



care® HYGIENE AND BEHAVIOR CHANGE COALITION (HBCC)
PROJECT END-LINE EVALUATION



**FINAL REPORT
SUBMITTED BY TRISTOVES LTD**

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Executive Summary

The Covid-19 pandemic remains a global concern, it has affected all social-economic spheres of life around the world. People have and continue to lose life. The global economies continue to decline. Countries and the development partners continue to spend millions of dollars in educating people on dangers, control and prevention of the Covid-19 pandemic. Multiple barriers can affect efforts to minimize transmission and harmful impacts of health emergencies; this is not different for COVID-19. The barriers vary from inadequate knowledge at individual and community levels and limited access to hygiene/WASH facilities among others. With such limitations, the risk of contracting Covid-19 increases. As part of Rwanda's Covid-19 response plan, CARE Rwanda designed and implemented HBCC project over the period of 1 year (July 2020-July 2021).

Project design and implementation: HBCC project was designed with an objective of supporting the government of Rwanda to minimize the transmission of and harmful impacts of covid19 by delivering inclusive and interactive gender responsive mass media and digital communications, supported by product availability and community interventions that improve personal and environmental hygiene practices, and reduce stigma and discrimination. Project targeted vulnerable women, youth, elderly and people living with disabilities living in remote communities of Rulindo, Gakenke, Nyabihu and Ngororero Districts. As matter of approach, CARE adopted a community-based approach that enabled community members for successful project implementation. The local Hygiene Focal Points (HFPs), District Sanitation and Hygiene Officer (SAHO), Community Environmental Officer CEHOs and local government authorities were closely engaged to implement the project. Existing government structures and platforms were fully utilized for project success. Project implementation facilitators (including CEHOs, SAHOs, CHWs, SEDOs, Village chiefs and CHC facilitators) in their catchment areas were trained to ensure that they are equipped with knowledge needed for successful project implementation and continuity. The project was designed with one outcome and three output areas: messages on hygiene, distribution of WASH products and training of health care staff on infection, prevention and control.

Project end-line Evaluation Objectives: the evaluation aims at documenting the extent to which HBCC project has achieved its set objectives. The evaluation process was guided by the project outcome indicators. Also the evaluation activities adopted OECD measurement indicators: project relevance, effectiveness and efficiency, impact and sustainability. Furthermore, the end-line evaluation focused on the identification of lessons learned and good practices derived from project implementation for future replication. The lessons learned and good practices identified served as tools for future planning and implementation of other similar projects for Search for Common Grounds.

End-line Evaluation Methodology: The evaluation study adopted both quantitative and qualitative data collection methods. The quantitative information was gathered by VIAMO virtually using online methods whereby a total of 2167 project beneficiaries were sampled using simple random probability sampling technique for end-line evaluation survey. The quantitative survey respondents included women and men across all districts of project intervention. The participants differed from one district to another based on the differing population. Out of the 2167, the 39% were of Nyabihu; 24.7% of Gakenke and 18% of Ngororero District. On the other hand, qualitative information for end-line analysis were gathered using wash'EM tools, key informant interviews (KIIs) and focus group discussion techniques. The total of 18 key informant interviews and 20 FGDs were organized during the evaluation.

End-line evaluation findings: The end-line evaluation results demonstrated the project was successful and overall project objectives were partially achieved. The objectives on "messaging and communication campaigns" were achieved by 26.5% against 19.9% of baseline values. The 6.6% change in a period of 1 year of a project implementation were relatively significant. The project outcome on "access to hand washing facilities" were not achieved beyond the baseline values. The end line results were 73.8% were below the baseline values (74.5%) set by the project, the variation comes with the fact that, some of project beneficiaries were not supported by project in accessing hygiene facilities particularly within Jenda sector of Nyabihu and Hindiro sector of Ngororero District. Also, the variation comes from the differing sample precision error between baseline (225 participants) and end-line (2168 participants). However, 93% (93.9% female; 92.5% male) who benefited from HBCC project have access to hand washing stations. The 63.3% have easy access to hand wash soap and sanitizers as a result of the project support. Furthermore, the project outcomes on access to quality and quantity of hygiene kits were found to be achieved to the tune of 85.1%. The 66% (29,9% satisfied and 36.1% very satisfied) were satisfied with quality of hygiene kits distributed by the project.

The project achieved its set objectives on handwashing knowledge and practices. The hand washing frequency increased whereby 56.4% of project beneficiaries washed their hands more than normal. the majority (65.4%) were found to have used clean water and soap for more than 40 seconds while only 21.4% cleaned their hands with clean water and soap for less than 40 secs. The 59.5% clean touched surfaces regularly while 27.1% clean touched surfaces as deemed necessary and only 13.3% never cleans the touched surfaces. The HBCC project beneficiaries are to large extent aware of COVID-19. The 31.5% of beneficiaries understands that they can easily get COVID-19 once there are in contact with effected people. Using WASH'Em tool on disease perception, it was deduced that project beneficiaries were fully aware of covid19 and dangers. The 100% of the FGDs reported that COVID-19 causes physical, social and economic impacts. The 83.3% of discussants reported that COVID-19 pandemic causes social exclusion and 91.5% considers COVID-19 among the top 5 illnesses of concern whereby 50% believed that COVID-19

can lead to serious illness or death. Also, 91.7% of FGDs participants believe that everyone is likely to contract COVID-19. The 78.5% fear COVID-19 and the 78.2% understands the symptoms of covid19. According to the outcomes of WASH'Em demonstration tool, it was evident that, project outcomes on hygiene behavior change were very limited whereby baseline values (61.5%) remained higher than end-line values (48%), the focus group discussants, trainings among project beneficiaries were inadequate training among direct project beneficiaries. However, limited change in terms of new preventive measures adaptation does not mean that, hygiene behavior changes among project beneficiaries but rather, implies that, "the project did not come with new preventive measures" instead, it adopted existing (national and global) measures.

On the other hand, focus group discussants reported that "there is a noticeable change in handwashing behavior among project beneficiaries. The practice of washing hands with soap and clean water has been adopted. The frequency of handwashing has also increased significantly". Majority (51.6%) of HBCC project beneficiaries adopted hand washing as the main preventive measure for covid19.

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Abbreviations

HBCC: Hygiene and Behavior Change Coalition

HFPs: Hygiene Focus Persons

OECD: Organization for Economic Co-operation and Development

KIIs: Key informant interviews

FGDs: Focus Group Discussions

DHU: Director of Health Units

RBC: Rwanda Biomedical Centre

MoH: Ministry of Health

COVID-19: Corona virus disease of 2019

CEHOs: Community environmental health officer

SAHOs: Sanitation and hygiene officer

CHWs: Community health workers

SEDOs: Social economic development officer

WASH: Water sanitation and hygiene

OECD: organization for economic cooperation and development

CHCs: Community hygiene clubs

DFID: department for international development

AEE: African Evangelistic enterprise

1. INTRODUCTION

1.1. Project Overview

COVID-19 has become a global pandemic. In case of Rwanda, the pandemic appeared in March 2020, since then the country's socio-economic status was negatively affected whereby a total of 1, 065 people lost lives¹. In pursuit to control the spread of Covid19, Rwanda received support from development partners including CARE International. Since the onset of the pandemic, CARE Rwanda has mobilized resources to respond to COVID-19. In this regard, the one-year (July 2020-August 2021) Hygiene and Behavior Change Coalition (HBCC) project was implemented.

The HBCC project was funded by Unilever and DFID and implemented by CARE Rwanda in partnership with AEE Rwanda. The main objective of the project was to minimize the transmission of and harmful impacts of Covid19 through improved personal and environmental hygiene practices. The project delivery mechanism was at community level, interactive, inclusive and gender sensitive through responsive messages and digital communications.

The project was implemented in 4 districts of Rulindo and Gakenke of Northern province and Nyabihu and Ngororero of Western Province. Through the project CARE implemented a diversified range of interventions mainly mass media, digital communication, and distribution of hygiene kits. The targeted project beneficiaries were both women, men, youth (boys and girls) and people with disabilities within selected regions of project coverage.

1.2. Evaluation Objectives and Approaches

As part of the project closure, end-line evaluation activity was initiated with an objective of assessing if or not the project outcomes were achieved. The OECD project evaluation criteria was adopted. In particular, the project was evaluated with an aim of determining its relevance, efficiency, effectiveness, impact, and sustainability. Also, as part of the evaluation outcomes, the lessons learned were documented based on which actionable and practical recommendations for future project design were recommended. The evidence of emerging impacts and information is presented in a way most useful to wide range of stakeholders. The evaluation approach was outcome based. A mix of qualitative

¹ RBC- Covid 19 update report of august 29th 2021

and quantitative information were adopted to gather information needed to assess each outcome indicator.

2. EVALUATION APPROACH AND METHODOLOGY

This section presents the approaches and methods adopted during end-line evaluation.

2.1. Quantitative Evaluation methods

The quantitative data gathered through household survey was used to evaluate the outcomes of HBCC project. The data were collected by VIAMO using structured questionnaire through interactive Voice Response (IVR) methodology. The data collection activity covered the entire project coverage area. The targeted project beneficiaries included men and women of different ages including people with disabilities.

Using simple random probability sampling technique, a total of 2,167 project beneficiaries were sampled and participated in the evaluation survey as presented in table 1. The large number of survey respondents were men. The majority (39%) of the respondents were found in Nyabihu, followed by 24.7% in Gakenke, 18.3% in Rulindo and 18% in Ngororero District. The variation among the total number of surveyed households exists.

Table 1: Survey sample Size by District by sex

Survey Respondents by sex						
District	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Gakenke	178	24.00%	357	25.10%	535	24.7
Ngororero	125	16.80%	265	18.60%	390	18.0
Nyabihu	269	36.20%	576	40.40%	845	39.0
Rulindo	171	23.00%	226	15.90%	397	18.3
Total	743	100	1424	100	2167	100

The surveyed respondents were both female and male as presented in table 2. A significant number of respondents were older people aged between 35-50 years, followed by youth, aged between 18-35 years. This implies that, the large number (57.4%) of project beneficiaries were still young.

Table 2: Survey respondents by Age

Age of Respondents	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
18-25 years	179	24.10%	243	17.10%	422	19.5
25-35 years	229	30.80%	592	41.60%	821	37.9
35-50 years	307	41.30%	536	37.60%	843	38.9
60 years	28	3.80%	53	3.70%	81	3.7
Total	743	100	1424	100	2167	100

source: VIAMO end-line primary survey data 2021

The respondents were characterized based on sex, age and social wealth (ubudehe) categories. As presented figure 1, the large number of respondents were in ubudehe cat2, followed by those in category 3. The variation was associated with the fact that most of the project beneficiaries were in ubudehe category 2. The dominance of beneficiaries in ubudehe category 2 was not intended as per project design but rather since, a significant number of people in project area are found in category 2.

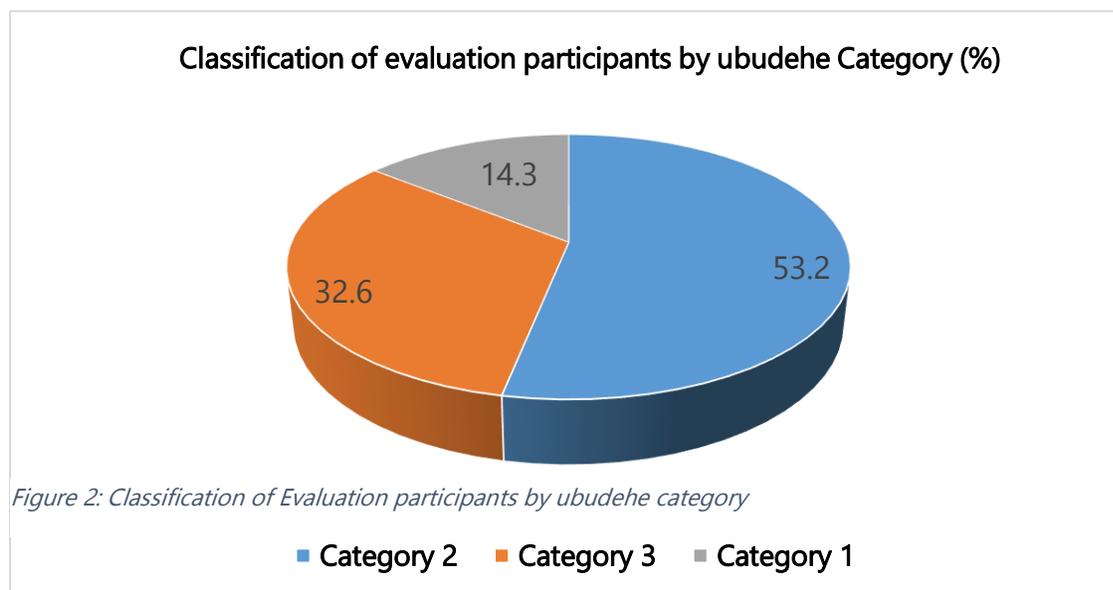


Figure 2: Classification of Evaluation participants by ubudehe category

Figure 1: Classification of survey respondents by ubudehe category

2.2. Qualitative Evaluation Methods

The qualitative data was collected using WASH'Em tools together with key informant interviews (KIIs) and focus group discussions (FDGs) based on sex and age. The KIIs techniques were adopted by the consultants while gathering qualitative information directly from project implementing institutions, facilitators and indirect stakeholder institutions that supported or benefited from the project. The targeted stakeholders for KIIs included but not limited to: HBCC project' implementing partners mainly CARE, AEE, and Girl Effect, project focal persons and facilitators and District directors of health. The KIIs participants were selected and sampled purposively based on their role in project as presented in tables 2. The total of 19 KIIs that were concluded during HBCC end-line evaluation process.

