END-TERM EVALUATION REPORT FOR HESED AFRICA ON GVA23 AFYA ZAIDI PROJECT – IMPROVING HEALTH AMONG VULNERABLE AND REFUGEE POPULATION IN THE INFORMAL SETTLEMENTS OF EASTLEIGH AND KASARANI, NAIROBI.

Nurse administering immunization vaccine at Eastleigh Maternal Child Health section.
Source: Howard & Associates Research Team

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TABLE OF CONTENT

LIST OF ACRONYMS AND ABBREVIATIONS

AAAQ	Availability, Accessibility, Acceptability, and Quality
AMREF	African Medical and Research Foundation
CBOs	Community-Based Organizations
CHAs	Community Health Assistants
CHCs	Community Health Committees
CHPs	Community Health Promoters
CME / CMEs	Continuous Medical Education
CRS	Catholic Relief Services
DANIDA	Danish International Development Agency
DHIS:	District Health Information System
DRC	Democratic Republic of Congo
FGM	Female Genital Mutilation
FGD	Focused Group Discussions
GBV	Gender-Based Violence
GVA	Generalitat Valenciana
HHs	Households
HIV	Human Immunodeficiency Virus
HMIS	Hospital Management Information Systems
IDPs	Internally Displaced Persons
IGA	Income Generating Activities
IPV2	Inactivated Polio Vaccine (2nd dose)
KES	Kenyan Shillings
KHC	Kasarani Health Centre
KII	Key Informant Interviews
KNBS	Kenya National Bureau of Statistics
MCH	Maternal and Child Health
MEAL	Monitoring, Evaluation and Learning Systems
MSVS	Mujeres Supervivientes de Violencia Sexual (Marginalised and Most Vulnerable Groups)
MOH	Ministry of Health
NCCK	National Council of Churches of Kenya
NGO	Non-Governmental Organization
NHIF	National Hospital Insurance Fund
NWSC	Nairobi Water and Sewerage Company
ODPP	Office of the Director of Public Prosecutions
PEP	Post Exposure Prophylaxis
PHF	Primary Healthcare Fund
PPE	Personal Protective Equipment
PWDs	People living with Disabilities

RSD	Refugee Status Determination
SDGs	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
SHIF	Social Hospital Insurance Fund
SMART	Specific Measurable Achievable Relevant Timebound
SPSS	Statistical Package for the Social Sciences
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health Rights
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
ToC	Theory of Change
ToR	Terms of Reference
TOT / ToT	Training-of-Trainers
UNHCR	United Nations High Commission for Refugees
USAID	United States Agency for International Development
WASH	Water, Sanitation and Hygiene Practices
WHA	World Health Assembly
WHO	World Health Organization

LIST OF TABLES

LIST OF FIGURES

EXECUTIVE SUMMARY

1.0 Background

The Foundation for Health and Social Economic Development Africa (HESED Africa), in partnership with Farmaceuticos Mundi (Farmamundi), implemented the GVA23 Afya Zaidi project (a 15-months project) in the sub-counties of Kamukunji and Kasarani; within Nairobi County from 1st June 2024 to 31st August 2025. The project aimed to promote the right to health from a biopsychosocial approach by putting people at the center and strengthening MSVS and GBV protection and rights restitution mechanisms among the refugee, internally displaced and local populations in the informal settlements of Eastleigh and Kasarani.

This end term evaluation assesses the achievements accomplished towards the project's planned impact and outcome indicators. The evaluation has therefore assessed the project design, its effectiveness, efficiency, adequacy and appropriateness, impact, connectedness and coordination as well as ownership and participation as guided by VGA MEAL guide and the TOR.

2.0 Methodological Approach to the End-term Evaluation

The end-term evaluation employed a mixed-methods approach, gathering both quantitative and qualitative data from primary sources including household surveys, Key Informant Interviews (KIIs) and Focus Group Discussions (FGDs). The evaluation mainly used purposive sampling for qualitative data and random sampling for quantitative data. Based on the target population, the study used the Krejcie & Morgan (1970) formula to determine a sample size of 410 participants, from the two sub-counties. The household survey covered a well-balanced sample across Kasarani (51.5%) and Kamukunji (48.5%) sub counties, providing representative insights from both implementation areas. In total, the evaluation reached 498 respondents (8% Male, 92% Female), both for quantitative and qualitative data, across the two sub-counties.

3.0 Context Review

Growing Urban Refugee Population and Recognition: Kenya's refugee and asylum-seeker population reached 854,876 by 30th June 2025, with a growing share residing in urban areas such as Nairobi, Nakuru, and Mombasa. Registered urban refugees numbered about 115,433, reflecting a significant increase and underscoring a broader shift toward cities as spaces for livelihoods, self-reliance, and social integration. Urban refugees are predominantly of working age, with the largest groups originating from the Democratic Republic of Congo and Somalia. Despite their increasing presence and contribution to urban economies, formal recognition and support systems have not expanded proportionately, leaving many refugees reliant on informal networks and coping strategies in the absence of adequate services.

Inadequate Implementation of Refugee Management Frameworks: Although the Refugee Act 2021 guarantees refugees the right to reside in urban areas, access services, and engage in formal employment; implementation remains weak, particularly for urban refugees outside established camps. Persistent backlogs in refugee status determination and documentation, driven by underfunding and limited administrative capacity, continue to restrict access to work permits, banking, and mobile services. Bureaucratic hurdles and employer uncertainty about refugee documents limit access to formal employment, leaving refugees in insecure work.

Launch of the Shirika Plan: The Shirika Plan, launched in March 2025, marks a major policy shift toward a government-led, development-oriented approach to refugee inclusion in Kenya. Anchored in the Refugee Act 2021, the plan seeks to integrate refugees into national socioeconomic systems by expanding access to work, education, business opportunities, and property, while also strengthening host community economies. Key components include policy and institutional reforms, new regulations on movement and economic participation, a refugee management information system, and investments in skills development, recognition of prior learning, and microfinance.

SHA Rollout and Health Requirement Changes: The introduction of the Social Health Authority (SHA) in October 2024 replaced the NHIF and operationalized the Social Health Insurance Act, 2023 to advance universal health coverage in Kenya. While SHA registration is formally open to all residents, including refugees, lack of valid documentation prevents many refugees and asylum seekers from enrolling and accessing the full range of health services. This exclusion limits the flow of primary healthcare funding to facilities serving refugee populations.

Withdrawal and Reduction of USAID Funding: The abrupt reduction of USAID funding in January 2025 significantly disrupted Kenya's healthcare sector, particularly programs targeting HIV, tuberculosis, and other infectious diseases. Many clinics in informal settlements that relied on USAID support now face uncertainty or closure, leading to increased patient loads at the few remaining facilities supported by other partners. This shift has strained already limited resources and exposed gaps in continuity of care for vulnerable populations, including refugees. The funding withdrawal has prompted renewed discussions on the need for stronger government leadership and diversified financing to sustain life-saving health services.

Health Worker Shortage: Kenya faces a critical and worsening shortage of healthcare workers, threatening progress toward universal health coverage. While the country produces approximately 7,650 new health workers annually, it requires tens of thousands more to meet current and future demand driven by rapid population growth. Demand for healthcare services is rising faster than workforce expansion and without urgent investment in training, recruitment, and retention, the health worker gap is projected to widen significantly by 2030 and beyond.

Health Care Financing: The government's allocation of KES. 138.1 billion to health in the 2025/2026 budget represents an increase from 127 billion and signals commitment to universal health coverage, yet overall financing remains fragile and heavily donor-dependent. Health spending accounts for only 3.3% of the national budget, highlighting structural constraints. At the same time, stagnant funding for vaccines persists despite a national shortage, raising concerns about child health outcomes. These trends underscore the need for more sustainable domestic financing and improved prioritization within the health sector.

Increased Refugee Women and Children Vulnerability: Economic hardship and weak support systems in urban informal settlements have heightened vulnerability among refugee women and children, with a growing number of female-led households relying on precarious informal livelihoods. Refugee women face increased risks of exploitation, harassment, and gender-based violence, which often remains under-reported. Children in these contexts experience reduced supervision due to caregivers' long working hours and stress, increasing exposure to neglect, exploitation, and early engagement in risky activities.

4.0 Analysis of the Evaluation Findings

Survey Demographics: The quantitative data was collected from 410 project participants in the two sub-counties where the project was implemented. Most participants were young and middle-aged adults; nearly 70% aged 18-35, mainly economically active and responsible for childcare and household tasks. The age group increased from 40% at baseline, showing growth in the young population and their high participation reflects deliberate efforts to boost youth involvement in the project. More than half of the respondents were from DRC, Ethiopia, and Somalia; reflecting the project's targeting of 60% refugees. Regarding health service utilization, Eastleigh Health Centre was identified as the primary facility for nearly 50% of respondents, followed by Maji Mazuri at 38.5%.

Most households rely on a single income earner and are predominantly engaged in informal livelihoods such as small-scale trade and casual labor with a median household incomes cluster of KES. 15,000 per month. The evaluation observed a significant increase in the number of respondents relying on small-scale trade, from 36.1% at baseline to 65.6%, and on casual employment, from 40% to 54.6%, indicating an expansion of livelihood opportunities with contributions from the Afya Zaidi project. Dependence on aid declined from 3.5% to 1%, indicating reduced reliance on external assistance and strengthened resilience through economically viable opportunities.

Outcome 1: Provision of acceptable, safe and quality primary health care services, with an emphasis on MCH and SRH, is ensured in Nairobi's informal refugee settlements throughout the life cycle, with equity and without discrimination.

The evaluation noted renovations at Eastleigh North Health Centre's maternity and mother-and-child clinic, which improved hygiene, safety, and dignity by installing sinks, toilets, and hot showers. The project provided medical equipment, including oxygen concentrators and delivery couches, along with antenatal laboratory reagents, medicines, and drugs for routine and emergency care, thereby strengthening maternal and newborn services. A youth-friendly SRH Centre was also built within the MCH unit, providing a safe space for community members to access information on family planning, STIs, and reproductive health rights.

The project improved access for women from low-income areas to respectful maternity care, benefiting many in Kamukunji and its surroundings. Findings show that 79.5% of respondents experienced increased access to primary healthcare services, with an overall satisfaction rate of 90%. Most respondents (87.6%) rated health facility infrastructure as good or very good, with high confidence in healthcare workers (94.3%) and strong satisfaction (90.2%) with their services.

Outcome 2: Actions implemented to address community-based social and gender determinants of health among the local and refugee population of Eastleigh and Kasarani through the promotion of SRHR and co-responsibility in decision-making.

The project aimed to distribute WASH, hygiene, and nutritional kits to the most vulnerable populations (refugees, locals, and IDPs) in the Eastleigh and Kasarani settlements. 600 living units were targeted for hygiene kits, 500 co-housing units for WASH kits, and 500 for nutritional kits.

FGDs confirmed households are taking measures to ensure water safety. Most households actively treat drinking water, mainly through boiling (65.1%) and chemical treatments such as use of water guard (57.8%). 59.0% of respondents received water treatment tablets, and 32.9% received jerry cans, demonstrating the project's investment in household water safety. The evaluation also established that among the community members who attended a food demonstration session, almost all (99.2%) reported adopting at least one positive practice at home; the majority (94.3%) indicated they had adopted hygiene practices while 76.1% indicated they had adopted food safety practices. Other adopted practices were nutrition practices, clean up practices, safe cooking practices that is age appropriate, safety around cooking areas as well as organization and planning.

Outcome 3: Protection and integral recovery circuits for Marginalized and Most Vulnerable Groups (MSVS) are strengthened under a biopsychosocial approach that promotes the restitution (physical, psychological, social, legal and economic) of their rights violated by guaranteeing safe spaces for participation and promotion of autonomy.

The SRHR awareness was rated at 88.3%, indicating nearly nine in ten community members understand their sexual and reproductive health rights, essential for informed decisions and claiming services. Progress was noted at 75.6% on awareness of pathways for SGBV survivors. Among those experiencing or witnessing GBV or SGBV (34.4%), 61.0% reported to police, 39.0% to health facilities, 22.7% to community health promoters, and 15.6% to community paralegals. Of survivors at health facilities, 80.0% underwent STD and HIV testing, 66.7% pregnancy tests, and 40.0% received PEP kits, showing timely post-exposure prophylaxis for many.

About 67% of survivors or witnesses feel the support received met their expectations, but nearly 33% remain dissatisfied. This is an improvement from the baseline, where 49.0% rated these programs as effective. The improvement indicates that a significant proportion view the provided services as beneficial. The remaining 33% who were dissatisfied highlight opportunities to improve timeliness, quality, and survivor-friendly approaches in health, justice, and community services in Afya Zaidi areas.

Among the psychosocial supports received, individual counselling was the most common, used by 60.7% of respondents. Mutual support groups were accessed by 46.6%, showing strong peer support. Family and caregiver support involved 34.1%, reflecting involvement of close family members. Nearly 30% were referred to specialized mental health care, indicating higher-level services for more complex needs. Vulnerable households accessed cash transfer and income-generating skills, mainly for home-based and small enterprises requiring low capital. Sewing and soap-making were the most common trainings received as reported by 36.1% and 35.6% of respondents, respectively.

Outcome 4: Spaces and mechanisms for community participation and accountability are promoted in all phases of the project cycle based on the articulation of an inclusive, participatory and co-responsible intervention

The end-term evaluation survey shows strong uptake of community dialogue platforms, with 72% of the respondents indicating they attended HESED Africa-organized dialogues on strengthening participation in health decision-making. These forums are serving as key spaces for information sharing, priority-setting, and collective accountability. However, the 28% who have not yet participated indicates the need for targeted mobilization and more flexible outreach to ensure no groups are left behind. In addition, community engagement is moving beyond

awareness into action; 59.3% of respondents reported having taken part in advocacy activities with HESED Africa on SRHR and protection for SGBV survivors. Community members, through CHPs and CHCs, participate in identifying community needs using scorecards and provide feedback on services through HESED's exit surveys. This demonstrates growing community ownership and shared responsibility in advancing rights and accountability.

Summary of findings based on the OECD Criteria.

Design: The project was based on the premise that enhancing access, availability, coverage, and quality of sexual and reproductive health services, including SGBV services, would increase their acceptability among both refugee and local communities. This approach was built on a thorough context analysis and a baseline study conducted at the project's onset, which outlined the status of the key indicators. The evaluation appreciated the well-integrated approach combining care, prevention, knowledge management, and livelihood support to offer comprehensive assistance. Additionally, the evaluation recognized efforts to address crosscutting issues such as gender equality, interculturality, age, human rights, advocacy, and environmental impact reduction.

The evaluation recommends developing a Theory of Change for future projects to visualize the pathway to change. It is essential to have a clear follow-up mechanism for initiatives to monitor outcomes and impact. The project needs more effort to improve the participation of persons with disabilities, who are particularly vulnerable in the refugee context. Additionally, there is a need to increase male participation to empower men to support women in child nutrition, reproductive health, mental wellness, and preventing gender-based violence.

Adequacy and Appropriateness: The project was designed to serve 60% refugees and 40% local population, with beneficiaries including young girls, boys, teenage mothers, persons with disabilities (PWD), and other vulnerable groups within the community. The project's interventions aligned well with the Nairobi County government's priorities. Through focused group discussions and key informant interviews, it was consistently affirmed that the interventions addressed genuine, urgent, and interconnected issues as identified by the various stakeholders, such as malnutrition, gender-based violence (GBV), income deficits, substandard sexual and reproductive health (SRH) outcomes, and inadequate water, sanitation, and hygiene (WASH) services. The emphasis on urban refugees was particularly significant, considering systemic barriers related to documentation, employment, and access to health insurance. The evaluation identified emerging needs, such as recent policy updates on immunization, including the transition from two HPV vaccine doses to a single dose for girls aged 10 to 14, which requires increased awareness among the target population.

Efficiency: Consultations with the Finance department personnel and beneficiaries indicate that the allocated budgets were sufficient for the partners, and expenditures conformed to the authorized budget. Overall expenditure was consistent with the approved budget. The final evaluation noted that there were no significant variances throughout the entire budget. The absorption rates of the allocated resources for most budget lines were on schedule, reaching 100%. Regarding actual expenditures, it was observed that administrative costs remained within the allocated budget and were deemed appropriate for the project. Overall, the GVA23 project demonstrated robust budgetary management, with total expenditures fully aligned with the approved financial plan. Variances across individual budget lines remain within acceptable limits.

The evaluation recommends allocating additional resources towards community awareness initiatives. The evaluation also noted deficiencies in resource allocation for the follow-up of participants in some key project interventions and therefore recommends increased allocation to project participants follow up as well as strengthening peer/support groups and using CHPs to improve follow-up for greater impact. Future and related projects should consider increasing investments in research, particularly surveys, in areas where gaps have been identified. Further, it is important to enhance the sharing and dissemination of information to ensure that project insights are communicated effectively to other stakeholders.

Effectiveness: The project used five key approaches: Provision of quality health care, Prevention health related issues, Knowledge management, livelihood support and integration of crosscutting issues. All were effective in improving access, availability, acceptability, and the quality of health services. Connecting health initiatives with education and community programs through schools and organizations helped prevent some communicable diseases and psychosocial issues. The project also built the health personnel's capacity in GBV and SRH care, quality data collection, management and reporting for improved decision-making. All planned project activities were successfully completed. Recommendations include supporting health staff in digitizing records into the DHIS system and building capacity in Emergency Obstetric and Newborn Care (EmONC) to reduce maternal and neonatal preventable mortality.

