



Kenya – SSH4A Results Programme Extension endline brief

Between 2017 and 2019, over 214,000 more people gained access to safe sanitation and hygiene; almost 154,000 more people practised handwashing with soap (HWS); and open defecation (OD) rates fell from 26% to 11%. These results are based on the Sustainable Sanitation and Hygiene for All Results Programme (SSH4A RP) household survey conducted in November 2019 in sub-counties within Homabay, Kericho, Elgeyo Marakwet and Kilifi counties in Kenya.

This endline practice brief summarises key achievements since the programme commenced in the four counties, with progress measured against the baseline survey conducted in January 2017. Disaggregated sanitation and hygiene outcomes are presented, with data on the counties’ most vulnerable groups: households in the poorest wealth quintile, female-led households, and households with people with disability.

In 2017, incidences of toilet collapse were prevalent in the programme areas, caused mainly by soil structure and heavy rains. Kilifi county, for example, was subject to both flooding and drought, the water table was relatively high and the majority of households neither owned nor used toilets because they believed toilets would pollute their ground water. Due to high construction costs, many households resorted to short-term options such

Key achievements by household (2017-2019)

74% have access to a toilet (**48% in 2017**)



81% practise hygienic use and maintenance of toilets (**51% in 2017**)

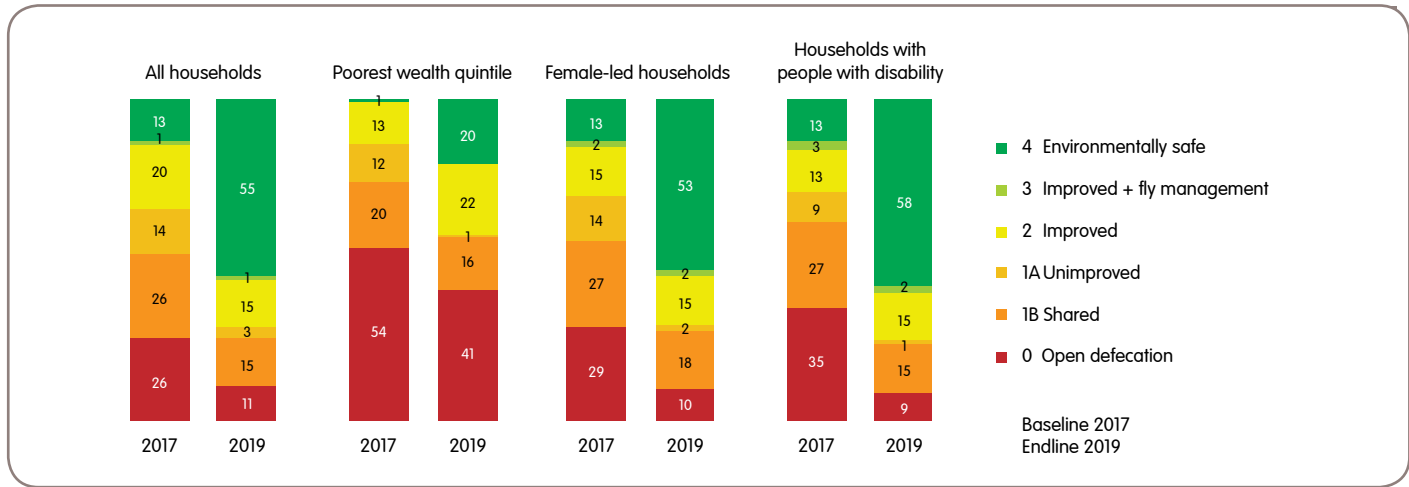


25% have access to a handwashing facility with soap after defecation (**4% in 2017**)



Figure 1: Percentage of households with access to toilets, 2017 and 2019

Access rate: 74% (2019 endline) 
48% (2017 baseline)



Note: Households with toilets categorised as Level 1A through Level 4 are considered to have access to sanitation, as defined in the programme by the UK Department for International Development (DFID).

as sharing toilets or practising OD. Barriers to change included lack of disposable income to build sanitation and handwashing facilities, poor availability of sanitation technologies that could withstand local climatic and soil conditions, and cultural acceptance of shared latrines. Most people in the programme areas lived in compounds (homesteads) where sharing of toilets by extended families was common practice – 26% of households shared toilets while 26% practised OD. Cultural practices were shown to contribute to OD. For example, it was considered a taboo for certain family members to share toilets.