Table 3: KIIs-District Hygiene focal persons (HFPs)

District	Sectors	HBCC Focal Persons
RULINDO	Kisaro	1
	Ntarabana	1
	Murambi	0
Sub-total		2
GAKENKE	Muzo	1
	Rushashi	1
	Gashenyi	1
Sub-total		3
NGORORERO	Ngororero	1
	Muhororo	1
	Hindiro	1
Sub-total		3
NYABIHU	Jenda	1
	Kintobo	1
	Karago	1
Sub-total		3
Total –KIIs		11

Table 4: KIIs-HBCC Project implementing Partners and other district officials

Institution	#Participant	No. of KIIs
CARE Rwanda	Project coordinator	1
AEE	Project coordinator and 1 field officer	2
GIRL Effect	Project coordinator	1
District	Director of Health Unit (DHU)	3
KIIs-Total		7

The FGD technique was adopted to collect qualitative information direct project beneficiaries for analysis. Each FGD was composed of at least 6 participants obtained from selected sectors of the district in question. The discussants in each locality were selected using purposive sampling technique. The individuals to participate in FGDs were selected randomly from the beneficiary database obtained from CARE Rwanda. As part of selection criteria, individuals who participated in FGDs only included those who participated in baseline survey and those who benefited from the project during its implementation. The selection process of focus group discussants was facilitated by the local district-based project facilitators. The consultant used non-probability sampling of convenience sampling, where the sample was taken from the group of people easy to contact and reach-out. In each sector there were 3 kinds of focus group discussions, 1 FGD for men: 1FGD for women and 1 for youth. Each FGD was composed of at least 6 discussants. The limited number of discussants per session had been associated with the prevailing covid19 control measures which discourages large gatherings and physical meetings.

As presented in the table 4 there were a total of 20 FGDs in all districts of project intervention. FGDs and KIIs were conducted during the day, upon the availability of participants. Any FGDs respondent who failed to participate in the survey were replaced by another, who was randomly selected from the same sector per respective District.

Table 5: Total Number of FGDs per District

District	Sectors	FGDs- Women	FGDs-Youth	FGDs-men	Total FGDs
RULINDO	Kisaro	1	0	1	2
	Ntarabana	0	1	0	1
	Murambi	1	0	1	2
Total District RULINDO		2	1	2	5
GAKENKE	Muzo	1	0	1	2
	Rushashi	0	1	0	1
	Gashenyi	1	0	1	2
Total District GAKENKE		2	1	2	5
	Ngororero	1	0	1	2

District	Sectors	FGDs- Women	FGDs-Youth	FGDs-men	Total FGDs
NGORORERO	Muhororo	0	1	0	1
	Hindiro	1	0	1	2
Total District NGORORERO		2	1	2	5
NYABIHU	Jenda	1	0	1	2
	Kintobo	0	1	0	1
	Karago	1	0	1	2
Total District Nyabihu		2	1	2	5
Grand Total		8	4	8	20

The detailed list of individuals who participated in FGDs were developed in close consultation and support from district-based project focal persons. The FGDs were facilitated by well-trained facilitators which included a moderator and note taker. The face-to-face discussion approaches were adopted. With the support of district-based project focal persons, the exact places for physical-FGDs were determined per sector. During the FGDs, the prevailing covid-19 safety and control measures were respected.

The KIIs were conducted physically or virtually depending on the availability of the participant including district and central level project partners. The consults worked closely with CARE project team to identify and obtain contacts of people who participated in the FGDs per sector for ease of logistical planning and FGD meeting management. Also, as part of qualitative evaluation approaches, WASH'Em Tools on disease perception, touchpoint and hand washing demonstrations were used to gather information for analysis. The WASH'Em technique was adopted and used to gather data related behavior changes, attitude and practices to COVID-19 related knowledge, practices and adopted to hygiene and COVID-19 prevention measures among HBCC beneficiaries.

Through FGDs and demonstration at household level, the HBCC beneficiaries provided their perception of their behaviors, attitudes and their knowledge towards hygiene and COVID-19 measures and demonstrated their practices on handwashing practices and facilities. A total of 12 FGDs were conducted using WASH'Em tool where Touchpoints were used in 7 FGDs and disease perceptions were used in 5 FGDs and 40 households were visited for handwashing demonstration, observations and physical verification tool, all Wash'Em Tools provided testimonies and WASH demonstrations as a way to re-confirm behavioral change created by the project.

Table 6: No. of Households surveyed for Observaon by sector per District

District	Sectors	Wash'Em Tools (Disease perception, Touchpoint, Demonstration)		
		Demo Tools/visited Household	Touchpoint Tool	Disease perception tools
RULINDO	Kisaro	5	1FGDs women	1FGDs men
	Ntarabana	5	-	-
	Murambi	0	1FGDs women	
Sub-total		10	2	1
GAKENKE	Muzo	3	1FGDs men	1FGDs women
	Rushashi	4		
	Gashenyi	3	1FGDs women	
Sub-total		10	2	1
NGORORERO	Ngororero	4		1FGDs women
	Muhororo	3		
	Hindiro	3	1FGDs women	1FGDs men
Sub-total		10	1	2
NYABIHU	Jenda	3	1FGDs women	
	Kintobo	4		
	Karago	3	1FGDs men	1FGDs women
Sub-total		10	2	1
Total (households)		40 Visited Household-Demo	7FGDs-Touchpoint	5 FGDs-Disease perception

2.3. Data Analysis

The quantitative data collected by VIAMO Team together with qualitative data gathered by Tristoves Ltd were analyzed using STATA vers.16 and excel statistical tools. Data analysis were systematically done using different statistical measures and narrative writing techniques. The quantitative data (graphs, tables, and figures) computed and obtained through datasets and report shared by VIAMO through CARE was analyzed per HBCC project outcome indicators.

Qualitative analysis involved transcribing and translating the answers of the interviewees and discussants of the FGDs. The consultant generated text files that were further scrutinized to spot patterns, relationships using a thematic approach. The consultant also strived to code all related quotes as aired by the Project beneficiaries as best practices and lessons learnt and report on most significant themes. WASH'Em findings were obtained through FGDs findings answered to touchpoint, disease perceptions and demonstrations were analyzed using their decision tables. The findings of WASH'Em

measured behavior changes of HBCC beneficiaries with regards to knowledge, attitude towards Hygiene, COVID19 prevention measures, and practices on handwashing and facilities.

These all findings from data analyzed helped Project team, stakeholders, partners, donors to reposition in terms of concluding on the level of relevance, effectiveness, efficiency and sustainability of the Project. Both quantitative, qualitative, WASH'Em information were triangulated for explaining the phenomena, and supporting each other during interpretation for better approving and convincing about changes brought by the HBCC project comparing the situation before and after the implementation of the project.

The overall evaluation findings were analyzed against the project set of outcomes indicators. The results were presented in accordance with the project indicators in comparison with set targets and baseline data as presented in annex 2.

2.4. Quality Assurance and Evaluation Ethics

2.4.1. Ethics and Confidentiality

The evaluation followed international best practice standards and is subject to scrutiny by the research team. The evaluation team were underpinned by a commitment to integrity, honesty and competence. The FGDs participants were given short introduction on evaluation objectives and their participation requirements. Each focus group discussant was required to sign a consent form. However, only one person representing the entire group signed the consent form on behalf of others. Alternatively, focus group discussants were required to verbally agree to their participation in the end-line evaluation. The consultant committed to observe the principle of confidentiality.

All information provided by the respondents were treated and analyzed in aggregation and no individual data were exposed. The principle of anonymity was observed. No individual names or any other information of identity was included in the report and hence no one was identified or was linked to the quotations obtained during any form of data collection. Data containing individuals' names and identification were removed from the final datasets that was shared by the consultant. All quotes were assigned a character representing the actual respondent.

2.4.2. Data Management

Due to the complexity of the evaluation exercise, it was necessary to incorporate various quality assurance and quality control mechanisms. In this regard, consultants performed

daily data quality checks so that mistakes and/or inconsistencies in data were tracked and addressed immediately with the team. Each morning, enumerators received feedback on data collection progress and areas of improvement.

All enumerators were thoroughly trained on the tools and field supervision were conducted to ensure completeness and accuracy (all sampled participants were reached as per guidelines). On a daily basis, enumerators were debriefed, and any errors and gaps were detected early enough and rectified. The programming of tools also included validations and logical patterns that minimized errors normally done during data collection and recording. All raw data were stored on a password secured server that only the data manager had access to. This minimized any risks of compromising the data.

2.4.3. Administrative Requirements

The Introduction of both the objectives of project end-line evaluation and the consultants to key stakeholders including the district Authorities, project partners were done by CARE International Rwanda. Field project officers introduced the evaluation process and enumerators to the FGDs and KIIs participants.

2.4.4. COVID-19 Control and Protocol Measures

In this time of COVID-19 pandemic, the consultants, enumerators, and CARE team that facilitated the field data collection ensured that measures established by the Government for controlling the spread of COVID-19 were observed. The following measures were observed:

- ❑ Consultants and enumerators wore masks as required and recommended by Ministry of Health (MoH) in Rwanda and World Health Organization (WHO). The research team further kept masks while conducting KIIs and FGDs. Also, participants of FGDs were required to always wear face masks properly.
- ❑ Each consultant and enumerator had a bottle of hand sanitizer and washed the hands of each respondent before data collection process commences.
- ❑ During FGDs and Interviews, required social distancing (2 meters) between data collectors and participants were observed.
- ❑ Data collectors and consultants consulted and discuss with district and/or sector authorities on the best approach was used to collect data without compromising.

- All enumerators and the project team who supported the data collection were tested of COVID-19 before starting the data collection on the field.

2.4.5. Informed consent

All respondents were provided detailed information about the evaluation prior to interviewing them. A consent form detailing the evaluation and the rights of the participants were provided and only those who agreed to sign or provide verbal consent were interviewed. No incentives or any other personal benefits were provided for participation in evaluation, but CARE Rwanda paid transport fee to FGDs participants. A detailed consent form was obtained from CARE International Rwanda at later stage for data collection.

3. END-LINE EVALUATION FINDINGS

This evaluation report is based on the observations and analysis of qualitative and quantitative evaluation findings. The evaluation findings per outcome area are presented in the proceeding subsections.

3.1. Project outcomes

The HBCC project had 1 outcome, measured along five outcome indicators. The level of achievement per indicator differed from one to another.

3.1.1. Messaging and communication campaign

The messaging and communication companions were one of the key activities of HBCC project. Comparing the baseline value of 19.9% and end-line value (26.5%) presented in figure3, messaging and media campaigns project outcomes made a positive increase trend of achievement. The radio talks were the most communication channel used in messaging and communication campaign (86.1%).