Impact: The review noted good progress towards project impact, including increased access to quality health care for refugees at level three hospital, improved health information systems at the health centers, better health-seeking behavior, and enhanced awareness on SRHR and GBV leading to reduced GBV/SGBV, fewer teenage pregnancies, and strengthened community cohesion. Unplanned changes included growth in women-led businesses challenging traditional gender norms, more men supporting their wives' work and participating in project activities, and improvements in reproductive health with more men willing to use family planning and support their partners at clinics.

Ownership and Participation: The GVA23 AFYA ZAIDI project was well received in Kamukunji and Kasarani, with stakeholders including county health officials, local health facility in-charges, the ministry of education, local administration, host communities, refugees and PWDs. The evaluation recommends documenting a stakeholder engagement plan to improve collaboration with NGOs and government bodies. It is important to consider low-cost, community-led interventions that communities can sustain independently, such as finding alternative sources or self-improvised sanitary towels. Additionally, enhancing feedback mechanisms through online platforms such, WhatsApp groups is crucial.

Sustainability: The sustainability prospects for the GVA23/Afya Zaidi project are positive, suggesting a moderate likelihood of maintaining benefits beyond donor support. This is attributed to the project's foundation in institutional integration, capacity enhancement, community involvement, and multi-sectoral collaboration. The evaluation observed that the core interventions were aligned with government systems, delivered through public health facilities, and supported by trained personnel and community structures capable of sustaining key activities beyond the project's lifecycle. The ongoing reliance on external financing for services for refugee and undocumented populations, and limited integration of migrants into national health financing mechanisms present risks to the continuity of inclusive service delivery following the withdrawal of external support. The

evaluation also recommends a formalized exit and transition strategy that do not leave the stakeholders at a limbo when they exit.

Key Recommendations:

1. A graphic Theory of Change (ToC) would be ideal for showcasing the pathway from activities to long-term impact and the logic behind expected results.
2. Livelihood training options should be expanded and diversified based on regular market assessments and the expressed interests of beneficiaries to ensure relevance and sustainability.
3. Programs should be designed to target men and boys in areas such as sexual and reproductive health (SRH), gender-based violence (GBV) prevention, and livelihood opportunities to foster inclusive community engagement.
4. Strengthen alignment with government priorities by adopting the Shirika plan and other key strategies developed by the government department, including the National Nutrition Strategy, as well as GBV and social protection strategies.
5. Enhance integration with governmental systems by aligning project activities with the structures of the Ministry of Health (MOH) and conducting joint review meetings to foster collaboration.
6. There is need to enhance information sharing and dissemination to ensure that insights from the project are widely communicated to other stakeholders.
7. Consider implementing low-cost and community-led interventions; promote initiatives that communities can maintain independently of donor support, while also assisting communities in identifying alternative sources for items such as sanitary towels.
8. There is a significant opportunity to further strengthen partnerships and collaborations. The initiatives should primarily be community-led.
9. Enhance community feedback mechanisms by maintaining suggestion boxes, utilizing WhatsApp groups and community forums.
10. The project should deliberately mainstream the inclusion of Persons with Disabilities (PWDs) in all aspects of design, implementation, and monitoring to ensure equitable access to services as well as improve overall service utilization and community cohesion.

1.0 BACKGROUND AND INTRODUCTION

1.1 About Foundation for Health and Social Economic Development Africa (HESSED- Africa)

The Foundation for Health and Social Economic Development Africa (HESED Africa) is a duly registered and legally operational non-profit organization in Kenya, founded in 2004 and registered in 2007 by the Non-Governmental Organizations Co-ordination Board established by section 3(1) of the Non-Governmental Organizations Coordination Act No. 19 of 1990. The Organization is registered under Certificate of Registration No. OP.218/051/2007/0268/4738.

HESED is dedicated to working with vulnerable populations across urban and rural Kenya. With the mission of improving livelihoods through the development of health, social, and economic capacities, tailored to the needs of both refugee and host communities in informal settlements. The organization works to address the following cross-cutting issues:

- Primary Health Care: Strengthening health systems and community-based health initiatives.
- Gender-Based Violence (GBV) prevention and response.
- Social protection and psychosocial support.
- Economic Inclusion: Business development services and livelihoods support.

Further, HESED Africa collaborates with key government ministries, including the Ministry of Public Health and Sanitation, Ministry of Medical Services, Ministry of Interior and Coordination, and Ministry of Education at national, county, and sub-county levels.

1.2 About Farmamundi

Farmacéuticos Mundi (Farmamundi) is an NGO development cooperation, humanitarian action and emergency with extensive experience in promoting holistic health and pharmaceutical assistance to disadvantaged countries. Although it started working in 1991 in Valencia (Spain) as a solidarity association with a different name and scope in the early years, it was not until July 2, 1993 when it was established as an NGO, with headquarters in Valencia. Currently, it is the first non-profit organization specializing in supplying pharmaceutical aid to humanitarian organizations and developing countries.

1.3 About AFYA Zaidi Project

Afya Zaidi was a 15 Months project implemented in Nairobi County, specifically Kamukunji and Kasarani sub-counties. The general objective was to contribute to ensuring the realization of the right to health and a life free from violence in Nairobi, Kenya, due to the increase in forced displacement resulting from drought and chronic conflict in the Horn of Africa. The project aimed to promote the right to health from a biopsychosocial approach by putting people at the center and strengthening MSVS and GBV protection and rights restitution mechanisms among the refugee, internally displaced and local populations in the informal settlements of Eastleigh and Kasarani (Nairobi).

The project focused on 4 key results (Outcomes):

Outcome 1: Provision of acceptable, safe and quality primary health care services, with an emphasis on MCH and SRH, is ensured in Nairobi's informal refugee settlements throughout the life cycle, with equity and without discrimination.
Outcome 2: Actions implemented to address social and gender determinants of health at the community level among women and men, local and refugee population of Eastleigh and Kasarani from the promotion of SRHR and co-responsibility in decision making.
Outcome 3: Protection and integral recovery circuits for MSVS are strengthened under a biopsychosocial approach that promotes the restitution (physical, psychological, social, legal and economic) of their rights; violated by guaranteeing safe spaces for participation and promotion of autonomy.
Outcome 4: Spaces and mechanisms for community participation and accountability are promoted in all phases of the project cycle based on the articulation of an inclusive, participatory and co-responsible intervention.

The project sought to ultimately contribute to 'universal access to sexual and reproductive health rights as agreed upon in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the final review documents' (target 5.6 of the SDGs).

1.4 Purpose of the Evaluation

The evaluation of the GVA23 Afya Zaidi project has been conducted as a requirement under the Generalitat Valenciana's regulations, provided in the MEAL guide, defining evaluation as a process of identifying and reflecting on the effects of projects and programmes that have been implemented and assessing their value. This evaluation has therefore assessed the project design, its effectiveness, efficiency, adequacy and appropriateness, impact, connectedness and coordination as well as ownership and participation as guided by the MEAL guide and the TOR. The evaluation has further provided actionable feedback to inform future programming and strengthen the quality of intervention delivery. The end-term evaluation specifically addressed the following:

i. The adequacy and relevance of the intervention design in relation to the context.
ii. The levels of achievement of the planned results of the intervention. The extent to which the activities carried out enabled the achievement of the expected results.
iii. The implementation practices of the actors involved, especially with regard to the collaboration between Farmamundi and HESED Africa, paying attention to communication, coordination and decision-making procedures to facilitate the transfer of good practices.
iv. The participation of rights holders in the management of the project and to what extent the experience has contributed to strengthening their role and leadership in local development.
v. The degree of continuity of the processes involved in the project (Sustainability).
vi. Develop a Results Socialization Plan to strengthen the sustainability of the project.

1.5 The Evaluation Scope

Time Frame: The evaluation covered the period of project implementation from June 1st, 2024 to August 31st, 2025.

Geographical Location: The evaluation covered the two sub-counties i.e. Kasarani and Kamukunji where the Afya Zaidi project was implemented.

Thematic scope: The evaluation considered all components of the intervention and therefore provides clear judgments on the degree to which the humanitarian activities were adequate to local needs, the achievements in the context of the protracted crisis, the broader effects of the project, the interrelationships generated, and the sectors of the population reached.

1.6 Structure & Content of the Evaluation Report

This report is divided into five sections, in addition to the executive summary and the preliminary pages. Section 1 provides background information. Section 2 highlights the methodology and approach. Section 3 presents the context of the review. Section 4 highlights the findings of the end-term evaluation, section 5 presents lessons learned, recommendations, and conclusions, while section six contains the annexes to the evaluation report.

2.0 METHODOLOGY AND KEY STEPS

2.1 Evaluation Approach

The GVA23 Afya Zaidi project end-term evaluation used a mixed-methods approach, gathering both quantitative and qualitative data from primary and secondary sources. Primary data were collected through participant surveys, key informant interviews, and focus group discussions with stakeholders across the two sub-counties, namely Kasarani and Kamukunji, where the Afya Zaidi project was implemented. The literature review focused on the project documents provided by HESED Africa. These included project baseline and progress reports, log frame, and other key documents. The evaluation also involved a documentary on the interventions implemented by the project.

2.2 Sampling Criteria

The evaluation primarily used purposive sampling for the qualitative component and random sampling for the quantitative component as guided by the HESED Africa team. The project targeted 10,780 rights holders (6,010 women and 4,770 men) to directly benefit from the project activities. Based on this, the study employed the Krejcie & Morgan (1970) formula to determine a sample size of 373 participants for the survey from the two project locations. Taking into account the non-response rate, the sample size was increased by 10%; hence, 410 participants were distributed across the two locations.

2.3 Data Collection

Following approval of the inception report and data tools, Howard & Associates conducted a training for the ten research assistants prior to the actual data collection. The goal was to familiarize the data collection team with the project and the data collection tool, Kobo Collect. The primary data collection was conducted from 8th December 2025 to 13th January 2026 on a rolling basis. A detailed list of participants is included in the Annexure.

Table 1: Summary of stakeholders engaged for data collection

Approach of Engagement	Male	Female	Total
Key Informant Interviews (KIIs)	12	28	40
Focus Group Discussions (FGDs) (Mixed group, women only, girls only and boys only)	14	34	48
Project Participant Survey	16	394	410
Total	**42**	**456**	**498**

Table 2: Stakeholders consulted through Key Informant Interviews

Stakeholder Category for KII	Gender		Total
	Male	Female	
HESED Staff	1	9	10
Donor partner (Farmamundi)	0	1	1
Health Officials	7	12	19
Government Officials (DRS,	2	5	7
Community leaders (Chief, Religious leader,	2	0	2
Partner Agencies/ Community Based Organizations	0	1	1
TOTAL	**12**	**28**	**40**

2.4 Data Analysis/ Aggregation

The consultant organized and categorized the data by source and type, then reviewed it to identify similarities, themes, subtopics, and frequencies. Qualitative data was organized to highlight major themes and differences among stakeholders. Thematic analysis was performed on all transcripts to fulfil the review objectives. Quantitative survey data was coded in SPSS; crosstabs and frequency analyses were conducted, and tables, graphs, and descriptive statistics were created for the report.

2.5 Data Quality Assurance

A team of skilled research assistants was trained and engaged to collect data. A pre-test of the survey tool was conducted before the actual data collection; this ensured the tool was aligned with respondents' context. The Kobocollect application provided real-time updates on data validity, reliability, consistency, quality, and usefulness, enabling participant-level verification of outliers and skewed data. Daily supervision and check-ins with research assistants were also conducted to ensure data quality. Data cleaning was conducted daily during data submission, mainly using MS Excel.

2.6 Limitations of the Study

Stakeholder selection and engagement in data collection prioritized gender and disability inclusion. However, the evaluation faced challenges in mobilization of the male, especially for the survey participants. Despite these challenges, we are confident that the collected data provides an adequate representation of the various groups involved in the project's interventions.

3.0 CONTEXTUAL DEVELOPMENTS

The evaluation focused on developments that may in one way or the other impacted on the project performance subsequently contributing to emerging issues that require attention in subsequent or future related projects. The noted developments included:

Growing Urban Refugee Population and Recognition: According to UNCHR, the refugee and asylum-seeker population in Kenya stood at 854,876 persons as of 30 June 2025, comprising 626,557 (73%) refugees and 228,319 (27%) asylum-seekers. As of 30 June 2025, the Dadaab population stood at 432,480 individuals. Under Kakuma, the registered population stood at 306,963, with 224,721 in Kakuma Camp, 79,867 in Kalobeyei settlement, and 2,375 in Eldoret. Under Nairobi, the registered population stood at 115,433, covering Nairobi, Mombasa, and Nakuru town areas. The number of refugees in urban areas, including Nairobi, Nakuru, and Mombasa, increased from 301 to 115,443 by June 2025, a 15% increase. Males constitute 53.1 %, while females constitute 46.9%, with the majority between 18 and 59(39.6%). DRC (39,711, 34.4%) and Somalia (26,003, 22.5%) were the largest refugee populations in urban areas by June 2025. These refugees increasingly seek economic opportunity and social inclusion, even as formal recognition and support lag behind policy intentions. The percentage of refugees in urban areas has risen, and urban areas have become critical for livelihoods, self-reliance, and community building, even as support services have not kept pace.

Inadequate Implementation of Refugee Management Frameworks: Although the Refugee Act 2021 provides for the rights of refugees including living in urban areas, accessing services, and engaging in formal employment; the implementation of these provisions has remained weak, especially for those outside established camps. Urban refugees often live informal and precarious lives, with limited policy recognition of their specific needs and inconsistent application of legal rights in practice.

The persistent challenge has been the backlog in Refugee Status Determination (RSD) and documentation processes due to underfunding and limited administrative capacity[1]. Even though the Act grants refugees the right to engage in gainful employment and enterprise, in practice the bureaucratic requirements for Class M work permits and associated documentation create significant barriers. Employers are often hesitant to hire refugees due to confusion over documentation, and many refugees struggle to secure work permits, bank accounts, or mobile services that require nationally recognized identity records[2]. To mitigate the persistent gap between refugee policy and practice, future programming should prioritize documentation and rights-navigation support, integrate livelihoods interventions with legal compliance mechanisms, and strengthen advocacy and coordination to promote effective implementation of the Act among the urban refugee populations.

There is need for the Kenyan Government to develop a comprehensive refugee policy that will articulate what constitutes refugee hood, the practical application of the law, and the broader vision of sustainably addressing the decades-long encampment.

[1] Urban-refugee-policies-and-legislation-kenya-and-uganda-2025
[2] Refugees' international reports 2025; Removing-red-tape-to-get-kenyas-refugee-act-right

Launch of the Shirika Plan: The Government of Kenya has launched the Shirika Plan, a comprehensive initiative designed to integrate refugees into the country's socioeconomic fabric. Unveiled on 28th March 2025, the plan represents a fundamental shift from a humanitarian-driven response to a government-led, development-oriented approach, aimed at fostering sustainable inclusion for both refugees and host communities. The plan focuses on several key pillars to drive its objectives. It prioritizes policy and institutional reforms, including the full implementation of the Refugee Act 2021, granting refugees access to business opportunities and work, pursuing education, and enabling access to property. The Refugee Act No. 10 of 2021 underpins the Shirika Plan, providing a legal framework that supports refugee protection and integration. New regulations introduced in 2024 outline specific conditions under which refugees can travel, reside, and participate in economic activities.

The Shirika Plan seeks to bolster refugees' inclusion while simultaneously strengthening local economies and fostering social cohesion. The economic empowerment and skills development component of the plan will expand vocational training programs to match market demands, establish a Recognition of Prior Learning (RPL) framework for skilled refugees, and enhance access to microfinance for refugee and host community entrepreneurs.

SHA Rollout and other Health requirement Changes: The Social Health Authority (SHA) was officially launched in Kenya on October 1, 2024, replacing the National Health Insurance Fund (NHIF) and implementing the Social Health Insurance Act, 2023 to provide universal healthcare coverage[3]. The SHA system seeks to provide access to essential services through a combination of government-funded and contributory schemes. While SHA registration is technically open to all residents, including refugees and asylum seekers, those without formal documentation are not able to register to the insurance funds that unlock the full range of services. Supporting the refugees' access the required documents to register for SHA will unlock more primary healthcare fund channeled to the health centers[4].

Withdrawal/ Reduction of USAID funding: The sudden reduction in USAID grants in January 2025 significantly impacted Kenya's healthcare system, which relied heavily on USAID support, both directly and indirectly, across various capacities. This disruption interrupted longstanding initiatives aimed at controlling the spread of diseases such as tuberculosis and HIV[5]. Consequently, various health facilities in informal settlements in Kenya are facing uncertainty regarding its essential care clinics for HIV/AIDS, tuberculosis, and related infections. Limited clinics supported by external partners, outside of USAID funding, are experiencing an increased influx of patients and requests from community members who previously received assistance from organizations formerly funded by USAID, and now lack alternative sources of care. This situation has resulted in heightened pressure on the remaining facilities. This is leading to new discussions about how the Kenyan government and other NGOs should respond to ensure life-saving care continues.