By the end of 2019, shared toilets had reduced to 15% of households and OD had reduced to 11%. Most households with toilets reconstructed them after collapse to avoid the shame associated with practising OD, or shared toilets with other households on a temporary basis until their own could be used again. The reduction in OD was accredited to sustained outreach campaigns by promoters, clan elders, and village elders as well as water, sanitation and hygiene (WASH) monitoring and evaluation (M&E) interns.

Access to toilets up by 26 percentage points, access to improved sanitation up by 37 percentage points (fig 1)

The endline results reveal that access to sanitation facilities rose from 316,000 households at baseline to 530,000, translating to an increase of 26 percentage points in households accessing toilets.¹ Within the programme area, OD fell from 26% at baseline to 11%, with this progress realised largely due to work with community-based promoters and structured support across different levels including M&E interns,² Public Health Officers and the SSH4A programme team.

In the poorest wealth quintile, access to improved sanitation went up by 28 percentage points and OD reduced by 13 percentage points. Despite the poor having a higher dependency ratio³ and therefore greater strain on their limited income, 20% of these households had adopted environmentally safe toilets by 2019. In female-led households, access to sanitation increased by 28 percentage points while OD decreased by 19 percentage points. In households with people with disability, access to sanitation went up by 38 percentage points between surveys and 58% of these households had adopted environmentally safe toilets by 2019. The introduction of disability-friendly facilities for households with people with

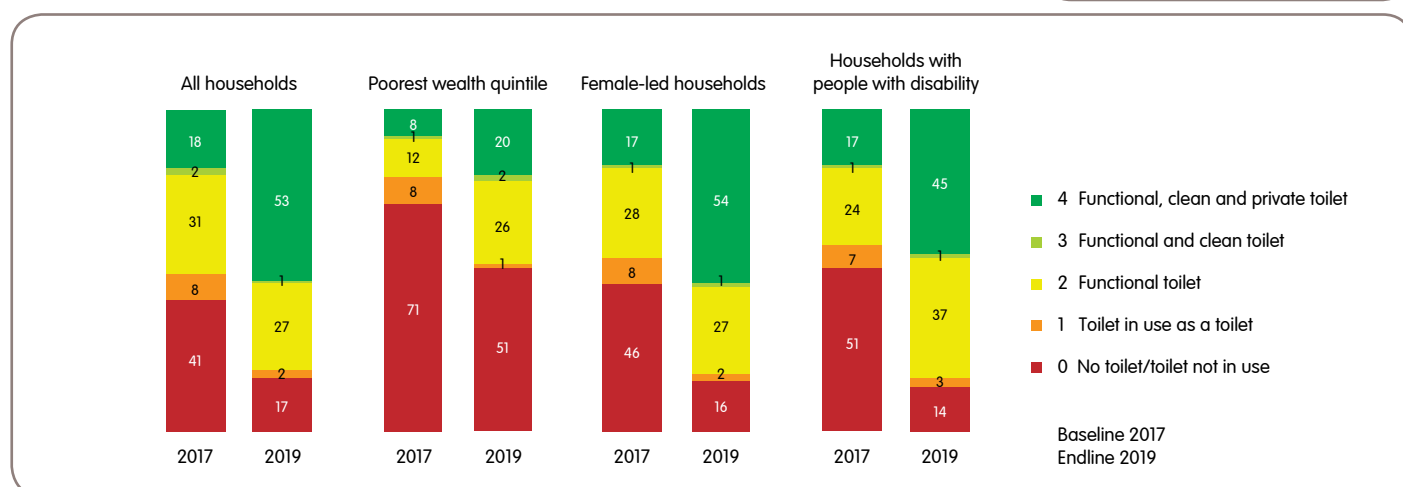
¹ All percentage changes (increases and decreases) are given in absolute not relative terms – that is, we give the percentage-point difference between baseline and endline results. Please also note, the percentages given in this briefing are rounded, therefore there may be small variances between these and the raw data.

