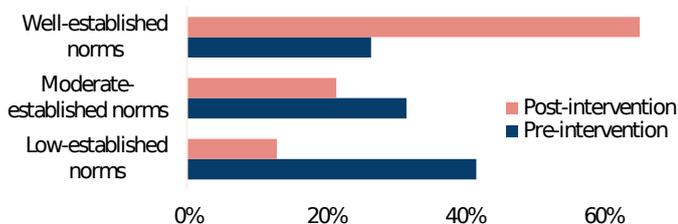


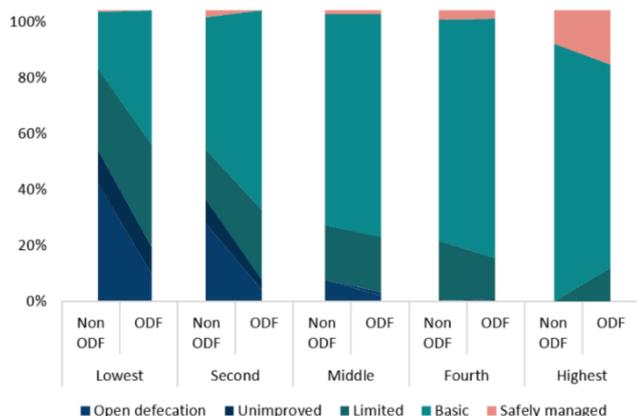
Figure 6: Comparison in level of social norms of handwashing between pre- and post- intervention communities



Sustainability of ODF

The findings show that overall, 78.3% of the households reported continued access to basic sanitation and hygiene facilities in previously declared ODF villages. The subcounties of Gatanga, Naivasha, Narok South and Tharaka North recorded the highest proportion (over 90% each) of households with continued access to basic sanitation and hygiene facilities in previously declared ODF villages. Kinango and Wajir East subcounties were the lowest at 47.9% and 54.2% respectively. Disparities were also noted in regard to the wealth quintiles with the households in the upper quintiles reporting higher sustainability score (85.4%, 88.0% and 88.7%) as compared to the households in the lowest wealth quintile (61.6%).

Figure 8: Comparison in access to sanitation facilities between previously non-ODF and ODF communities



Satisfaction

A composite score for satisfaction with latrine use was developed, consisting of four questions intended to measure perceived privacy, cleanliness and safety (range: 0 to 4 points). A median score of 3.0 was reported across the sampled respondents on the composite of the 3 attributes implying high satisfaction with WASH services amongst the female respondents, the persons with mobility/vision limitations, and the persons over 65 years. Overall, only 5.5% of the respondents scored 0 on the composite score.

Figure 7: Female caregiver satisfaction with sanitation facilities in following dimensions

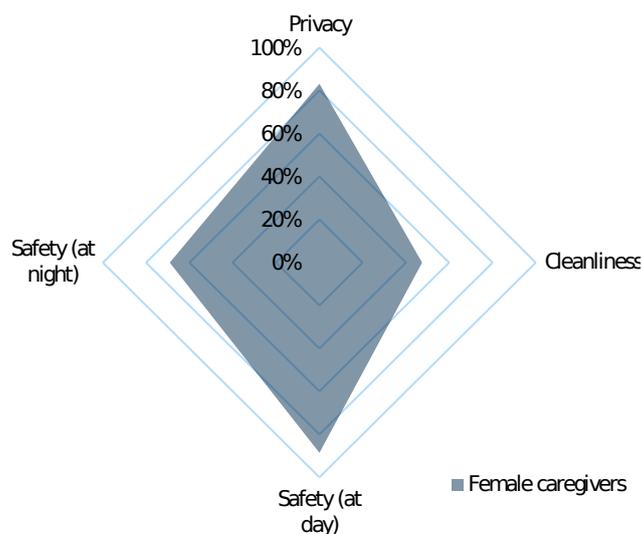
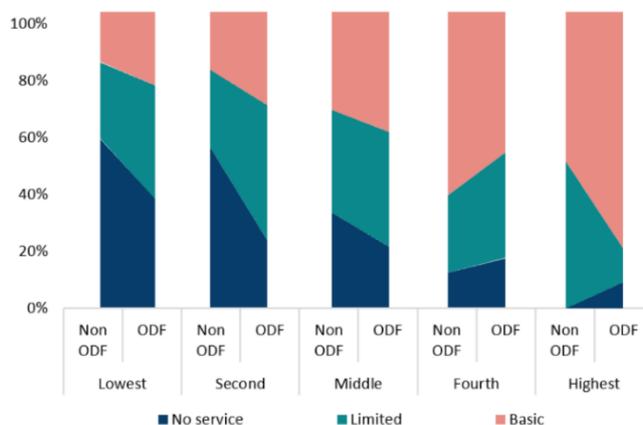