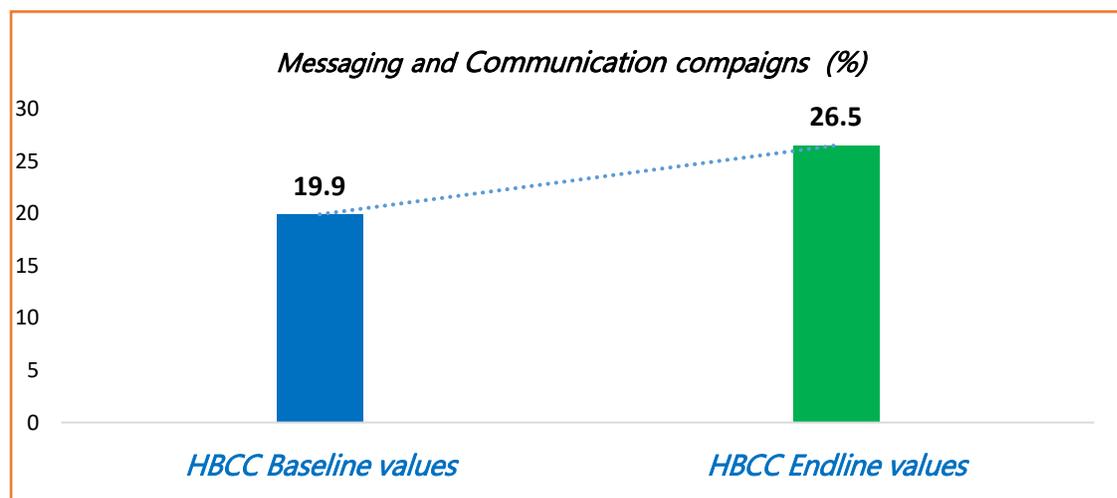


Figure 3: % level of project achievement on messaging and communication

The project success in messaging and communication campaigns were closely associated with appropriate media channels adopted by the project. As presented in table 3, different media channels were adopted during the project implementation. Many (86.1%) of the project stakeholders accessed information on COVID-19 control measures through local and national radio talk/ announcements. According to focus group discussants "many people have mobile phones through which there are able to listen to the radio

announcements and talks on COVID-19 control and prevention organized by CARE Rwanda and RBC'.

Table 7: Media channels adopted by HBCC project and % accesses among project beneficiaries

Media channels	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Posters	13	1.7%	27	1.9%	40	1.8
Radio	646	86.9%	1220	85.7%	1866	86.1
Social media	28	3.8%	92	6.5%	120	5.5
TVs	56	7.5%	85	6.0%	141	6.5
Total	743	100	1424	100	2167	100

Also as shown in table 4, HBCC project beneficiaries accessed hygiene and COVID-19 control and preventive messages through other platforms. Such platforms included community health workers (22%), community meetings (3%), local leaders (14.7%) and other government aided institutions.

Table 8: Sources of updated Information on Covid19

Other sources of information on	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Community Health workers (CHWs)	171	23.0%	306	21.5%	477	22.0
Community meetings	24	3.2%	40	2.8%	64	3.0
Health facilities	166	22.3%	317	22.3%	483	22.3
Local leaders	121	16.3%	198	13.9%	319	14.7
Other sources	6	0.8%	34	2.4%	40	1.8
TVs	255	34.3%	529	37.1%	784	36.2
Total	743	100	1424	100	2167	100

The above-mentioned media channels were corroborated by key informants and focus group discussants. Using the Wash'Em tool with the focus group discussants, it was revealed that beneficiaries accessed information through different channels. Among other media channels, information on covid19 were accessed through religious institutions (77.7%), followed by CARE-saving and loan groups (73.3%) among others.

Table 9: Other sources of information on Covid19

Communication Channels used to communicate HCC beneficiaries	Percent
Religious Institution (Mosque/Church/temple)	77.7
Saving and loan groups	73.3
Hairdressers or beauticians	71.1
Community meetings	68.8
Health workers who do home visit	67.7
Mobile megaphones	66.7
Buses and taxis (including bikes/motorbikes)	66.7
Radio	66.6
School	66.6
Local information shared	61.1
Women groups, men's groups, youth groups or disability organizations	58.8
Television	53.3
Respected community individuals	53.3
Sport, music, or theatre event	50.0
Café and Restaurant	50.0
Social Media	43.3
Other People who do home visit	41.1
Local Cinema (Ikinamico)	40.0

The

Directors of Health Unit (DHUs) testified that a mix of media channels adopted by the project. A significant number of project stakeholders accessed information easily and in short time possible. According to DHUs "use of megaphones was among the most effective mode of communication" while other project team members mentioned that "SMS and voice messaging using telephones were also most effective". Also, FGDs participants from Ngororero District emphasized that Community Health Workers and family evening forum served as useful source of information".

The posters and radio channels were found to be effective for community education and awareness on COVID-19 pandemic. As presented in figure 4, the 46.9% of project beneficiaries were able to listen to radio talk shows organized by CARE and RBC on hygiene and covid19 prevention mechanisms.

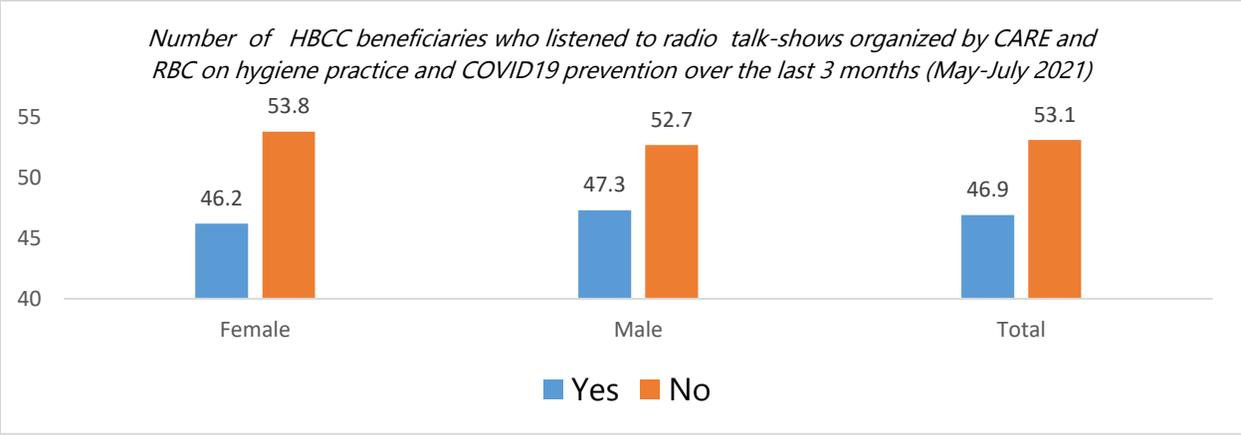


Figure 4: % of HBCC project beneficiaries who listened to radio talks organized by Care and RBC on hygiene and Covid19 prevention.

Alongside the radio talks, the information on covid19 were obtained through billboards and posters displayed by CARE International Rwanda on hygiene and covid19 control measures. The 51.5% of project beneficiaries were able to see billboards or posters displayed by Care or AEE on hygiene and covid19 prevention measures as presented in figure 5.

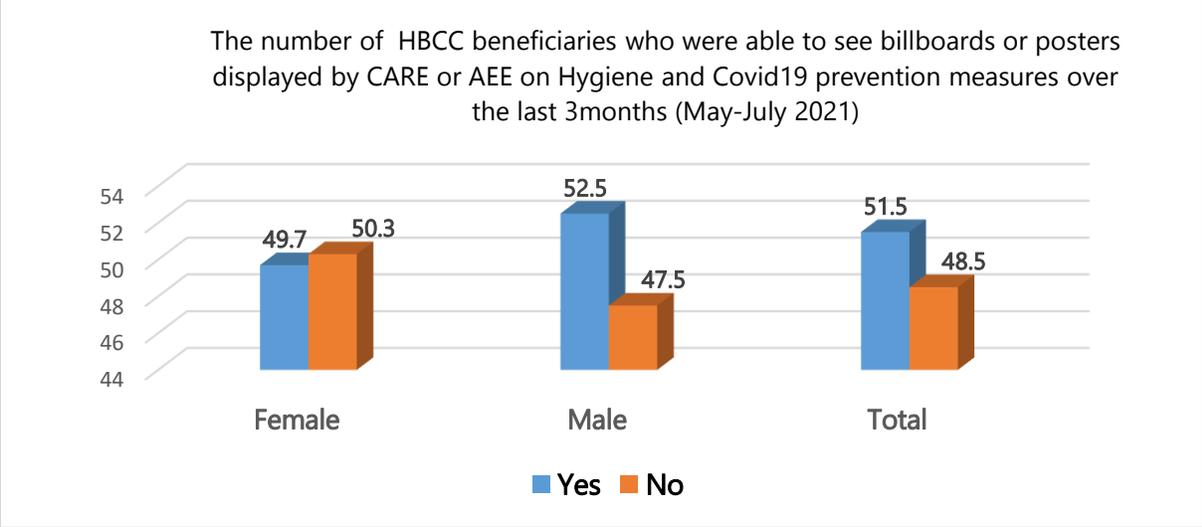


Figure 5: % of HBCC project beneficiaries who were able to see billboards or posters displayed by Care or AEE on hygiene and covid19 prevention measures during the months of May-July 2021

The evaluation findings confirmed that, the published information by AEE and CARE on COVID-19 through different media channels were found helpful and relevant. As presented in table 10, the 51.5% of HBCC project beneficiaries' found it helpful.

Table 10: % Level of helpfulness of information shared by AEE and Care on covid19

	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Helpful	376	50.6%	741	52.0%	1117	51.5
Not helpful	72	9.7%	122	8.6%	194	9.0
Somewhat helpful	295	39.7%	561	39.4%	856	39.5
Total	743	100.0%	1424	100.0%	2167	100.0

3.1.2. Access to Handwashing Facilities

The sufficient access to handwashing facilities remains paramount for effective hand cleaning. As presented in figure 6, the overall project contribution in supporting its stakeholders to have appropriate handwashing stations was insignificant. The baseline (74.5%) values remain higher end-line (73.8%) values. The variation comes with the fact that, some of project beneficiaries were not yet receive and access hygiene facilities particularly within Jenda sector of Nyabihu and Hindiro sector of Ngororero District. Also, the variation comes from the differing sample precision error between baseline (225 participants) and end-line (2168 participants).

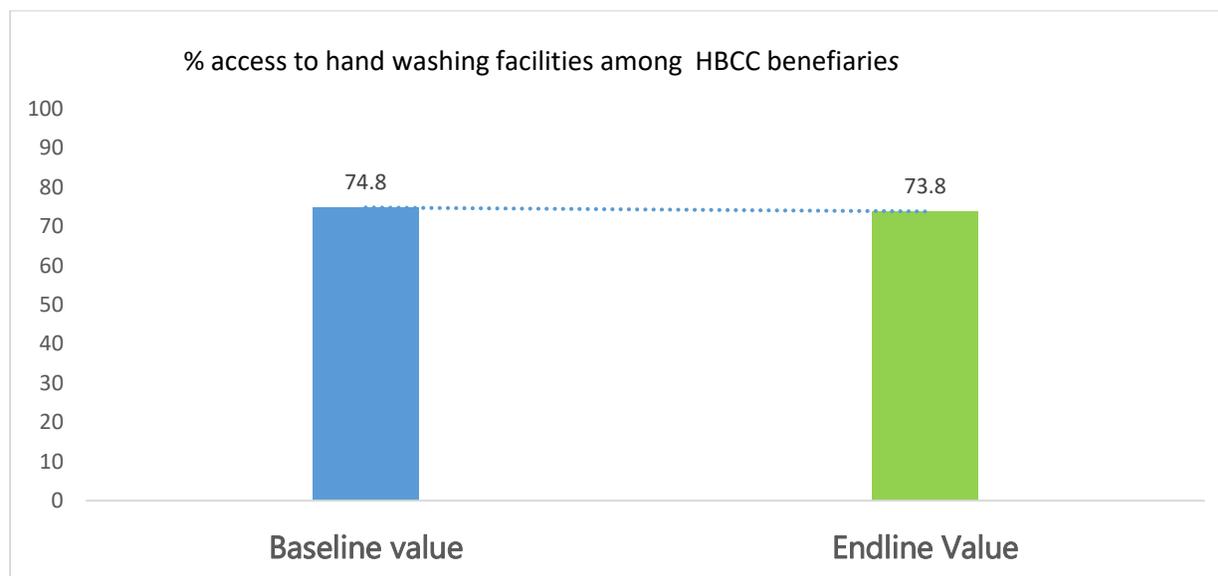


Figure 6: Overall project contribution in supporting households in accessing to hand washing facilities

Comparing the baseline (85.8%) and end-line (86%) values presented in table 7, it is evident that the project contribution was only 0.4% in terms supporting its beneficiaries in having proper hand wash stations. Also, the project did not make a change in respect to supporting beneficiaries in accessing water to their hand wash stations. However, a

slight (1.1%) change was brought by the project by supporting them to access hand soap and rubbing tools for effective handwashing.