² Interns were drawn from a pool of fresh graduates who volunteered in health facilities in programme areas.

³ Kenya National Bureau of Statistics (KNBS), *Kenya population and housing census*, vol. 1, Nairobi, KNBS, 2019. The average household size for those in the poorest quintile stands at 7, above the national average of 3.9 people.

Figure 2: Percentage of households with hygienic use and maintenance of toilets, 2017 and 2019

Use rate: 81% (2019 endline)
51% (2017 baseline)



Note: Levels 2 through 4 are considered to indicate improvements in hygienic use and maintenance of toilets.

disability was carried out through door-to-door campaigns by community-based promoters and programme staff. Uptake of toilet options, like *Safi* toilets,⁴ was enhanced by the installation of demonstration toilets for select households. Disaggregated data by latrine types and ownership was also used by community-based promoters to enable targeted outreach.⁵ The use of a household-focused mobile-to-web-based reporting and progress system made it possible for programme staff to receive and monitor data from geographically 'hard to reach' areas.

Hygienic use and maintenance up by 30 percentage points (fig 2)

The endline results show an increase of 30 percentage points in hygienically maintained toilets (levels 2 to 4), with most households (53%) investing in 'functional, clean and private' toilets by 2019. This implies that a considerable number of households heeded the campaign messages which targeted all who did not have their own toilets and raised awareness of the quality, cleanliness, operation and maintenance of constructed toilets.

The increase in toilet innovations and available options for upgrades also stirred up household interest in facility improvements. The household

sensitisation approach employed by the Kericho team of promoters, chiefs, clan elders, village elders and WASH M&E promoters, for example, involved the use of OD-free (ODF) verification and certification indicators to assess hygiene and maintenance levels during each follow-up session. This entailed checking whether households had their own toilet with a clean floor, squat hole cover and superstructure for privacy, and if there was evidence of usage with a functional handwashing facility with soap.

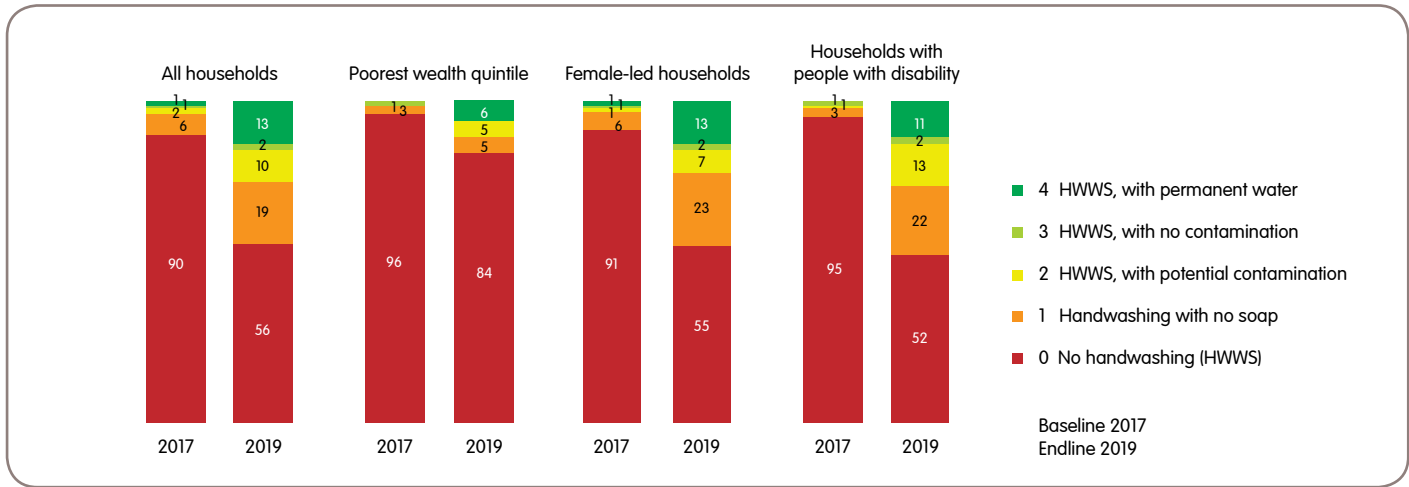
By 2019 an additional 27% of households in the poorest wealth quintile had hygienically maintained toilets. Households with no toilets (or toilet not in use) reduced from 71% to 51%. Although progress in access to hygienically maintained toilets was slower among poor households than other groups, those with access were taking a keen interest in keeping their toilets clean. This is an indication that the behavioural change communication (BCC) campaigns were effective across all households. Similarly, female-led households and those with people with disability saw increases of 36 and 41 percentage points, respectively, in access to hygienically maintained toilets.

