

Evaluation of UNICEF's Sanitation Programme in Nepal

August 2022



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UNICEF's Sanitation Programme in Nepal**

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Executive Summary

Access to water and sanitation is recognized by the United Nations as a human right; fundamental to everyone's health, dignity, and prosperity. In accordance with the key priorities of Country Program Action Plan (CPAP), the main purpose of UNICEF Nepal's sanitation programme for 2018-2022 was to ensure people access to basic sanitation facilities for 500,000 people. 70 percent of the target population hailed from Madhesh Province and the rest of the target population resided in Province 1, Bagmati, and other provinces. During the period 2018-2020, UNICEF and the Government of Nepal reached 547,643 households that were provided access to basic sanitation services. The number of people reached were more than 500,000 as planned in UNICEF's country programme for 2019-2022. The total fund utilized for achieving access to basic sanitation facilities was US\$ 2,210,000, including technical assistance of about US\$ 1,000,000. In supporting the government's efforts to end open defecation UNICEF's major activities included coordination and collaboration with the WASH stakeholders working in the districts for joint planning, facilitation, triggering, social mobilization, monitoring and review of the sanitation status at district and palika levels.

The main purpose of the evaluation was to utilize the crafted lessons and recommendations for more effective future plans and interventions for sustainable ODF Nepal. Specific objectives of the evaluation were:

- To evaluate the performance of the sanitation programme in their relevance, effectiveness, efficiency, and sustainability.
- To assess and compile good practices and lessons learned and to draw a comprehensive situation overview.
- To provide practical and feasible recommendations with strategic direction towards sustainable outcomes.

The evaluation was undertaken between April - May 2022 by CLTS Foundation Global, based in Kolkata India and Citizen Development Solution (CDS) based in Kathmandu Nepal.

Through the application of a valid sampling approach and covering a representative sample, the evaluation accessed multiple and diversified data sources. The evaluation team was composed of a gender-balanced, multi-disciplinary team of international and national experts of core consultants and twenty-six (26) survey enumerators who were engaged in the data gathering process. For the collection and gathering of data and information both secondary and primary sources were explored. Using a participatory and mixed method approach, the gender and age disaggregated multiple methods of primary data collection were applied. The evaluation covered a total of 3,042 respondents amongst which 40 percent were Dalits, other vulnerable and marginalized population groups. In addition to conducting a household level Knowledge, Attitude and Practice (KAP) survey, the evaluation conducted a total of eighty (80) qualitative data collection activities through application of Focused Group Discussion (FGD), Key Informant Interview (KII), Semi Structured Group Interview (SSGI), Direct Observation, Province level Validation and Lessons-Learnt session,

and a National-level validation session. Most data gathering activities involved a multi-stakeholders participatory group-based approach, which not only eliminated biases but also ensured continued validation, transparency, data authenticity, and reliability. The methodology included analysis of both quantitative and qualitative data; gathered from both primary and secondary sources. Triangulation was done both in quantitative and qualitative parameters to verify opinions and ideas provided by different stakeholder categories.

The evaluation found the project strategies and interventions were relevant to convert OD practising communities into ODF but were inadequate in making post-ODF follow up to address the issues that led to slippage to OD again. The elements of sustained behaviour change were not addressed adequately. Post ODF follow-up was very weak. Despite the lack of systematic gender mainstreaming into the programme cycle, one of the main strengths of the programme was the active participation of women and girls in promoting improved sanitation and hygiene services in their communities.

In terms of effectiveness, the evaluation confirms that the interventions delivered by the project are credible in building thousands of new household toilets. The project has successfully created desired output in creating access to basic sanitation services for a population of 580,956. The programme also made remarkable achievements in developing the capacity of the sector to legislate, plan, and budget for the improvement of WASH systems, including mainstreaming disaster risk management. However, the evaluation divulges that increased access to sanitation facilities did not produce desired outcome of reducing the practice of OD. Although access to basic sanitation on a larger scale was promising but drilling down to the status of toilets and their usages revealed a more complex picture. Although 78.8 percent of households having their toilets but 37.30 percent of those toilet pits are already filled with sludge and have therefore been rendered useless. It was recognized that 15 percent of these households built new latrines, but 22 percent went back to the practice of OD. Further, 69.40 percent of households having person(s) with disabilities (PWD) did not build toilets that provide access and services to PWDs. 15 percent of household toilets did not have a drop-hole lid to cover the pit, which led to emission of foul odour and infestation of flies. 36.8 percent of households rarely cleaned their toilets resulting in faeces often being visible in the toilet pan and on the floor. As the JMP 2021 estimated unimproved sanitation facilities in Nepal were 3 percent thus this percentage in the category of unimproved latrines was greater than the national average. Percentage of the population practicing Open Defecation were 16 which increased to 22.7 percent during the time of this evaluation. Similarly, there was little effect on hand washing practices at the household level. The findings revealed that 54.70 percent of households' (HHs) latrines did not have hand washing facilities and 44.2 percent of the HHs had no hand washing stations alongside the toilet. While 60 percent of the population used soap to wash hands then 40 percent had water only for hand washing.

Regarding efficiency, due to the emergence of COVID-19 the programme faced grave difficulties in delivering interventions which were further aggravated by the non-functional mechanism of WASH-CCs at different levels after federalization. Despite these gigantic operational challenges, the programme has been able to achieve high operational efficiency. With the Project Direct Investment (PDI) of US\$2,210,000, the programme was not only credited with providing 580,965 people access to basic sanitation but also humanitarian WASH services to a population of 383,353. Further,

the PDI not only catalysed counterpart financial support by the federal government to Palikas but also catalysed construction of thousands of toilets by the community members who invested on an average of about US\$100 per toilet. Unfortunately, in terms of transformation of costs and inputs into sustained ODF outcomes, the cost-effectiveness of the programme has diminished. However, the evaluation firmly recognizes that the policy guides and Management Information Systems (MIS) that have been developed and operationalized would have continued utility value in the long term and added value to the fund invested.

The Sanitation and Hygiene Master Plan (Master Plan 2011) of the Government of Nepal described the following indicators/criteria for an ODF area (a village, ward, and municipality).

- There is no OD in the designated area at any given time.
- All households have access to improved sanitation facilities (toilets) with every member of the family using it and being responsible for its repair and maintenance.
- All schools, institutions, and offices within the designated areas must have toilet facilities.

Following the above-stated criteria, a large percentage of villages and wards achieved ODF status during the period 2018-2019. However, those villages and wards were unable to sustain the ODF status at a later stage. Due to several constraints such as access to toilets, proper usage, maintenance of facilities, and sustained improved hygiene practices, a significant proportion of the population returned to the practice of OD. In all the ODF declared municipalities, including three Dalit communities, the evaluation team intensively observed 19 villages and found that 15 villages failed to retain the ODF status. Internal factors that affected the retention of ODF status are:

- Inadequate intervention towards sustaining the achievement of ODF status and steering the progress further.
- Weak monitoring of processes and changes.
- Lack of post-ODF interventions.
- Inadequate interventions for collective behaviour change.
- Inadequate attention to address the special needs of Dalits.
- Inefficient faecal sludge disposal.
- Inadequate rolling out of the process at the Ward WASH-CCs after federalization and addressing the legacy of WASH-CC has become weak.
- Inadequate inputs for capacity development.

Besides the emergence of COVID-19, other external factors affected the retention of ODF status are:

- Low investment capacity of 50 percent HHs to obtain and maintain government prescribed latrines.
- Lack of access to water in hilly regions.
- Negative impact of an unhygienic and dirty toilet in schools and other public institutions.
- Lack of clarity in the roles and responsibilities amongst the staff of the three tiers of government.

In relation to making the sanitation programme more effective and to create sustainable ODF outcomes, the evaluation put across the following strategic lessons:

- Creation of a sustainable sanitation outcome requires an equal emphasis on building synergistic ties between all stakeholders including the local government and civil society etc.
- Behaviour Change Communication (BCC) strategy must focus on sanitation as a public good.
- Inclusive and equitable sanitation demands strategizing elimination of discrimination of caste and other vulnerable groups.
- Cost effectiveness could be enhanced by equally emphasising collective behaviour change and sanitary hardware.
- Deliberate intervention is required to reverse the prevailing perception that sustenance of ODF status is directly dependent on external funding.
- Communal sanitation facilities will not serve the purpose unless strategies and mechanisms of maintenance are introduced beforehand.
- Programme designs need to explicitly include Gender Equity and Social Inclusion (GESI), Disaster Risk Reduction and Climate Change Adaptation (CCA).
- It is important to have a strong and systematic programme monitoring system capable of taking corrective measures while monitoring ODF sustainability.
- Based on the principles of collective behaviour change training and capacity building of local government / WASH CCs is essential.
- To promote ownership within the local government/municipalities it is essential to allocate a dedicated budget.
- Existing human resource at the relevant government departments and local government is extremely inadequate to facilitate the Participatory Assessment Planning Implementation and Review (PAPIR) process with the communities. For collective behaviour change and community empowerment, it is essential to engage local NGOs as partners for Palikas.