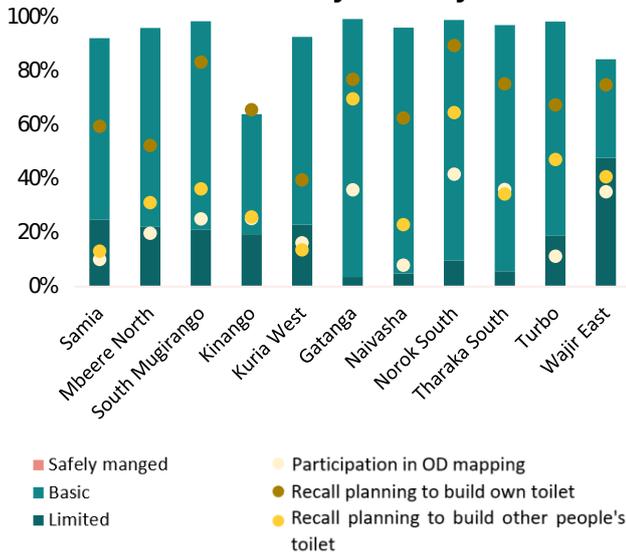
Figure 9: Comparison in handwashing facilities between previously non-ODF and ODF communities



Exposure to Programme Activities

Overall, 60% of the respondents had not attended any programme activity; with 41.3% of the respondents reporting that they participated in one or more activity. None of the sampled respondents participated in all the 4 activities that were implemented. More women (43.2%) were involved or participated personally in one or more of these activities as compared to men (36.4%).

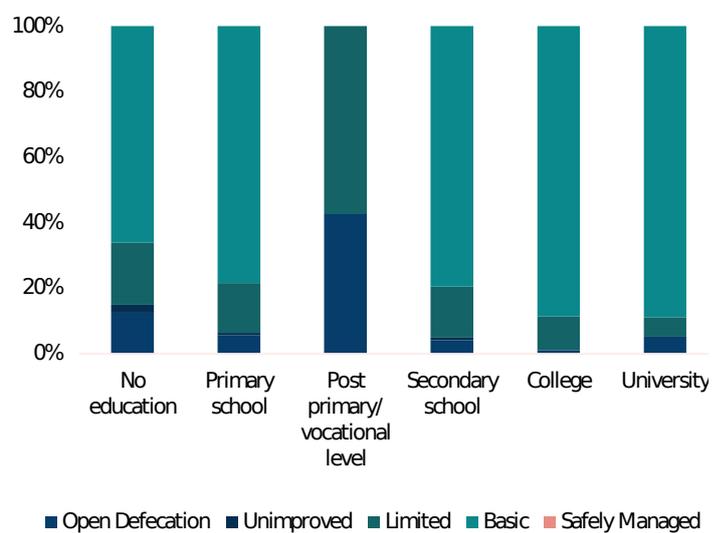
Figure 10: Comparison in level of activity exposure and the access to sanitation facilities by subcounty



Equity and Non-Discrimination

The findings indicated that 67.4% of the persons with disabilities reported that they could be able to use a latrine whenever they wished to; with 15.1% reporting that they used a bucket that is emptied into a latrine. In regard to decision-making, 58.1% reported that they were involved both in decision of the kind of toilet that would be built; as well as decision of where the toilet should be located.

Figure 11: Access to sanitation facilities by education of household head



Menstrual Hygiene Management (MHM)

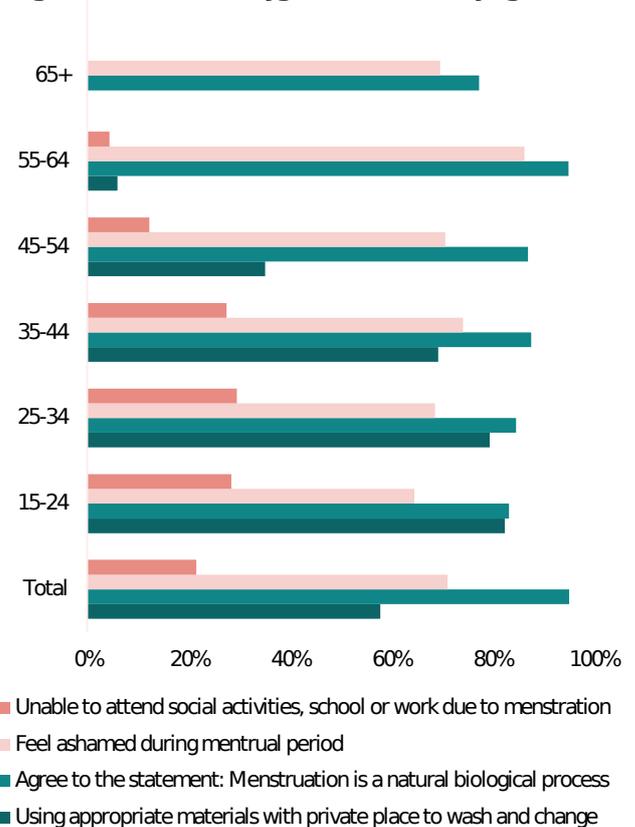
20 questions were included to assess perception and stigma about MHM to serve as a baseline for future programming:

