Editors’ Note

June is here and our ODF 2013 target is only 6 months away. Great strides have been made and the Government together with partners are doubling their efforts towards the campaign.

In this edition, there are articles on various initiatives by partners contributing towards improving sanitation in Kenya. We have stories from Kwale, Turkana and Pokot that provide insights into great strides made over the past few months!

You will also find out: what the century-old APHOK is up to in promoting professionalism in WASH; how MoPHS is courting the corporate world to enhance campaigns on WASH; stories on corporate, urban sanitation and urban interventions in sanitation highlights from the WASHWATCH website on Kenya’s performance against other Eastern Africa countries; JMP report 2013; and highlights of the ICC 3rd Quarter meeting held in Naivasha in March 2013.

It would also interest the reader to note that we now have our newsletters uploaded on the international CLTS website that is hosted by the Institute of Development Studies (IDS) in the UK: www.communityledtotalsanitation.org

For enquiries about the SSHIT newsletter- more information, contribution of articles, request for soft copies- contact the editor through; cltskenyahub@yahoo.com.

Ms Elizabeth Wamera – Knowledge Management Officer – MOH-DEH/HUB

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It gives me great pleasure to welcome you to our 2013 second quarter edition of the S.S.H.I.T Newsletter. We are proud of the achievements that have been made through our valued partners and stakeholders and these have been captured well in this edition.

I would like to extend a special welcome to our newly appointed Cabinet Secretary to the Ministry of Health, Mr. James Wainana Macharia. We look forward to benefiting as the department of environmental health on his vast experience by driving the sector in partnerships and networking with partners in achieving the set out goals.

I wish to reiterate, that the Government is committed to ensuring that its citizens have universal access to improved sanitation. My department endeavors to fulfill its obligations, including those outlined in the commitments made during the eThekwini declaration, subsequent High Level Meetings and the AfricaSan.

As we progress with the implementation of Community Led Total Sanitation (CLTS) in rural Kenya, our efforts and resources are focused beyond the attainment of Open Defecation Free (ODF). In our sanitation marketing initiative, we aim at increasing access to modern sanitation facilities both in the rural and urban areas. We also appreciate the new initiatives aimed at improving access to sanitation among the urban poor. We believe that Kenya can get back on track in attaining the MDG target for sanitation and with your continued support we can achieve it!

In addition, we recognize that Kenya has great potential to become the learning hub for other countries in the world. We are already leading in Eastern Africa, according to a WASHWATCH article (WASHWatch.org), and this should inspire us to increase our implementation momentum.

I wish to thank all those who have made contributions to this edition and welcome our valued partners to make this newsletter a priority avenue for sharing their experiences, progress and learning.

Thank you all and I hope you enjoy reading this edition!

Dr. Kepha Ombacho PhD, MBS,
Chief Public Health Officer,
Ministry of Health
Mr. James Wainaina Macharia was born in 1959. He was top in class for both “O” levels and “A” Levels (Kagumo High School, Nyeri). He attained a B. Com (Hons) University of Nairobi in 1983. On merit, he was selected by Deloitte & Touche to train as a Chartered Accountant in London, UK. Mr. Macharia is also a qualified CPA(K).

Mr. Macharia attained an MBA Degree on Strategic Management from Henley Management College, UK in 1996.

He joined Standard Chartered Bank in 1989, rising to become Financial Controller in 1994. Thereafter, he worked in Zambia as Managing Director, African Banking Corporation, and later transferred to Tanzania in the same position.

Mr. Macharia has been Group Managing Director with NIC Bank from 2005 to early 2013, when the Bank grew more than tenfold and with five subsidiary companies including Tanzania and Uganda.

He was appointed by the President of the Republic of Kenya, His Excellency Mr. Uhuru Kenyatta and Sworn in on the 15th May 2013, as the Cabinet Secretary to the Ministry of Health.
The WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation is the official United Nations mechanism tasked with monitoring progress towards the implementation of MDG 7, target 7c, which is to: “Halve, by 2015, the proportion of people without sustainable access to safe drinking-water and basic sanitation”.

Access to safe drinking-water and basic sanitation is measured by the MDG indicators:

- Proportion of population using an improved drinking-water source; and
- Proportion of population using an improved sanitation facility.

This article provides highlights on sanitation provided by the JMP 2013 update- which presents country, regional and global estimates for the year 2011. Since the JMP 2012 update, which presented 2010 estimates, results of 230 surveys have been added to the JMP database, bringing the total number of surveys in the JMP database close to 1700. As is to be expected from an annual update, the global estimates have hardly changed.

The highlights include:

- The world remains off track to meet the Millennium Development Goal (MDG) sanitation target, which requires reducing the proportion of people without access from 51% in 1990, to 25% by 2015.
- By the end of 2011, there were 2.5 billion people who still did not use an improved sanitation facility.
- The number of people practicing open defecation decreased to a little over 1 billion, but this still represents 15% of the global population.
- Sanitation coverage in 2011 was 64%.
- The world remains way below target in meeting the MDG sanitation target of 75% and if current trends continue, it is set to miss the target by more than half a billion people.
- By the end of 2011, there were 2.5 billion people who lacked access to an improved sanitation facility. Of these, 761 million use public or shared sanitation facilities and another 693. million use facilities that do not meet minimum standards of hygiene (unimproved sanitation facilities). The remaining 1 billion (15% of the world population) still practice open defecation. The majority (71%) of those without sanitation live in rural areas, where 90% of all open defecation takes place.
- Open defecation rates declined globally from 24% in 1990 to 15% in 2011.
- Only in sub-Saharan Africa is the number of people defecating in the open still increasing.
- In March 2013, the Deputy Secretary-General of the United Nations called upon the world to increase global efforts to accelerate progress towards the MDG sanitation target, which is among the targets for which progress has fallen furthest behind.
- In particular, he called upon governments, civil society, the private sector and UN agencies to pull together and help end the practice of open defecation by the year 2025.

The WHO/UNICEF JMP-led technical process on the formulation of post-2015 WASH targets and indicators which are hereby outlined;

**Target 1:** By 2025, no one practices open defecation and inequalities in the practice of open defecation have been progressively eliminated.

**Target 2:** By 2030, everyone uses a basic drinking water supply and hand washing facilities when at home, all schools and health centers provide all users with basic drinking-water supply and adequate sanitation, hand washing facilities and menstrual hygiene facilities and inequalities in access to each of these services have been progressively eliminated.