Based on the findings and lessons stated earlier the evaluation recommends the following for the future programme to be more effective:

- Training and Capacity Building at all levels need to be based on the principles of collective behaviour change process which does not exclude the outsiders.
- Addressing sociocultural variations through Institutionalizing Participatory Assessment, Planning, Implementation and Review (PAPIR) process at the villages/wards as the way forward.
- Ensure dedicated budget allocation, action plan and ownership of local government to sustain the already achieved ODF status in Nepal by 2030.
- Encourage local NGOs, CSOs, Users Committees, Cooperatives, and Women's Self-Help Groups etc. to get involved as equal partners in addressing the human resource needs of Municipal WASH- CCs.
- Intensify interventions through formulation of well-defined strategies for maintenance of sanitation facilities and usage.
- Adopt a clear and systematic mechanisms for sustaining and managing the sanitation services safely
- Apply the policy of positive discrimination for gender and inclusion

- Systematize programme monitoring.

The evaluation team concludes; most communities, wards, and municipalities in the programme- focused districts achieved ODF status in 2019, could not retain the status as they slipped back to the practice of OD. The key lesson learnt is that “an external agency-led social movement coupled with free/ subsidised sanitation hardware supply driven approach could be successful in achieving ODF status temporarily but may not necessarily retain the same without a collective behaviour change ingrained amongst the local communities”. The local communities must learn the essential need to stay away from the practice of open defecation forever. For many reasons, as explained, sustaining the improved hygiene behaviour change among members of the community depends on prevailing conditions, including the well-being of the entire community. Inability to cope with time and move up along the sanitation ladder in time needs individual household investment or support from the government/external agencies. This is more relevant for the poor families living in remote areas. It appears that it would be extremely difficult to achieve sustainable ODF status without empowering the communities in collective action-reflection, along with taking action to improve their sanitation status within their communities. This requires a shift in the role of WASH-CCs from implementers to facilitators, working to empower communities to improve their sanitation and realize the right to live in an ODF environment.

Acronyms

BCC	Behaviour Change Communication
CSO	Civil Society Organization
CBS	Central Bureau of Statistics
CPAP	Country Programme Action Plan
CCA	Climate Change Adaptation
CGD	Child, Gender and Disabled
CDS	Citizen Development Solution
CLTS	Community Led Total Sanitation
DWSSM	Department of Water Supply and Sewerage Management
FDG	Focus Group Discussion
GoN	Government of Nepal
GESI	Gender Equality and Social Inclusion
HHs	Households
IYS	International Year of Sanitation
IC	Informed Consent
IQR	Interquartile Range
IPC	Infection Prevention and Control
JMP	Joint Monitoring Programme
KPI	Key Performance Indicator
KII	Key Informants Interview
KAP	Knowledge Attitude and Practice
LGBTQIA	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual
LSS	Linear Systematic Sampling

MIS	Management Information System
MPI	Multi-dimensional Poverty Index
MICS	Multiple Indicator Cluster Survey
M & E	Monitoring & Evaluation
NSAW	National Sanitation Action Week
NSHCC	National Sanitation and Hygiene Coordination Committee
NGO	Non- Governmental Organisation
NDHS	Nepal Demographic and Health Survey
OD	Open Defecation
ODF	Open Defecation Free
O&M	Operation & Maintenance
PAPIR	Participatory Assessment Planning Implementation and Review
PDI	Project Direct Investment
PSU	Primary Sampling Unit
PWDs	Persons with Disabilities
PPS	Probability Proportional to Size
RFP	Request for Proposal
SHMP	Sanitation and Hygiene Master Plan
SSHE	School Sanitation and Hygiene Education
SSM	Sanitation Social Movement
SSU	Secondary Sampling Units
SPSS	Statistical Package for Social Sciences
SLTS	Schools Led Total Sanitation
SDG	Sustainable Development Goals
SSI	Semi Structured Interview
SWOT	Strengths Weakness Opportunities Threats

ToC	Theory of Change
ToR	Terms of Reference
UNEG	United Nations Evaluations Group
UNICEF	United Nations Children's Fund
WASH	Water Sanitation & Hygiene
WASH-CC	WASH Coordination Committee

Table of Contents

Acknowledgements	3
Executive Summary	4
Acronyms	9
Glossary	14
List of Figures.....	18
List of Tables.....	19
1. Object of the Evaluation	20
1.1. The context of the sanitation programme in Nepal	20
1.2. The sanitation journey and declaration of Nepal as an Open Defecation Free (ODF) country .	21
1.3. Evaluation of the UNICEF Nepal Sanitation programme	23
2. Purpose and Objectives of the Evaluation	29
3. Evaluation Methodology	31
3.1. Overall methodological approach of the evaluation.....	31
3.2. Evaluation framework development, data tools preparation, and coverage of samples	32
3.3. Data collection methods applied, and activities conducted	39
3.4. Data collection methods applied, and activities conducted	39
3.5. Compliance to research ethics and risk mitigation measures in primary data collection	42
3.6. Data analysis and development of findings	44
3.7. Limitations	46
4. Findings.....	48
4.1. Relevance	48
4.2. Effectiveness	54
4.3. Efficiency	65
4.4. Sustainability	71
4.5. Gender	88
5. Conclusions and Lessons Learned.....	90
6. Recommendations	95
Annexures	103
Annex 1: Evaluation framework	103
Annex 2: Data tools and Informed Consent.....	127
2.1: KAP survey questionnaire	127
2.2: Household observation guide	155
2.3: Sustainability of sanitation facilities: Assessment tool	161
2.4 : Guideline for preparing summary report of KII and SSI.....	165
2.5: Guideline for preparing FGD report	170
2.6: Informed Consent for the respondent of KAP Survey.....	178

2.7. Informed Consent for Key Infomart Interview (KII)	180
2.8. Informed Consent for FGD with respondent with age 16 and above.....	182
2.9. Assent of Child respondents of FGD	184
2.10. Parent's/ Guardian/Caretaker's Consents for Child for FGD	186
Annex 3: Bibliographic References	188
Annex 4: Survey Data Tables and Figures	190
Annex 5: Typology of participation	221

Glossary

Leave no one behind (LNOB): is a concept that is grounded on inclusive and rights-based development and is embedded in the Sustainable Development Goals (SDGs). Leave No One Behind prioritizes “putting the last first”, i.e., the most disadvantaged, most underserved, most left behind. The definition of who is “left behind” in society is left to be defined according to the context (*Gender Equality and Social Inclusion Strategy of the Health Sector*, 2018).

ODF: means Open Defecation Free, whereby no faeces are openly exposed to the environment/air (*Sanitation and Hygiene Master Plan*, GoN, 2011).

Total Sanitation: is a range of facilities and hygiene behaviours that lead to the establishment of a sanitized condition in any designated area. The first significant step toward ending Open Defecation is an entry point of making efforts to change behaviour. The next steps include all the arrangements leading up to sustainable hygiene and sanitation behaviours (*Sanitation and Hygiene Master Plan*, GoN, 2011).

Improved Sanitation Facilities (Toilet): according to the Joint Monitoring Programme (JMP) of UNICEF and WHO, an improved sanitation facility is defined as one that hygienically separates human excreta from human contact (*Sanitation and Hygiene Master Plan*, GoN, 2011).

Stakeholders: all the members of the National Sanitation and Hygiene Steering and Coordination Committee (NSHSC, NSHCC), as well as the provincial, district, municipal level WASH coordination committees, local government bodies, schools, child clubs, user committees, and any other agencies that play a role in water and sanitation promotion (Evaluation team, Evaluation of Sanitation Programme Outcome Nepal, 2022).

Joint Plan: a provincial and municipal level strategic plan/plan of action which the central government, local bodies, donors, and international/non-governmental organizations (I/NGOs) follow to promote total sanitation (Evaluation team, Evaluation of Sanitation Programme Outcome Nepal, 2022)

Universal Sanitation Coverage: cent-percent sanitation (toilet) coverage in each area.

Universal Access to Sanitation: all possible users have access to a toilet in any given area.

Sustainability: refers to the ability to maintain or support a process continuously over time.

Efficiency: refers to the peak level of performance possible when the least number of inputs are being used to achieve the highest amount of output. Efficiency requires

reducing the number of unnecessary resources used to produce a given output, including personal time and energy.

Behaviour Change Communication: is an approach to hygiene promotion that uses an in-depth understanding of people's behaviour to design persuasive communication (BCC Guidelines, SNV 2016).

Behavioural determinants: are the factors that may influence whether an individual has the opportunity, ability, and motivation to engage in each hygiene or sanitation behaviour. Behavioural determinants can either facilitate or inhibit the behaviour of interest among a certain population and can be internal or external (Sani-FOAM Framework, WSP, 2009).

Motivational drivers: are strong internal thoughts and feelings that motivate behaviour. They can be positive or negative and can stem from unmet physical, emotional, or psychological needs (Sani-FOAM Framework, WSP, 2009).

Communication channel: is a medium through which a message is transmitted to its intended audience, such as print media or a broadcast.

Health promotion is the process of enabling people to increase control over the determinants of health, and thereby improve their health. This definition is based on the World Health Organization Ottawa Charter 1986.