Table 11: % Level of access to handwashing facilities

Access to handwashing facilities	Baseline Value (%)	End line value (%)
Having hand washing device station in the household	85.8	86
Types of handwashing facilities possessed	25.2	21.5
having water in the hand washing device/station	94.7	93
Having a soap or other rubbing agents where the hand washing device is placed by Location	93.6	94.7
Overall values	74.8%	73.8%

The availability of hand washing stations at household level increased due to the project by 0.2% (86% baseline & 85.8% baseline) and only a limited (14%) number of project beneficiaries do not have proper hand wash stations or devices. The lack of such devices makes it difficult for households to clean their hands for controlled spread of covid19.

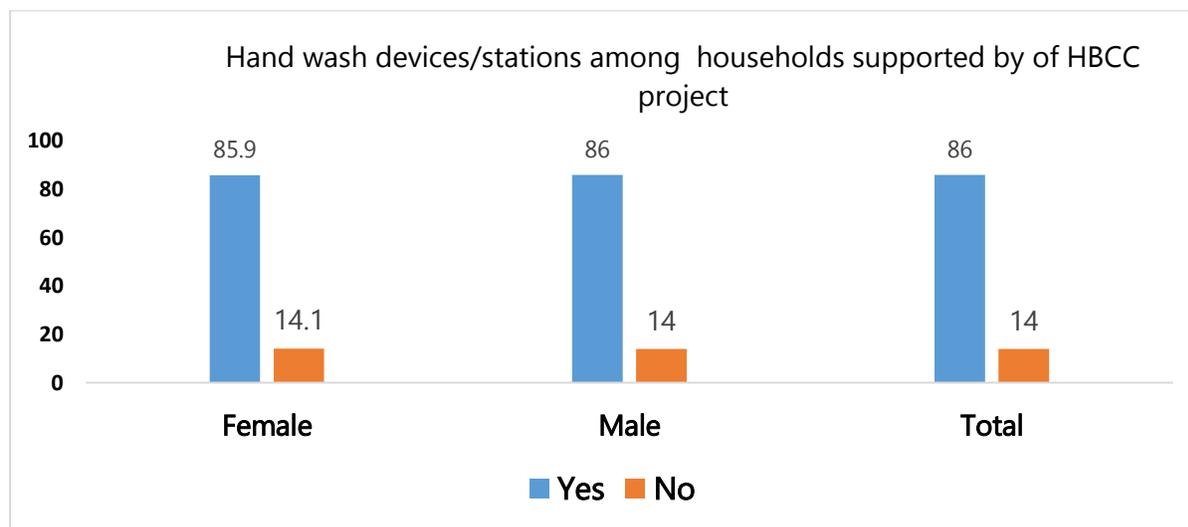


Figure 7: Availability of hand wash devices/ stations among HBCC project supported households

The hand washing devices were dominated (40.3%) basin or bucket by type, followed by tippy tap (31.6%) as shown in table 8. The devices are affordable and readily available on Rwandan market which makes it easy for project outcome continuity.

Table 12: Types of Hand wash devices among HBCC project beneficiaries

Hand-washing device Type	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Basin or bucket	286	38.5	587	41.2	873	40.3
Pouring device	96	12.9	181	12.7	277	12.8
Tippy tap	245	33.0	439	30.8	684	31.6
Others	116	15.6	217	15.2	333	15.4
Total	743	100	1424	100	2167	100

The FGDs participants reported that “project provided a range of hygiene facilities that includes bar soaps, plastic buckets and jerry cans as well as hand sanitizers but none of the groups received a drier as planned in the project design”. However, according to key informants, water tanks were provided, and this was confirmed by the focus group discussants who said, “water tanks were delivered and installed in public places such as health centers, schools, sector and cell offices”. The water supply to many of the hand washing devices are delivered manually, with direct connection municipal water supply. As a result, the 93% of the households have access to water for hand wash cleaning as depicted in figure 8.

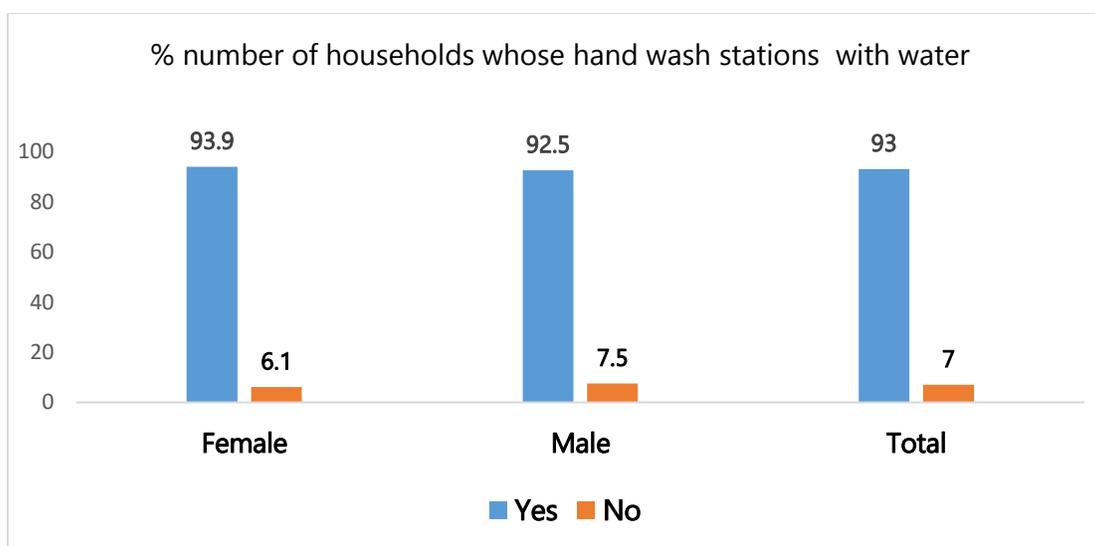


Figure 8: % households with water in handwashing stations

As depicted in figure 9, the evaluation findings revealed that, 63.3% (64.3% male and 61.3% female) have easy access to hand wash facilities particularly soap and sanitizers.



Figure 9: % access to hand wash soap and sanitizers by sex

The bar was the most (68%) commonly used soap among project beneficiaries. The commonality was associated with the fact that HBCC project distributed bar soaps to its project beneficiaries.

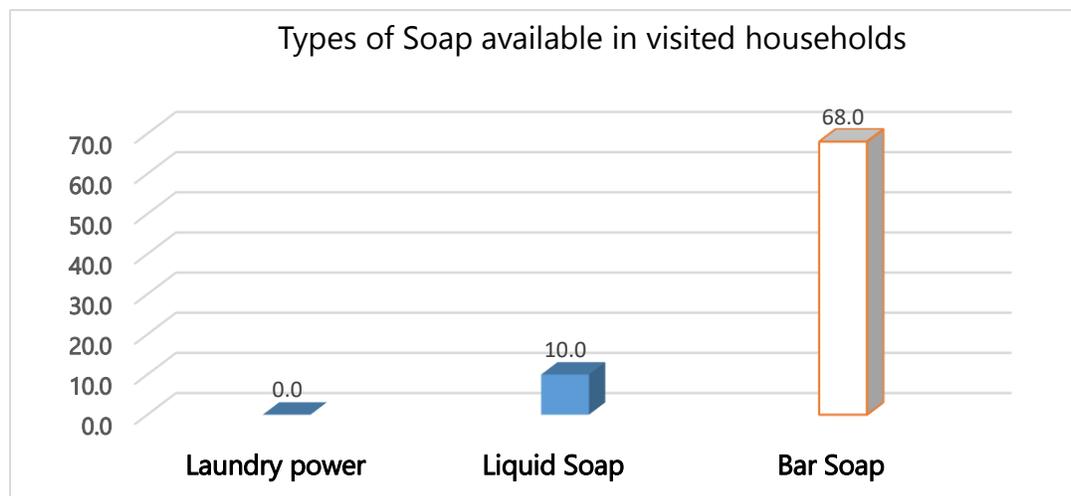


Figure 10: Types of handwashing soap used by HBCC project beneficiaries

As shown in table 9, the 63.3% (38.2% easy: 25.1% very easy) of the project beneficiaries find it easy to access hand washing soap and sanitizer. However, the significant number (30.2%) reported access to hand wash soap and hand sanitizer with difficulty while 6.5% reported no access to hand wash soap and sanitizer. According to focus group discussants, the issue behind no access were associated with project's failure to supply such materials and others lack their own money to purchase soap and sanitizer.

Table 13: % Ease of access to hand wash soap and sanitizer

Level of Easiness	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Easy	280	37.7%	547	38.4%	827	38.2
No access	60	8.1%	81	5.7%	141	6.5
Not easy at all	228	30.7%	427	30.0%	655	30.2
Very easy	175	23.6%	369	25.9%	544	25.1
Total	743	100	1424	100	2167	100

The 94.7% of handwashing stations were found to be equipped with soap and rubbing agents for effective hand washing as shown in figure 11.

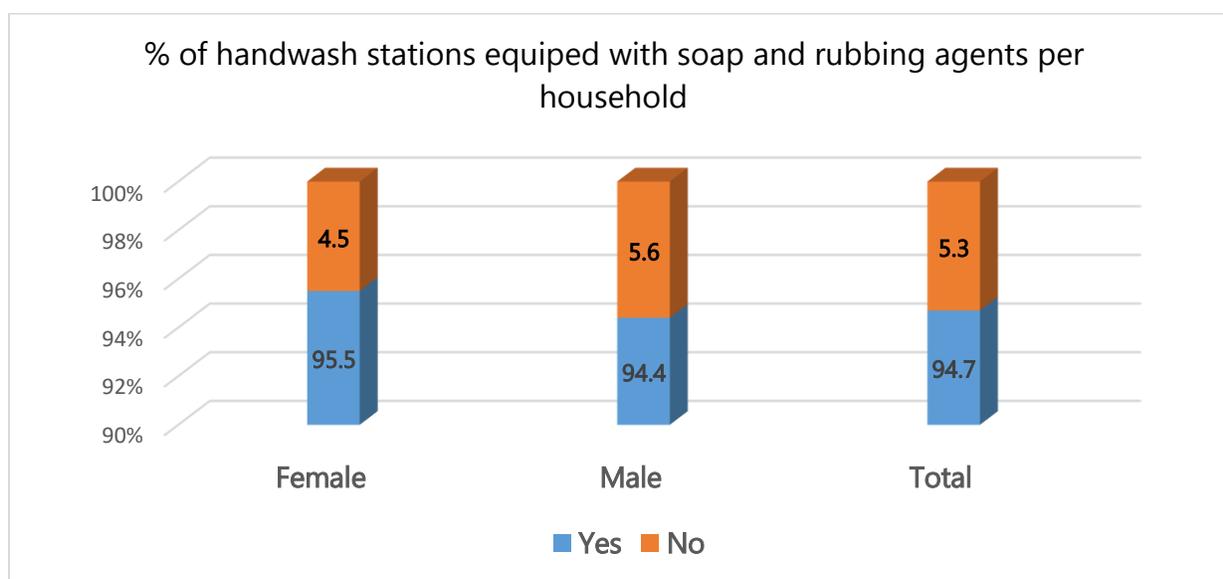


Figure 11: % of hand wash stations equipped with Soap and rubbing agents per household

3.1.3. Access to quality and quantity of hygiene kits

The project beneficiaries testified that the quality of hygiene kits supplied by CARE through HBCC project were good. In absence of the baseline values, the end-line evaluation findings presented in figure 12, reveals that 85.1% of HBCC project beneficiaries were satisfied with the quality and quantity of hygiene kits provided by the project.

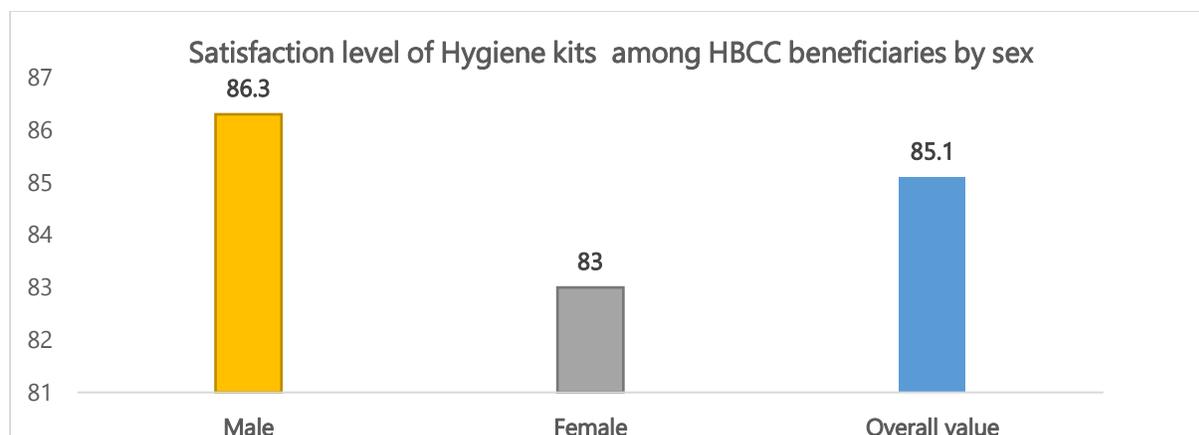


Figure 12: % level of satisfaction by sex on hygiene kits distributed by HBCC project.