**Target 3:** By 2040, everyone uses adequate sanitation when at home; the proportion of the population not using an intermediate drinking water supply service at home has been reduced by Half; the excreta from at least half of schools, health centers and households with adequate sanitation are safely managed and inequalities in access to each of these services have been progressively reduced.

**Target 4:** All drinking-water supply, sanitation and hygiene services are delivered in a progressively affordable, accountable and environmentally sustainable manner.

**Kenya:**

Currently in Kenya, the Country population estimates stand at 41,600,000 and the table below presents the estimates on sanitation. (Table)

JMP also considers shared facilities as unimproved; this pushes the number of Kenyans without access to improved sanitation higher. With less than three years to go, a final push is needed to meet the MDG sanitation target. This requires providing around 1 billion people with access to sanitation – a daunting task that can only be accomplished through the concerted efforts of all partners and stakeholders.

For more information go to; www.wssinfo.org

Ms Lilian Mbehi is a Sanitation Marketing Officer - MOPHS-DEH/HUB
Training: Capacity Building for CLTS takes root
by Ms. Janet Mule

Kenya has had varied experience in Community Led Total Sanitation (CLTS) since its introduction in 2007. Capacity building of CLTS practitioners is one of the specific objectives in the ODF roadmap, which was drawn in May 2011 by the Department of Environmental Health in the Ministry of Public Health & Sanitation, in collaboration with WASH sector partners. The road map set up a campaign that seeks to have Kenya Open Defecation Free (ODF) by December 2013.

Requisite facilitation and monitoring capacities at the various levels of Government are therefore critical resources to achieve the campaign goal. The country-wide scaling up of capacity-building for CLTS in the ODF road map indicates that it will require:

- Training of 3,000 Public Health Technicians and Public Health Officers (PHTs/PHOs) and some 500 NGO staff as CLTS facilitators;
- Training of 500 community consultants/natural leaders;
- Training of 100 MOPHS and County Government M&E staff.

Against this backdrop, the Department of Environmental Health and Sanitation has identified and trained fifty Master trainers, who are qualified to train staff from both the Ministry and NGOs/CBOs on CLTS. These are officers who have a track record in implementation of CLTS in various regions in the country.

The Chief Public Health Officer assigns duties to the Master trainers, to carry out all CLTS workshops in the country, with specific jurisdictions of scaling up CLST training across the country.

Further, there is an approved National CLTS Facilitators’ Training manual and Trainers’ notes developed by the Ministry in partnership with WASH stakeholders. Each newly trained CLTS practitioner is expected to have access to these documents in order to enhance their skills in a bid to implement CLTS and produce the desired results.

The Ministry in collaboration with the WASH partners has so far conducted over 30 CLTS facilitator’s trainings. A total of 600 PHTs and PHOs have been trained.

The CLTS Hub, based in the Ministry’s headquarters carries out the capacity-building coordination role. The Hub acknowledges the support provided in various forms by WASH sector partners, among others; UNICEF, Plan Kenya, AMREF, World Vision, FHI 360, APHIA+ and WSP. Finally, the training reports that partners produce and share with the Hub are invaluable sources for monitoring and evaluation of progress against the set targets, as well as developing new approaches for achieving the set and goals of CLTS.

Ms Janet Mule is the CLTS National Coordinator – MOPHS-DEH/Hub
There is a water and sanitation crisis. Across the world nearly 900 million people do not have access to safe water and 2.6 billion people live without adequate sanitation. It is a silent crisis, because it affects primarily those who have the least power to speak up: women, children, and those living in extreme poverty. Every year, 1.4 million children die from diarrhoea directly caused by unsafe water and poor sanitation, and hundreds of millions miss school as a result of being ill. Adults also miss work through illnesses and women are forced to spend hours ferrying water back from far-away wells— which often contain unsafe water. Improving access to water, sanitation and hygiene is crucial for human and economic development.

To ensure accountability, it is crucial to track whether governments are honouring political commitments made at events like SACOSAN and AfricaSan. WASHwatch.org makes this easy to do, in real time, and in a collaborative way. Anyone can add analysis, leave comments, and more.

It is not easy to assess whether governments are meeting their policy commitments on water supply, sanitation and hygiene (WASH). It is also often difficult to find out how much governments are budgeting for these services. WASHwatch.org aims to help address this gap.

WASHwatch.org is an online platform for monitoring government commitments and financing in a collaborative way. The criteria for analysis are objective and transparent, and therefore comparable across countries.

In early 2008, many African Ministers signed the eThekwini declaration on sanitation, and the Sharm El-Sheikh declaration on water and sanitation. Ministers in Africa have held several conferences on sanitation over the past few years, and each has made specific commitments. Who is checking whether these governments are sticking to what they promised? There have been efforts to do this, but they have been sporadic and confined to short documents without much explanation. By taking these monitoring efforts online, WASHwatch.org can ensure that anyone can view it at any time, and that the analysis is up to date and transparent.

Many of the political declarations mentioned above contain commitments to increase the funds available for WASH, but it is hard to follow up on their implementation. Some governments are doing as promised, but wading through the national budget can be a daunting task. They can be many hundreds of pages long, and confusing for even for a seasoned analyst.

Even then, it is necessary to perform calculations to see if the WASH budget is changing as a proportion of overall government expenditure. In many countries, it is hard even to get hold of the budget data at all. WASHwatch.org aims to get the key bits of information online in an accessible format, so that anybody can understand it, download it, and communicate it. Figures are taken directly from the national budget so there can be no confusion about what is being counted.

WASHwatch.org is a collaborative initiative. All 33 CSOs with knowledge of the WASH sector are invited to contribute information about their country. WASHwatch.org was set up by WaterAid but it aims to be a broad-based civil society initiative.

Sanitation Policy (Monitoring the eThekwini declaration)

The pie chart below indicates the country progress on delivering the eThekwini declaration according to reported information from various Eastern African Countries. Note that Kenya is among the leading countries in delivering the sanitation policy and meeting its commitments made during the AfricaSan.

A snapshot Sanitation Progress in Eastern Africa

There are a number of ways to measure the proportion of people that have access to sanitation and water in a country. Governments often use a combination of management information systems and household surveys.

The official data which the UN uses to monitor progress on the Millennium Development Goals (MDGs) comes from the WHO / UNICEF Joint Monitoring Programme (JMP). JMP aggregates data from household surveys carried out by governments. WASHwatch.org shows JMP data because it is comparable across countries and uses the MDG definitions of access to sanitation and water. Some Governments prefer to quote the latest data from their household surveys; the best source of this information is the national statistics bureau or its equivalent.