Hygiene education: involves activities aimed at raising awareness and conveying knowledge of the links between hygiene practices and health.

Hygiene promotion: is a planned approach that aims to reduce the incidence of poor hygiene practices and conditions that pose the greatest risk to the health of children, women, and men (WHO, Ottawa Charter, 1986).

Inclusive Governance: governance is inclusive when it effectively serves and engages all people; takes into account gender and other facets of personal identity; and when institutions, policies, processes, and services are accessible, accountable, and responsive to all members of society.

Person with disability refers to persons with physiological, intellectual, psychological, or sensory impairment and functional limitations which constrain their full and effective participation in society on equal terms with non-disabled people (GESI Strategy of the Health Sector, GoN, 2018).

Disability: is the exclusion of people with impairments, due to social and environmental discrimination that acts as a barrier to their participation (GESI Strategy of the Health Sector, GoN, 2018).

Disabled-friendly services refer to the provision of facilities and support to enable people with disabilities to use services on an equal basis as those without disabilities. This may include the provision or adaptation of infrastructure so that it is accessible to people who are physically disabled such as ramps, lifts, specially designed toilets, and the provision of assistive devices such as wheelchairs. It may also include the provision of transportation or waiver of fees in recognition of the physical and financial barriers people with disability face in accessing health services (GESI Strategy of the Health Sector, GoN, 2018).

LGBTQIA; Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual (LGBTQIA) communities are made up of diverse individuals. Communities included within this commonly used umbrella term have distinct experiences and needs, and different histories of collective identity and organization (<https://rainbowhealthaustralia.org.au/>).

Disaster: A serious disruption in the functioning of a community or society involving widespread human, material, economic or environmental losses and impacts, which exceeds the ability of the affected community or society to cope using its own resources (<https://en.wikipedia.org/wiki/Disaster>)

Disaster Risk: The potential disaster losses, in lives, health status, livelihoods, assets and services, which could occur to a particular community or a society over some specified future time period (<https://en.wikipedia.org/wiki/Disaster>)

Gender equality and social inclusion means changing the unequal power relations between women and men and between different social groups. It focuses on the need for action to rebalance these power relations and ensure equal rights, opportunities, and respect for all individuals regardless of their social identity (GESI Strategy of the Health Sector, GoN, 2018).

Equality: refers to the provision of equal rights, responsibilities, and opportunities to all as recognised by the Constitution. The pursuit of equality by the State of Nepal requires the adoption of policies and development of inclusive systems, institution and programmes that enable disadvantaged populations to exercise their rights, responsibilities, and opportunities (GESI Strategy of the Health Sector, GoN, 2018).

Equity: is an ethical principle related to human rights. Health equity means that people are not disadvantaged from attaining their full health potential because of social constructs such as gender, socioeconomic status, religion, caste/ethnicity or location (GESI Strategy of the Health Sector, GoN, 2018).

Social inclusion: is a process that ensures that those at risk of poverty and social exclusion gain the opportunities and resources they need to participate fully in economic, social, and cultural life and to enjoy a standard of living and well-being that is considered normal in the society in which they live. It ensures that such populations

participate in decision making on matters that affect them and achieve access to resources, opportunities and services to enjoy their fundamental rights (GESI Strategy of the Health Sector, GoN, 2018).

Gender equality and social inclusion mainstreaming is the process whereby barriers and issues faced by women, poor, and excluded people are identified and addressed in all functional areas of the health system: policies, institutional systems, work environment and culture, programme and budget formulation, service delivery, monitoring and evaluation, and research. It also involves evaluation of the institutional capacity to mainstream GESI, and the responsiveness and work environment of health agencies to be gender equal and socially inclusive. Evaluation is necessary to inform continuous improvement and bolster ownership and commitment to GESI (GESI Strategy of the Health Sector, GoN, 2018).

GESI-responsive policy and programme: refers to policy and/or programmes that are designed to be sensitive to and address the determinants of gender inequality and social exclusion. GESI responsive policies and programmes include an assessment and analysis of GESI in their formulation and implementation, the inclusion and participation of women, the poor, and excluded people in each stage of development and implementation and ensure that the outputs and results of the policy and programme measure and aim to benefit target groups.

Community Led Total Sanitation: is an innovative methodology for mobilizing communities to completely eliminate open defecation (OD). Communities are facilitated to conduct their own appraisal and analysis of open defecation (OD) and take their own action to become open defecation free (communityledtotalsanitation.org).

School Led Total Sanitation (SLTS): The school led total sanitation is an approach that emphasizes the complete elimination of open defecation from the catchments of the schools as a pre-requisite for improving hygiene and sanitation (Adhikari,K. *School Led Total Sanitation: Principles and Practices*, 2010).

List of Figures

FIGURE 1: THEORY OF CHANGE	25
FIGURE 2: ASSESSMENT CRITERIA OF THE EVALUATION	29
FIGURE 3: METHODOLOGICAL APPROACH.....	31
FIGURE 4: MAP SHOWING SAMPLE PROVINCES AND DISTRICTS	34
FIGURE 5: PERCENTAGE OF ADULT RESPONDENTS ACCORDING TO SEX	35
FIGURE 6: MULTIPLE METHODS APPLIED FOR QUALITATIVE AND QUANTITATIVE DATA COLLECTION	39
FIGURE 7: POPULATION USE LATRINE FOR DEFECATION BY AGE GROUOP	55
FIGURE 8: PERCENTAGE OF POPUALTION USE LATRINE FOR DEFECATION BY GENDER CATEGORY	55
FIGURE 9: PERCENTAGE OF HHS PRACTICING OD IN DIFFERENT PROVINCE	56
FIGURE 10: PERCENTAGE OF HOUSEHOLDS WHICH DO NOT HAVE AND DON'T USE TOILET FOR DEFECATION..	57
FIGURE 11: PERCENT OF HOUSEHOLDS' TOILETS WITH PROPER HAND WASHING FACILITIES	58
FIGURE 12: HAND WASHING PATTERN OF PEOPLE IN THE INTERVENTION AREA	58
FIGURE 13: DISTRIBUTION OF THE TYPES OF LATRINE AT THE LEVEL OF HOUSEHOLD.....	61
FIGURE 14: CASTE WISE DISTRIBUTION OF HOUSEHOLDS PRACTISING OD AND ODF.....	62
FIGURE 15: PATTERN OF DISPOSAL OF FAECAL SLUDGE FROM THE HH LATRINES.....	63
FIGURE 16: REASONS FOR NOT CONSTRUCTING A HOUSEHOLD TOILETS	63
FIGURE 17: TWO MAIN REASONS OF NOT EVACUATING SLUDGE FROM FILLED IN HOUSEHOLD TOILET	64
FIGURE 18: THREE MAIN REASONS OF NOT IMPROVING HOUSEHOLD TOILETS	64
FIGURE 19: TARGET AND ACHIEVEMENT IN POPULATION'S ACCESS TO SANITATION FACILITIES.....	66
FIGURE 20: TARGET AND ACHIEVEMENTS ON OTHER ASSOCIATED KPIs TO IMPROVE SANITATION AND HYGIENE BEHAVIOUR	66
FIGURE 21: AS PER 2018-22 CPAP: TARGET AND ACHIEVEMENTS OF TWO KPIs OF OUTPUT 3	67
FIGURE 22: REVISED KPI 2020-222: TARGET AND ACHIEVEMENT	67
FIGURE 23: COST EFFICIENCY AND COST EFFECTIVENESS	69
FIGURE 24: INCREASE IN PERCENT OF HOUSEHOLD-POPULATION THOSE DEFECATES IN THE OPEN IN MADHESH PROVINCE.....	73
FIGURE 25: PROVINCE-WISE PERCENTAGE OF POPULATION PRACTICING ODF	74
FIGURE 26: PERCENT OF OD AND ODF COMMUNITIES (TOLES/VILLAGES) FROM THE INTENSIVE DIRECTED OBSERVATION OF 19 COMMUNITIES.....	77
FIGURE 27: PERCENT OF OD AND ODF SCHOOLS FROM THE RANDOMLY VISITED 8 SCHOOLS.....	78
FIGURE 28: PROCESS DYNAMICS IN ODF SUSTAINABILITY	81
FIGURE 29: FACTORS AFFECTED RETENTION OF ODF STATUS	82
FIGURE 30: PERCENT DISTRIBUTION OF HOUSEHOLD PIT LATRINE FILLED UP BY PROVINCE	83
FIGURE 31: PROVINCE-WISE PREVALENCE OF OD (N=537).....	196
FIGURE 32. DISTRICT-WISE PREVALENCE OF OD (N=2468)	197
FIGURE 33. ADVANTAGES OF HAVING LATRINE (N=2468)	201
FIGURE 34. CRITERIA OF SAFE LATRINE (N=2468)	201
FIGURE 35. HAND WASHING	202
FIGURE 36. IMPORTANCE OF WASHING HANDS WITH SOAP	202
FIGURE 37. REASONS FOR NOT HAVING HOUSEHOLD LATRINE (N=537).....	205
FIGURE 38. DEFECATION AND EXCRETA DISPOSAL	212
FIGURE 39. PREVALENCE OF OD AND ODF BY CASTE (N=2468)	218
FIGURE 40. LATRINE STATUS.....	219