As presented in table 10, the 66% (29,9% satisfied and 36.1% very satisfied) were satisfied with quality of hygiene kits distributed by the project. Only 19.1% were some-how satisfied while 14.8% did not receive any hygiene tool kits. According to focus group discussants "Some of the project beneficiaries did not receive hygiene kits from the project. In other instances, hygiene kits were delivered or partial" this explains why some of the project beneficiaries were somehow unsatisfied.

Table 14: Hygiene kits and level of Satisfaction

Hygiene kits and level satisfaction	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Did not receive any hygiene kit	126	17.0%	195	13.7%	321	14.8
Satisfied	223	30.0%	426	29.9%	649	29.9
Somehow satisfied	148	19.9%	266	18.7%	414	19.1
Very satisfied	246	33.1%	537	37.7%	783	36.1
Total	743	100.0%	1424	100.0%	2167	100.0

3.1.4. Handwashing Knowledge and Practice

The proxy indicators such as use of clean water and soap while washing their hands, and frequency of hand washing and practices of cleaning touched surfaces were adopted. End-line results showed that, project beneficiaries gained knowledge and best practices of cleaning touched surfaces as part of covid19 control.

As shown in table 11, the majority (65.4%) were found to have used clean water and soap for more than 40 seconds while only 21.4% cleaned their hands with clean water and soap for less than 40 secs. This implies that, there is still a room for improving hand washing practices.

Table 15: Hand washing with soap and clean water for at-least 40 seconds

Hand washing using clean water and soap for at least for 40 seconds	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Do not remember	92	12.4%	193	13.6%	285	13.2
Hand washing with clean water and soap for at -least for 40 secs.	469	63.1%	949	66.6%	1418	65.4
Hand washing with clean water and soap for less than 40 seconds	182	24.5%	282	19.8%	464	21.4
Total	743	100.0%	1424	100.0%	2167	100.0

Based on evaluation findings presented in table 16, the frequency of hand washing practices among project beneficiaries remains high by 56.4% more than normal. but remained unchanged by 18.7% while 22.6% remained below normal. In other instances, limited number of 2.3% of the project beneficiaries did not wash their hands with soap and clean water.

Table 16: Hand washing Frequency per day with soap and water for at least 40 secs.

Frequently of daily hand washing with soap and water for at 40 seconds?	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
About the same as you normally do	140	18.8%	266	18.7%	406	18.7%
Do not wash hands with soap and water	19	2.6%	30	2.1%	49	2.3%
If Less than you normally do	174	23.4%	316	22.2%	490	22.6%
More than you normally do	410	55.2%	812	57.0%	1222	56.4%
Total	743	100	1424	100	2167	100

Besides frequent handwashing practices, the project beneficiaries demonstrated regular practices in cleaning touched surfaces. The 59.5% clean touched surfaces regularly while 27.1% clean touched surfaces as deemed necessary and only 13.3% never cleans the touched surfaces.

Table 17: Frequency and practices of cleaning touched surfaces

Frequency and practices of cleaning touched surfaces (such as doors, tables, and other public items)	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Never	105	14.1%	184	12.9%	289	13.3
Occasionally	177	23.8%	411	28.9%	588	27.1
Regularly	461	62.0%	829	58.2%	1290	59.5
Total	743	100	1424	100	2167	100

3.1.5. Awareness on COVID-19 Prevention Measures

The evaluation findings revealed that HBCC project beneficiaries are to large extent aware of COVID-19. As indicated in table 14, the high (31.5%) number of project beneficiaries understands that one may easily get COVID-19 once they are in contact with infected people.

Table 18: Awareness on Cause and Control of COVID-19 pandemic

Awareness on cause and control of COVID-19	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
All the previous are true	240	32.3%	424	29.8%	664	30.6
Contact between an infected person and others	232	31.2%	451	31.7%	683	31.5
COVID-19 is caused by coronavirus	57	7.7%	120	8.4%	177	8.2
Social distancing, hand washing, face mask	214	28.8%	429	30.1%	643	29.7
Total	743	100	1,424	100	2,167	100

Using WASH'Em tool on disease perception, it was deduced that project beneficiaries were fully aware of covid19 and dangers. The 100% of the FGDs reported that COVID-19 causes physical, social, and economic impacts. The 83.3% of discussants reported that COVID-19 pandemic causes social exclusion. As depicted in table 15, the 91.5% considers COVID-19 among the top 5 illnesses of concern whereby 50% believed that COVID-19 can lead to serious illness or death. Also, 91.7% of FGDs participants believe that everyone is likely to be contracted by COVID-19.

Table 19: Disease perception and awareness

Disease perception and awareness		Percent
Perception of Corona Virus	Corona Virus/top five illnesses	91.5
likelihood of getting corona virus	It will happen	8.3
	It might happen	50
	I don't think it will happen	33.3
Coronavirus and serious illness or death	It will happen	25.0
	It might happen	50.0
	I don't think it will happen	25.0
Between you family and Neighbor who is more likely to get coronavirus	Neighboring family	8.3
	Same risks for both families	91.7
	My family	0.0
Risk of getting Covid19 between displaced people and your family	My family is less at risks than displaced people	33.3

	The risks are the same	0.0
	Family is more at risks	0.0
Perceived impact of Corona Virus	Physical and mental impact	33.3
	Economic impact	8.3
	Productivity impact	25.0
	Social impact (Exclusion)	83.3
Perception and Covid19 prevention	Covid19 prevention	8.3
Change in handwashing practices	More often-fear of disease	15.0
	More often-live in dirtier environment	10.0
	More often- way of coping with heat	75.0

The fear of COVID-19 pandemic was found to be high. However, the fear of the pandemic reduced by 0.8% comparing baseline values (79.3%) and 78.5% of end-line values as depicted in figure 13

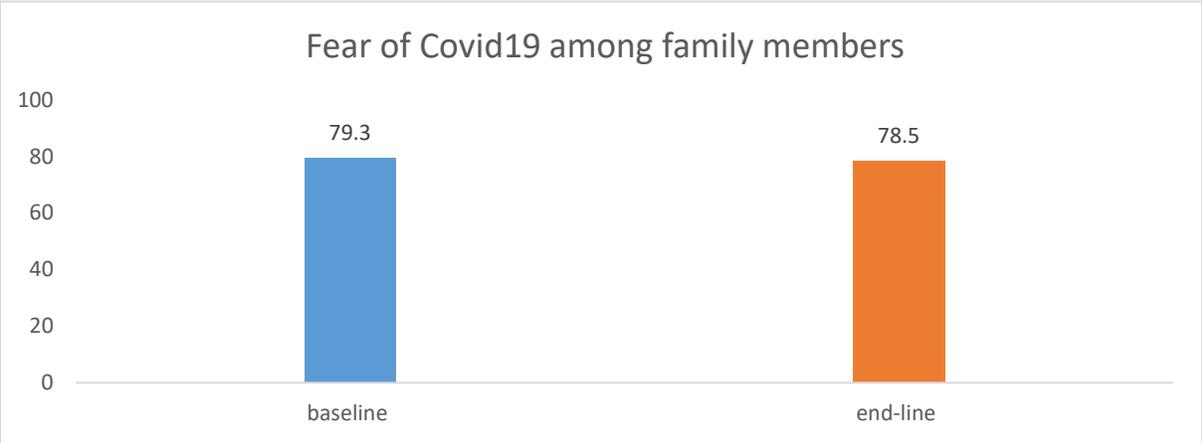


Figure 13: Fear of Covid19 among family members

In terms of sex, the 79.1% of male fear that their families can contract Covid 19 as opposed to 77.4 % female as presented in figure 14.

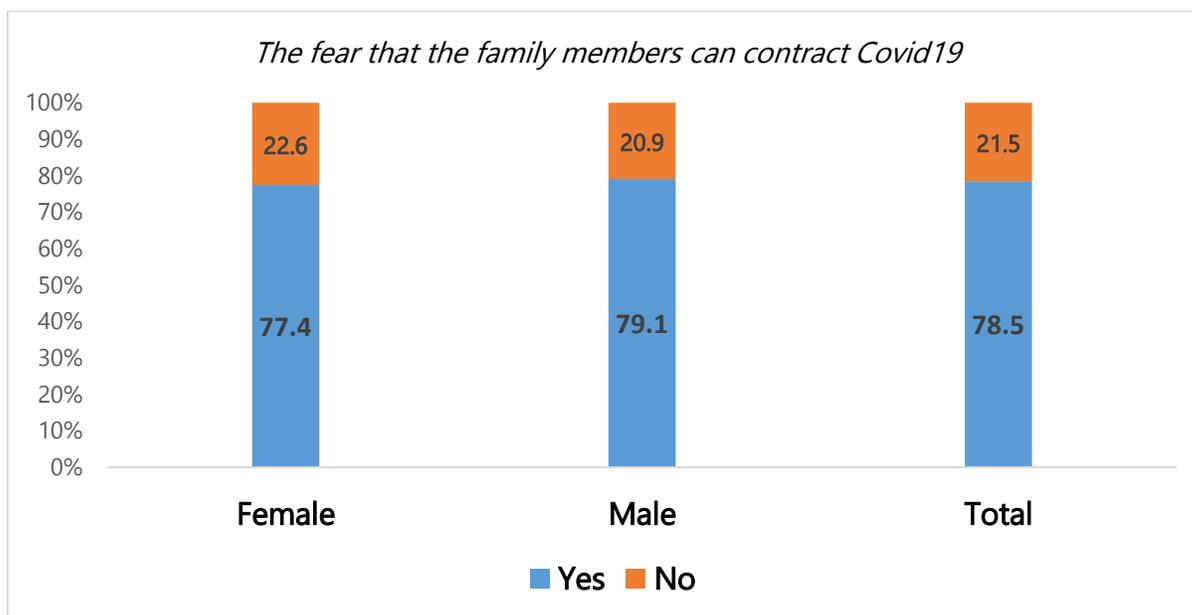


Figure 14: % fear of contracting covid19 pandemic by sex among HBCC project beneficiaries.

The symptoms of COVID-19 were found to be well understood among HBCC beneficiaries. The evaluation findings revealed that a high (78.2%) of beneficiaries understands the symptoms of COVID-19 as shown in table16.

Table 20: Awareness on symptoms of Covid19

Awareness on symptoms of COVID-19	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
Fever, cough, and shortness of breath	579	77.90%	1115	78.30%	1694	78.2
Fever, frequent urination, and swollen legs	109	14.70%	182	12.80%	291	13.4
Fever, vomiting and nausea	55	7.40%	127	8.90%	182	8.4
Total	743	100	1424	100	2,167	100

The beneficiaries understand preventive measures for the pandemic. As presented in table 17 covid19 preventive measures were understood. The common preventive measures were dominated by hand washing (36.4%); 6.5% social distancing and 5.1% use of face masks among others.

Table 21: Covid19 preventative measures known and adopted by project supported families

COVID-19 preventive measures adopted and known by project supported families	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
All the above	395	53.2%	722	50.7%	1117	51.5
Masks	40	5.4%	71	5.0%	111	5.1
Nothing at all	2	0.3%	8	0.6%	10	0.5
Social distancing	46	6.2%	95	6.7%	141	6.5
Washing hands	260	35.0%	528	37.1%	788	36.4
Total	743	100	1424	100	2167	100

When survey participants were asked about what they would do in case they suspect themselves or one of their family members is suspected of being infected with COVID-19, it was noted that only a limited (4.1%) of the respondents were not sure of what to do in either case. As depicted in table 18, the majority (56.7%) indicated that they would isolate themselves while 35% would immediately go for COVID-19 test at the nearest health centers.