[3] Health.go.ke/kenya-officially-launch-social-health-authority-october-1-2024

[4] https://eastleighvoice.co.ke/health/257433/locked-out-of-care-why-migrants-in-kenya-and-globally-still-struggle-to-access-healthcare

[5] https://reliefweb.int/report/kenya/cfk-africa-witnesses-devastating-effects-kenya-end-us-agency-international-development-support

Health worker shortage: According to AMREF[6] Kenya is facing a critical shortage of healthcare workers that threatens to derail the country's plan to deliver universal health coverage, according to a recent assessment by the World Health Organization. The country currently produces 7,650 new health workers each year, yet it needs 70,000 more to ensure all Kenyans can access care. The shortage is expected to grow by more than 114,000 by 2030 and could reach 170,000 by 2035 if urgent action is not taken to increase training and hiring Kenya's rapidly growing population, projected to exceed 63 million by 2030, is contributing to the demand for healthcare services. While the health workforce is growing at an annual rate of 3.4%, demand for services is rising faster, at 4.7%. The situation comes as the government recently announced a KES 38.7 billion budget cut to the health sector, which could affect the delivery of essential services.

Health Care Financing: In 2025, the government increased its health budget to KES. 138.1 billion for the financial year 2025/2026 from KES. 127 billion. This represents 3.3% of the total budget and marks an 8.7% increase on the KES 127 billion allocated in the current fiscal year. This budget increase signals the government's commitment to Universal Health Coverage (UHC). However, it also highlights the fragile state of Kenya's healthcare financing, which remains heavily dependent on donor support[7]. Meanwhile, despite a national shortage of essential childhood vaccines, funding for vaccines in Kenya has not changed. Both the 2024/2025 and 2025/2026 budgets have earmarked KES. 4.6 billion for vaccine acquisition. This is particularly concerning given the ongoing shortfall in vaccine supply, estimated at KES. 4.27 billion.

Increased Refugee Women and Children Vulnerability: Structural pressures in Nairobi's urban informal settlements continued to shape household dynamics and vulnerability patterns among refugee and displaced populations. Economic hardship, limited access to stable livelihoods, and weak support systems have contributed to an increasing number of women-led households in mixed-status urban settings. Refugee women often engage in informal economies under precarious conditions, shouldering household responsibilities in the absence of reliable work opportunities and with limited protection from exploitation or harassment, which has implications for their own safety and that of their children. This economic insecurity and lack of support networks create environments where gender-based violence (GBV), including sexual and physical abuse, is more prevalent and under-reported. The inherent challenges of life in informal settlements also have significant implications for parental supervision and child protection. Caregivers in these set ups often have limited time and resources to engage in nurturing care and supervision due to long working hours, unstable employment, and the absence of adequate childcare support. Children, especially adolescents and older siblings in child-headed or female-headed households, are frequently left with limited adult oversight, heightening risks of neglect, exploitation, and early entry into risky livelihood activities[8]. This poses a need to integrate parenting support and caregiver wellbeing components, including positive parenting, stress management, and trauma-informed care. These interventions can strengthen caregivers' capacity to provide nurturing supervision despite economic pressures and displacement-related stress, reducing risks to children in high-stress environments.

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6 https://newsroom.amref.org/news/2025/08/kenya-faces-looming-health-worker-shortage-as-demand-outpaces-supply/

7 https://nation.africa/kenya/health/critical-areas-suffer-cuts-despite-sh138-1bn-health-budget-boost-5082062

8 Kaaria, J. & Murithi, I. K. (2025). *Determinants of Women Empowerment: Case of Refugee Women Living in Nairobi, Kenya*. *Economies*, 13(2).

4.0 DETAILED FINDINGS, ANALYSIS & RECOMMENDATIONS

This section of the report presents key findings of the Afya Zaidi's project end-term evaluation. The findings are organized under different themes that guided the evaluation: Findings from the Survey, Design, adequacy and appropriateness, ownership and participation, efficiency, effectiveness, impact, sustainability, lessons learnt recommendations, and conclusion.

4.1 Findings from the Survey

4.1.1 Participants Demographics

The quantitative data were collected from 410 respondents in the two sub-counties where the project was implemented. The table below summarizes the statistics for respondents consulted through the survey.

Table 3: Summary of Participants Demographics

Demographic Variable	Category	Overall (%) or Value
Sub County	Kamukunji	48.5%
	Kasarani	51.5%
Gender of Respondent	Male	4%
	Female	96%
Age of Respondent	18-35	69.3%
	36-50	24.4%
	51-60	3.7 %
	Above 60	2.7%
Nationality of Origin	Kenyan	42.7%
	DRC	24.9%
	Ethiopian	15.6%
	Somalia	14.1%
	Other	2.7%
Marital Status	Married	53.4%
	Single (Never Married)	27.6%
	Separated	9.3%
	Divorced	5.6%
	Widowed	4.1%
Highest Level of Education	Primary	41%
	Secondary	45%
	College	7.4%
	Pre-Primary School	2.8%
	University	2%
	Adult Education	0.9%
	Vocational Training	0.6%
	Other-Specify	0.3%
Length of stay in the settlement in years	Mean	11.1

	Range	1-61
Household Head	Yes	35.6%
	No	64.4%
Number of Household members including Children	Mean	5
	Range	0 -14
Number of children 5 years and below in the household	Mean	1
	Range	0 to 5
Number of female household members aged 10 to 17 years	Mean	1
	Range	0 to 10
Household member living with disability	Yes	12%
	No	88%
Forms of Disability	Blind / Vision Impaired	10.4%
	Deaf & Dumb	14.6%
	Physically Handicapped	45.8%
	Mentally Challenged	25.0%
	Autism Spectrum Disorder	20.8%
Number of household members engaged in income-generating activities	Mean	1.6
Household Income Generating Activities	Casual Employment	54.6%
	Small Scale Trade	65.6%
	Formal Employment	6.1%
	Aid	1.0%
	No Employment	3.2%
	Cash Transfer	0.5%
Average household monthly income (KES)	Mean	17,500.12
Sources for awareness on MCH, SRHR, GBV and SGBV	At a Health Facility	68.5%
	Community Forums	44.6%
	Phone Messaging	20.2%
	TV	13.2%
	Radio Stations	8.5%
	Social media (Youtube, Tiktok, Instagram, Whatsapp, Facebook)	4.1%
	Posters	3.2%
	Road Shows	2.0%
Primary health facility	Eastleigh HC	48.5%
	Maji Mazuri	30%
	Mwiki Health Centre	11%
	Kasarani Health Centre	10%
	Biafra	0.5%

The Afya Zaidi household survey covered a well-balanced sample across Kasarani (51.5%) and Kamukunji (48.5%) sub counties, providing representative insights from both implementation locations. Respondents were largely female (95.9%), reflecting women's central role in household health decision-making and engagement with community health services.

Most participants were young and middle-aged adults with 70% being between 18 and 35 years old, reflecting a predominantly economically active group responsible for childcare and household tasks. The evaluation noted a significant rise in this age group, which was at 40% initially, indicating a growth in the relatively young population. The high participation also demonstrates deliberate efforts by the project to increase the youth participation/ involvement within the project.

More than half of the respondents were from the Democratic Republic of the Congo (DRC), Ethiopia, and Somalia. The review observed a significant increase in the number of respondents from the DRC, which rose from 2.4% at baseline to 24.9%, and from Ethiopia, increasing from 1.9% to approximately 15.6%. Conversely, the proportion of Kenyan respondents declined from 71.4% to 42.7%, indicating improved targeting in line with the project's objectives and focus.

Most respondents were married (53.4%), though a sizeable proportion were single or previously married, highlighting varied household structures and potential vulnerabilities. Education levels were generally low, with most respondents having only primary or secondary education, underscoring the need for simplified, accessible health and rights messaging.

Households were largely long-term residents, with an average stay of over 11 years. The average household size was five members. Approximately one in nine households included a person with a disability, most commonly physical impairments, followed by mental or cognitive conditions and autism spectrum disorders. Visual and hearing impairments were less prevalent but still significant, highlighting the importance of including the PWDs in the interventions' programming.

Regarding health service utilization, Eastleigh Health Centre was identified as the primary facility for nearly 50% of respondents, followed by Maji Mazuri at 38.5%. The evaluation noted increased usage of the Maji Mazuri facility which was at less than 1% at the baseline.

Most households rely on a single income earner and are predominantly engaged in informal livelihoods such as small-scale trade and casual labor. Household incomes cluster around a median of KES 15,000 per month. The evaluation observed a significant increase in the number of respondents relying on small-scale trade, from 36.1% at the baseline to 65.6%, and on casual employment, from 40% to 54.6%, indicating an expansion of livelihood opportunities. Dependence on aid was noted to have declined from 3.5% at baseline to 1%, reflecting reduced reliance on external assistance.

4.1.2 Assessment of the Project Outcomes

The project defined four key outcomes against which the project was evaluated. The findings are thus documented as follows:

Outcome 1: Provision of acceptable, safe and quality primary health care services, with an emphasis on MCH and SRH, is ensured in Nairobi's informal refugee settlements throughout the life cycle, with equity and without discrimination.

In line with this outcome, the project targeted strengthening the operational capacity of Eastleigh North health center to ensure the delivery of primary health care services, with emphasis on quality in child and maternal health (MCH) and sexual and reproductive health (SRH).

The GVA23 Afya Zaidi Project strengthened health service delivery for both refugee and host communities in Eastleigh and Kasarani by providing critical equipment, infrastructure improvements, and capacity-building for health workers. The evaluation noted the refurbishment of the maternity and mother-and-child clinic at Eastleigh North Health Centre. The project upgraded the maternity ward infrastructure by installing handwashing sinks, flushable toilets, and hot showers to improve hygiene, safety, and dignity of healthcare. The project also supplied essential medical equipment, including oxygen concentrators and delivery couches. To further strengthen maternal and newborn care, the project supplied antenatal laboratory reagents for maternal profiling and provided essential medicines to the pharmacy, ensuring the availability of primary drugs needed for routine and emergency care.

According to the project baseline survey, 49.9% of respondents reported that delivery care services was not available. Further, 23.4% (109 individuals) indicated that they do not know whether delivery care services are available. This high percentage raises concerns about the potential risks faced by pregnant individuals, as lack of access to skilled delivery care can lead to adverse maternal and neonatal health outcomes.

Based on the end-term evaluation, 79.5% of respondents reported an increase in access to maternal health services. Additionally, 75% of respondents confirmed the availability of essential maternal medicines and supplies. A significant 69.9% of respondents at baseline indicated that their children were receiving immunizations, and the end-term evaluation observed an improvement, with 87% of respondents noting that project interventions contributed to enhanced access to immunization and vaccination services. Overall satisfaction with maternal services reached 90% at the conclusion of the project, reflecting satisfactory performance.

Approximately 22.3% of respondents expressed disagreement or strong dissatisfaction regarding the cleanliness and maintenance of the delivery room and ward environments. Additionally, between 14% and 17% voiced strong discontent with the adequacy of postnatal care or the availability of skilled and supportive personnel during delivery. These instances of dissatisfaction highlight specific areas requiring enhancement in infection prevention measures, ward conditions, and the consistency of intra-partum and postnatal care.

From the Focused Group discussions, it was indicated that this outcome area enabled women from low-income areas access respectful and dignified delivery services. The support has enabled many women from Kamukunji and surrounding areas to benefit from both Antenatal (ANC) and Postnatal (PNC) care.

Table 4: Summary Table on Maternal Service Experience Ratings

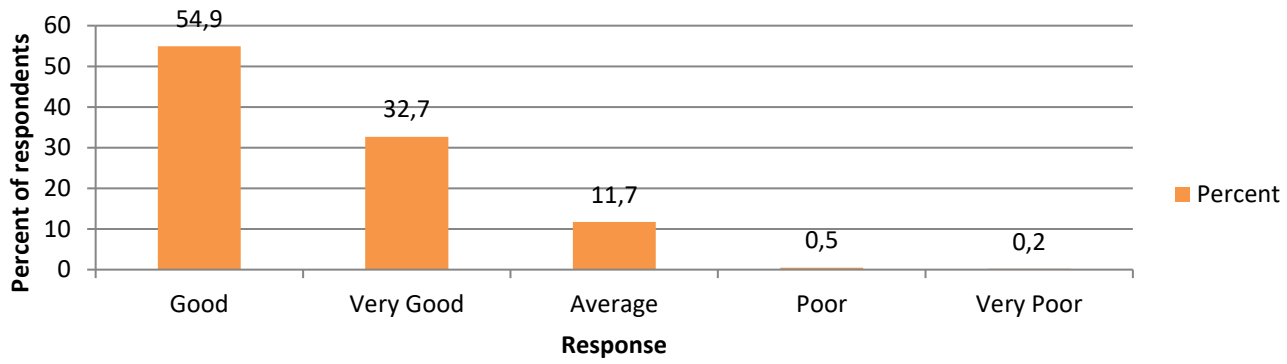
Statement	Strongly Agree %	Agree %	Somewhat Agree %	Disagree %	Strongly Disagree %
Maternal Services easily accessible	30.2	49.3	7.1	1.1	12.3
ANC visits thorough with clear information	27.0	50.1	10.1	0.5	12.3
Delivery room clean and well maintained	24.0	37.9	15.8	3.0	19.3
Given helpful information on care after delivery	27.2	47.1	9.3	2.2	14.2
Skilled and supportive personnel during delivery	27.2	39.0	13.9	3.3	16.6
Received adequate care after giving birth	24.8	47.7	9.3	1.9	16.3
Health workers treat community members with respect and dignity	37.1	58.6	2.5	0.8	1.1
Essential maternal medicines and supplies available	24.3	51.0	10.6	4.4	9.8
All required immunization vaccines available	31.6	55.3	6.3	1.1	5.7
Overall satisfied with maternal services	31.6	58.3	6.5	0.8	2.7

The project also constructed a dedicated youth-friendly SRH Centre within the MCH unit, creating a safe space for the community to access services and information on family planning, STIs and STDs, and sexual and reproductive health rights. In addition, health care providers were trained on GBV management and survivor-centered care, enhancing their capacity to deliver quality, confidential and respectful SRH services while also supporting community sensitization.

Under Outcome 1, the project also aimed to strengthen and supply the Eastleigh Health Centre with essential and specific medicines for the treatment of prevalent health-related conditions, namely Mother-and-Child and Sexual and Reproductive Health (SRH).

According to the baseline report, 77.8% of respondents indicated that they received treatment at health facilities, demonstrating access to relevant services and medical care at these establishments. The analysis of the end-term survey reveals that the majority of surveyed community members reported recent contact with these facilities for general outpatient care and health education, at 62.4% and 61.2%, respectively. Coverage of antenatal care services is also comparatively high at 51.7%, and maternal nutrition services were accessed by 42.0% of respondents. Utilization of child nutrition services and postnatal care was reported by 36.3% and 33.7% of respondents, respectively. 18.8% of respondents reported having received skilled delivery or intrapartum services, and 15.4% had accessed emergency obstetric and newborn care lifesaving services for complications within the past year. In the end-term evaluation, the survey showed that most respondents were satisfied with their primary health facilities' infrastructure, with 87.6% rating it as good or very good.

Figure 1: Current general infrastructure of the Health Facilities



Over half of respondents (53.4%) expressed confidence that their health facility consistently has essential prescribed drugs available, while nearly one-third were neutral. A smaller proportion reported dissatisfaction with drug availability. The findings indicate generally positive but mixed perceptions, highlighting the need to strengthen supply systems and improve client confidence in the consistent availability of essential medicines across project facilities.

Figure 2: Level of agreement that the facility consistently has essential drugs prescribed to patients

The baseline assessment identified increased SGBV and psychosocial cases, harmful cultural practices such as FGM, weak referral systems, poor documentation, and limited health worker capacity in GBV/SGBV management, SRH, cervical cancer screening, as well as proper data capture and use.

In response to the challenges, the project strengthened capacity among health care workers and community health promoters through targeted trainings on the integrated biopsychosocial approach, clinical and forensic management of GBV/SGBV, youth-friendly SRH, referral pathways, quality data collection and documentation, and health information systems, alongside sensitization on Linda Mama/SHA and community engagement roles. Linkages between communities and facilities were enhanced, and communities became more empowered to report and seek timely GBV and SRH services. The trainings were aimed at improving the health care workers' attitudes and competencies, service delivery and uptake (including facility deliveries), strengthening data quality and use for decision-making through improved documentation and register correction.

The end term evaluation findings show very high client confidence (94.3%) in the competence of health care workers and 90.2% in their satisfaction of the health service delivery. The health workers' competence is perceived very positively, representing a key strength of the project. This pattern suggests that the health facilities are largely meeting the expectations of the communities they serve, reinforcing the importance of sustaining the current standards of care while leveraging these positive perceptions to further strengthen community trust, engagement, and continuity of care within the project areas as well as continued investment in supportive supervision, mentoring, and ongoing professional development.