If you want to be involved in the future development of WASHwatch, please email washwatch@gmail.com.

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Ms. Elizabeth Wamera – Knowledge Management Officer – MOH-DEH/HUB
AFRICASAN East Africa Regional Meeting
By Ms. Janet Mule

The AfricaSan East Africa regional meeting was held in Addis Ababa from 11-14 April, 2013. In attendance were delegates from Uganda, Tanzania, Rwanda, Burundi, Djibouti, South Sudan, Somalia, Kenya and hosts Ethiopia.

The objectives of the meeting included reviewing sanitation action plans, and monitoring progress of the e-Thekwini declaration, among others.

Some of the key lessons in this meeting included:

**Capacity building:**
- To attain high and sustainable outputs; institutionalization of training of CLTS in learning institutions
- For quality control; standardization of training materials is key to high quality trainings
- Optimum capacity building; can be attained by identifying relevant beneficiaries based on felt needs for the trainings of CLTS.
- Capacity building should be linked to deliverables with proper feedback mechanism established.

**Financing for sanitation by governments:**
Getting government ministries to document commitment on increasing financing for sanitation would increase in achievements. This has been witnessed in some countries like Uganda where a Memorandum Of Understanding (MOU) was signed between Ministry of Health, Ministry of Water Irrigation and Ministry of Education, with each ministry committing some percentage of money to sanitation.

**WASH Sector:**
Cross sector integration – Kenya is a good example of sector coordination whereby there is an Interagency Coordinating Committee (ICC) which brings on board Ministries of Water, Public Health & Sanitation and Education, the civil society and media in planning and implementing as the WASH sector, leading to great achievements in the sector.

**Vulnerable Groups:**
It has been learnt that uniformity of approaches could lead to exclusion of some groups, unless consideration is made to such realities, such as access to latrines for the physically disabled, minority groups, children, HIV patients and pregnant women. Prioritizing of vulnerable groups needs during programming would ensure inclusion in planning and implementation. One of the critical steps identified toward inclusion is availability of data on the vulnerable groups.

**Monitoring and evaluation system**
Some critical lessons drawn from monitoring and evaluation systems include:
- Standardization of indicators is important at all levels.
- There should be specific focal persons for Monitoring and evaluation at all levels.
- Monitoring and evaluation officers should have the relevant capacities required, if not, their capacities should be built.
- Any monitoring system should have baselines.
- Definition of indicators should be harmonized and agreed upon by all stakeholders.
- Those who collect data should understand the process and importance of the data collected.

**Next Steps:**
Member countries were assigned specific actions for follow up and reporting on progress from the meeting. For Kenya, the following were raised:

**Short-term**
Harmonize eThekwini and High Level Meeting commitments (HLM). This is scheduled to happen in the next three months (April – June 2013) and will be coordinated by the Deputy Chief of Public Health – Dr. John Kariuki.

**Long-term**
Develop a tool to capture vulnerable and marginalized person’s data. This is scheduled to take place in the next six months coordinated by the Monitoring and Evaluation officer at the Hub – Mr. Benjamin Murkomen.
The CLTS Story in Kanu Village in Kwale County
by Ms. Redempta Muendo & Mr. Vincent Mosomi

It only took ten days for Kanu village in Kwale County to attain ODF through the CLTS approach. That is how simple concerted community-participatory efforts by stakeholders can lead to success.

Kanu village is in Kwale County, Matuga sub-county. It is among the 18 villages forming Tiwi location. The village has 84 households and is served by 4 CHWS. The village is among the four villages forming Mwachema Community Unit and linked to Tiwi Health Facility.

Planning before triggering;
The MoPHS and PLAN international had conducted sensitization training to CHWS in community the units before triggering was done.

After the sensitization meeting, the CHWS, with the help of the Public health staff, were asked to carry out a baseline survey to identify a village that has few households without latrines. The premise was to trigger that village and attain ODF in the shortest time possible so that it could act as a ‘CLTS Model village’ in Tiwi location. This model village would then be a reference point for triggering the rest of the villages.

The tasks to be accomplished in the process of attaining an ODF included:

- Carrying out a baseline survey to identify the number of latrines in villages forming Mwachema Community Unit
- Triggering a village that was to achieve ODF in the shortest time possible.
- Consolidating efforts between the Community Unit CHWS and the community members of the triggered village.
- Follow ups and Behavior Change Communication

Baseline survey;
After carrying out the baseline survey of the 4 villages-Mwachema, Mbohweni, Manunduni and Kanu that form Mwachema Community Unit, it was identified that Kanu village had the least number of households lacking latrines. The names of household heads were first registered. Of the 84 households, 18 were identified as lacking latrines Thus Kanu as the village for carrying out an ODF through CSLT in the shortest time possible. It thus came to an agreement between the CHWS and the Public Health Staff that Kanu village would be triggered.

Triggering;
On 3rd Oct, 2012, a group of public health staff triggered Kanu village-members of the community, administrative staff, and all CHWS from Mwachema Community Unit were in attendance. After the demonstration, some community members admitted that they had been unknowingly been eating their feces.

An elderly woman retorted, “Wakati uchinya vuweni, ni mtswano sana lakini nagundua kunya ndani ya choo ni bora zaidi”, meaning “it feels so sweet when defecating outside the latrine , but today I have known the pain and disgust it causes!”, sending fellow villagers into uncontrollable laughter.

After the triggering exercise, a village CLTS committee comprising 5 members was formed. Supported by the CHWS, the team was tasked with spearheading the rest of the process to its decisive conclusion – mainly to ensure ODF was attained by the 15th of October, eleven days
after the triggering.

Mweria Drive

After triggering, the CHWS sub-divided themselves into groups of two-to-three people. These groups, working closely with the family members who lacked latrines, came up with a work schedule as follows.

**Success Factors**

The success of the ODF was attributed to a number of factors. First, Most of the CHWS, even from the neighbouring villages, agreed to participate in the mweria drive—social support that was motivating to the community members. Secondly, there was support from the local administration. Immediate follow-up by the public health staff, after the triggering, helped sustain the high momentum. Also, those who completed their latrines on time went ahead to improve them by, for example, cementing the floor.