⁴ The *safi* latrine (meaning 'clean' in Swahili) was designed by SNV through action research and is an adaptation of the easy latrine designed by International Development Enterprises (iDE) in Cambodia.

⁵ A team of between five and 10 WASH M&E interns and promoters made joint follow-up visits in designated village/s (areas) and reached out to all the households together with the community-based promoters based on the household register data. Follow-up visits were then made at agreed times based on noted progress and individual plans agreed with the households.

Figure 3: Percentage of households with access to a handwashing facility with soap near toilet, 2017 and 2019

Access rate: 25% (2019 endline)
4% (2017 baseline)

Note: Levels 2 through 4 are considered to indicate access to a handwashing facility with soap.

Access to a handwashing facility with soap near toilet up by 21 percentage points (fig 3)

By 2019 there was a 34 percentage-point decrease in households with no handwashing station, an indication that the intensive BCC campaigns conducted by community-based promoters through door-to-door campaigns and meetings were effective. Improved handwashing facilities were promoted and sold, with many households preferring to place their handwashing facilities indoors. There was also an increase in uptake of facilities for handwashing with soap (HWWS) in areas where the campaigns were sustained for lengthy periods of time.

However, households with no access to soap increased from 6% in 2017 to 19% in 2019. The low uptake of soap was due to the perceived high cost of soap for handwashing and the low priority attributed to it. Although SSH4A RP encourages the use of soap substitutes such as ash, only about 9% of households used soap substitute while 45% had no soap nor a substitute. Indeed, many households perceived the use of ash as retrogressive and inconsistent with the messages that were urging them to aspire for improved toilets. There was also a lack of clear responsibility for replacing soap once it had been used up or perhaps stolen, which also led to slow access to HWWS. Such obstacles can be addressed by constant follow-up and outreach sessions by all promoters. In areas where women travelled long distances to fetch water, priority was given to water for cooking and drinking rather than handwashing.

Among households in the poorest wealth quintile there was an increase of 10 percentage points in access to HWWS and a decrease of 12 percentage points in households with no HWWS stations. However, financial constraints are likely a hindrance for the poor as the data show that richer quintiles had invested mostly in the more durable and desirable bucket and tap system compared to the more affordable tippy taps or leaky tins.

The survey findings show that female-led households made progress in accessing HWWS after defecation especially at level 4 – with an increase to 13% of these households accessing HWWS compared to only 1% at baseline. Overall, households with people with disability improved the most amongst the vulnerable groups with 26% accessing HWWS facilities in 2019 compared to 2% at baseline. This group also saw a 43 percentage-point decrease between surveys in households with no handwashing stations.