Appropriate materials with private place to wash and change: Overall, 59.2% of respondents had appropriate MHM facilities in the home. The percentage of female respondents who could access pads or cloth or cotton to manage their last menstrual period was 60.4% while the percentage using appropriate menstrual hygiene materials with a private place to wash and change while at home was 58.0%. At least half of the female respondents in all subcounties had a private place to wash and change while at home and using appropriate materials during their last menstruation.

MHM related awareness: Overall, 37.1% of females were aware of their first period and 34.0% knew how to manage it.

Exclusion of activities during menstruation: Overall, 21.6% of the female respondents had failed to participate in social activities, school or work due to their last menstruation in the last 12 months. Those most affected were from Mbeere North and Kuria West subcounties with a percentage of 37.5% while least affected were those from Gatanga subcounty. Those most affected also were in the age ranging from 24-34 years and/or in the middle class of the wealth index.

Figure 12: Menstrual hygiene indicators by age



Schools

Schools

Data were collected from a sample of 42 schools, 34 were drawn from the K-SHIP intervention communities and 8 were drawn from the K-SHIP pre-intervention communities:

Access to water, sanitation and hygiene: The research findings showed that most of the surveyed schools had water from improved sources (52.9%) and they had improved latrines (92.9%) for their students, but less than one in five schools had a handwashing place with water and soap. “Basic” level of water and sanitation services as per JMP criteria were available at most schools, but less than 23.5% of schools had “basic” level of hygiene services.

Menstrual hygiene management (MHM): Schools reportedly provided education to students about menstrual hygiene management but materials and facility support for MHM was very uncommon. At the time of the survey, only 29.4% of the respondents could show the materials or resources used for MHM education. In a majority of the schools (79.4%), the preferred means of disposal for menstrual hygiene waste was toilets and pit latrines; with 14.8% reporting that their schools had no disposal mechanism available. The findings showed that only 20.6% of the schools had separate places for women to change and wash, aside from the latrines.

Equity and non-discrimination: Despite the fact that one in three schools had a student with limited mobility or visual impairment, few schools had handrails at the toilet or handwashing place, and the toilets generally did not have adequate space for a wheelchair to enter.

Health Facilities

The analysis also included health facilities serving villages selected for the outcome survey, with data collected from a total of 18 health facilities:

Access to water, sanitation and hygiene: The findings showed that most health facilities had an adequate supply of water, and all toilets were improved latrines. All the facilities were found to have toilet facilities with pit latrines with slab being the most common type of toilet for the sampled health facilities. Almost all of the main water sources were observed to have water at the time of the study. Moreover, the water from the sources was reported to be used for patient care, for equipment reprocessing and for cleaning the equipment or facility. Half of the observed sources of water for the facilities were located 500m within the premises of the facility and 38.9% were on the premises. Chlorination was the highly used way of purifying water for drinking in the health facilities. However, not all handwashing places had water and soap available, and 2 of 18 sampled health facilities did not have a handwashing place. At the time of the study, 84.8% of the hand-washing facilities were found to have water and 39.1% were found to have soap.

Equity and non-discrimination: Most the hand washing facilities, 87.0% were accessible by persons with limitations by having a clear path without obstructions, and water and soap being accessible from a seated position and water operable with feet or one closed fist. Toilets and handwashing places at the health facilities were not designed to be accessible in a friendly manner to those with limited mobility. Although 95% of the toilets in health facilities were improved latrines, there were challenges similar to those encountered in communities with CLTS programs with regard to accessibility for those with limited mobility.

RECOMMENDATIONS

The project should initiate post-ODF activities that will ensure that more households are able to move from unimproved access and limited access to basic access; and later on, have households progress from basic access to safely managed access (found to be 0% in the outcome survey).

The outcome survey was limited to collection of quantitative data with qualitative inquiries being excluded. As such, further qualitative studies may be conducted to understand how GSF programme’s interventions have contributed to the outcomes observed, and how the program interventions can potentially be improved and scaled.