**Overcoming challenges**

There were challenges to this end too. For example, some CHWS did not honor some commitments to the initial work plan, thus leaving the burden to other CHWS; some households could not complete the installation of the superstructure even after being assisted in placing the floor slab. Since it was during a rainy season, some pits collapsed due to wet ground, leaving some community members disillusioned. However the public health staff through CHWS maintained steady support and encouragement to the community.

Some community members were upset during the implementation period following the triggering where public health staff publicly depicted them as eating their faecal matter.

“Wanabananga sana kuonyesha atu mavi genhu” meaning “you did the worst thing exposing our faecal matter to the public during the triggering day.” One of the disgruntled community members decried.

**Current status of the village, May 2013;**

This is the leading village in Tiwi location with latrine coverage 92%. The shortfall is attributed to seven incomplete latrines, albeit their construction is on-going. All said and done, Kanu village has won the accolade of almost becoming the first CLTS model village and a reference point for neighbouring villages, with the project improving the health standards of the community.

Ms Redempta Muendo is the CoPHO, Kwale County & Mr. Vincent Mosomi is Div. PHO, Tiwi Location

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**Day 1-6:** pegging and digging of a pit of a minimum 10 feet

**Day 7:** day-constructing the floor of the dug pit with locally available materials

**Day 8:** erecting the superstructure i.e. walling and roofing using locally available materials.

**Day 9-10** installing Leakey tins and posting information in the bushes to stop defecating there and BCC.

**Day 11:** Commissioning of the ODF.
True Kenya! the Turkana Story
by Ms. Elizabeth Wamera – Knowledge Management Officer – MOH- DEH/Hub

The implementation of CLTS is set to change the face of health and sanitation in Turkana County. A concerted effort has been hyped in the sanitation campaign – ODF 2013, improving CLTS from the reported 37% latrine coverage to an impressive 75% latrine use. CLTS has also contributed significantly to the improvement of the living standards of the communities against a backdrop of poor education, morbidity, access to health facilities and food insecurity.

Turkana County is located on the North Rift part of Kenya. It comprises five districts; namely Turkana Central, Turkana South, Turkana North, Turkana East and Loima. It covers an area of 77,000 km2 with a population of 895,800 people (KNBS 2011). The population density is 12 persons/km2. Open defecation stands at 96% with a latrine coverage at 37% by March 2013 (MOPHS 2013).

Main causes of morbidity are hygiene and sanitation-related diseases with children under 5 years and women being the most affected. Only 1% of the children’s faeces are disposed in latrines.

There is frequent cholera outbreak due to prolonged drought and flooding when it rains.

Unknown to many, is that the Turkana are a very proud lot, they are specific to their way of life, evident in the way they build their houses and how their homes are organized. They actually refer to themselves as “TRUE KENYAN!” with so much pride!

Since the inception of CLTS in 2010, there have been various activities that have been going on. Sixty villages that have been triggered with positive progress noted, despite challenges of attaining ODF. There are 13 villages that are ODF and awaiting 3rd party verification. These villages include Lolupe, Nayuu, Natotol, Loloturerei, and Hinrey.

Due to the low literacy rate in Turkana that stands at 36%, the CLTS approach is best understood in this community as it targets to use the most available local resources to trigger the community
A lady in Nayuu showing off her latrine

Disease incidence in Turkana between 2004 – 2009

into action. Below is an illustration used by the office of the County Public Health Officer in discussing the sanitation ladder during triggering.

The Turkana were very upset on learning that they eat their faeces during triggering! Faeces in Turkana dialect is referred to as NG’ACHIN! This led to the emergence of very strong natural leaders, such as Cathrine Ajikon in Turkana Central. She has carried out door-to-door and public campaigns through churches, barazas and women groupings in an effort to eradicate open defecation, as well as promoting construction and use of latrines.

As concerted effort hyped in the sanitation campaign – ODF 2013, the County Public Health Officer Mr. Innocent Sifuna has set out to re-focus the sanitation practitioner’s contribution towards CLTS to attain the ODF status, improving from the reported 37% latrine coverage to an impressive 75% latrine use.

There is evidence that the situation is improving progressively, with the table below indicating disease trends since 2004 – 2009, however, then, the diarrhea cases kept on swinging with no definite reduction which has benefited from the onset of CLTS with a reported decrease of diarrheal cases.

To have a better understanding of Turkana and share more of the stories on the work of the WASH sector, contact the County Public Health Officer –

Mr. Sifuna on innocentmunyefu@gmail.com

Ms Elizabeth Wamera – Knowledge Management Officer – MOH-DEH/ HUB
Sanctions that gave birth to an ODF village: A field story from West Pokot

by Ms. Debra Katina – Coordinator

Gladys Cheplekee, a 56-year old mother of five is a Community Health Worker (CHW) in Chepareria in West Pokot. Gladys attended Chepareria mixed primary school and later joined Chepareria girls’ secondary school up to form two, when she dropped out and got married. She was a very active member of Akiriamet community, which resulted in her with four other women- being appointed CHWs for the Akiriamet village.

The five CHWs decided to construct toilets themselves before they asked others to do so, following the triggering of their village by Yang’at CBO in 2011. Then they visited all local churches around the community, mobilizing a community meeting that resulted in triggering the whole community.

During the community triggering meeting, discussions centred on the importance of building latrines. The meeting resolved to construct one pit latrine for every homestead within one month.

One month after, not a single pit latrine had been put up. Unfortunately, briefly afterwards there was a cholera outbreak. The CHWs re-convened a similar meeting during which, they convinced the community that the outbreak would have been avoided had it stuck to the initial commitment of one pit latrine per homestead. It was stressed during the meeting that the cholera broke out and spread to the villages due to open defecation.

The community was scared that the situation would escalate if the CLTS was not implemented. This second meeting yielded in a few pit latrines being constructed, though the villagers complained that it was expensive to put them up. A resolution was passed to sanction every homestead to construct one.

To reinforce this, a new approach was adopted. The community relies on each other’s support to educate their children and most times hold fund raising meetings to raise funds for school fees. Fundraisers are held at least in every homestead, and the CHWs felt that it would be very strategic to design a community sanction touching on this, as this was one of the major social events in the community that brought together many community members. With the help of the local administration, the community agreeably with CHWS sanctioned every homestead that wanted to hold a fundraiser to have a latrine in place before a permit for the function was issued.