List of Tables

TABLE 1: EVALUATION FRAMEWORK TEMPLATE	32
TABLE 2: DATA TOOLS.....	32
TABLE 3: PROVINCES, DISTRICTS, AND MUNICIPALITIES COVERED.....	33
TABLE 4: NUMBER OF RESPONDENTS BY MULTIPLE METHOD CATEGORIZATIONS	35
TABLE 5: NUMBER OF RESPONDENTS FROM MARGINALIZED AND VULNERABLE GROUPS	35
TABLE 6: NUMBER OF RESPONDENTS FROM ADMINISTRATIVE TIER, ACCORDING TO GENDER	36
TABLE 7: SAMPLE SIZE TO ESTIMATE A PROPORTION OR APPARENT PREVALENCE (AP) WITH SPECIFIED PRECISION.....	36
TABLE 8: SAMPLE DISTRICTS, MUNICIPALITIES, WARDS AND NUMBER OF HOUSEHOLDS IN KAP SURVEY.....	37
TABLE 9: COVERAGE OF HH- KAP SURVEY SAMPLES.....	38
TABLE 10: NUMBER OF DATA COLLECTION ACTIVITIES CONDUCTED	41
TABLE 11: CRITERIA-SPECIFIC POINTS FOR ANALYSIS	44
TABLE 12: LIST OF INTENSIVELY OBSERVED WARDS/VILLAGES/TOLES PREVIOUSLY DECLARED ODF	73
TABLE 13: PERCENTAGE OF POPULATION PRACTICING OPEN DEFECATION	74
TABLE 14: PERCENTAGE OF HOUSEHOLDS NEGLECTING TO COMPLY WITH OTHER SUPPORTIVE ODF CRITERIA	75

1. Object of the Evaluation

1.1. The context of the sanitation programme in Nepal

Often perceived as a Himalayan gateway, Nepal is a landlocked country with diverse ecology and culture. According to the 2021 Nepal Census¹ the country has a population of 29,192,480 people organized into 5,643,945 households and 6,761,059 families. Nepal is home to 125 ethnic groups, which historically had uneven access to basic services, resources, and opportunities². Nepal aspires to graduate from least developed country status to developing country status by 2022 and as per UNDP further to a middle-income country from 2026³. Even though Nepal has made significant progress in decreasing poverty, two-thirds of all children are still deprived of at least one of the seven basic needs. The Nepal Human Development Report (2022)⁴ states, Nepal's Human Development Index value for 2021 is 0.602 — which put the country in the Medium human development category, positioning it at 143 out of 191 countries and territories. In addition, there are significant disparities within the country in terms of wealth, region, language, education, caste, ethnicity, gender, age, disability, and income. The Multi-dimensional Poverty Index (MPI)⁵ 2021 report states that 17.4 percent of Nepal's population is yet to overcome poverty. Across provinces, Karnali Province has the highest MPI (39.5 percent of people) followed by 25.3 percent in Sudarpashchim Province, and 24.2 percent in Madhesh Province. Nepal has a more than 20% socially- and economically marginalized Dalit⁶ population who for generations have been treated as untouchables and excluded from many spheres of social life. Furthermore, the MPI 2021 shows that nearly 3.2 percent of the population lives in households where at least one of its members has a disability and is usually excluded from access to sanitation. Although detailed data is yet to come, there is a rough estimate that 900,000⁷ people in the LGBTQIA community are living in the country and are also excluded from many spheres of social life including access to sanitation.

Although Nepal has made significant progress, in addressing challenges but there is substantial room for improvement across the spectrum of children's rights, including addressing disparities in levels of achievement and access to resources. In 2017,

¹ The 2021 Nepal: Central Bureau of Statistics, Nepal.

² UNDP- Nepal, Country Programme, 2018-2022

³ UNICEF-Nepal, Country Programme Action Plan 2018-2022

⁴ Nepal Human Development Report (2022) UNDP

⁵ Multi-dimensional Poverty Index (MPI) Report 2021, National Planning Commission, Government of Nepal

⁶ The Situation of the Dalits in Nepal. (2012), Durga Sob, Article Publishes in *Voice of Dalit*, Volume: 5 issue: 1, page(s): 57-62. Online publication <https://journals.sagepub.com>

⁷ LGBTQ people to be counted in Nepal's census for the first time (Feb 2020), Article by Gopal Sharma and Annie Banerji . Thomson Reuters Foundation, Kathmandu Nerpela, Web published <https://www.csmonitor.com>

Nepal moved from a unitary to a federal system. This has resulted in three tiers of government at the federal, provincial, and local levels and many government functions related to children are yet to be developed at the local and provincial levels. The new governance structure presents opportunities for public actions to improve the situation of children in response to their local situation. For this, substantial efforts are needed to formulate relevant policies and systems, and to strengthen capacities at different levels.

Sanitation is important, and is also necessary for health, nutrition, education, tourism, and the holistic development of children. Sanitation is one of the most important aspects of community well-being because it protects human health, extends life spans, and is documented to provide benefits to the economy. Although Nepal has made significant progress in its sanitation situation over the last few decades, the JMP (2021) estimates that 77 percent of the population has access to at least basic sanitation; 11 percent has access to limited/shared facilities; and 10 percent population is without sanitation facilities⁸. Children, women, and socially marginalized lower caste communities are particularly affected by poor sanitation, as are those in the LGBTQIA community and persons with disabilities (PWDs). As stated in the UNICEF Nepal website, 20 percent of the government schools lack improved water and sanitation facilities, with an additional 19 percent lacking separate toilets for girls and boys and menstrual hygiene management facilities. Sanitation in government offices and public institutions also deserves attention. Nepal's socio-culturally implanted, and deeply rooted caste-stratified power structure dictates a crucial need for a sanitation approach that weaves in appropriate strategies to ensure active inclusion and participation of historically marginalized Dalits and other vulnerable groups.

1.2. The sanitation journey and declaration of Nepal as an Open Defecation Free (ODF) country

In Nepal, sanitation promotion formally started after the commencement of the International Drinking Water and Sanitation Decade (1981-1990).⁹, Later, National Sanitation Policy 1994 expanded the scope of sanitation, not only for the construction of toilets but also for promotion of sanitation and hygiene and for the improvement of public health. The School Sanitation and Hygiene Education Programme and National Sanitation Awareness Campaign have been promoted in Nepal since 2000. Since 2000, with the support of UNICEF, Nepal has been implementing the School Sanitation and Hygiene Education (SSHE) programme. The SSHE programme was designed to promote water supply and sanitation facilities in schools, to transform student behaviour through raising awareness, and to promote community sanitation through child club mobilization. During the period 2003-2004, Nepal applied the Community Led Total Sanitation (CLTS)¹⁰ approach. However, before the

⁸ <https://washdata.org/data/household#/npl>

⁹ Open Defecation Free Nepal- Narration of the Journey: A Booklet with Materials on country Open Defecation Free and a Step to Total Sanitation Declared Ceremony, 30 September 2019: Secretariat of National Sanitation and Hygiene Coordination Committee.

¹⁰ Kar, K and Chamber, R (2008) Handbook on Community-Led Total Sanitation. Plan UK and Institute of Development Studies at the University of Sussex.

systematization and scaling up of the CLTS approach beginning in 2005, Nepal conceptualized and started to apply the School Led Total Sanitation (SLTS)¹¹ Approach. The basic assumption of the SLTS approach was that schools could act as an entry point for sanitation improvement in the communities if it is triggered and facilitated. Students of a triggered and ODF school worked as agents for changing their catchment VDCs to ODF. The SLTS approach was developed by combining elements of the SSHE programme and CLTS triggering tools. Despite severe inequalities¹² regarding school and education access among Dalit children, SLTS was applied as one of the predominant approaches in Nepal.

With the worldwide celebration of the International Year of Sanitation (IYS) 2008, the promotion of the sanitation program gained new energy and momentum in Nepal as well. The Government of Nepal (GoN) formulated and implemented the Nepal Country Plan for IYS 2008 and put sanitation and hygiene at the forefront of its development agenda. In the same year, formulation of a master plan was initiated and the Sanitation and Hygiene Master Plan (SHMP) 2011¹³ came into being. The central focus of this master plan was to ensure Open Defecation Free (ODF) status with universal access to toilets in both urban and rural areas in Nepal using the total sanitation approach. It provided the following strategic direction:

- Empower local bodies to lead participatory planning processes, implementation, and monitoring of hygiene and sanitation programme.
- Apply gender-sensitive participatory approaches to sanitation improvement intervention.
- Intensify hygiene and sanitation promotion initiatives.
- Establish well-coordinated participatory and coherent programs, planning and implementation systems for multi-stakeholders.