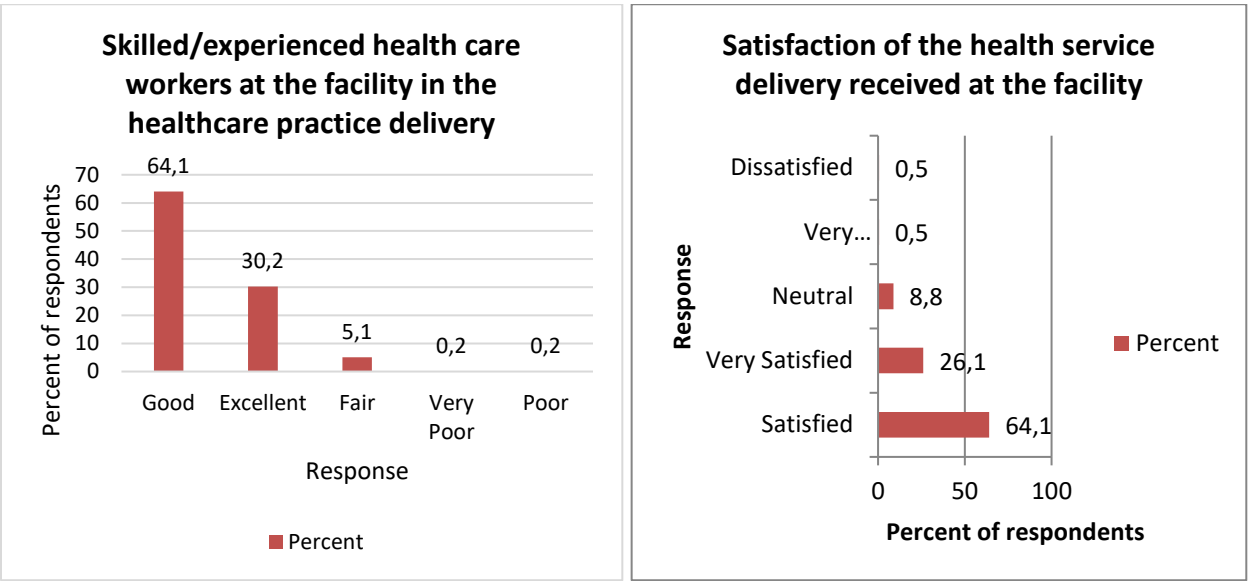


Figure 3: Confidence levels in health care workers' experience and health facility service delivery

The strongest area of confidence relates to respectful care. Close to 95.7% of respondents agreed or strongly agreed that health workers treat community members with respect and dignity. Similarly, 86.9% felt that all required immunization vaccines are available, and 75.3% reported that essential maternal medicines and supplies are usually available.

Outcome 2: Actions implemented to address community-based social and gender determinants of health among the local and refugee population of Eastleigh and Kasarani through the promotion of SRHR and co-responsibility in decision-making.

The project targeted the distribution of WASH, hygiene and nutritional kits among the most vulnerable population (refugees, locals, and IDPs) of the settlements of Eastleigh and Kasarani. 600 living units were targeted for hygiene kits, 500 Co-housing units for wash kits and 500 for Nutritional Kits.

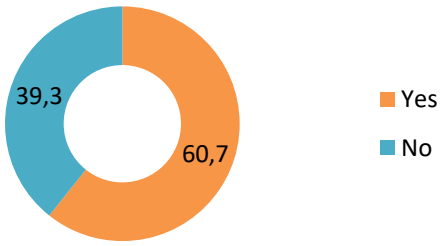
a. Water, Sanitation and Hygiene Practices (WASH)

According to the survey 71.2% of respondents indicated that supply of water from their main source is sufficient for household needs without compromising health and safety, while 28.8% indicated that it is not sufficient. This suggests that although the majority manage to meet daily water demands, nearly one in three households still

experience some level of water stress or compromise, which can undermine both hygiene practices and overall health outcomes. 57.3% of surveyed community members reported experiencing water shortages in the past three months, while 42.7% reported no challenges. This means that more than half of households are still facing constraints such as unreliable supply, cost, distance, or quality issues, which can undermine hygiene practices and increase vulnerability to WASH-related diseases. Several respondents explicitly linked water problems to environmental and hygiene challenges; during the focus group discussions, the respondents linked shortages to dirty surroundings, waste accumulation, poor sanitation, and an increased risk of waterborne diseases. According to participants, the population increase has put pressure on limited water points. The findings underscore the importance of continued investment in reliable, affordable, and safe water and sanitation services within the project areas.

Most surveyed households depend on communal infrastructure for their daily water needs. About 57.3% reported using a communal tap as their main source, while 30.7% have piped water inside their dwelling. A much smaller share relies on alternative sources, including water vendors at 6.3% and community boreholes at 5.1%, with only 0.5% citing other sources. This pattern points toward shared water points, with a smaller group enjoying more convenient in-house connections.

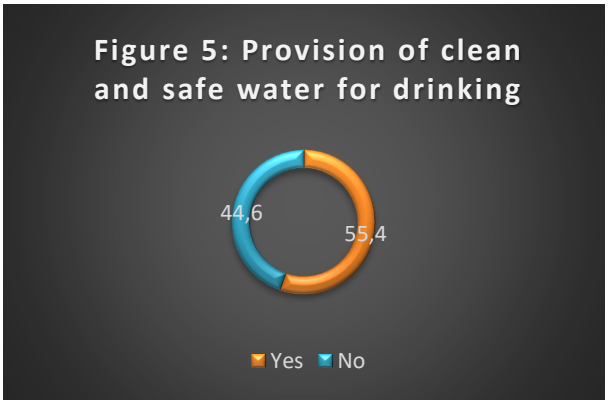
Figure 4: Safety of the local water source.



According to the baseline, 16.1% of respondents reported not having access to safe water. During the end-term evaluation, 60.7% of surveyed community members consider their local water source safe, while 39.3% feel it is not. This indicates almost four-in-ten segment doubts the safety of their water points, highlighting a risk in the safety of the water points.

Regarding water quality, 55.4% believe their main source provides clean, safe drinking water, whereas 44.6% say it does not. This gap between perceived sufficiency and perceived potability indicates that many households may have enough water in terms of volume but remain concerned about quality, which underscores the need for future interventions focus more on treatment, storage practices, and routine water quality assurance in future phases / related projects.

Figure 5: Provision of clean and safe water for drinking



Hygiene and WASH kits received from the Afya Zaidi project

The survey indicated that most households actively treat their drinking water, with a strong preference for methods that directly address microbial contamination. From the FGDs, it was clear majority of households in the project area are taking deliberate steps to ensure drinking water safety. Boiling is the most common practice, reported by 65.1% of surveyed community members, followed closely by the use of water guard or similar chemical treatment at 57.8%. This suggests high awareness of the need to make water safe at point of use, even where source quality is uncertain. A smaller but important group relies on physical clarification methods. Decanting to separate dirt is used by 10% of households, while sieving with a cloth is used by 8%. About 14.9% reported using other methods, including combinations of storage, filtration, or purchased treated water. The continued presence of less effective methods, such as simple sieving and decanting, highlights an opportunity for the future related project to strengthen behavior change communication on correct and consistent water treatment practices.

According to the end-term evaluation survey, 59% of respondents reported receiving water treatment tablets, and 32.9% reported receiving water treatment jerry cans, indicating a significant investment by the project in improving safe water storage and treatment at the household level.

The distribution of WASH and hygiene kits shows that the Afya Zaidi project has prioritized items that directly support personal and household hygiene, as well as safe water handling. Bars of soap are the most widely received item, reported by 71.2% of surveyed community members, followed closely by dignity kits, which include toiletries and menstrual hygiene materials, received by 65.1%. These two categories underscore a strong focus on cleanliness and dignity for women and girls. Intimate hygiene items, such as pants, have been provided to 45.1% of participants, further reinforcing the project's attention to gender-sensitive hygiene needs.

Food Demonstration Sessions

Almost two thirds of surveyed community members (64.4%) reported that they have attended at least one food demonstration session organized at the health facilities or community forums, while 35.6% had not. This suggests that the project-led nutrition and food preparation sessions have reached a substantial proportion of households in the target areas, creating a strong platform for promoting improved dietary practices and child feeding behaviors. At the same time, more than one third of respondents have not yet been exposed to these sessions, indicating clear scope for expanding coverage, with particular attention to hard-to-reach groups who may benefit most from practical, skills-based nutrition education. Among community members who attended a food demonstration session, almost all reported adopting at least one positive practice at home, majority (94.3%) indicated they had adopted hygiene practices and food safety practices (76.1%).

Table 5: Practices adopted from the food demonstration sessions

Practice adopted	Frequency	Percent (%)
Hygiene Practices	249	94.3
Food Safety Practices	201	76.1
Nutrition Practices	171	64.8
Clean Up Practices	142	53.8
Safe Cooking Practices age appropriate	141	53.4
Safety Around Cooking Areas	140	53.0
Organization and Planning	59	22.3
None	2	0.8

The project targeted 75% of respondents recognize good health promotion and disease prevention practices/strategies and identify available community resources for care and protection. According to the survey, awareness of basic hygiene and water-related practices was very high among the community members. Regular handwashing with soap stands out as the most widely known behavior, with 83.4% mentioning it, followed by keeping hands, nails, and body clean at 62.4% and using clean, treated, or boiled drinking water at 53.4%. These patterns show strong alignment between community knowledge and core public health messages on infection prevention.

Beyond personal hygiene, a considerable proportion of respondents also recognize safe handling and washing of clothes and bedding (39.5%), use of a clean toilet or latrine (35.4%), and proper storage of water in clean, covered containers (33.2%). Practices related to food hygiene, such as washing fruits and vegetables (28.8%), washing hands before preparing food (20.2%), and storing food safely in covered containers (16.3%), are also well represented, though with more room for improvement.

Environmental and vector control measures, including proper garbage disposal, removing stagnant water, and sleeping under insecticide-treated mosquito nets, are known by a smaller but meaningful share of the community, around 10% to 13%. Lifestyle-related practices such as eating balanced diet, limiting sugary foods and drinks, adequate rest and hydration, and regular physical activity are least frequently mentioned, typically below 15%.

Type of toilet facility used by the household

Most surveyed households reported using household flush toilets as their main sanitation facility, accounting for 42.2% of respondents. A further 32.4% rely on communal flush toilets, and 13.7% use a shared communal pit toilet, indicating that a large share of the population still depends on shared sanitation infrastructure. Household pit latrines are used by 11.5% of households, and a very small proportion, 0.2%, reported no toilet facility or open defecation. Overall, the distribution shows relatively high coverage of improved sanitation, but with heavy reliance on communal and shared facilities that may present challenges for privacy, safety, and hygiene.

Table 6: Use of sexual and reproductive health services in the last one year

SRH service	Frequency	Percent (%)
Sexual Health Education	306	74.6
Family Planning and Contraceptive Services	303	73.9
HIV Services (Testing and Treatment)	280	68.3
Gender Based Violence (GBV) Support	247	60.2
Prevention and Treatment of STIs	224	54.6
Cancer Screening Related to Reproductive Health	128	31.2
Infertility Services	83	20.2

The evaluation noted that a large share of surveyed community members has interacted with core sexual and reproductive health services in the last year. According to the baseline, 56.7% reported awareness of sexual educational programs in their community. The end-term evaluation registered good progress, with 74% of respondents confirming they had received sexual health education.

The proportion of respondents receiving family planning services increased from 71% at the baseline to 73.9% at the end-term evaluation. Understanding of family planning choices was noted to be strong at the end term evaluation, with around 89% reporting that they understood the available options based on the guidance received. Availability of essential SRH supplies such as testing kits and counselling materials is also rated highly, with about 86% in agreement. This pattern points to a trusted and acceptable SRH service platform that the project can continue to build on while addressing small pockets of disagreement regarding supplies and information clarity. The treatment rate for STIs declined from 64.5% to 54.6%, the evaluation assumes a reduction in exposure to sexually transmitted infections, which can be attributed to improved access to Sexual Health education. No significant change was observed in the uptake of HIV testing and treatment.

While the foundational aspects of the Sexual and Reproductive Health (SRH) service package are relatively well utilized, there remains scope to enhance demand creation, referral processes, and service readiness for cancer screening and infertility care.

Table 7: Perceptions of Sexual and Reproductive Health services provided at the Health Facilities

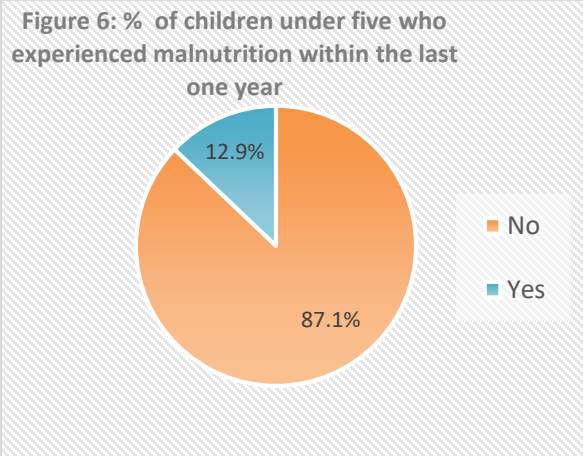
Statement (short description)	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree (%)
SRH services are available when I need them	24.9	66.3	5.1	1.2	2.4
Health workers are competent in SRH services and information	30.5	58.5	5.4	3.4	2.2
My privacy is respected during SRH visits	33.7	59.3	5.1	1.0	1.0
Essential SRH supplies are usually available	25.9	60.0	11.2	2.0	1.0
I understand family planning options from the guidance given	32.2	56.8	4.9	2.4	3.7

Statement (short description)	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree (%)
I would recommend this facility for SRH services	30.7	63.2	4.9	0.5	0.7

Overall perceptions of sexual and reproductive health services in the health facilities are very positive among surveyed community members. For all statements, more than 85% agree or strongly agree, indicating high confidence in both the service environment and the support provided.

Access and availability are viewed positively, with about 90% agreeing or strongly agreeing that SRH services are available when needed. Perceptions of provider competence are similarly strong, with about 89% of the respondents affirming that health workers are competent in delivering SRH services and information. Respectful care is a particular strength, as around 93% report that their privacy is respected during SRH visits.

Table 8: % of Households that received nutritional kits from the Afya Zaidi project.



Nutritional kit item	Percent of these households
Cereals	51.1
Milk	42.6
Maize	40.4
Other items	42.6
Sugar	34.0
Oil	29.8
Soya	29.8

The survey established that only 12.9% children under five had suffered malnutrition in the last one year. Among the households that reported child malnutrition, over half received cereals through the Afya Zaidi project, and about four in ten received milk, maize, or another form of nutritional support. Smaller but still notable proportions reported receiving sugar, oil, and soya. The survey results indicate nutritional kits are reaching many of the affected households, with a mix of staple foods and complementary items that can support household level recovery and improved child nutrition. While reported malnutrition among children under five is relatively limited in scale, there remains a clear need to sustain and possibly expand targeted nutrition support for the households that do report these challenges, alongside preventive actions through routine health and nutrition services.

Decision making on family health is mainly concentrated at individual and couple level. Almost half of respondents, 48.5%, said that they themselves usually decide on family health matters, while 29.3% reported that their partner is the main decision maker. A further 16.3% indicated that parents make these decisions, and 5.9% mentioned other decision makers, such as extended family or guardians. This pattern suggests that in most households,

health decisions are made within the nuclear family, but there is still a significant portion where parents or others influence access to care, which can either support or delay health seeking depending on the dynamics.

Outcome 3: Protection and integral recovery circuits for Marginalized and Most Vulnerable Groups (MSVS) are strengthened under a biopsychosocial approach that promotes the restitution (physical, psychological, social, legal and economic) of their rights violated by guaranteeing safe spaces for participation and promotion of autonomy.

SRHR Awareness

Awareness of SRHR is high in the project areas; 88.3% of respondents reported that they are aware of SRHR, while 11.7% said they are not aware. This means that nearly nine in ten surveyed community members have at least some understandings of their sexual and reproductive rights, which is essential for informed decision-making and for claiming services. This was positive progress, considering that at the baseline whereby only 56.7% of such respondents reported that they were aware of such educational programs in their community.

Table 9: % awareness of SRH Rights (Top 2 mentions)

SRHR awareness	Frequency	Percent
Right to Access Health Services	277	76.5
Right to Privacy and Confidentiality	165	45.6
Right to Be Free from Discrimination	135	37.3
Right to Decide if and When to Have Children	124	34.3
Right to Quality Healthcare	124	34.3
Right to SRH Information	111	30.7
Right to Safe Pregnancy and Delivery Services	101	27.9
Right to Be Free from Harmful Practices	86	23.8
Right to Equality in Marriage and Family Life	75	20.7
Right to Bodily Autonomy and Integrity	68	18.8
Right to Participate in Decision Making	100	27.6
Other	2	0.6

Occurrence of Gender Based Violence (GBV) against girls and women

At the baseline 37.7 %, reported they had experienced or witnessed GBV or SGBV within the past year. According to the project end term evaluation, 34.4 % of the respondents stated that they had experienced or witnessed such incidents pointing to a slight decline in occurrence but showing that GBV remains a serious concern within the communities. An additional 2.9% were not willing to answer, which may point to fear or discomfort in discussing sensitive matters. These findings emphasize the importance of maintaining accessible reporting channels, strengthening survivor-centered services, and continuing community awareness efforts.