The CHWS also took it upon themselves to advocate for the same using the slogan; “If you don’t have a latrine, where will your visitors go after eating your food during the fundraiser?” The village elders, local administrators and the CHWs ensured that this sanction was adhered to and for any fundraising gathering, issues of latrine construction and usage were openly discussed in order to lead to an ODF village. Since the advocacy, this village has not faced any Cholera outbreak.

Cheplekee thinks that CLTS is the most effective method of ensuring that the community stays ODF, as it brings a clear connection of practicing open defecation and sickness from ingesting feces. She thanks the Ministry of Public Health, Yang’a and the local administration for ensuring that Akiriamet village is ODF now!

Ms Debra Katina is the Coordinator, Yang’a Community Development Organization

“Yang’a Community Development Organization, an indigenous Community Based Organization (CBO), is one entity that targets to transform access to clean water and improve sanitation for about 100,000 livelihoods in Pokot County in Kenya and Amudat County in Uganda by 2014. It also creates awareness and carries out training on sanitation and safe drinking water, using PHAST and CLTS in 10 new locations every year.”
The 3rd quarter Inter-Ministerial Coordination Committee (ICC) Meeting Held in Naivasha
by Ms. Elizabeth Wamera – Knowledge Management Officer – MOPHS- DEH/Hub

The 3rd quarter ICC was hosted by the Ministry of Public Health & Sanitation (MOPHS) Department of Environmental Health in collaboration with the World Bank – Water Sanitation Program (WSP-AF), on March 2013, in Naivasha. It was well attended by various ministry representatives and WASH sector partners. The meeting was officially opened by the Chief of Public Health – Dr. Kepha Ombacho and closing remarks were made by UNICEF – WASH section representative - Eng. Fredrick Donde.

There was an attendance of 80 participants in the two day meeting that involved sessions on progress updates in the sector, innovations and best practices developed. A field learning visit day was conducted in which the participants visited various areas based on specific learning themes. These included visits to a flower farm (Health care waste management), school (WASH in schools), hospital (Health care waste management), and a community (Sanitation – CLTS) around Naivasha.

The 4th ICC is scheduled for June 20th 2013, and will be held in Coast supported by the Ministry of Health and FHI360.

For more information about becoming a member of the WASH Sector, TWG or ICC or participating in the ICC write to: cltskenyahub@yahoo.com

Ms Elizabeth Wamera – Knowledge Management Officer – MOH-DEH/HUB
Field learning at the flower farm

Field learning at the hospital

Author in the field

DO Naivasha briefing a team during the field learning visit

Field learning at the field

Inter-Ministerial Coordination Committee (ICC) group
An Innovative Approach to Sustainable Sanitation in Urban Slums: Sanergy
by Mr. Joseph Githinji

Agnes Kwamboka, a resident of Mukuru Kwa Ruben, grew up brewing chang’aa (a local hard brew), an activity that she was already fed up with by the time she was a young adult.

Not only was she harassed by local authorities and coerced to give bribes, but she was also constantly harassed by her clients, sometimes treating her like a prostitute. One day after a reflection of her past and what the future held for her in that business, and her social and economic contribution to her community, she decided to throw in the towel. She quit!

She toyed with the best idea of transforming her community into a healthy, clean and prosperous community. As she was soul-searching, a business idea crossed her mind - Fresh Life Operator!

Today, Agnes runs three Fresh Life Toilets, earns a good income for her and her family, and is becoming a powerful voice for transformative change in her community. Agnes is part of a revolution of 100 entrepreneurs in her community who are now running a network of 177 sanitation facilities that serve 8,000 people every day with hygienic sanitation close to where they are living.

Some 8 million people in the slums of Kenya, including 500,000 people in Mukuru, lack access to adequate sanitation. The resulting diarrheal disease kills 27,000 children in Kenya each year. The high population density, lack of basic water and sewage infrastructure, and scarce resources makes the problem particularly acute in slums, where 75% of Nairobi’s population lives on just 5% of its land. In Kenya, 80% of slum residents currently pay up to 5Ksh per use for unhygienic and inaccessible sanitation options.

Sanergy and its network of entrepreneurs such as Agnes provide accessible, affordable, and hygienic sanitation in urban slums for everyone. “Solving the sanitation crisis requires more than just building toilets,” says Joseph Githinji, Sanergy Marketing and Branding Manager. “Sanergy takes an innovative systems-based approach to build out the entire sanitation value chain,” he adds. He outlines its sustainable
sanitation cycle, featuring three major parts:

1. **Franchise** – Throughout the slums, we build a network of Fresh Life Operators – local residents who purchase and operate our hygienic sanitation facilities as small businesses. In addition to installing a low-cost, high-quality sanitation facility, we provide ongoing operational, marketing and business support.

2. **Collect** – We ensure that the waste is collected on a daily basis and that Fresh Life Operators receive clean empty ones daily. The waste is safely removed from the community.

3. **Treat** – We treat the waste by converting it into a variety of useful by-products, such as organic fertilizer and renewable energy. 100% of the waste is safely treated. Sanergy, therefore, makes it sustainable to provide sanitation services in the slums. At each step, we create jobs and opportunity, while simultaneously addressing serious social, environmental and economic needs.

For more information contact us on; info@saner.gy

Mr. Joseph Githinji is the Sanergy Marketing and Branding Manager
Jigger infestation is a shameful problem that is not unique to Kenya. Neither is it only a central province issue as erroneously considered by many. There are about 1.4-1.6 million Kenyans suffering from jigger infestation. This number evidently depicts a national problem, considering that some city residents in Nairobi County are also affected including areas such as Kamukunji, Dagoreti and Githogoro near Runda among others. The major cause of jigger infestation is poor hygiene conditions.

The first evidence of infestation by jiggers or sand flea is a tiny black dot on the skin at the point of penetration. Because the flea is a poor jumper, most lesions occur on the feet, often on the soles, the toe webs, and around or under the toenails. It is the impregnated female jigger, scientifically referred to as Tunga penetrans, that embeds itself in the skin under the toenails and fingernails of humans - where the resultant sores may fill with pus and become infected. A small, inflammatory papule with a central black dot forms early. Within the next few weeks, the papule slowly enlarges into a white, pea-sized nodule with well-defined borders of 4-10mm in diameter. This lesion can range from asymptomatic to pruritic to extremely painful. Multiple/severe infestations may result in a cluster of nodules with a honeycomb appearance.