Conclusion

The progress realised in access to sanitation in the programme areas in Kenya is largely due to working with community-based promoters with structured support across different levels from M&E interns, Public Health Officers and the SNV team. In addition, the robust mobile-based M&E system and data from the toilet census ensured that there were focused household follow-ups and support given.



The commitment to sanitation and hygiene in the four county governments can be assessed based on the budget allocations for the subsector and is best anchored in the passing of policy and relevant laws. For example, the Community Health Services Bill passed by some counties allows for the payment of stipends to community health workers whose primary role includes ensuring that communities have adequate sanitation and proper hygiene facilities. Paying stipends will ensure that household sensitisation on sanitation continues. In Elgeyo Marakwet, for example, the Sub-County Sanitation Investment Plans have been used by the respective sub-counties to mobilise resources, especially during public participation forums in the county budgeting cycle held at the Ward level. Such forums have led to fund allocation of up to KES10 million (US\$ 100,000). Mobilisation of resources is expected to continue and, with proper M&E system and accountability frameworks in place with local civil society organisations, the attainment of ODF status can be achieved.

Access to HWWS after defecation increased by 21 percentage points across households. Many households do not consider handwashing facilities (tippy taps and leaky tins) installed near toilets to be sustainable, and have taken up the bucket and tap instead. However, these facilities are kept in the house and not included in the access numbers as they are usually more than 10 metres away. In addition about 13% of

the households had handwashing facilities with no soap, despite having the knowledge of soap substitutes such as ash. It is important for the counties to look into the affordability of soap so that more households may take up handwashing with soap fully.

Another area, which counties have agreed to, is in the review of the current M&E system (the District Health Information System) which currently has only one indicator on HWWS – the presence of a handwashing facility. The M&E system could be enhanced to include more indicators that track and monitor behaviours related to HWWS. Trained social behaviour change communicators are expected to spearhead this process to focus on behaviours related to usage, the presence of water and soap in facilities, and support in monitoring indicators during follow ups and other routine public health activities such as immunisation campaigns and mosquito net distribution.

Market centres are emerging rapidly in rural villages but, unlike in urban centres, sanitation is not well provided for here. Where sanitation facilities are available, the fill rates of toilets are quite high, which represent an opportunity for formal pit-emptying in rural Kenya. Currently reconstruction costs are high, so households are investing more in their toilets and are starting to make provision for emptying. While pit-emptying services are available in a number of urban centres, these could be offered to the emerging

centres in rural areas as well. This is an area that the counties need to address and the SSH4A programme has already shared existing knowledge and best practice in this regard.

The SSH4A programme has demonstrated that a multi-faceted strategy (demand-creation, BCC, supply chain and governance) and a well-structured workforce with a household focus can deliver results. The programme counties now have the knowledge and skills to replicate the SSH4A approaches as they aim

for county-wide access to sanitation. Although adequate resources and an enabling environment are needed, scale-up can be achieved through relevant policies and legislations, inclusive planning, knowledge-sharing, robust M&E systems, and accountability mechanisms. Political goodwill is also needed, and this can be achieved through advocacy for increased resource allocation as has already been demonstrated. With a motivated workforce and robust M&E system the gains realised to date can be sustained through focused and targeted outreach.

Sustainable Sanitation And Hygiene For All Results Programme (SSH4A RP)

SSH4A RP is a pioneering results-based financed programme implemented in select countries in Africa and Asia. The programme contributed to ending open defecation; increased use of safely managed, functional and private toilets; and increased access to handwashing with soap facilities. SSH4A RP in Kenya is a collaborative initiative with the Government of Kenya. It received generous funding from UKAID of the Government of the United Kingdom.