According to the end-term evaluation survey, physical violence was the most reported form of violence at 79.4%, sexual violence and psychological violence were each reported by 21.3% of the respondents, while 13.5% reported economic violence. The findings show that psychological violence in the project areas is severe and multi layered, often combining verbal abuse, fear, isolation, and control of movement and communication. Below is a breakdown of the various forms of GBV.

Table 10: Forms of economic GBV experienced or witnessed

Form of economic GBV	Percent (%)
Taking someone's income or property against their will	73.7
Blocking someone from working or forcing them to quit a job	63.2
Controlling all money in the household and refusing to give a partner or other person access to basic needs	57.9
Denying education or skills training so they remain financially dependent	42.1
Sabotaging employment, for example preventing someone from attending interviews	42.1
Withholding child support or maintenance as a way to punish or manipulate	42.1
None	0.0

These findings show that economic violence in the project communities is not limited to income control, but cuts across work, training, property, and support obligations.

Table 11: Forms of psychological GBV experienced or witnessed

Form of psychological GBV	Percent (%)
Insults, belittling, or constant criticism meant to make someone feel worthless	90.0
Threats or intimidation that cause fear, including threats to harm the survivor, children, or loved ones	70.0
Controlling behaviour, telling someone who they can talk to, where they can go, or what they can do	46.7
Gaslighting, making someone doubt their own feelings or sanity	46.7
Humiliation in private or public spaces	46.7
Isolation, preventing someone from seeing friends or family	40.0
Stalking or persistent monitoring, for example checking phone, movements, or social media	30.0
None	0.0

There was noted progress at 75.6% on awareness of the available pathways for SGBV survivors. Among the community members who experienced or witnessed GBV or SGBV, 61% reported the case to a police station and 39% reported to a health facility. 22.7% sought help from community health promoters, and 15.6% sought help from community paralegals. At the same time, 25.5% indicated that the incident was not reported at all, and 2.1%

were coded as not applicable. This underscores the importance of reducing barriers to disclosure and strengthening trusted community-based entry points.

Among the community members whose GBV or SGBV cases were not reported, almost half 47.2% cited fear of retaliation as a key barrier. Normalization of violence was mentioned by 36.1%, and stigma or shame by 27.8%, indicating that social norms and fear of blame, makes disclosure difficult. Economic dependence on the perpetrator was reported by 25%, while 22.2% pointed to poverty and cost barriers. Smaller shares highlighted inadequate support services, distrust in law enforcement and the judiciary, and emotional attachment and hope for change. These findings show that non-reporting is driven by a combination of safety concerns, economic vulnerability, social norms, and low confidence in available systems.

Mechanisms to protect GBV or SGBV survivors that were sought or provided

Among the 141 respondents who experienced or witnessed GBV or SGBV, 59.6% reported seeking or receiving immediate safety and protection measures, while 49.6% reported seeking or receiving health and medical support. Psychosocial and mental health support, and legal and justice mechanisms, were each noted by about one-third of respondents (34.8% and 34%, respectively). Social support systems, such as family or community networks, were involved for 29.1%, and 21.3% mentioned confidentiality and dignity safeguards. Referral pathways were used in 20.6% of cases, and 11.3% reported economic and social reintegration support. This pattern shows that the response within the Afya Zaidi project areas is anchored mainly in safety, healthcare, and justice services, with more limited coverage of long-term economic reintegration.

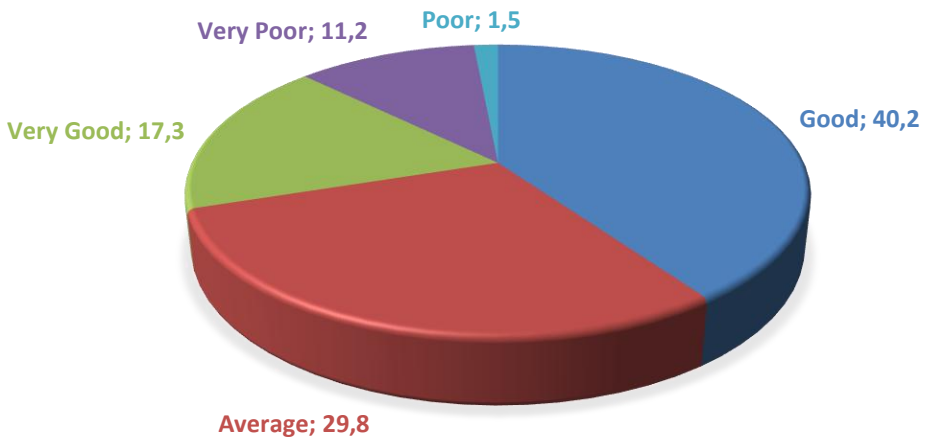
Among the GBV or SGBV survivors who received care at a health facility, 80% reported undergoing STD and HIV testing, and 66.7% received a pregnancy test. 40% received a PEP kit, indicating that timely post-exposure prophylaxis is being provided to a substantial share of survivors. A smaller group, 13.3%, reported not receiving any of these tests, and 3.3% mentioned other tests. Overall, the data suggests that core clinical services related to HIV, sexually transmitted infections, and pregnancy are available to most survivors who reach health facilities, but there is still a gap for a minority who do not receive the full package.

About two thirds of survivors or witnesses (67%) feel that the support they or others received met their expectations, but almost one third remain dissatisfied. This was an improvement compared to the baseline where 49.0% of respondents rated these programs as effective. The improvement indicates that a significant portion of the population believes these initiatives have a positive impact on raising awareness and promoting understanding of GBV issues. The 33% that indicated the support did not meet their expectations point to important opportunities for improving timeliness, quality, and survivor friendly approaches across health, justice, and community-based services in the Afya Zaidi project areas.

Psychosocial support care received within the past one year

Individual counselling sessions were the most commonly received form of psychosocial support, reported by 60.7% of respondents. Mutual support group sessions were accessed by 46.6%, showing strong use of peer-based support spaces. Family and caregiver support was reported by 34.1%, indicating that a substantial share of interventions intentionally involved close family or caregivers in the healing process. Nearly one third of respondents, 30%, had been referred to specialized mental health care, which shows that more intensive or complex needs are being linked to higher-level services when required. In addition, 19.3% mentioned other forms of psychosocial support, suggesting some tailoring to specific household or individual circumstances.

Figure 7: Quality of the psychosocial support received



Most community members who accessed psychosocial support found it helpful and of good quality, but about 1 in 8 felt the services did not meet their expectations, highlighting opportunities to strengthen consistency, follow-up, and survivor-centered care.

Social protection support received in the past year

Food assistance was rated the most common form of social protection received from the Afya Zaidi project, reported by 41.2% of respondents. 21.7% reported to have received cash transfers while 11.7% reported receiving health insurance. Smaller proportions have benefited from public works or temporary jobs (9.3%), education bursaries or scholarships (2.4%), and disability benefits (1.5%), with pensions reaching only 0.2% of respondents. At the same time, 45.6% of surveyed community members indicated none of these forms of support. This means that just under half of households in the sample reported no direct social protection benefit from the project in the past year, while the other half have benefited mainly through food assistance and cash transfers representing equity to the most vulnerable households.

IGAs trainings received from the AFYA ZAIDI Project

Among the specified trainings, sewing and soap making are the most prominent IGA training received, reported by 36.1% and 35.6% of respondents respectively. Henna and natural cosmetics were each mentioned by around one in five community members, 22.9% and 22.2%, while multipurpose cash transfer related training was reported by 8%. A significant share of households has been exposed to at least one income generating skills package, with a strong emphasis on home based and small-scale enterprises that can be started with relatively low capital.

Outcome 4: Spaces and mechanisms for community participation and accountability are promoted in all phases of the project cycle based on the articulation of an inclusive, participatory and co-responsible intervention.

At the baseline, 55.0% of the respondents reported that accountability platforms exist, where duty bearers meet with community members to assess services and address responsiveness to community needs. This suggests a commitment to fostering dialogue and collaboration, which is essential for ensuring that services are aligned with

the priorities of the population with majority pointing to community dialogues (76.9%) and Public baraza (22.5%) and others (0.6%)

The end-term evaluation survey shows strong uptake of community dialogue platforms, with 72% of the respondents indicating they attended HESED Africa-organized dialogues on strengthening participation in health decision-making. These forums are serving as key spaces for information sharing, priority-setting, and collective accountability. However, the 28% who have not yet participated indicating the need for targeted mobilizations and more flexible outreach to ensure no groups are left behind.

In addition, community engagement is moving beyond awareness into action: 59.3% of respondents reported taking part in advocacy activities with HESED Africa on SRHR and protection for survivors of SGBV. This reflects growing community ownership and co-responsibility in advancing rights and accountability, though the 40.7% who are not yet involved highlight further opportunities to broaden and deepen participation.

4.2 Project Design

The evaluation assessed the quality of the project design by focusing on the rigor of the context analysis, the availability of a results framework to guide project monitoring, and the integration of key project elements. The project design was premised on the assumption that if access, availability, coverage and quality of sexual and reproductive health services (including SGBV) are improved, the acceptability of such services among the refugee and local population will be improved, with a special focus on the youth and adolescent population, and if the health information systems of the sub-counties are improved, the exercise of sexual and reproductive rights in the area will be improved.

The evaluation found that the Afya Zaidi project was based on a clear context analysis supported by prior health and household assessments, aligning with HESED's goal of improving livelihoods through health, social, and economic development for refugee and host communities in informal settlements, as well as Farmamundi' s aim of universal health improvement. The project baseline report established the initial status of indicators and guided performance measurement. The project had a results framework with high-quality (SMART) indicators to outline and document results, and an intervention strategy summary that articulates the desired change and its causal factors. The project activities also align well with the expected results.

The evaluation highlighted a strong integration between care, prevention, knowledge management, and livelihood interventions for holistic support. This alignment ensures interventions address both medical needs, nutritional and social support, enhancing overall health outcomes. The design incorporates long-term strategic goals, including sustainability and scalability in underserved areas.

The project implementation design engaged community structures, including CHAs, CHCs and CHPs, to identify community needs and issues through community scorecards. HESED Africa also received updates from the facility level that informed its project design on the priority needs among the community members to be addressed. This approach ensured targeted relevant interventions as well as continuous monitoring of community issues and facilitated timely response and resolution.

The evaluation also noted efforts to incorporate crosscutting issues such as gender equity, interculturality, age, human rights and advocacy and environmental impact mitigation. The project aimed to actively engage young people through the establishment of the SRH center supporting them to lead healthy, safe, and productive lives.

The evaluation also noted deliberate efforts to integrate baseline recommendations into the project design. These included strengthening community education and awareness through comprehensive programs on GBV, SRH, and available services; increasing access to services by supporting the establishment and promotion of child rescue centers and GBV survivor support groups; and promoting gender equality and community engagement by strengthening accountability mechanisms such as community dialogues and public barazas through regular, structured meetings and clear guidance on community participation.

Recommendations on the Project Design

1. A graphic Theory of Change (ToC) would also be ideal for showcasing the pathway from activities to long-term impact and the logic behind expected results. The evaluation therefore recommends the development of Theory of Change for future projects to visualize the pathway to the desired change
2. The project design did not document clear follow up mechanisms for the different project elements offered, considering the dynamics and movement of the refuges (Persons of Concern) it is imperative that the project documents and implement a clear mechanism for follow up to support in monitoring of outcomes and impact.
3. The project conducted ongoing risk monitoring, with reports submitted in quarterly and annual updates, which is commendable. The evaluation recommends developing a project-specific risk register to enhance monitoring of project risks and assumptions and to support risk reporting.
4. The project will require additional efforts to enhance the participation of persons with disabilities, who are considered particularly vulnerable within the refugee context. The survey indicated a substantial number of households with persons with disabilities, emphasizing the necessity to strengthen the integration of disability considerations into the project to ensure adequate engagement of persons with disabilities.
5. Future project models may consider using the Trainer of Trainers (TOT) model to enhance community awareness. This may involve working with men and women from the refugees setting since they are well positioned to communicate effectively with their community members, who can easily relate to them hence higher outreach and easier follow-up.
6. There is an opportunity to strengthen male participation in the project; this will empower men to better support women in areas such as child nutrition, reproductive health, mental wellness, and the prevention of gender-based violence.
7. There is a need to diversify IGA options by expanding the skills-training opportunities provided. This will ensure the creation of unique business options and support for youth and women to develop distinctive skill sets that will enhance their competitiveness. Additionally, there is an opportunity to review the duration of the courses offered, considering shorter modules that could improve access to income while simultaneously enabling participants to complete other modules.

8. The evaluation acknowledged commendable efforts to address the recommendations from the baseline assessment. Some recommendations that are yet to be implemented and require attention include conducting regular evaluations to assess the effectiveness of health promotion programs and community initiatives, identifying gaps and areas for improvement. Furthermore, gathering community feedback is essential to adapting services to better meet their needs.

4.3 Adequacy and Appropriateness

This section of the report examines the level of alignment of the project interventions with the various stakeholders targeted by the project.

1. Project Alignment to Right-holders

The project targeted 60% refugees and 40% locals, with target beneficiaries being young girls, boys, teen mothers, people with disabilities (PWD), and the vulnerable in the community. The project worked within a multi-sectoral framework. The implemented project activities included awareness campaigns, capacity building, and community outreach integrated with government community health extension workers, bolstering policy alignment and sustainability.

The end-term evaluation revealed that the AFYA ZAIDI/GVA23 project was highly relevant to the needs of the target demographic. Through focused group discussions and key informant interviews, it was repeatedly affirmed that the interventions tackled genuine, urgent, and interconnected issues, such as malnutrition, gender-based violence (GBV), income deficiencies, substandard sexual and reproductive health (SRH) outcomes, and insufficient water, sanitation, and hygiene (WASH) services.

The focus on urban refugees was particularly relevant, given systemic barriers related to documentation, employment, and access to health insurance. Community health promotion was implemented in most projects, and beneficiaries, especially survivors of GBV, mothers in need of ANC services, and those in need of psychosocial support, received the highest level of care. One of the FGD respondents from Congo commented:

"HESED has taught us women's rights, especially on family planning, so that we don't give birth to too many children that we are not able to raise well."

The household assessments revealed a considerable number of single mothers without income, women experiencing abuse, and health issues at the household level that adversely affected household income and increased women's vulnerability. Furthermore, inadequate skills among the women obstructed their access to livelihood opportunities. Economic empowerment remained very relevant to the refugee populations especially because access to work is complicated without proper documentation. Training on IGA Skills such as dressmaking, hairdressing and make up/beauty, business kitties and funds for rent payments and to start their own businesses were greatly appreciated.

There was appreciation for the mental health support across various stakeholders as noted through the key informant interviews, one of the health officers from Kasarani commented:

"*The entire journey of a refugee is trauma, particularly for women, considering the lack of livelihood, stigma, and discrimination associated with being a refugee. Such vulnerability often leads to SGBV as refugee women seek survival strategies. Communities tend not to embrace issues related to mental health, resulting in poor health-seeking behaviors concerning mental wellness. The project collaborated with CHVs who developed and equipped refugees with basic skills through community awareness sessions.*"

Another community health officer in Eastleigh commented:

"The project increased openness in discussion on issues such as GBV which heavily impacts on mental wellness. People are now talking about different forms of abuse they are going through that nobody knew or talked about before, the self-referral pathways have also been strengthened which has addressed the stigma and discrimination that was a key challenge before proof that the people are now more empowered"

The project targeted teenagers (9-24) with hygiene kits based on focus group discussions. Most within this age group have started their menses, but sanitary towels are quite expensive, leading many girls to stay home due to a lack of supplies. In the implementation location, girls are also vulnerable because of poverty, worsened by poor parenting; many are not at home and may be unaware of what happens to their children when they are not in school. According to community health officers, many girls lack knowledge on menstrual hygiene management and risk infections. The project provided young girls with hygiene kits and life skills training, which was highly appreciated by various stakeholders.

The Eastleigh Center was leading among other centers regarding teenage pregnancies and the incidence of second pregnancies. The sexual health education and rights initiatives have enhanced contraceptive use. The girls are more empowered. The project established safer spaces where young women collaborated with others in smaller groups, thereby providing environments for young women to meet and converse.

2. Project Alignment to Duty Bearers- Health facilities

The Kenya Health policy 2014 -2030 focuses on ensuring equity, people centeredness and a participatory approach, efficiency, a multisectoral approach, and social accountability in the delivery of healthcare services. The policy embraces the principles of protection of the rights and fundamental freedoms of specific groups of persons, including the right to health of children, persons with disabilities, youth, and minorities, the marginalized and older members of the society, in accordance with the Constitution. By working with the refugees, the project was aligned to the Government on the principles of protection of the rights and fundamental freedoms of specific groups of persons moreover the project was aligned to the government commitment to multisectoral approach in delivery of health services.

The government remains responsible for the supply of medical commodities and infrastructure development. HESED Africa complemented these efforts by providing laboratory reagents, antenatal supplies, and nutritional supplements, contributing to improved maternal and newborn health outcomes. However, malnutrition remained a significant challenge among both refugee and host communities. Many mothers faced difficulties introducing complementary feeding after delivery due to financial constraints, resulting in continued child malnutrition, particularly among refugee households.