Heavy infestations may lead to severe inflammation, ulceration, and fibrosis. Lymphangitis, gangrene, sepsis, the loss of toenails, auto amputation of the digits, and death may also occur. In most cases, however, this lesion heals without further complications. Nonetheless, the risk of secondary infection is high. Tetanus is a common secondary infection that has reported associations with death.

Preventive measures;

The prime preventive measure of the jigger is observing cleanliness. Wearing of shoes should also be encouraged to ensure that the flea does not find entry into one's feet. In infested areas, people should check their feet daily for freshly burrowing jiggers, which are visible as minute black spots and cause an itchy sensation.

The fleas may also be deterred by a repellent applied to the skin, although walking barefoot in dirt quickly removes it. If it is possible to identify grounds where jiggers originate, it could be burnt off or sprayed with a suitable insecticide in an effort to kill the fleas.

For a complete eradication of the bug, the homes should be thoroughly fumigated and any animals that also have the fleas treated. To ensure that the home is bug free, the victim and the rest of the family have to be educated on the need to observe hygiene and ensure that the bugs do not find a home in their homes again.

John Mwangi Ragui is a senior Pastor with the Holy Redeemer Ministry Ruiru District Kiambu County and was the head of the research team that developed the jigger remedy and currently the contact person at Ninave Anti Jiggers Movement International.

God Bless You All and God Bless Kenya!

Ninave anti - Jigger Movement International is an indigenous NGO that aims to restore dignity to jigger-infested people in Kenya and beyond. The organization was born out of intense research by a corporate organization, in partnership with Kenyatta University’s department of Complementary Medicine of Health Science, which came up with a jigger remedy. The products were tested and passed by Kenya Bureau of Standard (KBS) in 2010. They were used in Gatanga, Teso North and Teso South districts and recorded positive results, and consequently approved by the District Public Health Officers.
Over 3 million people in Nakuru are drinking fluoride-free water thanks to the Catholic Diocese of Nakuru. This has been made possible through sale of 4,000 household filters, construction of 120 community water de-flouridation plants, and 80 institutional filters, distributed through individual households, CBOs, NGOs, private institutions and government agencies.

Flourosis is a chronic menace affecting a large population worldwide. It is associated with the ingestion of high levels of fluoride ion in the diet. In Kenya, the major source of the ion is thought to be from drinking water, especially in those regions of the country associated with volcanic rocks and hot springs.

Other important sources of fluoride include food and drinks, as well as dust in some of the lake regions. In Nakuru and other parts of the Rift Valley, cases of dental and skeletal flourosis are evident with many having browned teeth and weak bones. Apart from Nakuru being in a volcanic region, the dust in the area has been shown to have concentrations of fluoride of between 2800 and 5600 ppm. Consequently, many boreholes have been shut due to high levels of fluoride.

It is against this backdrop that the Catholic Diocese of Nakuru sought to intervene by supplying corporate, NGO and CBO partners with de-flouridation plants to remove fluoride from water targeted at domestic consumption.

In 1998, CDN found that more than 70% of 350 boreholes drilled had high levels of fluoride exceeding the maximum allowed of 1.5 mg/L. This called for an urgent mitigation against the harmful effects of fluoride intake. As a result CDN introduced the Water Quality Programme (CDN WQP) and the first priority of this programme was to research, develop and implement an appropriate technology that would remove fluoride from water.

CDN partnered with the Danish organization MS KENYA that financed the research and development of the bonechar (BC) technology.

Later in 2003 the Belgium Technical Cooperation (BTC) funded initial research on the Nakuru Technology. The Nakuru Technology uses soluble calcium phosphate-based pellets combined with BC to increase the lifespan of the filters by above 5 times that of BC alone. Later in 2006, Miserior, a German based organization, funded implementation of the pilot projects.

In 2009 the Swiss Federal Institute of Aquatic Science and Technology (EAWAG) funded further research on the Contact Precipitation (CP) or Nakuru Technology.

In March 2011 CDN WQP founded the Nakuru De-flouridation Co. Ltd. (NDC), which took over bone
char research and implementation with a bright future in mind. The expected outcome was for the company to become sustainable and be able to carry out research and production of filter material alongside implementation.

The NDC has maintained national and international clientele, who range from private customers, water service providers, NGO’s, and neighboring East African countries. This has been necessitated by vigorous and new marketing strategies.

Currently the company has 12 staff members, 50% in the office and Managerial functions and another 50% in production and installation.

NDC is self-financing from the sales of the technology to its clients who are NGO’s working in water, sanitation, hygiene and health sectors, with no external funding from any partners or donors.

Company Plans

NDC is now focusing on full optimization of the Nakuru technology and is limited by several factors such as raw water concentrations, urban settings and population demands on water quantity.

The company still needs to find a solution to the provision of fluoride-free water to poor rural communities.

The company is seeking partnerships to reduce the cost of maintenance of the technology which tends to be unaffordable to the poor communities in fluorotic zones

Company achievements

• The program has been able to construct 120 community water Defluoridation plants, 80 institutional filters, and 4000 household filters have been sold. These have been installed in schools governed by different parishes both catholic and non catholic, government and private institutions, and also domestic individual households. The filters have benefited more than 3 million consumers who are now taking fluoride free water.

• Increased collaboration with other development partners e.g. Oxfam, WSUP, World Vision and GOK ministries.

• Increased optimization of the technology by carrying out research and development in collaboration with the Swiss Federal Institute of Aquatic Science and Technology (EAWAG).

• Offered technical expertise on the birth of a Defluoridation pilot project in Ethiopia in collaboration with Oromo Self Help Organization (OSHO).

Ms. Esther Wanja Mwangi is the Sales & Marketing Manager, Nakuru Defluoridation Company
Safe Community Water: LifeStraw Community pilot for schools and clinics in Western Kenya

by Ms. Tara Lundy

While much emphasis has been placed on ensuring households have access to safe water, an equally important gap that requires filling is community level institutions. In Kenya, only 37% of schools have safe water sources in the school yard or 200 meters from the school. In addition, clinics and other medical institutions also have an acute demand for safe water.

Study Overview

Vestergaard Frandsen has just completed a 3-month study of a new water purifying technology designed for community settings. The LifeStraw Community has a 50-litre capacity, with built-in safe storage and four taps. It removes all water-borne disease pathogens including viruses, bacteria and protozoa, and preventing illness such as diarrhea, typhoid, cholera and cryptosporidiosis.

The trial took place in Kakamega, Kenya, between November 2012 and January 2013. Three schools and four clinics were selected for the study and a total of 15 units were tested. The training was conducted on site with facility staff, and in schools, with designated school children from the health clubs or student leaders.