SNV

SNV is a not-for-profit international development organisation that makes a lasting difference in the lives of people living in poverty by helping them raise incomes and access basic services. Focusing on three sectors – Agriculture, Energy and Water, Sanitation and Hygiene (WASH) – SNV has a long-term, local presence in over 25 countries in Asia, Africa and Latin America.

This SSH4A RP endline brief was prepared by Anne Mutta and Fanuel Nyaboro, with support from Rosenell Odondi and Anjani Abella. It was edited by Joanna Fottrell and designed by Belle Phromchanya.

Photos ©SNV

(FRONT): BCC material read by school girl sparks interest to help her parents construct a handwashing facility (SNV/Admedia)

(P5) SNV staff follow-up visit to households to observe and assess effectiveness of BCC messages (SNV/Fanuel Nyaboro)

For more information

Fanuel Nyaboro
SSH4A RP Programme Leader in Kenya
fnyaboro@snv.org





In collaboration with the Government of Kenya, SNV supported local governments to lead and accelerate progress towards area-wide sanitation coverage in rural areas. Between January 2017 and November 2019, the Sustainable Sanitation and Hygiene for All Results Programme (SSH4A RP) was extended to the county governments of Homabay, Kericho, Elgeyo Marakwet and Kilifi.¹ The programme reached 710,238 people. The endline achievements are highlighted here. From January 2017 through November 2019...

214,337

people
gained access to sanitation



**Access to
toilets**

43%

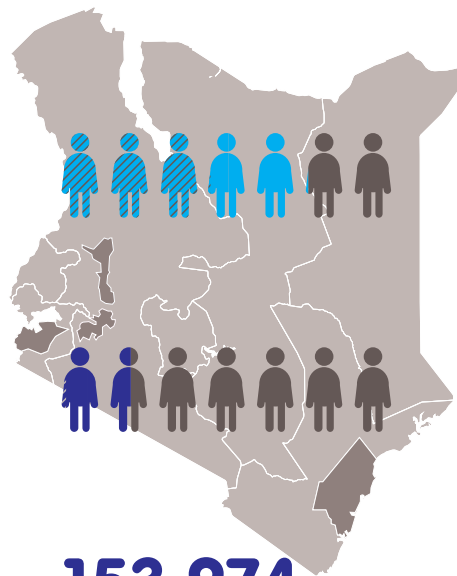
of the poorest households,
up from 26%

72%

of female-led households,
up from 44%

76%

of households with people with disability,
up from 38%



153,974

people
began handwashing
with soap after defecation



**Hygienic
use and
maintenance
of toilets**

48%

of the poorest households,
up from 21%

82%

of female-led households,
up from 46%

83%

of households with people with disability,
up from 42%



Handwashing with soap after defecation

11%

of the poorest households,
up from 1%

22%

of female-led households,
up from 3%

26%

of households with people with disability,
up from 2%

¹The extension phase of the SSH4A RP was implemented in five new sub-counties, namely: Suba North and Karachuonyo in Homa Bay County, Marakwet East in Elgeyo Marakwet County, Kipkelion East in Kericho County and Kilifi North in Kilifi County. The extension also covered 55 new sub-locations in Kaloleni, Malindi, Magarini, Kericho East, Kericho West, Kipkelion West, Keiyo South and Marakwet West sub-counties.



= 100k People



= Baseline
January 2017

Sustainable Sanitation and Hygiene for All (SSH4A) is an integrated approach that supports local governments in achieving area-wide rural sanitation and hygiene. The goal is to meet the needs of the entire population: no one should be left behind.

Introducing the SSH4A components

The SSH4A approach contributes to building systems and capacities in rural areas. SSH4A integrated components include:

- ✔ **Strengthening capacity to steer and implement sanitation demand creation** of local governments and partners to generate community demand for quality sanitation services, and to take this demand to scale.
- ✔ **Strengthening capacity for sanitation supply chains and finance** to develop and deliver appropriate and affordable market-based sanitation solutions that address the needs or desires of various consumer segments.
- ✔ **Strengthening capacity for behavioural change communication (BCC) for hygiene** to institutionalise hygiene promotion and sustain positive hygiene behaviours.