The Eastleigh Health Center underwent significant infrastructure upgrades that improved sanitation, water supply, and access, enhancing patient experience and operational efficiency. Sanitation improvements included full renovation of toilets and bathrooms across departments, installation of hot water showers, and separation of male and female restrooms, directly addressing community-identified gaps and boosting client satisfaction. Before the upgrades, clients brought hot water necessary for women who had natural births from home; now, hot showers are readily available in the facility. The facility gate was widened and leveled to allow easy entry of small and large vehicles, including NWSC lorries, improving supply logistics and patient access. This upgrade removed barriers to deliveries and allowed emergency vehicle access. It supports smoother operations and better alignment with the facility's evolving service demands. However, persistent water supply challenges remain due to lack of connection to Nairobi water grid, leading to reliance on intermittent water bowsers. This limits consistent use of water-intensive systems like macerators and flushing toilets.

The government has a key responsibility in development and provision of the health workforce, the AFYA ZAIDI project supported the local health centers in empowerment of staff through Continuous Medical Education (CMEs) on different areas such as GBV, Infection Control. Among those trained were the Kenya Police service who were mostly trained on how to handle GBV reporting and a GBV desk was formed. Previously, the situation was not good in the way victims would be received when going to report a violation of their rights, as expressed by one Congolese refugee during a FGD session; *"I have gone through a lot of challenges and reported to Mwiki Police Station, but they did not assist me. They instead told me to go and look for the perpetrators, and in case I found them, I go back and inform them, yet the fact that I was insulted meant that they overpowered me, so how would I have looked for them? I lost hope and went back home."*

The GVA23 AFYA ZAIDI project, integrated well with existing community health structures to address key local health priorities like GBV, nutrition, and mental health through targeted training and community dialogues. HESED Africa conducted a five-day training for CHPs and CHAs focused on identifying priorities based on local data. Community dialogue and action days engaged stakeholders and residents in identifying and collectively addressing health challenges. Stakeholder forums involved opinion leaders to strengthen program implementation and community buy-in. These interventions empowered CHPs to improve referral pathways and community health education.

The community health strategy in Kamukunji sub-county focused on delivering primary health services at the household level through a network of 520 community health promoters (CHPs) supervised by 8 community health assistants (CHAs). This approach allowed tailored health interventions at the household level, improving reach and service quality. Capacity building emphasized equipping health workers with skills to handle issues such as sexual and gender-based violence (SGBV), early pregnancy, and mental health. The cascading training model ensured that knowledge flowed from CHAs to CHPs, impacting over 52-community health units. This structure integrated government standards with community needs, supporting sustainable service delivery.

3. Partnerships and Stakeholder Engagement

The project's design integrated lessons from prior health assessments and aligned with Farmamundi's mandate on universal health coverage. The project's conceptualization is rooted in combining HESED Africa's field expertise

with Farmamundi's health-improvement mission. The partnership with GVA is structured to support these aims through coordinated funding and operational oversight.

HESED Africa is one of the primary active partners supporting community health in Kamukunji after funding cuts led other partners like St. John's and DREAMS to withdraw. The absence of other partners has left gaps in support for young mothers and adolescents. Cross-sector collaboration enhanced referrals and integrated care.

HESED Africa's ability to work within government frameworks enabled smooth integration. The established systems and trained personnel created a foundation for ongoing community health improvements. Institutionalizing these processes supports long-term health gains. The partnership model leveraged existing government structures for efficiency. Ongoing coordination with these departments is essential for sustainability. Government departments including immunization, family planning, GBV, mental health, clinical services, pharmacy, and maternal child health actively collaborated in the project. This multi-departmental engagement ensured comprehensive service coverage while the cross-sector collaboration enhanced referrals and integrated care.

4. Emerging needs

i. Recent policy updates on immunization, including the shift from two HPV vaccine doses to one dose for girls' aged 10 to 14, required program adjustments and community re-education. The change affected outreach schedules and advocacy approaches previously built around two doses. This calls for increased awareness among the target population.

ii. The government introduced new vaccines, such as the typhoid conjugate vaccine and an additional polio dose at nine months. These policy shifts necessitate ongoing communication and flexibility from implementing partners, such as HESED Africa, to align with government guidelines. This highlights the importance of adaptive capacity in community health programming. Ensuring community understanding is critical to maintaining vaccination coverage.

iii. The transition to SHA affects refugees, many of whom are not registered due to lack of documentation, especially asylum seekers without refugee cards. Language barriers hinder their ability to complete forms correctly, leading to higher costs. Supporting refugees in filling out applications is crucial.

iv. Medical screening needs to be conducted at the point of intake, at the refugee registration center. However, due to a shortage of sufficient staff, this has not been implemented. This situation presents an opportunity for HESED, through future project interventions, to collaborate with refugee services to support early identification and assistance for refugees at the registration point.

v. The Shirika plan is a pivotal driver of future humanitarian efforts. It is essential that the upcoming project planning align with the strategic pillars, particularly the health pillar, to support Government priorities and enable better collaboration. The plan's blueprint will be available in January 2026.

vi. Refugees encounter obstacles to achieving financial inclusion and face difficulties registering businesses. It is crucial to identify the factors hindering refugees' access to markets, as well as opportunities for collaboration to support their economic empowerment.

vii. Child neglect was noted to drive abuse in the project locations. Raising community awareness on parenting and collaboration between parents and educators can be more effective. Expanding the project to include more schools can broaden the project impact.

viii. The prevalence of drug abuse and addiction to hard drugs has been observed to be increasing among young refugees, particularly among Congolese and Ethiopian populations. This situation necessitates a comprehensive study to identify the factors contributing to the rise in addiction.

ix. There is a notable increase in the number of young mothers in the two project locations, contributing significantly to the rise in malnutrition cases, particularly among the Oromo and Somali communities. This situation necessitates enhancing training programs focused on child nutrition (Lishe Bora) specifically targeting the young mothers.

4.4 Ownership and participation

This section of the report appreciates that the project engaged other stakeholders to achieve its objectives and therefore looks at the stakeholders involved and activities implemented together with recommendations on what can be strengthened in future projects.

The GVA23 AFYA ZAIDI project was well received in the two project locations, Kamukunji and Kasarani sub-counties. Key stakeholders involved in the project included officials and workers from the County Ministry of Health, local health facilities such as hospitals and dispensaries, the Ministry of Education, local administration including area chiefs, the local community, as well as vulnerable groups such as refugees, the elderly, and persons with disabilities (PWDs).

There was active involvement of the county government, and health facilities in both Kasarani and Kamukunji sub-counties. For instance, when dealing with cases of GBV, HESED-Africa worked closely with the police stations which were a critical initial point for reporting and addressing Gender Based Violence. Multi-sectoral collaboration was used throughout the project period by bringing together all GBV-related actors: health, education, security, social protection and faith-based organizations. This approach enabled shared ownership of cases and referrals. County government collaborations ensured oversight and alignment with public health goals. HESED Africa's consultative approach before project rollout was lauded or aligning interventions with local priorities and needs. Government collaboration allowed program adaptation to policy shifts, such as the new Kenyan health insurance (SHA) system inclusion. HESED Africa also participated in the sector thematic working group, specifically within the livelihood and mental health subgroup. This engagement offered valuable opportunities to collaborate with various stakeholders, including the County Government of Nairobi. Being part of this group also facilitated the alignment of the GBV policy.

Community involvement through scorecards and feedback loops has been central to identifying needs, guiding projects, and measuring impact, ensuring the facility's services align with population demands. The community scorecard process involved collaboration with the communities quarterly, fostering shared responsibility for health service quality. Engagement of religious leaders; who have become allies in reducing stigma, promoting health-seeking behavior, and openly sharing personal experiences after empowerment sessions. This contributed to

improved community surveillance and reporting. Regular exit surveys and client interviews were used to continuously monitor satisfaction and service quality.

Healthcare workers were involved through trainings and capacity building, these significantly enhanced staff skills in cancer screening, pharmacy management, and gender-based violence care, leading to better patient outcomes and service quality. Continuous Medical Education (CME) sessions were conducted quarterly, keeping staff updated on emerging health issues. The training aligns with the facility's goal to provide comprehensive primary care with specialized services. Training on gender-based violence (GBV) care equipped staff to provide confidential, non-judgmental support, resulting in increased community trust and client uptake of counseling services.

Recommendations towards Increased ownership and stakeholders Participation

i. It is also necessary to systematically outline and document a comprehensive project stakeholder engagement plan to enhance collaboration with non-governmental organizations and government entities. Leveraging the expertise and resources of these stakeholders is essential for improving program implementation and community participation. Future project initiatives should consider increasing the involvement of religious and community leaders in project activities. Additionally, the project can leverage community volunteers to generate significant impact in health initiatives and facilitate broader access to services.

ii. Enhance integration with governmental systems by aligning project activities with the structures of the Ministry of Health (MOH) and conducting joint review meetings to foster collaboration. Additionally, there is an opportunity to reinforce resource sharing; the project may establish a resource-sharing agreement with the County Government to supply at least 50% of the budget, including pharmacy, laboratory, and non-pharmaceutical supplies. This approach is crucial for improving sustainability.

iii. Consider implementing low-cost and community-led interventions; promote initiatives that communities can maintain independently of donor support, while also assisting communities in identifying alternative sources for items such as sanitary towels.

iv. Enhance community feedback mechanisms by maintaining suggestion boxes, utilizing whatsApp groups and community forums, and fostering community-led identification of issues and development of solutions.

4.5 Efficiency

In determining the project efficiency, the review focused on both human and financial resources in line with the Afya Zaidi project objectives. This review also focused on the policies, systems, processes, structures and tools in the organization and how they support the delivery of the project results as well as the management of the available resources. The findings were as follows:

Funding: The AFYA Zaidi project was a 15-month project (June 2024–August 2025) with an approved budget of 292,064 Euros, which translates to KES 39.574.676,40. Disbursements were released in three tranches, i.e., 1st disbursement on 2nd July 2024 (34%), 2nd disbursement on 7th Nov 2024 (36%), and the 3rd on 31st Jan 2025 (30%). The budget was developed collaboratively between the HESED Africa program team and the donor, and therefore the approved budget was in line with the agreement. Disbursements were based on the focus, which

was done on a quarterly basis. The review established that during the period, there were foreign exchange gains that were channelled to program activities. A designated bank account for this project was maintained, with both Euro and KES accounts, and clear signing mandates for the Director and Board Chairman. Upon the end of the project, it is expected that the bank accounts are closed.

To facilitate field activities, beneficiaries received cash allowances as safety nets under the Income Generating Activities (IGA) component. A total of 35 women were supported through the IGA project, with each beneficiary receiving KES 8,000 per month. Payments were documented through signed forms with vouchers authorized by the Director.

Reporting: HESED Africa prepared monthly reports for the donor, using a designated template that HESED-Africa completed and uploaded to an online-shared folder for review. Physical supporting documents were sent via courier after three months. The project developed quarterly and annual reports as per the funding requirements. The donor appointed an auditor who performed a comprehensive audit of the project. HESED-Africa is yet to commission an institutional audit; it is anticipated that this will also cover the Afya Zaidi Project within the designated period.

Resource Utilization and Optimization: Consultations with the finance personnel and beneficiaries indicate that the allocated budgets were adequate for the partners, and expenditures were aligned with the approved budget. Discussion with the project partners pointed to the project resources being sufficient except a few instances where they pointed to lack of consistency on the nutrition supplement, which sometimes resulted to default among project participants resulting to relapse of treatment. This underscores the need to strengthen planning and procurement processes to ensure consistent supply throughout the project period.

The donor approved all expenditures, with no variances requiring budget realignment or modifications. The project did not engage in asset procurement. Additionally, the evaluation confirmed that the staffing levels were sufficient to manage the project effectively.

Policies and procedures: HESED Africa maintained essential policies that guaranteed proper implementation of the project. These include payment verification protocols systematically followed, physical documentation sent to the donor, compliance with donor reporting timelines, and assurance of value for money through efficient resource utilization. The project adhered to the procurement guidelines outlined in the manual, following established approval procedures, and observing comprehensive policies covering human resources, finance, procurement, monitoring and evaluation (M&E), and resource mobilization strategies during purchasing processes. The organization has also launched a strategic plan for the period 2025-2029.

The policies are current as they were updated in 2025. The existing policies that were reviewed and ratified this year included the Human Resource manual, procurement, per diem under travel policy, guideline to finance support to third party's guidelines, finance policies, safeguarding, anti-corruption policies etc;

Budget Variances: The end term evaluation noted that there were no notable variances in the entire budget. The burn rates for most of the budget lines were on track, with most expected to have done about 100% as at the

project end term. Regarding actual expenditures, the administrative costs were noted to be within the budget, with expenditure levels being realistic for the project.

Overall expenditure aligned with approved budget. The variance across all the budget lines were deemed within acceptable range. Overall, the GVA23 project maintained strong budgetary control, with total expenditure fully aligned to the approved budget. Variances across individual budget lines falls within the allowed budget flexibility limit.

Risk Management: The project had put in place risk management mechanism; some of the anticipated risks included fraud; to avoid conflict of interest, segregation of duties, approval thresholds, as well as cash management the project minimize cash transaction, most of the payments were done via cheques using direct mobile payments on need basis. The organization has an institutional risk register.

Monitoring and Evaluation: The project fulfilled donor-reporting requirements and employed standardized monitoring tools at both the facility and community levels. Some of the developed monitoring tools included the intake form to capture fundamental information for right holders in the project, the log sheets which were customized to ensure confidentiality, and the mental wellness template. Household visits, monthly follow-ups, trainer observations, business monitoring visits, and feedback or periodic review meetings supported accountability and facilitated course correction. The project utilized MoH registers, Kobo Toolbox surveys, attendance sheets, pre- and post-tests, distribution and delivery list and routine supervision to monitor performance. Data collected from the project informed adaptive programming, such as aligning community sensitization topics with facility disease trends, thereby demonstrating operational efficiency by effectively integrating evidence into practice.

Most project data was collected from health facilities in summarized form, reducing paperwork at facility level. The data was used to monitor the top five diseases and to inform targeted health talks and community discussions.

The end term evaluation observed manual data systems and limited integration of programmatic and financial data tracking hence constraining efficiency analysis and timely decision-making. The evaluation also noted gaps in systematic evaluation, particularly in school health and livelihood components, limited opportunities to optimize resource allocation during implementation.

Recommendation towards Improved Project Efficiency

i. Future or related projects should ensure that more resources are allocated towards community awareness sessions. Some of these sessions last for more than four hours; therefore, it is essential to secure a conducive venue for the meetings. It is important that SGBV survivors are trained outside the environment where they faced abuse. There is a need to introduce an indirect cost, such as 10%, to support the organization's operations and enable it to carry out other activities. Additionally, more resources are required for the facilitation of CHVs to support communication and follow-up within the community. This is vital for fostering an empowered team capable of continuing to provide services to the community.

ii. The evaluation identified a deficiency in the follow-up mechanism for participants in some key project interventions, such as food demonstrations. The evaluation recommends reinforcing peer/support groups, including nutritional support groups, and utilizing Community Health Volunteers (CHVs) to enhance follow-up efforts and ensure greater impact. Additionally, the project did not track defaulters to understand the underlying reasons for defaulting. This highlights the need for increased allocation towards monitoring and evaluation.

iii. There is a need to enhance information sharing and dissemination to ensure that insights from the project are widely communicated to other stakeholders. This underscores the importance of developing a comprehensive knowledge management guide to aid projects in such processes.

iv. Future and related projects at HESED Africa may consider increasing investments in research, particularly surveys, especially in areas where gaps are identified. This includes issues under emerging topics, such as the rising drug addiction among youth.

4.6 Effectiveness

This section focused on the project delivery approaches as well as the extent to which the planned activities were achieved as provided in the variance analysis of the planned activities. The activities variance analysis is provided as an Annex to this report.