SHMP 2011 adopted the “one household-one toilet” sanitation campaign model with the goal of making Nepal an ODF country. An inter-sector participatory structure of coordinated implementation was created from the central to the local levels. WASH Coordination Committees (WASH-CCs) were formed at each tier with the participation of relevant stakeholders including NGOs, CSOs, and private organizations. With the objective of attaining total sanitation through ODF, the Total Sanitation Model Village Promotion Programme was formulated and implemented in 2012. The new Constitution¹⁴ of Nepal (2015) acknowledged sanitation as a fundamental right. Nepal’s Water, Sanitation and Hygiene Sector Development Plan (2016-2030)¹⁵ has the goal of achieving prosperity through development of the Water, Sanitation and Hygiene (WASH) sector. Similarly, a Total Sanitation Guideline was formulated and implemented in 2017 to sustainably maintain ODF status. Suggested strategies of the SHMP-2011 with a huge leap of investment and support from UNICEF accelerated an approach called Sanitation Social Movement (SSM)¹⁶, which had already been

11 Guidelines on School Led Total Sanitation (2006). Steering Committee for National Sanitation Action, Department of Water Supply and Sewerage and UNICEF-Nepal

12 LAMSAL, H. AND CHARMAKAR, R.B. (2015). EQUITY WATCH: NEPAL DALIT'S RIGHT TO EDUCATION.LALITPUR. SAMATA FOUNDATION

13 Government of Nepal (2011) Sanitation and Hygiene Master Plan (2011) Page V

14 Nepal's Constitution of 2015. Constituteproject.org. *Unofficial translation by Nepal Law Society, International IDEA, and UNDP*.

15 Nepal Water Supply, Sanitation and Hygiene Sector Development Plan (2016 – 2030). Government of Nepal Ministry of Water Supply and Sanitation Sector Efficiency Improvement Unit (SEIU)

16 WAHL Technical Paper (TP/02/18) Lessons from a Post-ODF Assessment of Nepal, UNICEF Nepal

launched by the Department of Water Supply and Sewerage Management (DWSSM) and UNICEF in 2015. Under the leadership of local government institutions, thousands of WWASH CC members from the districts and municipalities (including police and military) actively engaged in SSM to create community motivation and mobilization to build and use individual household toilets. For this purpose, partnerships from various organizations, such as local government institutions, development partners, various sectoral stakeholders, students, teachers, media personnel, civil society, and private entrepreneurs were mobilized. Besides intensifying message dissemination and raising awareness, material incentives were provided to marginalized households for the construction of improved toilets as prescribed by the government. SSM were tremendous in fostering construction and use of toilets in cent-percent households and working to reduce open defecation practices. On 30 September 2019, the Government of Nepal declared the Country ODF with the assumption that all districts and local governments had declared ODF based on the following ODF criteria described in the SHMP 2011:

- There is no open defecation in Nepal at any given time.
- All households have access to improved sanitation facilities (toilets) which are being used by all members of the family. The operation and maintenance of the toilet is also managed by the respective families and a high standard of sanitation is ensured.
- All the institutions, including schools and offices, should have toilet facilities.

1.3. Evaluation of the UNICEF Nepal Sanitation programme

Anchored on the National Sanitation and Hygiene Master Plan (2011) the key priorities of UNICEF Nepal in the Country Programme Action Plan for 2018-2022, include ending open defecation and ensuring equal access to basic sanitation for all children. The main goal of the UNICEF country programme for Nepal for the period of 2018-2022 is to provide 500,000 people with access to basic sanitation facilities. 70 percent of the 500,000 people live in Madhesh Province and the rest of the target population reside in Province 1 and Bagmati.

According to government data, Nepal had 95.4 percent sanitation coverage at the end of 2017, while 45 districts had still not declared themselves to be open defecation free (ODF). Out of UNICEF's ten priority districts, all the eight in Madhesh Province, Mugu, and Kapilvastu had not been declared ODF. UNICEF provided technical and financial support to the government of Nepal through the treasury and a direct funding modality for 10 more districts in Madhesh Province: Jhapa, Morang, Sunsari, Ramechhap, Dolakha, Kavre, Kathmandu, Dhading, Nuwakot, and Kailali.

The findings of the UNICEF survey conducted in 2018 showed that basic sanitation coverage in Madhesh Province was at 51 percent and limited sanitation coverage was at 2 percent. According to government data, access to sanitation was at 86.5 percent in Madhesh Province at the end of 2017. Another study conducted by the National

Sanitation and Hygiene Coordination Committee in 2017, covering 7 districts of Nepal, including one affected by the Gorkha earthquake (Bhaktapur), found that 96.5 percent of the households used toilets. Out of this, 87.4 percent used improved and not shared (basic) toilets and 9 percent used shared toilets. 3.5 percent were still practicing open defecation.

According to the 2019 Multiple Indicator Cluster Survey (MICS) carried out by the Central Bureau of Statistics with support from UNICEF, 94.5 percent of the population had access to improved sanitation facilities while nearly 80 percent of the households had access to basic sanitation (improved toilet, not shared); 15 percent used shared toilets; and 5 percent practiced open defecation. In Madhesh Province, the proportion of the population using toilets was 84 percent (73 percent using at least basic sanitation) and 16 percent were practicing open defecation. 11 percent of the population were using shared toilets while 27 percent were yet to build household toilets as a means to achieving basic sanitation access.

Major activities by UNICEF supported government efforts to end open defecation. This includes coordination and collaboration with WASH stakeholders working in the districts to accomplish joint planning, facilitation, triggering, social mobilization, monitoring, and review of the sanitation status at both district and *palika* levels. UNICEF also supported the government in reaching the poorest households, providing easy latrines through sanitation marketing, and mobilizing youth to support construction of toilets for households. This also includes monitoring and follow up with households on the usage of toilets.

During the period from 2018 to 2020, UNICEF and the Government of Nepal reached a population of 547,643 who were being provided with access to basic sanitation services. The number of people covered was more than 500,000 as planned in the UNICEF country programme for 2020-2022. The total fund utilized for achieving access to basic sanitation facilities is US\$ 2,210,000, including technical assistance of about US\$ 1,000,000. In addition, some households built their own toilets and contributed an average of US\$ 100 per household.

The summary results framework of the WASH component presented as the Nepal Country Programme Action Plan (CPAP), 2018-2022 (page 54) has been synthesized in the following logical framework to convey the Theory of Change (ToC) that was undertaken in the programme.

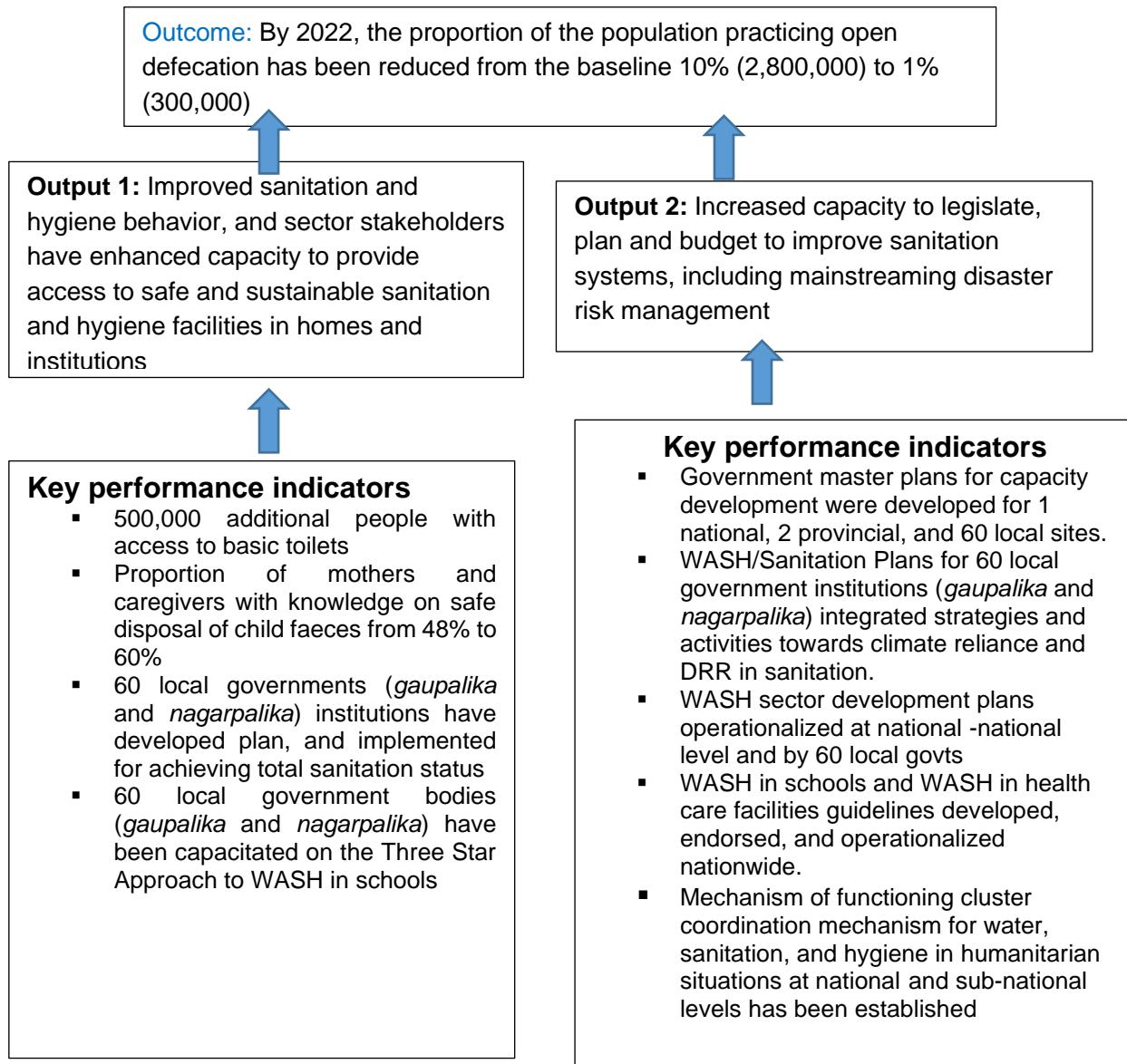


Figure 1: Theory of Change

The above-stated CPAP was signed between the MOF and UNICEF based on which UNICEF signed onto a rolling work plan for 30 months, with the sector ministry following Key Performance Indicators (KPI):