Table 22: Immediate actions in case of or one of family members is suspected to have Covid19

Actions	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
COVID-19 Test	251	33.8%	508	35.7%	759	35.0
Enough rest	38	5.1%	54	3.8%	92	4.2
Self-isolation	430	57.9%	798	56.0%	1228	56.7
Not sure	24	3.2%	64	4.5%	88	4.1
Total	743	100	1424	100	2167	100

3.1.6. Hygiene Behavior Change

The evaluation findings revealed that a significant number of HBCC project beneficiaries adopted a range of hygiene behaviors for controlled spread of COVID-19. However, the end-line evaluation findings presented in figure 14, shows no change in % behavior change as the baseline values (61.5%) remained higher than end-line values (48%). According to the key informants, the limited change in terms of new preventive measures adaptation does not mean that, hygiene behavior changes among project beneficiaries but rather, implies that, " *the project did not come with new preventive measures*" instead, it adopted existing (national and global) measures.

On the other hand, focus group discussants reported that "there is a noticeable change in handwashing behavior among project beneficiaries. The practice of washing hands with soap and clean water has been adopted. The frequency of handwashing has also increased significantly".

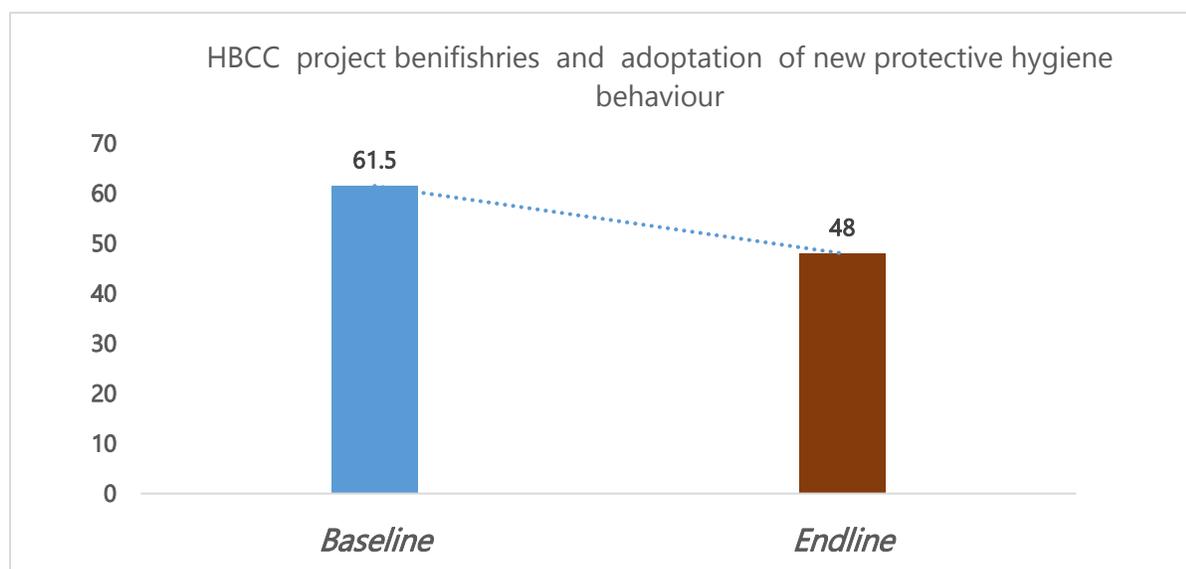


Figure 15: % new preventive hygiene behavior adopted by project beneficiaries

The covid19 preventive measures transferred by the project included use of face masks, social distancing and frequent hand washing as presented in table 19, these hygiene measures were not unique to HBCC project but rather global innovations.

Table 23: Covid19 preventive measures transferred by HBCC project

COVID-19 preventive measures adopted and known by project supported families	Baseline values	End-line values
	Overall %	Overall %
Face Masks	6.0	5.1
Social distancing	6.5	6.5
Washing hands	49	36.4
Total	61.5%	48%

The commonly (51.6%) used hygiene behavior was found to be handwashing as presented in table 20. In fact, it was observed that 9.4% of the evaluation participants did not adopt any preventive hygiene measures which justifies the need for continued awareness and education on COVID19 preventive behaviors.

Table 24: New protective behaviors adopted to fight the spread of covid19

New protective hygiene behaviors adopted to fight the spread of COVID19	Female		Male		Total	
	Count	Percent	Count	Percent	Count	Percent
None	58	7.8%	145	10.2%	203	9.4
Putting on face mask	136	18.3%	271	19.0%	407	18.8
Social distancing	151	20.3%	288	20.2%	439	20.3
Hand washing with soap	398	53.6%	720	50.6%	1118	51.6
Total	743	100	1424	100	2167	100

4. DISCUSSION OF EVALUATION FINDINGS

4.1. Assessment of Project Relevance and Design

The HBCC project was relevant by design. The evaluation findings revealed that COVID-19 pandemic was indeed a major threat to health and safety of Rwandan population. The HBCC project objectives, implementation strategies and activities were deemed relevant to the needs of the targeted project beneficiaries.

The project design was fully aligned with Rwanda’s COVID-19 prevention and control agenda. The project activities were not unique to itself but rather like those implemented by the Government of Rwanda. The stakeholder (rural men, women, girls, and boys including elderly and people living with disabilities) project targeting was relevant. However, the project activities were not differentiated by age, sex, and disability at the time of project design.

Also, project design weaknesses were observed during project initiation phase. The specific needs of the project stakeholders were not known at the time of project implementation. This was justified by the fact that the project baseline survey of December 2020 took place while the project was already under implementation.

Furthermore, HBCC project document did not reflect the project coordination and management by design. But still, the existing management structures championed by CARE and its stakeholders mainly AEE well managed project implementation operations and stakeholders. The strategy of engaging District health unit directors and use of hygiene focal persons were relevant for maximized community and beneficiary ownership of project outcomes. With the absence of clear project management and implementation

structures by design makes it difficult to gauge of cost effectiveness of core management services delivered; and the true costs of projects are understated.

4.2. Assessment of Project effectiveness

The project effectiveness is defined as the extent to which the higher-level objectives of the project were achieved. There was limited quantitative information on effectiveness rates. However, according to key informants, HBCC project has met most of its stated objectives. At outcome level, the project has contributed directly and indirectly to minimizing the risk of spread of COVID-19.

The project beneficiaries demonstrated full awareness of COVID-19 and its dangers as well as its control and preventive mechanisms. There has been a hygiene behavior change due to innovative approaches and media channels adopted by the project. However, with the ongoing rigorous efforts adopted by the Government of Rwanda, it is rather difficult to attribute such positive changes to HBCC project interventions.

The increased awareness and practices on hand washing, surface cleaning and responsiveness of project beneficiaries about covid19 testing and self-isolation practices may be a good proxy indicator of the effectiveness of HBCC project.

4.3. Assessment of Impact

From the evaluation findings, it is evident that the project was impactful. However, the 1-year project implementation period (July 2020-August 2021) was relatively short for impact evaluation. There has been no time to assess if the spread of COVID-19 reduced within the project area.

Despite the difficulties of quantifying project outcomes, the impact of HBCC project is assessed as positive and substantial. The project beneficiaries demonstrated full awareness of COVID-19 and its dangers as well as control and preventive measures. The culture of handwashing with clean water and soap on regular basis has increased with improved attitude of hygiene for disease control.

4.4. Assessment of Sustainability

The project has succeeded in reaching out to its targeted direct beneficiaries. A reasonable proportion of HBCC project beneficiaries have fully understood the needs for proper hygiene in relation to disease control. The evaluation results provide confidence that the projects outcomes are likely to continue after project closure. The continuity stems from the fact that, the hygiene behavior changes among project beneficiaries were quite significant which builds confidence that people will continue to wash their hands even after the project. Already several households have access to appropriate hygiene kits

and most importantly, the approaches, hygiene facilities and skills given to the district-based hygiene focal persons (HFPs) remains relevant for continuity of project outcomes. Also, the HBCC project sustainability lies on the decentralized network of HFPs and engagement of district authorities. As part of project's exist strategies, CARE engaged its key stakeholders (AEE, Girl Effect and district authorities) to inherit some of project's hygiene instruments and achievements. Sustainability Risk exists. The trainings on WASH were limited and did not reach to the grass root leaders such as village chiefs and community heads of Isibo.

5. LESSONS LEARNED

The lessons learned during the implementation of HBCC project exist as outline below:

Project design and implementation: The project's completion process has been carried through efficiently and on time. However, during end-line evaluation, problems which stems from project design encountered being scarcity of information from the early stages of project design. Some of the project outcomes by design were not informed by the baseline survey, consequently, some of the project indicators had not baseline values set at the time of the project design. As part of project implementation, some of project activities were not implemented adequately as planned due to resources (time and financial) constrains.

Project target group: the project targeting of rural households, vulnerable groups of women, men, girls, boys, elderly, and people living with disabilities was shown to be appropriate, relevant, and effective as means to support them access information on COVID-19 control, but the chosen groups needed a different set services to enable them access WASH facilities. By design, there was no clear guidelines and criteria for providing special services or focus on the most vulnerable groups such as elderly, single mothers and people with disabilities as targeted in the project.

Monitoring and evaluation: The project Monitoring log frame lacked critical information particularly the performance targets and baseline values per project outcome indicators. This made it difficult to assess the successful implementation of the project. Also, with the limited project implementation period, there were no mid-term evaluation.

Economical delivery approaches and mechanism: The involvement of key stakeholders such as AEE and Girl Effect and local government authorities through HFPs served as an effective mechanism for successful project implementation and safeguarding the project outcomes beyond project life. The readiness of implementing partners was cost-effective,

but there is formal agreement on integration or adaptation of project outcomes beyond project lifetime.

Survival of project initiatives: it likely that project outcomes will continue beyond CARE financing due to the strong commitment of both government and other project stakeholders (AEE and Girl Effect), the full ownership and appreciation of media channels by districts, and the cadre of skilled technicians (HFPs) at the sector level now available to continue educating households on matters of hygiene for disease control exist. Also, the survival of the project outcomes relies on the fact that, project interventions are fully aligned with Rwanda's COVID-19 response measures. In contrast, the project outcomes may not last long because of limited resources and facilitation mechanism needed to continue training and supporting the project beneficiaries to access hygiene facilities.

6. KEY RECOMMENDATIONS

To scale up and sustain project outcomes and based on project evaluation findings, the following are the proposed key recommendations:

Project extension: Due to the registered benefits and gains of the projects. The implementation period of 1 year was a bit short to reach to many and for greater impact. This calls for project extension phase 2 of the project needs to be designed for effective for broader outreach and impact beyond the existing project's geographical coverage to other parts of the country by reaching out to most vulnerable and living with disabilities.

Sustainability: The evaluation recommends the development of a new project that engages local government authorities for smooth integration and mainstreaming of project outcomes for continuity and sustainability.

7. IMPORTANT ANNEXES

This section presents important annexes to the evaluation report. The annex 1 presents the overall project log frame with clear end-line results by outcome indicator against baseline values and annex 2, presenting data collection tools.

Annex 1: Project log frame with end-line evaluation figures per outcome indicator

Purpose: Contribute to reducing incidences of covid19 transmissions						
Outcome	Indicator	Baseline (incl. reference year)	Current value (April,2021) HBCC indicator Tracking Report	Targets (incl. reference year)	Sources and means of verification	End-line Values
Outcome: People in targeted areas practice frequent handwashing with soap at key times for at least 40 seconds to interrupt the spread of covid19 transmission	% of women, men, boys, and girls including the elderly and those living with disabilities recalling at least one message from CARE's communication campaign (e.g., radio, billboards, posters etc.)	19.9%				Overall (26.5) Female: 26.4 Male: 26.6
	% of women, men, girls, boys, the elderly, and those living with disabilities, who report sufficient access to handwashing soap, hand sanitizer				Survey Report	Female: 61.3% Male: 64.3% Overall: 63.3
	% of women, men, the elderly, and those living with disabilities, who report being satisfied with the quality and quantity of hygiene kits distributed **collect during PDM**	NA	Female: 54% Male: 61 %		Survey Report	Female: 83.0% Male: 86.3% Overall: 85.1%

% of women, men, girls, boys, the elderly, and those with disabilities reporting being able to wash their hands with water and soap for at least 40 seconds, safely and conveniently at the public places	NA			Survey Report	Male 67.0% Female 63.1% Overall: 65.4%
% of people disaggregated by sex, age and disability claiming to have adopted at least one new protective hygiene behavior	Male:61.0% Female:62% Overall: 61.5%	Female: 42.7% Male: 24.4%		Survey Report	Male: 46.6% Female: 48.8% Overall: 48.0%
% of mothers/caregivers recalling at least 3 key times for handwashing with soap and water	NA	One time: 82%, Twice: 68%, Third time: 65%		Survey Report	NA
% of mothers/caregivers who demonstrate correct handwashing practice with water and soap for at least 40 seconds	NA	harmful of the product in a cupped hand and covering all surfaces Female: 54% Male: 33%		Survey Report	NA
% of mothers/caregivers observed to wash hands with water and soap for 40 seconds before preparing food	NA	77.7%		Survey Report	NA
% of mothers/caregivers observed to wash hands with water and soap for 40 seconds before feeding young children	NA	78.7%		Survey Report	NA

% of mothers/caregivers observed to wash hands with water and soap for 40 seconds after using the toilet	NA	84.8%		Survey Report	NA
% of people disaggregated by sex, age and disability observed washing hands with water and soap for at least 40 seconds after removing face masks		Female: 86% Male: 90%		Survey Report	NA
% of people disaggregated by sex, age and disability demonstrating correct wearing of masks	NA	Female: 41% Male 30% Physical Disability: 15%		Survey Report	NA
% of people disaggregated by sex, age and disability observed to wash hands with water and soap for 40 seconds before entering house/indoor.	NA	15%		Survey Report	
% of people disaggregated by sex, age and disability who report cleaning frequently touched surfaces	NA	Female: 10% Male: 12%		Survey Report	60%
% of people disaggregated by sex, age and disability who are aware of COVID-19 prevention measures	NA	Female: 100% Male: 99%		Survey Report	

Annex 2: End-line evaluation qualitative data collection tools

The qualitative data collection tools used during evaluation are presented under the following sections.