Table 13: Summary of the assessment of project implementation approaches

Approach	Evaluation findings and effectiveness of the approach
1. Provision of Quality Health Care	This approach was therefore deemed effective in providing level 3 public health facilities with an acceptable means of delivering services to the community. Community members who participated in the evaluation indicated that, following improved services at the health facilities, they are now confident in seeking primary health care at the respective facilities. Afya Zaidi project supported in strengthening of the Eastleigh and Kasarani health centers by enhancing the following: i. **Accessibility**; Services are affordable through the use of SHA funds availed to the facility and are physically reachable. The project provided visible signages, clear branding and pavements that made the facilities passable. ii. A**vailability**: through the provision of essential health products like lab reagents for tests, drugs, and complementary supplies. Essential services, staff, medicines, and equipment are present. iii. **Acceptability:** Health facility acceptability was enhanced through infrastructure improvements, including repairs to leakages and sewer systems, and by providing services that respect cultural, social, gender, and age differences. Care was delivered with dignity, privacy, and confidentiality, using simple and understandable language. Facilities were made more inclusive and responsive by offering youth-friendly, disability-inclusive, and

	gender-responsive services, as well as providing care at convenient times and locations. Community engagement in planning and feedback further strengthened acceptability, with clients reporting that they felt respected, listened to, and comfortable returning for care. iv. **Quality;** in capacity building/ improving the knowledge and technical skills of the healthcare staff and community health promoters to provide better services while ensuring human rights are observed. The project ensured that national and WHO clinical guidelines are followed, offered comprehensive package of services (prevention, promotion, treatment, rehabilitation), ensured continuity of care and proper follow-up especially for the malnourished children as well as ensured regular monitoring, supervision, and quality improvement by conducting exit surveys with the patients at the facilities to ensure better service delivery & timeliness. **Recommendations** i. The facilities are not connected to Nairobi water for continuous supply of water. They only rely on the purchased water buzzers. Supporting this connection will provide a lasting solution on water supply. ii. For better antenatal care for the pregnant mothers, ultrasound services are essential to ensure the baby is well monitored. There is need to support the facilities with ultrasound machinery.
2. Prevention of Health-related Challenges	The project focused on connecting health with educational and community programs in the area liaison with schools and community organizations was a very effective approach in preventing some of the communicable diseases and psychosocial challenges. By constructing a youth-friendly SRH center with qualified health personnel, including nurses and counselors, the Afya Zaidi project provided comprehensive SRH orientation to people of childbearing age in the intervention area. Community promoters and trained educational agents connected health structures with the community and schools by raising awareness through campaigns promoting SRHR and responsible sexuality among young people, messaging, and peer learning. Qualified health personnel were always available at the center to respond to needs raised and offered psychosocial support to GBV and SGBV survivors. This improved the acceptability of SRH services, influencing both cultural and relational change. In the prevention of communicable diseases, the Afya Zaidi project created awareness and built capacity on various public health issues related to Water, Sanitation and Hygiene (WASH) as well as proper nutrition among pregnant women and children under 5 years of age. The distribution of WASH, hygiene, and nutritional kits among the most vulnerable population helped reduce diseases such as cholera and malnutrition.

	The project also offered psychosocial support to the most vulnerable and survivors of GBV/SGBV, reinforcing their protection and integral recovery circuits; hence preventing them from becoming victims of vulnerability. The prevention approach was found to be effective as it reduced illness and premature deaths as well as increased productivity and learning outcomes among the community members.
3. Capacity Building	The project supported capacity building of the health personnel in proper data collection using the desired variables, data quality assessment in SRH and GBV, epidemiological surveillance as well as antimicrobial stewardship in terms of resistance. Capacity building in the health information system has improved collection and use of quality data for decision making and planning within the facilities. **Recommendation** i. There is still need for more capacity building on the entire HMIS components as well as support the health personnel in digitizing the records into the DHIS system. This is because most records are on paper which do not guarantee long term storage and management.
4. Livelihood support	The project provided cash transfers, IGA training, and food items to the most vulnerable individuals and GBV/SGBV survivors, strengthening their socio-economic resilience and reducing vulnerability.
5. Cross cutting issues	*Human rights-based approach:* The project ensured that the interventions upheld the rights, dignity and entitlements of all beneficiaries. The approach guided service delivery to meet the principles of availability, accessibility, acceptability and quality (AAAQ), while prioritizing equitable access for adolescents, women and children. Community participation and accountability were strengthened through dialogue forums, feedback mechanisms and engagement of community health structures, enabling rights-holders to influence service design and quality. The project also promoted informed choice, confidentiality and non-discrimination in SRH and MCH services, thereby improving client trust, service utilization and alignment with national and international human rights standards. *Gender and Age:* The project applied a gender-responsive approach that intentionally focused on addressing the specific needs, barriers and vulnerabilities of women and adolescents in accessing Maternal, Child Health (MCH) and Sexual and Reproductive Health (SRH) services. The interventions were targeted to ensure the services responded to unequal power relations, harmful gender norms and structural barriers that limit girls' and women's ability to seek and receive care. The project promoted safe, confidential and youth-friendly service environments, strengthened the capacity of health workers to provide gender-sensitive care, and also engaged men and community leaders to support positive gender norms. *Environment:* Environmental considerations were mainstreamed through community education on safe water, sanitation, hygiene, waste management and the health impacts of environmental degradation, recognizing the strong link between a healthy environment and improved maternal,

	child and reproductive health outcomes. The project strengthened community and facility-level practices to reduce environmental health risks, promote clean and safe surroundings, and support behavior change for sustainable environmental management. Through this approach, the project contributed to improved environmental awareness, reduced exposure to preventable environmental health hazards, and enhanced the overall health and well-being of targeted communities. *Diversity (cultural, conflict sensitivity, disability):* Project design and implementation deliberately promoted inclusion, equity and mutual respect, ensuring that services and community engagement activities were accessible and responsive to the distinct needs of different population groups. Conflict sensitivity was integrated by avoiding actions that could cause tensions, while dialogue forums, joint activities and community structures were used to strengthen social cohesion and a culture of peace. Through this approach, the project contributed to improved trust, cooperation and peaceful coexistence between refugees and host communities, creating an enabling environment for equitable access to health and social services. **Recommendation** i. The project should deliberately mainstream the inclusion of Persons with Disabilities (PWDs) in all aspects of design, implementation, and monitoring to ensure equitable access to services as well as improve overall service utilization and community cohesion.

Challenges Experienced over the Project Period

1. Movement among the refugee households posed significant challenges in monitoring and tracking the project participants. These challenges extended to the oversight of businesses beyond the initial setup. Additionally, follow-up after service termination proved problematic. Community mobility disrupts continuity of care, complicating tracking efforts and occasionally leading to the loss of particularly sensitive cases.
2. Adoption of an alternative approach to dispute resolution posed a challenge in case management within the community, contributing to the perpetuation of SGBV. The cases were resolved at the victims'

expense. Occasionally, violence from family members or spouses occurred during follow-up with the GBV survivors.

3. Rising demand for therapy has strained counselling services and increased the workload of community health promoters, highlighting the need for stronger community mental health awareness.
4. Reluctance and resistance to receiving or accepting information, as particularly observed among the youth, who, in some instances, have demanded compensation to participate in meetings or awareness sessions. Additionally, boys and men generally remain hesitant to discuss mental wellness issues.
5. The increased insecurity has led to police harassment and frequent arrests of refugees. Consequently, there is no safe or conducive environment for refugees or persons of concern to engage in livelihood opportunities, as most lack adequate documentation.

4.7 Impact

The evaluation observed some changes as a result of the project interventions; such changes have the potential to develop into long-term changes/ project impact through sustained efforts. The following were some of the changes observed from the evaluation:

Increased Access to Quality Health for Refugees: The project contributed to improvements in the infrastructure, supplies, and staff capacity significantly enhancing the availability, accessibility, acceptability, and quality (AAAQ) of health services at Eastleigh and Kasarani health facilities. HESED Africa's support strengthened healthcare workers' and Community Health Promoters' capacity in gender-based violence (GBV) identification, forensic evidence collection, cancer screening, pharmacy management, and data use for informed decision-making. The establishment of a dedicated SRHR unit and improved water supply enhanced service comprehensiveness, infection prevention, and patient comfort. Continuous medical education among health officials also ensured up-to-date clinical skills, contributing to improved service quality, increased client satisfaction, and increased patient utilization. Higher service uptake translated into increased SHIF claims, boosting facility revenue to support other needs and improvements, while HESED Africa-supported drug supplies ensured continuity of care. Refugees' access to services improved through insurance registration and health education, and community awareness campaigns led to positive behavioral changes in nutrition, sexual health, and disease prevention. The project also contributed to improved access to mental health services for the refugees.

Improved Health Information Systems (HIS): The project contributed to improved health information systems by strengthening routine data collection, reporting, and use at the facility and community level. Healthcare workers were supported to consistently capture service delivery data using the right indicators that could be measured leading to improved data completeness, accuracy, and timeliness. This enabled these facilities to generate more reliable evidence for planning, monitoring service utilization and epidemiological trends, and tracking priority health indicators. As a result, decision-making became more data-driven, supporting better allocation of limited resources, improved follow-up of vulnerable populations, and enhanced accountability to both communities and health authorities.

Improved health-seeking behavior: Community sensitization on the importance of preventive and curative health care, combined with the availability of affordable, quality services at Eastleigh and Kasarani health centers, has increased community responsibility and willingness to seek timely health care. This includes seeking both medical advice and treatment. A key informant from the MCH clinic noted that :*"HESED has been supplying reagents which has helped in increasing number of mothers seeking ante-natal services. Initially mothers stopped coming for clinics when they realized there were no reagents."* Outpatient attendance at Eastleigh Health Centre increased from 17,810 in 2023 to 18,544 in 2024, with a decline to 8,771 in 2025 attributed to prolonged health worker strikes; however, patient numbers were higher during periods of full facility operation.

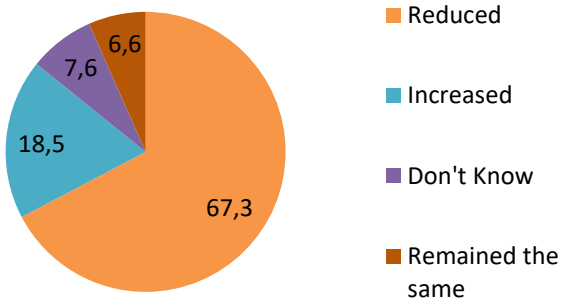
Capacity building in gender-based violence (GBV) care enabled staff to provide confidential and non-judgmental services, strengthening community trust and increasing uptake of counseling. There was also a notable rise in preventive service utilization, including child vaccination and routine immunization. Adolescents increasingly self-referred for counseling and SRHR services, reflecting reduced stigma, improved trust in the health system, and greater empowerment among young people.

The project improved tracking and referral of survivors and defaulters, encouraging better health-seeking behaviors. Additionally, CHVs enhanced detection and alert systems to report cases, enabling timely access to health solutions. Awareness sessions helped reduce stigma and discrimination, further motivating individuals to seek help. Support groups also played a role in reinforcing these health-seeking habits. Moreover, the project increased health solution uptake among the youth by creating a safe environment for them to access assistance.

Improved knowledge and awareness: The evaluation findings indicate a notable improvement in community knowledge and awareness regarding maternal and child health, Gender-Based Violence (GBV), Sexual and Reproductive Health and Rights (SRHR), and mental health. Target populations demonstrated increased understanding of health rights, available services, prevention strategies, reporting and referral mechanisms. This enhanced awareness contributed to more informed health-related decision-making and strengthened the community's capacity to identify risks and appropriately seek available support services.

Reduced GBV/SGBV: The evaluation noted that the rate of GBV in the community has reduced. The findings suggest that although many community members perceive progress, a substantial proportion still see rising or unchanged GBV levels, showing the need for continued prevention efforts and stronger support systems.

Figure 8: Rate of GBV within the community compared to one year ago



The majority of respondents reported feeling secure, with 62.2% indicating comfort when around family members of the opposite gender. Another 29% felt slightly secure, showing that some households experience mild discomfort or uncertainty. Only 8.8% reported feeling not secure, which highlights that although most households experience safety and trust, a smaller group may require additional support in strengthening family relationships and addressing underlying concerns related to gender dynamics.

The project contributed to a reduction in Gender-Based Violence (GBV) and Sexual and Gender-Based Violence (SGBV) through increased community awareness of human rights, the harmful consequences of GBV, and available prevention and response mechanisms. Improved knowledge led to increased reporting and disclosure of GBV cases, reflecting positive shifts in attitudes and behaviors toward relationships grounded in respect and non-violence. Beneficiaries, including refugees, demonstrated greater confidence in seeking justice, including engaging formal structures such as police stations when incidents occurred.

Engagement of men and boys in GBV prevention dialogues strengthened community-level accountability and promoted norms that discourage violence. The establishment of a dedicated GBV center, supported by the project enhanced access to confidential, survivor-centered, and quality GBV services. Economic empowerment of SGBV survivors through livelihood support enabled women to establish independent income-generating activities, which contributed to reduced vulnerability to abuse and increased decision-making autonomy. In cases where violence persisted, survivors were better equipped to make informed choices, including exiting abusive relationships.

Psychosocial well-being among beneficiaries was strengthened through peer support groups, which provided sustained platforms for mutual support, shared learning, and collective problem-solving, further reinforcing resilience and recovery among survivors.

Healthy and stable households: The project contributed to healthier and more stable households through integrated prevention, early treatment, and livelihood interventions. Improved access to preventive and curative health services reduced disease outbreaks and costly health complications. Enhanced hygiene practices in households and schools, including increased handwashing, contributed to reduced incidence and impact of waterborne diseases such as cholera. In collaboration with Nairobi County, additional handwashing facilities were installed in targeted primary schools, with learners adopting proper hygiene protocols. School Health Clubs gained practical skills in soap making, while girls received education on safe menstrual hygiene management, contributing to improved school attendance and psychosocial well-being.

Improved nutrition and livelihood outcomes were achieved through income-generating activities and cash transfers, which enabled vulnerable households to meet basic needs, support children's education, and

strengthen overall household stability. Women and youth acquired practical skills and established small businesses, increasing economic independence and contributing to reduced GBV/SGBV linked to poverty-related stress. During a KII session with the school health coordinator, she mentioned that *"significant reduction in malnutrition and improved hygiene among the learners increased school enrollment for children, and a decrease in school absenteeism, dropouts and even teenage pregnancies".*

Increased awareness and uptake of family planning and antenatal care services contributed to improved maternal and neonatal health outcomes, including reduced maternal and neonatal deaths. Improved birth spacing, particularly among refugee communities, enhanced the health and well-being of mothers and children, contributing to more resilient and socially stable communities.

Reduced teenage pregnancies: The project interventions contributed to positive behavioral change and improved adolescent health outcomes through increased access to accurate sexual and reproductive health information, enabling informed decision-making regarding family planning and responsible sexual behavior. These efforts resulted in a measurable reduction in early pregnancies, with Kamukunji Sub-County improving its county ranking from first to seventh in reported early pregnancies. Health facility records from Eastleigh Health Centre indicate a 22% reduction in pregnancies among adolescents and young people aged 10–24 years, declining from 295 cases in 2024 to 229 cases by the end of 2025. This reduction reflects strengthened community engagement, increased uptake of SRHR services, and improved adolescent empowerment to make informed reproductive health choices.

Strengthened community cohesion: The project significantly strengthened community cohesion by fostering inclusive participation through community dialogues and feedback forums that brought together diverse groups regardless of gender, ethnicity, or country of origin. These platforms enabled collective identification of shared challenges and promoted mutual understanding and social inclusion. Counseling services demonstrated strong positive effects, particularly among women beneficiaries, while Community Health Promoters (CHPs) emerged as trusted and reliable agents for outreach, referral, and follow-up, expanding the reach and effectiveness of interventions.

Engagement of men and boys through male involvement groups contributed to positive shifts in attitudes and social norms, including reduced tolerance for gender-based violence and increased support for women's empowerment. Facility–community linkages were strengthened through improved coordination between CHPs, health facilities, and referral actors, resulting in faster follow-up of GBV survivors, improved referral completion, and enhanced tracking of service defaulters.

Community group sessions evolved into sustained learning and peer-support platforms, as evidenced by continued participation and proactive information-seeking even during implementation gaps. Additionally, engagement of religious leaders helped to reinforce trust, collective responsibility, and social cohesion within the community.

Unforeseen Positive Changes

1. Increased confidence among women to walk away from abusive marriages, contributing to a reduction in GBV cases.

2. Growth in the number of businesses established by female refugees, challenging traditional norms that view money and finances as solely a man's responsibility.
3. Increase in the number of men, especially from the refugee community, supporting their women to work and requesting inclusion of their wives in project activities.
4. Improved confidence and integration among refugee women, who took ownership of project activities and became mentors and trainers within church groups, chamas, and other community structures.
5. Improved household-level resource sharing, reducing friction and quarrels within families.
6. Improved reproductive health outcomes, with more men willing to use family planning methods and accompany their partners to child welfare and family planning clinics.

Unforeseen Negative Impacts

1. The free health services provided under the Primary Healthcare Fund (PHF), for Level 3 hospitals, supplemented by HESED Africa's support for improved service delivery at Eastleigh and Kasarani Health Centers, have attracted clients from neighboring locations. This has placed additional pressure on the limited resources available for the most vulnerable. The high number of refugees who lack alien cards for SHIF registration, are also served as vulnerable populations since they can't be denied the primary healthcare, and this internally strains the facilities as funding only covers registered numbers.
2. Community resistance and participation fatigue were observed in some areas. Some community members only engaged when financial incentives, such as snacks, were provided, creating expectations for monetary compensation.
3. Unconditional cash transfers intended for seed businesses often lacked clear tracking of usage, with some funds diverted to pressing household needs. This made it difficult to accurately measure the impact of the support.
4. Social dynamics sometimes constrained spending choices, as control over cash by women's families limited their individual agency over investment decisions.

4.8 Coordination and Coverage

The government's Universal Health Coverage Program aims to provide equitable, quality health care for all, regardless of income or insurance status. Kenya collaborates with development partners, NGOs, global agencies like WHO, and the private sector to strengthen service delivery, health financing, and innovation. The contribution of the project in providing essential drugs, pharmacy commodities, and nutritional supplements, supplemented government supplies to ensure uninterrupted patient care. The project support was vital since 40% of clients are non-Kenyans, including undocumented refugees not covered by government reimbursement.

The project supplemented erratic government supplies by consistently providing pharmaceutical products such as antibiotics, analgesics, antihypertensives, and blood glucose medicines, as well as lab commodities for antenatal care and nutritional supplements for malnourished children. This support ensures continuous outpatient care despite government supply gaps. Collaboration with the government allowed the project to support policy shifts, such as the inclusion of the new Kenyan health insurance (SHA) system. The project structure aligned well with government-established structures and with community health structures, such as CHPs linked to a facility.