Level		Statement		
Outcome		By 2022, children and their families will have improved and equitable access to and use of safe and sustainable drinking water and sanitation services. They will also have learned improved hygiene practices.		
Output 1		5.1 Increased capacity to improve water quality and functionality and to deliver and sustain safe water (including schools and health care facilities)		
	Indicator No.	Output indicators	Baseline	MYP Target-consolidated (July 2020 - Dec 2022) (Net, not cumulative)
	1.1	Number of people with access to a safe drinking water source in the reporting year – as a result of UNICEF direct support.	16,234	37,400
	1.2	Number of people living in water-safe communities in the reporting year – as a result of UNICEF direct support.	9,634	39,400
	1.3	Number of local governments (municipalities) with water quality monitoring mechanisms in operation.	37	74
Output 2		5.2 Improved sanitation and hygiene behaviour among community and sector stakeholders to enhance the capacity to provide access to safe and sustainable sanitation and hygiene facilities in households and institutions.		
	Indicator No.	Output indicators	Baseline	MYP Target (July 2020 - Dec 2022) (Net, not cumulative)
	2.1	Number of additional people with access to basic sanitation services through UNICEF supported programmes.	545,000	38,000
	2.2	Hand washing behaviour change programming exists at community level (ward).	39	256
	2.2	Number of schools with WASH services that meet national Three Star category, including menstrual hygiene management and standards.	5	288
	2.3	Number of healthcare facilities (clinics, health centres, hospitals, etc.) with basic WASH services in the reporting year – as a result of UNICEF direct support.	40	49

Output 3		5.3 Increased capacity of sector to legislate, plan, and budget for the improvement of WASH systems, including mainstreaming disaster risk management		
	Indicator No.	Output indicators	Baseline	MYP Target (July 2020 - Dec 2022) (Net, not cumulative)
	3.1	Number of local governments with WASH Plans integrating climate resilient development and/or risk management developed.	2	81
	3.2	Number of national /sub-national WASH sector policy instruments developed and operationalized: WASH Act, WASH Policy, Guidelines on WASH Plan, HCF, Water Quality Monitoring, Water Safe Community, Sustainability.	0	5
	3.3	WASH sector information and management system MIS (with N-WASH) developed and operationalized.	0	6
	3.4	Existence (Initiating) of functioning cluster coordination mechanism for water, sanitation, and hygiene in humanitarian situations (at sub-national level) operationalized. (# Province + # of Palika)	weak	22
	3.5	UNICEF-targeted population in humanitarian situations accessing appropriate WASH facilities/services (water supply, sanitation, hygiene) in community, schools, temporary learning spaces and other child friendly spaces.		

The programme applied the following intervention strategies and inputs to get the desired outcome:

- Facilitating multi-stakeholders (Gov-NGO-CSO) partnership and joint planning at federal, province, district, and municipal levels.
- Capacity building of all actors engaged in the programme,
- Facilitating triggering, mobilizing, and engaging different stakeholders such as CSOs, local networks, journalists, youth group, etc.
- Direct monitoring and review of programme by UNICEF staff.
- Fostering access to latrines through sanitation marketing.

The ‘change path’ of the programme was conceptualized with the following assumptions:

- If open defecation practices are stopped, then children and their families would be able to have improved and equitable access to safe and sustainable sanitation services, improved hygiene practices, and ensured usage. The direct target for input delivery is not the children but their families and institutions (i.e. schools, public places, and offices). If all adult members of the family and institutions change, it will impact the well-being of the children in terms of health, education, and other related aspects.
- Open defecation practices can be stopped/reduced AND sanitation and hygiene behaviour practices of community members and institutions can be improved substantially if:
 - ❖ Sector-stakeholder capacity to provide increased access to safe and sustainable sanitation and hygiene facilities at homes and institutions is augmented.
 - ❖ National legislation policy encourages and provides an enabling environment for systematic multi-stakeholder partnerships, planning, and implementation processes at both the central and local levels.
 - ❖ Federal, provincial, and district administrations are systematically empowered to decide and act on improving sanitation based on the local context.
 - ❖ Climate Change and Disaster Risk Reduction is systematically integrated within the sanitation programme.
 - ❖ Deliberate efforts are made for inclusion of vulnerable groups, including LGBTQIA.
 - ❖ Participatory sanitation planning, implementation and review process is facilitated by multi-stakeholders.

2. Purpose and Objectives of the Evaluation

The purpose of the evaluation was to contribute to the enhancement of UNICEF sanitation programmes in Nepal. The ToR stated, “the evaluation will deliver comprehensive analysis, also reviewing lessons learned to help in foresight planning and designing interventions for sustainable ODF Nepal”. The specific objectives of the evaluation were to:

- Evaluate the performance of the sanitation programmes in their relevance, effectiveness, efficiency, and sustainability.
- Assess and compile good practices and lessons learned and draw a comprehensive situation overview.
- Provide practical and feasible recommendations that guide strategic direction towards sustainable outcomes.

In accordance with the goals stated above, criteria for the assessments assigned were relevance, efficiency, effectiveness, and sustainability in which gender inclusion was a cross-cutting criteria.

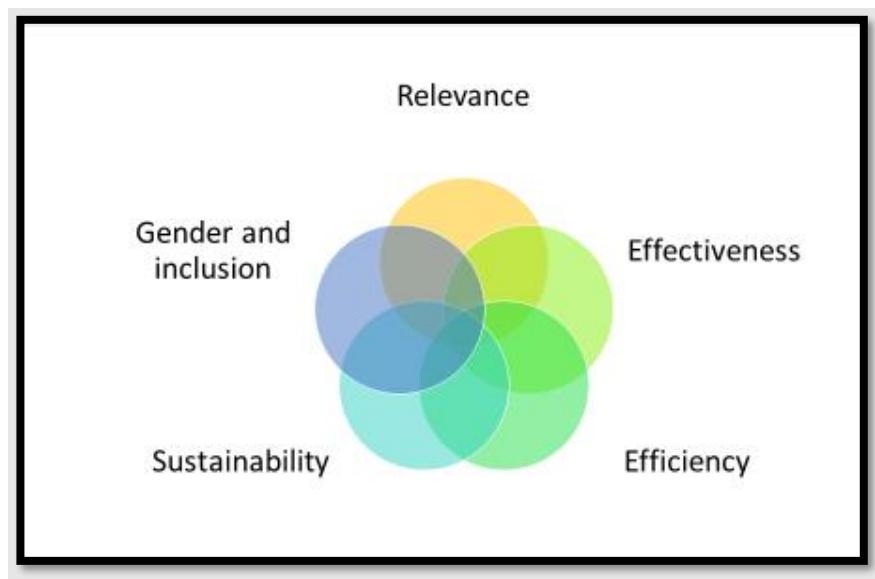


Figure 2: Assessment criteria of the evaluation

Criteria-specific key evaluation questions were:

Relevance: the extent to which the sanitation programme met the needs of children, women, and their families; the most vulnerable and marginalized groups including persons with disabilities.

- To what extent did the sanitation programme meet the needs of children, women and their families, persons with disabilities, and others in the most vulnerable and marginalized groups during the period 2018 - 2020?
- To what extent did the sanitation programme interventions address the sanitation needs of the population in their households and local public spaces?

Effectiveness: the extent to which the sanitation programme achieved its intended results.

- To what extent did the sanitation programme achieve its intended results and how did it contribute to reducing open defecation in the target areas?

Efficiency: the extent to which inputs allocated for the programme contributed to achieving the planned outcomes.

- To what extent did the inputs and monitoring of the sanitation programme contribute to achieving the planned outcomes in a timely and cost-efficient manner?
- Were the financial and human resources of the programme sufficient for implementing the planned activities?

Sustainability: the extent to which the targeted locations under the sanitation programme are capable of remaining ODF.

- To what extent are the targeted locations under the sanitation programme remaining ODF after implementation?
- What internal and external factors can affect the sustainability of the sanitation programme?
- The evaluation of programme sustainability will also involve experts who will assess sanitation facilities, and check standards and quality in the target locations. The exercise will involve assessment of durability, quality, and the likelihood of sustainably maintaining the facilities by users over the long term.

Gender and inclusion: To what extent are gender and inclusion issues being mainstreamed in the programme?