ANNEX: DATA COLLECTION TOOLS

Part1: Guide Questionnaire for FGDs: (Direct HBCC project Beneficiaries (men, women, and people with disabilities). **Buri Kibazo Saba ibisobanuro birambuye, kuvuga yego cyangwa Oya ntibihagije.**

Transcription format FGDs _.....

	Basic information	Answers
1	Name of enumerator (Facilitator)	.....
2	Name of enumerator (Take Note)	.....
3	Date of interview:	.....
4	Location of the discussion group (village, cell, sector, district):	Village: Cell: Sector: District:
5	Type of FGD (circle the one that applies):	A: Women B: Youth C: Men
6	Number of participants (between 8-12) + coding: Options for anonymity: A) I prefer to stay anonymous B) Only my position can be referenced C) My name and position can be referenced	Note for each participant their name, function (if any) or type of respondent and gender. Also add the anonymity option A, B or C (see left).
		E.g.:
		# 1 KABANDA Joseph Male
		# 2
		# 3
		# 4
		# 5.....
#6.....		
#7.....		
7	Spoken languages during FGDs:	Kinyarwanda
8	Duration of the FGDs:	Start at
9	Audio recording available:	NO

Part1: Guide Questionnaire for FGDs: (Direct HBCC project Beneficiaries (men, women, and people with disabilities).

Ibibazo ngenderwaho

A. General questions

a. Ibibazo rusange

1. Do you know HBCC CARE project? **Muzi umushinga wa Care witwa HBCC?** What were the project activities? **Ni ibihe bikorwa by'uyu mushinga muzi?** Were the project objectives achieved? **Uyu mushinga waba warageze ku ntego wihaye?** Explain **Mubisobanure.**
2. Were the project interventions relevant and aligned with beneficiary needs and national priorities? **Ese umushinga mu ishyirwa mu bikorwa ryawo witaye ku byifuzo by'abagenerwabikorwa, ndetse n'ibyigenzi ku rwego rw'igihugu?**
3. To what extent has HBCC project facilitated improved hygiene behaviors for the prevention of Covid19? **Ni mu ruhe rwego umushinga HBCC wafashije mu kuzamura imyumvire yo kwita ku isuku mu rwego rwo kurwanya Covid19?**
4. Which disease did the HBCC project focus on? **Ni iyihe ndwara umushinga HBCC ikurikirana cyane?** What were the symptoms, causes, control measures and impact? **Ni ibihe bimenyetso byayo, iterwa n'iki ,ni izihe ngamba zo kuyirwanya, ese izo ngamba zageze kuki?**

Indicator specific guide questions

Messaging and communication campaign

5. Are you aware of covid19 control measures? **Mwaba muzi ingamba zo kwirinda Covid19?** How did you get to know about Covid19 control? **Covid19 mwayimenye mute?** From which agency/organization did you hear about Covid-19 control measures? **Izo ngamba zo kurwanya Covid19 wazimenyeshejwe cyangwa wazikuye mu wuhe umuryango?** Which channel of communication did you hear this from? **Ni uwuhe muyoboro w'amakuru cg igitangamakuru wazumviseho?**
6. What form of messaging and communication campaign platforms were effective and why? **Ni ubuhe buryo bw'ubukangurambaga buboneye mu gutanga ubutumwa n'amatangazo? Kubera iki?** What were the challenges of accessing published information? **Ni izihe ngorane muhura nazo zituma mutagera ku makuru atangazwa?**
7. Were you given handouts or copies of such messages for continued reference and information dissemination? **Mwahawe imfashanyigisho cg impapuro ziriho ubutumwa kugira ngo mubuhereho mukwirakwiza amakuru? (kuri Covid19)?** What messages do you

recall from the handouts? **Ni ubuhe butumwa bwari bukubiye muri izo mfasha nyigisho mwaba mwibuka?**

Access to handwashing facilities

8. Did you have sufficient access to handwashing facilities? **Mworoherejwe bihagije uburyo bwo gukaraba intoki?** Such as appropriate hand wash stations, clean water, soap, hand sanitizers & drier etc.? **nk'aho mukarabira hameze neza, amazi meza, isabune, umuti wica udukoko ku ntoki, kumutsa intoki n'ibindi?** Did HBCC project support you to access any of those facilities? **Umushinga wa HBCC waba warabateye inkunga mu kubona ibyo bikoresho byo kwirinda Covid19?**
9. Were you supported to get rainwater harvesting facilities? **Mwafashijwe kubona byoroshye ibigega byo gufata amazi y'imvura?** Explain. **Sobanura.** Do you know any rainwater harvesting facility that was provided by HBCC project? **Mwaba muzi ubufasha mu kubika amazi y'imvura bwatanzwe n'umushinga HBCC?** How access it? **ubwo bufasha bwagezweho gute?** Please explain? **Mugerageze gusobanura.**
10. In your resources, will you still be able to maintain the provided handwashing facilities beyond HBCC project life? **Mu bushobozi bwanyu muzishoboza kubungabunga ibyo mwahawe mu rwego rwo kubasha gukaraba intoki, igihe umushinga HBCC waba ubacukije?**
11. Is there any hand wash facility access challenges to-date? **Hari izindi ngorane zaba zihari kugeza ubu mu bushobozi bwo gukaraba intoki?** Explain. **Musobanure.**

Access to quality and quantity of hygiene kits

12. Did you receive any hygiene kits through HBCC Care-project? **Hari ibikoresho by'isuku mwahawe n'umushinga HBCC?** Were those kits sufficient and relevant? **Ibyo bikoresho byari biboneye kandi bihagije?** Were you satisfied with their quality? **Mwishimiye ubuziranenge bwabyo?**
13. Were you sufficiently trained/oriented on management and use of hygiene kits? **mwahuguriwe bihagije gufata neza no gukoresha neza ibikoresho by'isuku?**

Handwashing knowledge and practice

14. Do you have adequate knowledge and skills on handwashing? **Mufite ubumenyi buhagije ku bijyanye no gukaraba intoki?**
15. What do you use to wash your hands? **Mukoresha iki mukaraba intoki?** How long do you wash your hands **Iyo mukaraba intoki, mumara igihe kingana iki?**
16. Were you trained by HBCC project on hand washing? **Mwahuguwe n'Umushinga HBCC ku byerkeye gukaraba intoki?** Were you given posters/flyers on hand wash guidelines? **Ese mwaba mwarahawe udutabo dukubiyemo amabwiriza yo gukaraba intoki?**

Hygiene Behavior change

17. Did your attitude, practices and hygiene behavior change because of HBCC project? **Imyitwarire yanyu, imigirire n' imico yanyu ku byerekeye isuku, yaba yarahindutse kubera Umushinga HBCC?** explain by comparing your behavior before and after the project? **Musobanure mugereranya imyifatire yanyu ya mbere y'Umushinga na nyuma yawo?**
18. Why should you or anyone else wash their hands properly and observe good hygiene? **Kuki buri wese agomba gukaraba neza intoki kandi agahorana isuku?**
19. How regular and when do you wash your hands? Explain. **Ni kangahe, na ryari ugomba gukaraba intoki? Musobanure ?**
20. How many times do you wash your hands in a day? **Ukaraba intoki inshuro zingaha ku muni?** What are the challenges? **Ingorane uhuriramo nazo ni izihe?**
21. Have you mastered hand washing practices? **Igikorwa cyo gukaraba intoki ugikora neza?** Demonstrate and explain. **Byerekane kandi ubisobanure?**

Awareness on covid-19 prevention measures

22. Are you fully aware of Covid-19 prevention measures? **Wamenyeshejwe byuzuye ingamba zo kwirinda Covid19?** Specify which measures that you are conversant with? **Sobanura ingamba wafashe wabwira n'abandi?**
23. What were the key challenges that arose during the project implementation and how could these have been mitigated? **Ni izihe ngorane zikomeye zagaragaye mu ishyirwamubikorwa ry'umushinga, n'uburyo zakemuwe?**
24. How can these lessons be integrated into CARE International programmes for future similar programming? **Ni gute aya masomo umuryango Care International wayagira ayawo ngo azafashe no muri gahunda z'ibihe bizaza?**

PART 2: Key Informant Interview (KIIs) - Guide Questions Per Specific Project Stakeholders

	Basic information	Reply
1	Name of enumerator (Facilitator)	.....
2	Name of enumerator (Take Note)	.....
3	Date of interview:	DD/MM/YYYY
4	Location of the KII,s (village, cell, sector, district):	District.....
5	Circle the type of interview here:	A) Director Of Heath
6	Name and function of respondent:	.....
7	Gender of respondent:	Man / Woman
8	Consent statement read and accepted:	Yes / No NB: If Yes but not signed the Consent form add Comment (Respondent didn't sign the Consent Form)
9	Options for anonymity:	A) I prefer to stay anonymous B) Only my position can be referenced C) My name and position can be referenced
10	Spoken language(s) during interview:	.....
11	Duration of the interview:	Start and End.....
12	Audio recording available:	Yes / No

KII-guide questions to district Health Director of Unit (HDUs)

- How relevant was HBCC project in context of beneficiary needs and aligned to national health and hygiene priorities? **Ese mubona uyu mushinga w'Isuku waraje ukeneze? Waba waraje kubafasha gukemura ikibazo mwari mufite? Ese waba uri mu murongo w'ibiyhutirwa bijyanye na gahunda za Leta mu bijyanye n'isuku n'ubuzima?**
- What were the positive outcomes of HBCC project? explain **Ni izihe mpinduka nziza uyu mushinga wazanye? Sobanura.**

3. Did the project bring any change to the community among project beneficiaries (men, women and people leaving disabilities) and their communities? Explain **Uyu mushinga waba warazanye impinduka ku bagenerwabikorwa aho mutuye? (ku bagabo, abagore, abantu bafite ubumuga), ndetse n'abo baturanye?**
4. Were the project approaches and methods of communication and messaging easy to adopt and reached out to all project beneficiaries? What methods worked best, and which methods did not work? **Ese uburyo Umushinga wakoresheje utanga amakuru, bwaba bwaraboroheye kugera ku bagenerwabikorwa? Ni ubuhe buryo bwakoze neza? Ni ubuhe butakoze neza?**
5. What activities are likely to continue beyond HBCC intervention and what activities will stop? **Ni ibihe bikorwa mubona bizakomeza Umushinga nurangira? Ni ibihe bizahita bihagarara?**
6. Was the training to Health Focal Points (HFPs) adequate? Will they continue to serve as HFP after the project? Explain how. **/Amahugurwa y'abahagarariye Ubuzima yaba yaragenze neza? Ese bazagumana izi nshingano Umushinga nurangira? Sobanura.**
7. What were the shortcomings of HBCC project (if any)? **Ni izihe mbogamizi umushinga HBCC wagize niba zihari?**
8. What HBCC activities or approaches will the government institutions adopt and continue some of the project best practices and why? Explain. **Ni ibihe bikorwa cyangwa se uburyo bw'imikorere inzego za Leta zaba zarigiye kuri uyu mushinga, zikaba zanabikomeza nyuma y'uko urangiye? Kubera iki ? Sobanura.**
9. What innovative ways did the project use if any? **Ni akahe gashya Umushinga waba warazanye niba gahari?**
10. What were the lessons learnt (if any)? Explain. **Haba hari amasomo mwigiyeye muri uyu mushinga? Sobanura.**
11. How can these lessons be integrated into CARE International programmes for future similar programming? **Ni gute ayo masomo yakwinjizwa muri gahunda za Care, mu yindi mishinga iri imbere isa n'iyi?**
12. What were the key challenges that arose during the project implementation and how could these have been mitigated? **Ni izihe mbogamizi zaba zarabonetse mu ishyingirwa mu bikorwa ry'uyu mushinga? Ni gute zashoboraga kwirindwa?**