Capacity building by the project addressed the previous lack of knowledge and safe spaces for GBV victims. The project supported in capacity building of basic human rights, different forms of GBV, legal referral pathways, cancer screening and treatment. This intervention directly improved patient care and community trust in reporting GBV. Training on rational drug use and forecasting helped prevent stockouts and promote efficient resource use. The cascading training model ensures knowledge flows from CHAs to CHPs, impacting over 52 community health units.

Improvements in infrastructure at health centers have sustained service delivery and improved infection control. The GVA23 project improved water systems at Eastleigh Health center including provision of water tanks and pumps, unblocking the sewers, piping as well as fixing sinks and hot showers powered by solar system. The old and rugged outlook of the facility was improved with the project fixing a new and wide gate, installing cabros, and painting the walls. *''The facility is now clean and the patients at the maternity do not request for hot water from home any more. They are now enjoying the hot showers."* Facility in-charge, Eastleigh H. C

The AFYA ZAIDI project has worked extensively with all involved parties; both national and private. In the duration of one year that the project operated in the Kamukunji and Kasarani sub-counties, collaborations were developed and initiated with actors working within the settlements. HESED Africa worked collaboratively with a wide range of partners whose complementary roles strengthened service delivery and community impact. NGAO structures, including the chiefs and "*Nyumba Kumi"* structures, played a critical role in addressing community challenges and mobilizing residents for health interventions such as immunization. Community Health Committees provided trusted local leadership and influence, supporting acceptance and uptake of services. Médecins Sans Frontières (MSF) supported emergency preparedness and response, regularly providing refreshments during activities, responding to emergencies, and offering walk-in services for survivors of gender-based violence (GBV).

The Kenya Red Cross supported non-communicable disease (NCD) clinics through screening and provision of medication, while Catholic Relief Services (CRS) strengthened disease surveillance for polio, measles, and environmental risks to enable early detection and timely reporting. The National Council of Churches of Kenya (NCCK) supported vulnerable clients by assisting with referral bills, ensuring continuity of care. Fikra Moja Youth Group played an important role in community mobilization, particularly engaging young people. The Nairobi City County Government provided health personnel and technical guidance on service delivery priorities and implementation areas. Refugee Point complemented the efforts through medical camps targeting refugee populations. Save the Girl contributed to GBV and female genital mutilation (FGM) prevention and response, while the Danish Refugee Council (DRC) supported economic and social interventions that addressed underlying vulnerabilities. Together, these partnerships enhanced coordination, responsiveness, and the overall effectiveness of the AFYA ZAIDI Project.

4.9 Sustainability

The sustainability prospects of the GVA23/AFYA ZAIDI point to a moderate likelihood of maintaining benefits beyond donor support. This is attributed to the project's foundation in institutional integration, capacity enhancement, community ownership, and multi-sectoral collaboration. The evaluation observed that the core interventions were aligned with government systems, delivered through public health facilities, and supported by trained personnel and community structures capable of sustaining key activities beyond the project's lifecycle.

The moderate level of sustainability is attributed to the lack of a formalized exit and transition strategy, ongoing reliance on external financing for services for refugee and undocumented populations, and limited integration of migrants into national health financing mechanisms, especially the Social Health Authority (SHA). These limitations present risks to the continuity of inclusive service delivery following the withdrawal of external support. Efforts towards sustainability were noted to include:

Institutional Integration and Systems Continuity: The AFYA ZAIDI project collaborated and coordinated with multiple actors and government institutions including community health structures in ensuring that they acknowledge ownership and participate in the interventions. This collaboration enabled shared ownership of cases, strengthened referral pathways, and improved accountability. Through integrated service delivery, long-standing strategic partnerships, and community-centered approaches, the project strengthened access to quality services for refugees, survivors of GBV, women, adolescents, and other vulnerable groups in the challenging urban informal settlements. Services were embedded in public health facilities and aligned with Ministry of Health (MoH) structures, and use of national tools and protocols. Integration of services within public health facilities enhanced quality, confidentiality, and trust, while community health promoters played a critical role in project outreach, prevention, referrals, and behavior change. Notable progress was achieved in GBV reporting, survivor support, mental health awareness, adolescent health outcomes, and women's economic resilience. One of the health officials from the Kamukunji sub-county noted that there is increased reporting of GBV case, attributing to HESED Africa's trainings and community awareness forums. She says *"We have witnessed increased GBV case reporting and community awareness, all attributed to HESED's training and outreach efforts, improving access to police gender desks and formal reporting channels."*

Infrastructure investments; such as the SRH and GBV units, are tangible and permanent assets that will continue serving both refugee and host communities beyond the project lifecycle.

Capacity Building and Human Resource: The project invested significantly in building the capacities of Community Health Practitioners (CHPs), health workers, counsellors, social workers, and nutrition staff. Skills gained; particularly in GBV response, psychosocial support, adolescent health, nutrition education, and referral management, remain with individuals and institutions. Peer mentoring, refresher trainings, and the integration of project discussions into routine facility meetings support ongoing knowledge transfer. Sustainability in this project was further reinforced by strengthened human capacity as Health workers, Community Health Practitioners (CHPs), teachers, counsellors, and social workers acquired transferable skills that remain in place. One of the respondents says *"Capacity building addressed previous lack of knowledge and safe spaces for GBV victims. This intervention has directly improved patient care and community trust in reporting GBV."*

Community Ownership and Behavioral change: At community level, sustainability is driven by increased awareness, behavior change, and peer support structures rather than material dependency. Women and caregivers have demonstrated confidence in applying knowledge gained through food demonstrations in their households in the choice of foods being prepared at the households. Mutual support groups, peer learning forums, and open-door access to HESED Africa for consultations reinforce resilience and self-reliance. Communities

increasingly recognize their role in protecting shared resources, reporting GBV cases, and advocating for their rights. Reduced expectations for incentives and increased willingness to engage voluntarily indicate a positive shift toward sustainable, community-led action.

Despite these strengths, sustainability is limited by structural and financing gaps. The absence of a documented exit or sustainability strategy limited systematic transition planning and accountability for post-project continuity. Additionally, exclusion of many migrants and refugees from the Social Health Authority (SHA) reimbursement system poses a major risk. Unreimbursed services currently covered by HESED Africa threaten long-term financial viability of facility-based services unless migrant inclusion in national health financing is addressed through policy advocacy.

Recommendations towards Improved Sustainability

i. Strengthen alignment with government priorities by adopting the Shirika plan and other key strategies developed by the government department, including the National Nutrition Strategy, as well as GBV and social protection strategies. Additionally, it is important to bolster community ownership by ensuring that most responsibilities are transferred to the community. Consequently, the project should identify community ambassadors to support community interventions.
ii. There is a significant opportunity to further strengthen partnerships and collaborations. The initiatives should primarily be community-led. The project should also consider seeking support or collaborations for some interventions, such as the food basket and community awareness campaigns, among others.
iii. There is a need to focus on low-cost, community-led interventions; hence, reducing the number of handouts or items distributed to the community, while placing the community at the center of identifying and addressing their own issues.
iv. Strengthen advocacy by building evidence; this involves sharing data and project results as part of the evidence. This also pertains to enhancing the community feedback mechanism, thereby enabling the community to participate in evaluating progress and providing input into the project's advancement. Future project interventions should also focus on strengthening advocacy to ensure the government allocates adequate resources within its plans to enhance health outcomes. Additionally, there is a need for increased involvement in the development of the County Integrated Development Plans (CIDPs) to influence the county government to allocate more resources towards health outcomes.
v. Strengthen the transparent sharing of information regarding available resources. With a reduction of resources within the humanitarian context, it is imperative that the project avoids duplication by openly sharing what they possess and their intended uses.
vi. Consider enhancing collaboration with Community-Based Organizations (CBOs) and community-led organizations as a strategy to strengthen sustainability. Additionally, there is a need to increase the number of Community Health Volunteers (CHVs). When empowered, they can serve as peer mentors, ensuring that skills are retained within the community for an extended period.

5.0 LESSONS LEARNT, RECOMMENDATIONS & CONCLUSIONS

5.1 Lessons learnt

The lessons learnt from the HESED Afya Zaidi Project are fully informed by the evaluation findings. They are based on the KII Interviews and the FGD's conducted and include:

1. Community engagement & ownership in the project: Early and continuous involvement of community members; including Community Health Promoters (CHPs), Community Health Committees (CHCs), local leaders, youth, and women, significantly enhances programme acceptance, trust, effectiveness, and sustainability. Strong community ownership reduces dependency on external support and contributes to longer-term impact, while continuous socialization builds shared understanding, and helps to reduce resistance to programme activities. Stakeholders' empowerment at the project onset reduces dependencies as well as increases the project outcomes.

2. Importance of government partnerships in ensuring smooth project sustainability: Strong multisectoral collaboration with county, sub-county, and facility-level government structures, each partner appreciates what they do and reduces pressure on one partner subsequently enhances programme effectiveness and sustainability and ensures continuity of services beyond the project period. Alignment with Ministry of Health (MOH) systems, tools, and reporting frameworks strengthens data credibility and promotes institutional ownership of interventions.

3. Multi-sectoral & stakeholder collaboration in ensuring the project achieves and makes a bigger impact: Partnerships across sectors; including health, education, justice, WASH, security, faith-based institutions, and NGOs, help reduce the burden on individual actors while improving the effectiveness and reach of interventions. Broad stakeholder involvement mitigates potential backlash, reinforces cultural sensitivity, and enhances social acceptability within communities. In addition, working under umbrella platforms with like-minded organizations strengthens coordination, promotes synergy, and optimizes the use of available resources.

4. Capacity building improves service delivery in health care services: Training health workers, Community Health Promoters (CHPs), teachers, police officers, and paralegals improves the quality of care, responsiveness, and accountability, and should be conducted with increased frequency to maintain effectiveness. Regular refresher trainings on emerging and trending issues are strongly recommended, particularly in light of frequent staff turnover within government systems, to ensure continuity and consistency of service provision.

5. Gender & inclusion dynamics: Male engagement is critical to reducing gender-based violence (GBV), teenage pregnancy, and household conflict, and it also reinforces the effectiveness of the community-based approach adopted in the project design. Male engagement is essential across the board, engaging the male ensures shared decision making at the household level which is key in increasing the project outcomes. Youth engagement requires interactive models; this needs to have younger people training the youth and use of youth friendly approaches to ensure effectiveness. Cultural and religious sensitivity is especially important for project success, particularly where interventions are perceived to challenge cultural norms. Working with religious leaders increases acceptance hence the need to ensure they are represented in the project design.

6. Livelihood & economic empowerment insights: Livelihood support contributes to increased household resilience; however, its sustainability is often constrained by limited access to capital and narrow skill options. Diversification of income-generating activity (IGA) skills strengthens resilience and improves overall income outcomes.

7. Health system strengthening and upgrades: Facility upgrades, availability of medical supplies, and timely infrastructure repairs are critical to maintaining service quality and effective patient care. To address these gaps, strong collaboration with partners is essential to sustain supplies and ensure continued facility functionality, particularly during periods of resource shortages.

8. Data, learning & adaptability: Data-driven decision-making strengthens accountability and improves programme quality. Regular monitoring, joint review processes, and structured feedback loops enhance programme responsiveness and allow timely adjustments. In addition, external shocks and funding limitations underscore the importance of designing programmes that are flexible, adaptive, and resilient. This speaks the need for the strengthening of the MOH tools to ensure quality data is collected for the project.

9. Psychosocial & mental health: Psychosocial and mental health support is essential for improving overall well-being and resilience among rights holding populations. Training community health workers, counselors, and other frontline staff enhances their capacity to identify and address mental health needs. Integrating mental health services into existing community and health structures ensures accessibility and sustainability, while promoting community awareness, reducing stigma, and fostering supportive networks.

5.2 Recommendations

The overall recommendations from the evaluation include:

1. Program scale-up & sustainability: There is a need to scale up interventions to reach a greater number of facilities, schools, migrants, and vulnerable populations within host communities. From the outset, projects should develop clear exit and sustainability strategies to ensure long-term self-sufficiency and continuity of services. Diversifying funding sources and mobilizing resources beyond traditional donors is essential to reduce dependency and mitigate the impact of funding withdrawal shocks.

2. Strengthen government & stakeholder coordination: Improving communication, joint planning, monitoring, and reporting with sub-county and county teams is essential to reduce frustrations and streamline project implementation. Establishing umbrella coordination forums for stakeholders working in similar thematic areas will strengthen collaboration, reduce duplication of efforts, and improve overall programme effectiveness.

3. Capacity building & training: Livelihood and community support programmes should expand and continuously train Community Health Promoters (CHPs), equipping them to handle trending and challenging situations. The frequency of refresher trainings for health workers, police officers, paralegals, teachers, and community leaders should be increased to maintain and update skills. Additionally, introducing Training-of-Trainers (ToT) models will

facilitate community-led knowledge transfer, promoting sustainability and local ownership of capacity-building initiatives.

4. Gender, youth & male engagement: Programmes should be designed to target men and boys in areas such as sexual and reproductive health (SRH), gender-based violence (GBV) prevention, and livelihood opportunities to foster inclusive community engagement. Youth-focused vocational and professional skills training, including ICT and technical skills, should be expanded to enhance employability and economic empowerment.

5. Livelihoods & economic empowerment: Livelihood training options should be expanded and diversified based on regular market assessments and the expressed interests of beneficiaries to ensure relevance and sustainability. In addition to skills development, programmes should introduce structured business development support, including income tracking tools and value-chain approaches that link beneficiaries to suppliers and markets.

6. Health facility & infrastructure improvements: Health facilities should be rehabilitated and expanded, including upgrades to medical operation spaces, signage, security, aesthetic improvements, and essential medical equipment. Consistent supply of essential medicines and MCH commodities must be ensured to prevent stock-outs and maintain uninterrupted care.

7. WASH & environmental health: WASH interventions should implement the WASH-FIT facility improvement tools to enhance the quality of care for both refugees and host communities. Access to clean drinking water, handwashing stations, and functional toilets must be ensured. Waste management should be strengthened through proper waste segregation, training of waste handlers, consistent use of personal protective equipment (PPE), and Hepatitis B vaccination.

8. GBV, protection & justice: GBV prevention, response, and psychosocial services should be continued and expanded, following Ministry of Health (MOH) protocols to ensure standardized and effective care. Collaboration with the police, Office of the Director of Public Prosecutions (ODPP), children's services, and the judiciary should be strengthened, as these authorities are critical to delivering justice swiftly and effectively. Safe houses and temporary holding shelters for survivors should be established or supported to provide immediate protection.

9. Education, school health & menstrual hygiene: School health programs should be expanded to reach more schools and grade levels, including secondary schools, to ensure broader access to health services and education. A consistent supply of sanitary towels should be maintained, with consideration given to reusable pad options to promote sustainability. School WASH infrastructure should be improved to support effective menstrual hygiene management, providing safe, private, and functional facilities. Additionally, the number of peer educators should be increased, and participatory, multimedia learning approaches should be promoted to engage students and reinforce learning outcomes.

10. Monitoring, Evaluation & Learning (MEAL): Strong learning frameworks should be developed to continuously capture lessons learned and good practices throughout project implementation. Risk registers and routine context monitoring should be introduced to proactively identify and mitigate potential challenges. Gradual transition to digital data collection systems is recommended to improve data accuracy, timeliness, and accessibility.

Recommendation tracking matrices should be established to monitor the uptake of findings from baseline, midterm, and final evaluations. In addition, regular joint evaluations and feedback sessions with stakeholders should be conducted to enhance accountability, inform decision-making, and promote adaptive management.

5.3 Conclusion

The GVA23 / AFYA ZAIDI Project demonstrated strong relevance, effectiveness, and emerging impact in addressing complex, interlinked health, protection, mental health, nutrition, education, and livelihood needs among migrant and host communities in Kasarani and Kamukunji sub-counties. Through integrated service delivery, long-standing strategic partnerships, and community-centered approaches, the project strengthened access to quality services for refugees, survivors of GBV, women, adolescents, and other vulnerable groups in a challenging urban humanitarian context.

The project's success was supported by the effective collaboration between HESED Africa, Farmamundi, government institutions, community health structures, and legal actors. Integration of services within public health facilities enhanced quality, confidentiality, and trust, while community health promoters played a critical role in outreach, prevention, referrals, and behavior change. Notable progress was achieved in GBV reporting, survivor support, mental health awareness, adolescent health outcomes, and women's economic resilience.

However, the sustainability and scalability of these gains will depend on addressing several structural gaps. These include strengthening Monitoring, Evaluation, Accountability, and Learning (MEAL) systems; formalizing sustainability and exit strategies; expanding male engagement; diversifying livelihoods and nutrition interventions; and deepening institutional integration with government systems; particularly for refugees and undocumented populations who remain excluded from national financing mechanisms.

Overall, GVA23 / AFYA ZAIDI provides a credible and adaptable model for inclusive, multi-sectoral programming in urban, mixed-migrant settings. With targeted system strengthening and strategic adjustments, the project's approach holds strong potential for long-term impact and replication in similar contexts.