- Has the programme integrated gender and inclusion aspects in each step of the programme management?

The evaluation covered the UNICEF sanitation programmes during the period 2018-2022. The major focus of the evaluation was on 8 districts of Madhesh Province, where UNICEF interventions benefitted more than two-thirds of the target population. Muju in Karnali Province, Kapilavastu in Lumbini Province, Kavre in Bagmati Province, and Kailali Sudurpashchim Province were also part of the evaluation.

3. Evaluation Methodology

3.1. Overall methodological approach of the evaluation

The evaluation was designed and conducted based on a defined overall methodological approach. Figure 3 is presented here:

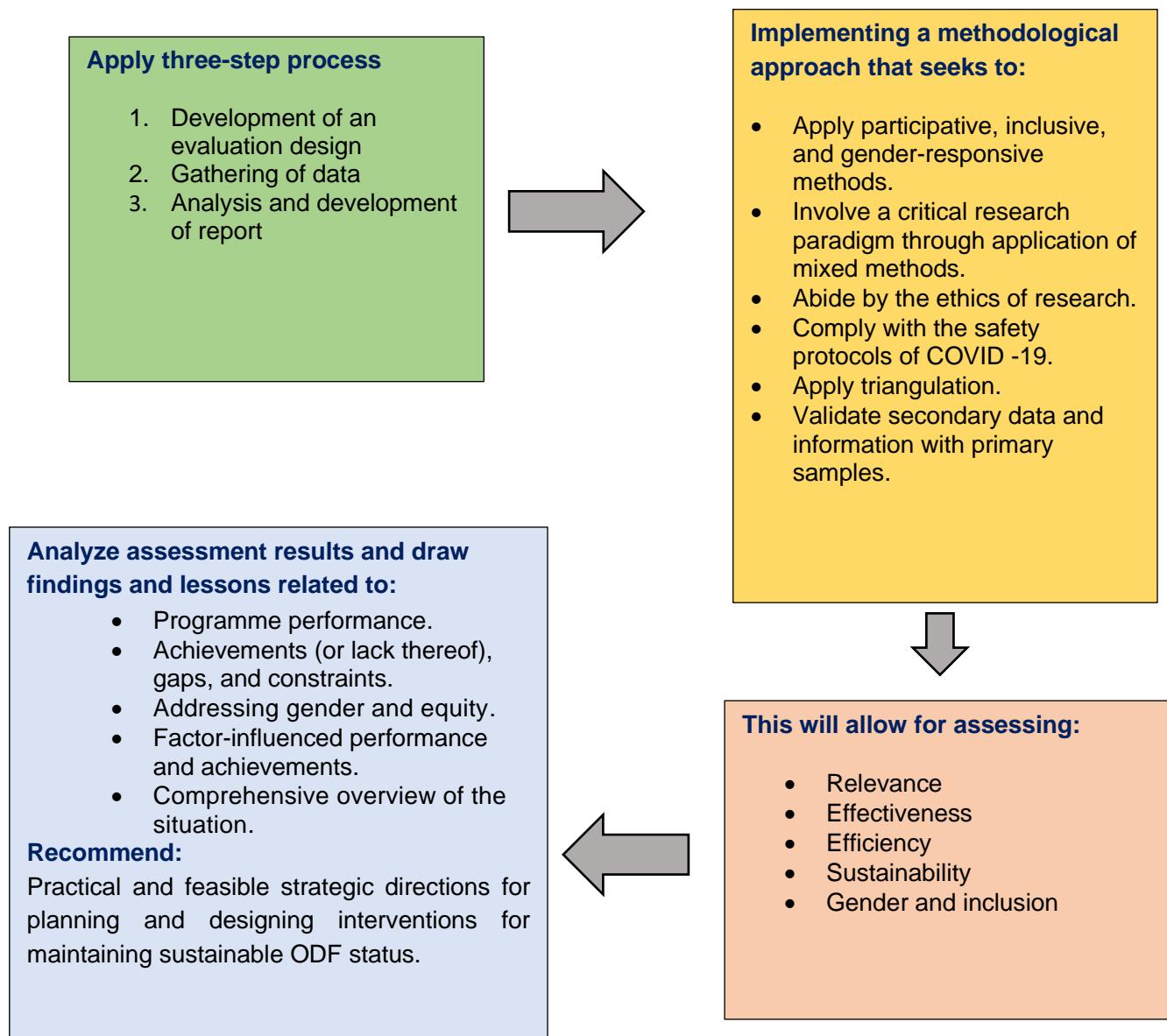


Figure 3: Methodological Approach

The following set of principles were applied to carry out the assessment:

Appropriate methods and tools must be participatory, gender inclusive, and responsive. In order to facilitate simultaneous learning, the evaluation applied a participatory evaluation approach. Although the type of participation varied at different levels depending on the methods and tools used to elicit data, the overall spirit of evaluation was mainly participatory in nature. Furthermore, primary data collection and consolidation was done in a disaggregated manner looking into age, sex, and special vulnerability groups. The spirit was to learn how to improve the quality and effectiveness of future programmes that have a similar nature.

Mixed method: The methodology included analysis of both quantitative and qualitative data that had been gathered from both primary and secondary sources.

Triangulation: The evaluation accessed multiple and diversified data sources. A gender-balanced, multi-disciplinary team of core consultants, plus twenty-six (26) survey enumerators, were engaged in the data gathering process. Data was collected through the application of various methods and tools. In the analysis and findings, triangulation was done to verify opinions and ideas provided by different stakeholder categories, both in quantitative and qualitative parameters.

3.2. Evaluation framework development, data tools preparation, and coverage of samples

In order to ensure objectivity, adherence to evaluation criteria/questions through desk review of project documents the evaluation design proceeded through the preparation of evaluation framework (Annex 1), using the following template:

Table 1: Evaluation framework template

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
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The evaluation framework provided a guiding basis for design, pre-test, finalization, and utilization of the following data tools and informed consent (IC) documents (Annex 2):

Table 2: Data Tools

Data Tools	Informed Consent (IC) Documents
<ul style="list-style-type: none">• Questionnaire for the household survey, Knowledge Attitude Practice (KAP).• Household observation guide for the survey enumerators.• Sustainability of sanitation facilities: Assessment tools	<ul style="list-style-type: none">• Informed Consent for respondents of the KAP survey.• Informed Consent for Key Informant Interviews.• Informed Consent for the FGD with respondents, age 16+

<ul style="list-style-type: none"> Guide questions for Key Informant Interview (KII) and Semi-Structured Group Interview (SSI). Guide questions for Focus Group Discussion (FGD). 	<ul style="list-style-type: none"> Assent of child respondents in the FGD. Parent/guardian/caretaker Consent for children in the FGD.
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The following table shows the provinces, districts, and municipalities where the primary data collection and gathering took place:

Table 3: Provinces, districts, and municipalities covered

Province	District	Municipalities
Madhesh	Bara (focused district)	Baragadhi RM (Wards 1-5) and Mahagadimai Municipality (Wards 1-4, 6-8, 10)
	Rautahat (focused district)	Durga Bhagwati Rural Municipality and Rajdevi Municipality (Wards 1-9)
	Sarlahi (focused district)	Chakraghatta Rural Municipality (Wards 1-9) and Malangawa Municipality (Wards 1-5, 7, 9, 10, 12)
	Saptari (focused district)	Kanchanroop Municipality (Wards 3-10) and Rupani Rural Municipality (Wards 2, 3, 4, 6)
Lumbini	Kapilavastu (focused district)	Shivaraj Municipality (Wards 2, 8)
Bagmati	Kavre (non-focused district)	Mahabharat Rural Municipality (Wards 6-8)
Karnali	Mugu (focused district)	Chayanath Rural Municipality (Wards 2, 3, 7)
Sudurpaschim	Kailali (non-focused district)	Dhangadhi Sub-Metropolitan City (Ward 10 and others)

Districts in each region were selected based on how representative they were of regional geographic characteristics. Parameters for selection consideration were:

- Programme coverage and types of interventions provided.
- Geographic and settlement character urban vs. rural.
- Population size.
- Sanitation coverage, percentage of HH with toilet and without toilet.
- OD and ODF status.
- Types of support provided by UNICEF.
- Socio-economic and cultural context.

- Geophysical and infrastructural characteristics.
- Exposure to natural disasters.