- ✔ **Strengthening capacity for WASH governance** to improve sector alignment of sanitation and hygiene initiatives and to address the needs and aspirations of traditionally disadvantaged groups – girls and women, the poorest, minorities, people with disability and the elderly.

Measuring SSH4A performance: outcome indicators

Progress in sanitation and hygiene is realised incrementally and measured in small steps as people climb up the 'ladder' of access and services. The performance and appropriateness of the approach is measured by three outcome indicator ladders, adapted from the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) Joint Monitoring Programme for Water Supply, Sanitation and Hygiene.

OUTCOME INDICATOR 1.

Progress in access to a toilet

Indicator level	Description
4 Environmentally safe	Human faeces contained and not in contact with humans or animals. No flies or rodents enter or exit the toilet. Human faeces do not contaminate surface water or ground water.
3 Improved with fly management	Human faeces contained and not in contact with humans or animals. No flies or rodents enter or exit the toilet.
2 Improved (basic)	Human faeces contained and not in contact with humans or animals, with the exception of flies or rodents.
1A Unimproved	Unimproved (private) toilet. Human faeces not contained and may be in contact with humans or animals.
1B Shared	Unimproved toilet shared between two or more households. Human faeces not contained and may be in contact with humans or animals.
0 Open defecation	No toilet; open defecation.

Outcome indicator 1 measures the presence and quality of a toilet within the household.

In the DFID-funded **SSH4A Results Programme**, progress in access to a toilet (outcome indicator 1) is counted from '1A Unimproved' level. For outcome indicators 2 and 3, households that reach level 2 'Functional toilet' and 'HWWS, with potential contamination' signify an improvement, respectively.

OUTCOME INDICATOR 2.

Progress in hygienic use and maintenance of a toilet

Indicator level	Description
4 Functional, clean and private toilet	Toilet used for its intended purpose. Functional water or seal cover (not blocked). No faecal smears on premises. Walls and doors in place. Cleansing materials and water available. Privacy assured (door can be closed and locked).
3 Functional and clean toilet	Toilet used for its intended purpose. Functional water or seal cover (not blocked). No faecal smears on premises. Walls and doors in place. Cleansing materials and water available.
2 Functional toilet	Toilet used for its intended purpose. Functional water seal or cover (not blocked).
1 Toilet in use as a toilet	Toilet used for its intended purpose.
0 No toilet/toilet not in use	No toilet on premises, or toilet not used for its intended purpose.

Outcome indicator 2 measures the general cleanliness and maintenance of a toilet within the household.

OUTCOME INDICATOR 3.

Progress in access to a handwashing facility with soap near toilet

Indicator level	Description
4 HWWS, with permanent water	Handwashing with soap within accessible distance. Hands do not touch water source. Permanent water available (running water, or handwashing at well).
3 HWWS, with no contamination	Handwashing with soap within accessible distance. Water container covered properly, with no risk of contamination. Hands do not touch water source.
2 HWWS, with potential contamination	Handwashing with soap within accessible distance. Water container not covered and easily contaminated when hands touch water source.
1 Handwashing with no soap	Handwashing station within accessible distance. No soap.
0 No HWWS	No handwashing station within accessible distance.

Outcome indicator 3 is measured by proxy – the presence of a handwashing station within an accessible distance of a household's toilet – rather than the behaviour of handwashing itself. A proxy indicator is used because questions about behaviour can prompt 'socially desirable' answers that do not reflect actual practice. Accurate measurement at household level is difficult.

The use of soap is considered more essential than the availability of permanent water. A handwashing station with permanent water, but with no soap is scaled down to Level 1, below the acceptable benchmark.

For more information

Fanuel Nyaboro | SSH4A RP Programme Leader in Kenya

✉ fnyaboro@snv.org