Unannounced follow-up visits were conducted at random to observe their use. Surveys were also administered to the caretakers. At the end of the study, 2 focus groups were held in order to gather further feedback about design and usability.

Snapshot of the Results

- 100% of schools filtered water on a daily basis for their pupils and 93% were able to demonstrate proper backwashing.
- 100% of respondents said the filter was easy to use and that, the water consumption had increased in the schools.
- A number of observations were also made during school visits - It was recommended that cups be provided alongside the filter and that proper tables to support the filters be identified.
- Based on observations of usage, capacity, filtration rate, crowding and behaviors during breaks, Vestergaard recommends a ratio of 50-75 students per filter.
- In the clinics, 75% of users said the taste and the appearance of the water had improved. 98% had filtered water for use that day, and 100% were able to demonstrate proper backwashing. 100% said they would recommend it for use by other clinics. Several of the clinics elected to place the filter in an ORT corner.
- All 4 clinics pre-made ORS solution with the filtered water and had it next to the filter.
- During the field test, slight modifications were made to the taps and some of the plastic components to increase usability and durability and are incorporated into the final design.

For more information about the LifeStraw Community filter and Vestergaard’s programming in Kenya, please contact Steve Otieno, SO@vestergaard-frandsen.com, +254733408520 or Tara Lundy, TAL@vestergaard-frandsen.com (+1-978-505-1159).

Ms Tara Lundy is the Concept Development Manager – Vestegaard Frandsen
The Safeguard Champions of Health Schools programme implemented by Procter and Gamble in conjunction with MoPHS and targeting school-going children, has had a tangible impact in promoting life-saving hygiene education, not only on children but to entire families in Kenya.

Procter and Gamble (P&G) are the makers of Pampers diapers, Always sanitary pads and Safeguard Anti-bacterial soap. Safeguard has for long partnered with the Ministry of Public Health and Sanitation (MoPHS) for the promotion of health and sanitation in Kenyan families.

A special programme was designed targeting school-going children through proven and effective School Programs. The programme which was executed in Coast, Nairobi, Nyanza, Central and Rift Valley regions reached over a million children.

P&G aims to teach proper hygienic practices to Kenyan families to a point where they can start co-relating between hygiene and hand washing. Last year, the campaign reached over 150 schools. Phase two of the programme has been concluded and an evaluation of its behavior-change is underway.

In the last year, Safeguard focused on promoting hygiene education in schools, as the brand recognized children as potential ‘change agents.’ By educating children through the Safeguard Champions of Health Schools programme about the importance of hand-washing with soap and good hygiene practices, the brand hoped that the children will adopt healthy habits early in life, with the capacity to influence their families and friends for many years to come; thus making children the ‘ultimate’ Champions of Health.

Through the Safeguard Champions of Health Schools Programme, children were taught that germs are everywhere- even on seemingly clean surfaces, and can be picked up through normal every day activities, such as playing.

Safeguard aims to be the champion of health and hygiene education and has sponsored a number of high profile public health and schools initiatives such as the Global Hand-washing Day. Success has come from credible third party partnerships with government bodies, international NGOs, local Medical Associations, and Civil Society groups. It has also been able to drive engagement with mothers.

Regionally, Safeguard has joined hands with the Africa Medical Association to create safe and hygienic communication infrastructure from the grassroots level.

Please visit http://www.pg.com for the latest news and in-depth information about P&G and its brands.

Ms Salome Mwaura is the External Relations Manager – Procter and Gamble, East Africa
Some 5,000 girls have consistently attended classes throughout the year in Western Kenya, Nyanza and Nairobi among others, thanks to I-Care sanitary pads. According to Afri-Can Trust, million of girls miss school on average 4 days every month due to lack of sanitary towels- one of the main causes of girls dropping out of school. Afri-Can Trust identified this easy-to-solve problem and decided to intervene and make a life-lasting impact in the lives of thousands of girls.

Afri-Can Trust began in the year 2006 as a volunteer project support vehicle based in the Netherlands. It was eventually registered as a trust in Kenya. Today the organization provides support and services to marginalized youth and women, including children and their families. Its assistance is designed to support individuals and their families through the different stages of development.

I-Care, a project started in 2011, is among several others that Afri-Can Trust implements.

Millions of girls miss 3-5 days of school every month during their monthly periods. This means that they miss 6 weeks of school every year. There is no money for sanitary towels and the cloths, blanket pieces, mattresses and other means that are used leak and are unsanitary. Shame keeps the girls from attending classes and as a result many of them drop out of school. This easy-to-solve problem is the biggest cause of eventual school drop-out.

I-Care pads exist to curb this problem through the production of high quality re-usable sanitary towels for the girls and women. The pads offer many advantages as it is durable (it can be used for a whole year!), hygiene friendly, affordable, environmental friendly, comfortable, it’s for women by women and it is all Kenyan made.

The product was developed in collaboration with Kenya Industrial Research and Development Institute (KIRDI), who played the role of carrying out a feasibility study, research on the product development and assessment of its impact to the girls and women. The process involved the end-users in giving their input and recommendations on the product design.

I-Care has a standardization mark from the Kenya Bureau of Standards (Lake Region) which means the pads are produced at I-Care centres.

The goal of I-Care is to empower the vulnerable girls and women through provision of re-usable pads and capacity building on menstrual hygiene management and reproductive health for improved performance and self-esteem. This is done through production and distribution of re-usable sanitary pads as well as ensuring provision of menstrual hygiene management education and facilities to girls in primary and secondary schools in Kenya. By acquiring knowledge on menstrual hygiene management, the overall health status of the girls are enhanced as myths and misconceptions that surround puberty and menstruation are demystified.
To date I-Care has reached more than 5,000 girls in Western Kenya, Nyanza, Nairobi and even distributed the pads to Uganda and Somalia. I-Care has worked with various partners who include amongst others Pamoja Foundation, FHI360, SANA International through the Football4WASH and HIRDA.

I-Cares’ dream is to provide the pads all over Kenya, so that girls and women don’t feel ashamed anymore but can step boldly into the dreams of their future.