Klls-Guide questions to Health Focal Points (Buri Kibazo saba ibisobanuro birambuye ubyandike)

	Basic information	Reply
1	Name of enumerator (Facilitator)	.....
2	Name of enumerator (Take Note)	.....
3	Date of interview:	DD/MM/YYYY
4	Location of the Kll,s (village, cell, sector, district):	Village: Cell: Sector: District:
5	Circle the type of interview here:	Focal Person of the Project (FP)
6	Name and function of respondent:	.....
7	Gender of respondent:	Man / Woman
8	Consent statement read and accepted:	Yes / No NB: If Yes but not signed the Consent form add Comment (Respondent didn't sign the Consent Form)
9	Options for anonymity:	D) I prefer to stay anonymous E) Only my position can be referenced F) My name and position can be referenced
10	Spoken language(s) during interview:	.....
11	Duration of the interview:	Start and End.....
12	Audio recording available:	Yes / No

13. What were your responsibilities as a Health Focal Point? **Inshingano zawe zari izihe muri uyu mushinga nk'uhagararye ibikorwa by'ubuzima?**
14. What has been the impact of HBCC in the community where you live? **Impinduka umushinga HBCC waba warazanye mu mibereho yanyu, aho mutuye ni izihe?**
15. Were you adequately and efficiently trained by HBCC project? what was the frequency of trainings? describe the training modules that you were given? **Amahugurwa mwahawe mu rwego rw'uyu mushinga, yaba yaragenze neza? Ese ubundi mwahuguwe inshuro zingahe/iminsi ingahe? Musobanure amwe mu masomo mwahawe?**
16. Were you given training manuals for future reference? **Mwaba mwarahawe imfashanyigisho kugira ngo muzazifashije no mu gihe kizaza?**
17. What plans do you have to continue as Health focal person even after HBCC project life? **Ni iyihe gahunda mufite nk'abashinzwe ibikorwa by'ubuzima, nyuma yuko Umushinga ugiye kurangira?**
18. Did the project bring positive or negative hygiene behavioral change within the community? **Ese mubona Umushinga warazanye impinduka nziza cg mbi mu bijyanye no guhindura imyitwarire mu rwego rw'isuku aho mutuye?**
19. Did WASH services/products (rainwater harvesting facilities, Hygiene kits) reach out to all targeted project beneficiaries? Explain **Ese ibigega byo kubafasha gufata amazi y'imvura ava ku mazu, ndetse n'ibikoresho by'isuku, mwese mwaba mwarabihawe nk'abagenerwabikorwa? Sobanura**
20. What challenges did you face as HFP in your community while delivering health services? How could these have been solved? **Ni izihe mbogamizi mwaba mwarahuye nazo, aho mutuye, mu bujyanye n'inshingano mwari mufite zo kubungabunga ubuzima? Zashoboraga kwirindwa gute?**
21. Any questions from you? **Haba hari kibazo mushaka kutubaza?**

Transcription format KIIs (AEE, CARE, GER)

	Basic information	Reply
1	Name of enumerator (Facilitator)	.....
2	Name of enumerator (Take Note)	.....
3	Date of interview:	DD/MM/YYYY
4	Location of the KII,s (village, cell, sector, district):	Location
5	Circle the type of interview here:	B) CARE C) AEE D) GER E) Other (specify).....
6	Name and function of respondent:	.....
7	Gender of respondent:	Man / Woman
8	Consent statement read and accepted:	Yes / No NB: If Yes but not signed the Consent form add Comment (Respondent didn't sign the Consent Form)
9	Options for anonymity:	G) I prefer to stay anonymous H) Only my position can be referenced I) My name and position can be referenced
10	Spoken language(s) during interview:	.....
11	Duration of the interview:	Start and End.....
12	Audio recording available:	Yes / No

KIIs-Guide questions to project team (Care, AEE Rwanda, Girl Effect Rwanda)

Saba ibisobanuro birambuye

13. What HBCC project objectives were achieved and not achieved. Why were some achieved, and others not achieved. **Intego z'Umushinga zaba zaragezweho ni izihe? Izitaragezweho ni izihe? Kuki zimwe zaba zaragezweho, izindi ntizigereweho?**

22. What activities were implemented and what activities were not implemented? Why were some activities implemented and others not implemented? **Ibikorwa byakozwe ni ibihe? Ibitarakozwe ni ibihe? Kuki bimwe byakozwe, ibindi ntibikorwe?**

23. What impact did the project have on the behavior outcome of the people? **Ni iyihe mpinduka Umushinga waba warazanye mu bijyanye no guhindura imyitwarire?**
24. Were there any unintended project outcomes? **Ese haba hari ibintu Umushinga waba waragezeho bitari biteganyijwe mbere?**
25. Were the project resources availed as planned and used efficiently? **Amafranga yari ateganyirijwe Umushinga, murabona yaba yarakoreshejwe neza?**
26. What were the media campaigns channels? how effective were those channels? **Uburyo bwakoreshejwe bwo kugeza amakuru ku baturage ni ubuhe? Ese bwaba bwari buboneye?**
27. What were the project implementation challenges? **Ni izihe mbogamizi Umushinga waba warahuye na zo mu ishyirwa mu bikorwa ryawo?**
28. What were lessons learnt? **Ni ayahe masomo mwaba mwarakuyemo?**
29. Will the project outcomes continue after HBCC project lifetime? Explain. **Ese mubona impinduka nziza Umushinga wazanye zizakomeza na nyuma y'uko Umushinga urangiye? Sobanura.**

WASH'Em Tools

Disease Perceptions

- This form is for FGDs
- This form must be completed for at least 2 FGDs in District (One for men and other for women)
- Enumerator must print and copy and fill one sheet per FGD
- Scoring system refers to the majority

Illnesses of most concern to this community (with Number 1 being the most serious concern):

1

2

3

4

5

Local definition of coronavirus:

Symptoms:

Causes:

<hr/>	<hr/>

Circle the answer that was agreed on by most participants:

Q1 Do you think that someone in your family could get coronavirus in the next 6 months?

I think it will not happen	I think it might happen	I think it will happen
-----------------------------------	--------------------------------	-------------------------------

Q2 If someone in your family did get coronavirus, do you think it could result in serious illness or death?

I think it will not happen	I think it might happen	I think it will happen
-----------------------------------	--------------------------------	-------------------------------

Q3 If you compare your family with other families who live near you, who is more likely to get coronavirus in the next 6 months?

Other families	We are all at the same risk	My family
-----------------------	------------------------------------	------------------

Q4 For displaced people only: All of you have been displaced recently. I want you to think of the place where you used to live, and the place where you live now. Do you think your family is more at risk of getting coronavirus here, or where you were before?

We are at less risk here	Our risk is the same	We are at high risk here
---------------------------------	-----------------------------	---------------------------------

Touch Point Tools

- This tool is for Focus Group Discussion
- People refers to FGDs participants
- To accepts "lof of" (Most) or "small" (few) refers to voting
- Enumerator must print and copy and fill one sheet per FGD
- Total = Sum of Yes, lot + Yes, small
- This form must be completed for at least 2FGDs in District (One for men and other for women)

Who uses this/goes to this place/attends?									Additional Questions
	No	Yes, lots of people	Yes, a small number of people	Women	Men	Children or young people	People with disabilities	Total	
Do people watch television? Who uses this?									Which is your favourite station?
Do people listen to the radio? Who uses this?									Which is your favourite station?
Do people have mobile phones? Who uses this?									Do people talk or text more often?
Do people use social media / the Internet? Who uses this?									Which social media do you use?
Are there other specific people you get information from or whose job it is to share information in the local area? Who normally receives information from these people?									Who are the sources for local information?

Do health workers visit homes regularly? Who do they visit?									What do they normally do during the visit?
Are there other people whose job involves them going house-to-house? Who do they visit?									What is the role of these people?
	No	Yes, lots of people	Yes, a small number of people	Women	Men	Children or young people	People with disabilities	Total	
Are there buses, taxis (including bikes or motorbikes), or trains? Who uses them??									Is there any advertising or posters on these modes of transport?
Is there a school nearby? Who goes? For the Men and Women categories ask: Do mothers/fathers attend events at school?									What kind of meetings and events are held at the school outside of school hours?
Is there a mosque, church, or temple nearby? Who goes?									

<p>Do you have community meetings? Who goes to them?</p>									<p>How often do these happen? What is normally talked about at the meetings? Where do these happen?</p>
<p>Is there a local cinema? If so, who goes to it?</p> <p>Note: this does not have to be a formal cinema it could just be a place where people gather to watch TV together.</p>									
<p>Are there sporting events in the community? Who would normally gather to watch them?</p>									
<p>Are there cafés or restaurants in your community? Who would normally go to them?</p> <p>Note: This can include informal tea, coffee, or snack vendors</p>									
	No	Yes, lots of people	Yes, a small number of people	Women	Men	Children or young people	People with disabilities	Total	

<p>Are there hairdressers or beauticians in your community (even if they are non-professional)? Who would normally go to them?</p>									
<p>Are there women's groups, men's groups, youth groups, or disability organizations in this community? Who would normally attend these groups?</p>									
<p>Are there savings and loans groups in this community? Who would normally attend these groups?</p> <p>Note: Savings and loans groups are usually informal groups set up between community members to save and support each other to buy necessary items.</p>									

DEMO Tool

DEMO TOOL/ HOUSEHOLD 10HOUSEHOLD IN DISTRICT MEANS 4 PER SECTOR

District:

Sector:

Name of Enumerators:

.....

Question	Answers	Findings:											
		Place a '1' in the box if the answer applies to that participant. Leave blank otherwise.											
		HH1	HH2	HH3	HH4	HH5	HH6	HH7	HH8	HH9	HH10	Total	
1. Is there a specific place for handwashing? (If you are unsure how to classify what you have seen check the examples and definitions on the next tab)	Yes - there are handwashing facilities near the toilet and the kitchen												
	Yes - there is a multifunctional handwashing facility (a basin or tap that is used for handwashing, and is used for other things like laundry, too)												
	No - there are no handwashing facilities available near the kitchen or toilet												
	No - there are handwashing facilities at the toilet, but not at the kitchen												
	No - there are handwashing facilities at the kitchen, but not at the toilet.												
2. If there is a handwashing place, is it in a location where other people can easily see it? (if someone doesn't wash their hands will people notice?)	Yes - others can see												
	No - others can't see												
3. If there are handwashing facilities, are they shared by more	Yes - the facilities are shared												
	No - The facilities are used only by one family or less than 10 people.												

than one family or more than 10 people?																			
4. Is there soap or ash in the home? If so, where is it kept?	Yes - Near the toilet or in the kitchen																		
	Yes - Elsewhere in the house																		
	No soap of any kind or ash is available																		
5. If soap is available, what type is it?	Liquid soap or foaming soap																		
	Bar soap that is designed for handwashing/bathing and is scented																		
	Laundry powder, laundry bar soap, dishwashing liquid or ash																		
6. Was there water available at the handwashing place?	Yes																		
	No - the person had to go elsewhere to get water before handwashing (for example, into the home to access stored water).																		
7. Are the handwashing facilities beautiful? (For example, through mirrors, better cleanliness or decorations.)	Yes - Handwashing facilities are already desirable and attractive																		
	No- Handwashing facilities are clean but not attractive																		
	No - Handwashing facilities are dirty and unattractive																		
	No - There are no handwashing facilities																		
8. Is the handwashing place convenient and easy to use? (more than one answer can be given per participant)	Yes																		
	No - the person doing the demonstration found it difficult to reach (too high or too low) or other people in the family might find it hard to reach																		
	No - people can only wash one hand at time																		
	No - it is fragile or easy to break																		

No – it is too far from the toilet/kitchen (for example, more than 10 steps away)

For. Quantitative Tools/ Consult VIAMO