For more information about I-Care Pads, contact us on; I-Care Pads, a business unit within Afri-Can Trust, Kondele – Migosi Junction, Along Kisumu - Kakamega Road. P.O. BOX 7139 – 40100, Kisumu, KENYA. Tel: +254 (0)712 337 244. Email: info@icarepads.com. Website: www.icarepads.com

Ms Chantal Cheutin is the Founder – AFRI-CAN TRUST
Around 2.6 billion people worldwide lack access to adequate sanitation and hygiene. The severe impact of this situation on human health is well documented: diarrhea is estimated to kill over 1.5 million children each year, and 88% per cent of these deaths are attributed to fecal contamination from inadequate sanitation, hygiene, and water supply.

Poor sanitation and hygiene are also closely associated with Acute Respiratory Infections (ARIs), the leading cause of death in children under the age of five.

Simple behaviours such as washing hands with soap can greatly reduce both diarrhea and ARIs.

Hand-washing with soap alone shows the greatest reduction in diarrhea morbidity (over 40%), and can also reduce respiratory tract infection by about one-third.

In January 2013, and as part of the MOPHS/WSP/IFC Sanitation Marketing program, a Product Design Consultant was brought on board to support the conduct of a research and product prototyping process for the design of a household hand-washing station in Kenya. The work focused on gaining in-depth insights into consumer needs and preferences to inform the design of a suitable hand-washing product.

The team developed 3 concepts, namely; Mrembo, Twiga and Karai.
1. Mrembo (The beautiful one): A wall mounted 10-litre unit with a built-in mirror.
2. Twiga (Giraffe): An intermediary piece to convert a 20-litre jerry-can into a hand-washing station. DIY stand if needed.
3. Karai (Sink): A water pump and plastic sink to convert a free-standing 20-litre jerry-can into a hand washing station.

Five locations were selected for the testing, based on water accessibility and availability; a mix of areas with good access, medium access, and poor access. These areas were; Rift Valley, Central, Nyanza, Eastern, and Nairobi, and the team sought to answer the following questions:

• How might we inspire people to adapt the hand washing behavior?
• How might we develop a low-cost yet durable product to be produced by local manufacturers?
• How might we assure the continuous use of the hand-washing station?

User testing of the prototypes took place in two different locations; Githunguri & Machakos. These two locations have different levels of water accessibility and were relatively close to Nairobi for a rapid evaluation. Following the initial deep-dive field research, the design team conducted a further round of prototyping and design refinements.

Not surprisingly, there was consensus in the field on Mrembo as the hand washing station of choice. They liked its functions, they were aware of its added value and they also liked it from an aesthetic point of view.

After some further design refinements based on the user feedback, the team is working on getting interested participating manufacturers to take it up – so you can expect to get more details soon on the final designs and next steps.

Ms Lewnida Sara is the Operations Analyst – WSP –AF - Kenya
Some communities are facing challenges in sustainability because the basic latrines constructed after triggering are collapsing (collapsing pits due to soil structure) or being swept away due to frequent floods. Still, a number of the latrines do not confer the full benefits of improved sanitation.

Sanitation marketing is started in communities that have attained ODF to enable them move up the sanitation ladder. The Ministry of Health with support from partners has carried out a formative research across the country with a view to developing an appropriate sanitation marketing strategy.

An outcome of this process will be to
• Inform the development of sanitation products that meet the needs and aspirations of low-income households in rural Kenya
• Present product options that meet consumer needs, specific to their most critical latrine improvement desires
• Initiate a social marketing campaign to increase demand for improved sanitation, and commercial marketing campaigns that increase demand for the sanitation products
• Strengthen the supply of products and services that meet demand for sanitation solutions. This includes engagement of private sector manufacturers, entrepreneurs and latrine providers in making the products affordable and available
• Making affordable financing options available for the rural communities interested in purchasing latrine improvements
• Strengthening policies that support the development of a thriving sanitation market without subsidy

The Joint Monitoring Program 2013 updates led by WHO/UNICEF estimate that, by end 2011, about 54% of rural Kenyans had access to unimproved sanitation, while a further 17% had no access to sanitation and practiced open defecation. Nationally, 57% use unimproved facilities, while OD is estimated at 14%.

From a purely business angle, this indicates the existence of a market of approximately 5.9million households in need of sanitation products and services. This presents an enormous market potential for private sector-manufacturers and supply channels.

For more information on Sanitation Marketing, contact; Ms. Mbeki on cltskenyahub@yahoo.com

Ms Lilian Mbeki is Sanitation Marketing Officer – MOPHS-DEH/HUB
The Association of Public Health Officers – Kenya (APHOK) is one of the century-old professional entities in Kenya. Started in 1901, its main objectives are; to promote the advancement and the diffusion of public health regarding hygiene, preventive medicine, health promotion and all matters pertaining to environmental health; to present the needs and views of its members to the authorities/council; to establish relations when and where desirable with public/environmental health bodies or organizations within or outside East Africa; and to formulate a code of professional conduct, among others.

APHOK is an association of public health officers, whose qualification for membership requires one to identify self as a practicing public health officer, with a degree, diploma or a certificate.

The principles and values of this noble profession are; social justice and equity, results oriented approach, partnership and collaboration, professionalism, accountability, high level of integrity and team work.

The association held its Bi-annual General Meeting in June 2012, during which election held. Mr. Samuel Muthinji emerged the winner of position of Chairperson, while Mr. Benjamin Murkomen was elected Vice-Chairperson.

The association, under the new leadership, is developing a strategic plan whose vision is an active and progressive entity accountable to its membership. It endears to provide an effective leadership that also mentors its members. It is also conceptualizing full participation by all stakeholders, including courting public/private partnerships for the betterment of the membership.

A number of quick-win task envisaged in the immediate future to strengthen the association include: formalization of office bearers with the registrar of societies; printing and dissemination of the revised constitution of APHOK; sponsoring development of a scheme of service; revised the monthly subscription fee from 100/- to 500/-; printed new certificates for serving public health officers and technicians; and facilitated and fast-tracked the PHOs and PHTs training; registration and licensing bill which was assented into law by the immediate former President in January 2013. The team also managed to establish the public health officers/technician council in February 2013, and accredited universities offering degrees in environmental health and reviewed their curriculums. The universities are namely: Mount Kenya University, Jomo Kenyatta University, Baraton University of East Africa and Maseno University.

The association is looking forward to strengthen advocacy and social marketing of the profession through print, electronic media and National scientific conferences.

For more information contact: APHOK office on info@aphok.co.ke or No: 0726 258933. www.aphok.co.ke

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**Mr. Samuel Muthinji – Chairman**

**Benjamin Murkomen – Vice Chair**