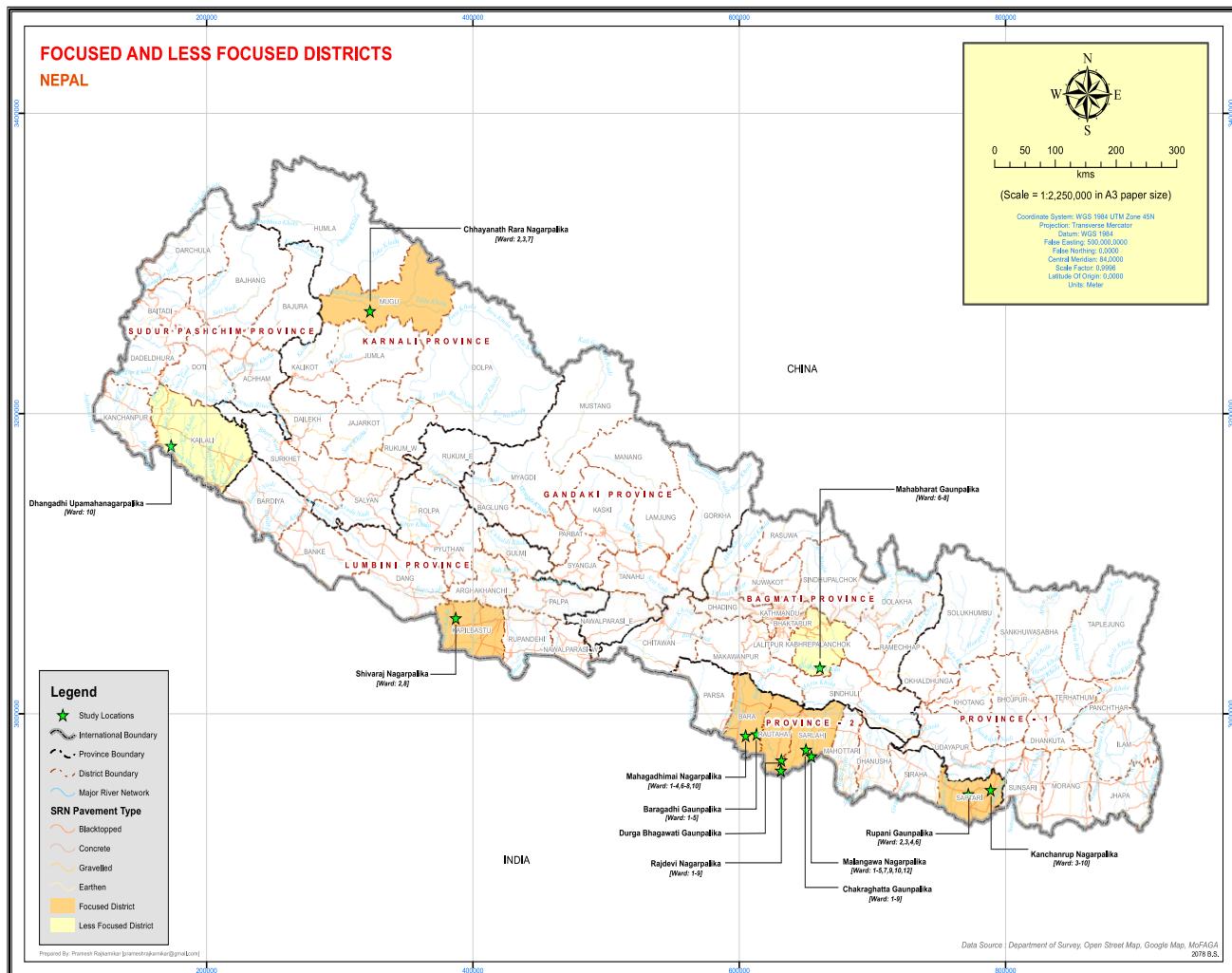


Figure 4: Map showing sample provinces and districts

For the primary data collection, the evaluation covered a total of 12 municipalities/palika, among which 6 were rural and 6 were urban. In addition to visiting and observation at 8 schools, the evaluation covered a total of 18 urban and 18 rural wards.

In order to gain perspectives, ideas, and opinions from those in disaggregated groups based on gender or other vulnerabilities, the application of multiple methods for primary data collection included 1,863 male; 1,031 female; 23 LGBTQAI; 34 boys; and 91 girls. The evaluation covered a total of 3,042 respondents.

With a focus on the lowest rung of caste groups, a total of 1,601 respondents in the study were Dalits or other vulnerable and marginalized people. This comprised about 40 percent of the total respondents in the study.

Table 4: Number of respondents by multiple method categorizations

	Male	Female	LGBTQIA	Boys	Girls	Total
Survey	1602	851	15	0	0	2468
FGD	63	143	6	34	91	337
SSGI	174	33	1	0	0	208
KII	24	4	1	0	0	29
TOTAL	1863	1031	23	34	91	3042

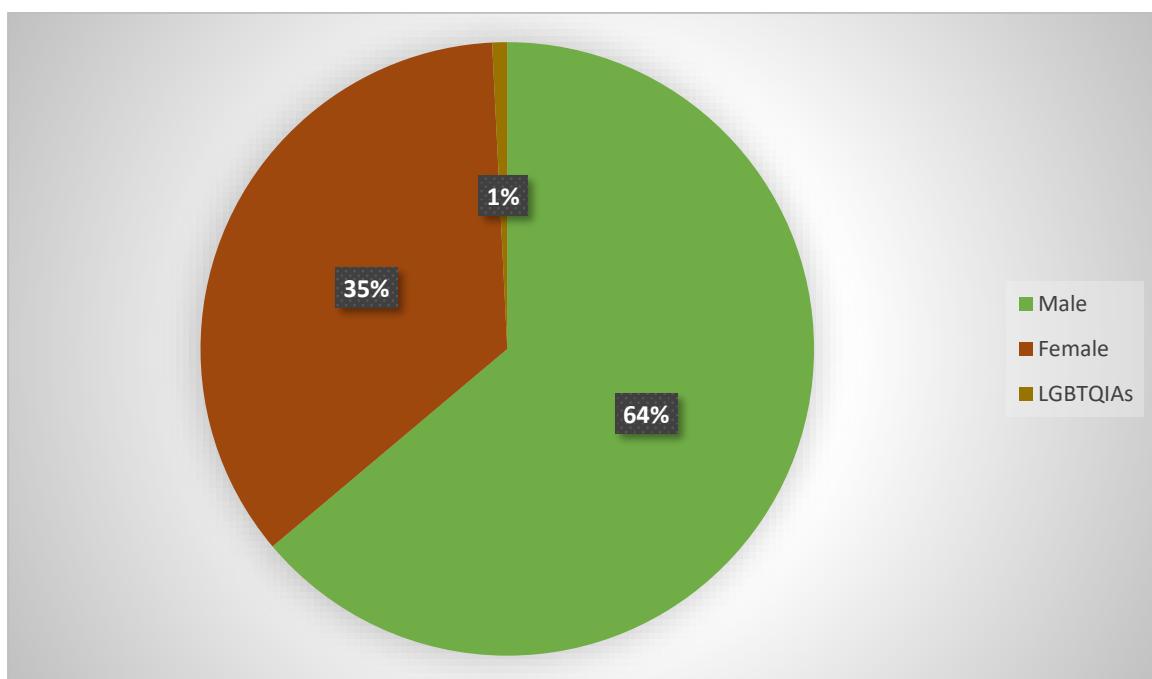


Figure 5: Percentage of adult respondents according to gender

Table 5: Number of respondents from marginalized and vulnerable groups

	Dalit	Senior Citizens	PWDs	LGBTQIA	Total
Survey	1041	313	0	15	1369
FGD	105	36	0	6	147
SSGI	43	30	2	0	75
KII	7	2	1	0	10

TOTAL	1196	381	3	21	1601
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Table 6 shows 267 respondents had good overall representation of multiple stakeholders in each of the administrative tiers, ranging from municipal to federal.

Table 6: Number of respondents from administrative tier, according to gender

	Male	Female	LGBTQIA	Total
Federal	19	10	0	29
Province	16	6	0	22
District	48	10	6	64
Municipality	127	25	0	152
TOTAL	210	51	6	267

Sampling and coverage of household by KAP survey: For determination of sample size for the Household KAP Survey, EPITOOLS software (URL: <https://epitools.ausvet.com.au/oneproportion>) was utilized and the following calculation formula was applied:

$$n = (Z^2 \times P \times (1 - P)) / e^2$$

Where Z = value from standard normal distribution corresponding to desired confidence level (Z=1.96 for 95% CI); P is the expected true proportion; and e is the desired precision (0.05).

Using the formula above, a total of 2,430 households was determined to be the scientific sample size.

Table 7: Sample size to estimate a proportion or apparent prevalence (AP) with specified precision

▪ Estimated true proportion: 0.945 (Source: Multiple Indicator Cluster Survey (MICS))	AP = 0.01	AP = 0.02	AP = 0.05	AP = 0.1	AP = 0.2	AP = 0.5
Precision = 0.01	381	753	1825	3458	6147	9604
Precision = 0.02	96	189	457	865	1537	2401
Precision = 0.05	16	31	73	139	246	385
Precision = 0.1	4	8	19	35	62	97

Precision = 0.2	1	2	5	9	16	25
5 percent non-response rate is taken as 20 385+20=405						

In each of the sample districts, two strata were formed from the latest urban-rural definition (Municipality and Rural Municipality) and samples were independently obtained. The sample size of each stratum was calculated using the power allocation with a power value of 0.2 using the following formula:

$$n_h = \frac{N_h^p}{\sum N_h^p} \times n$$

nh=sample size in hth stratum

Nh=population size in hth stratum

p=power value=0.2

The number of sample HHs for focused and non-focused districts yielded by the formula stated in the following Table 8:

Table 8: Sample Districts, Municipalities, Wards and number of households in KAP survey

Table 8: Sample Districts, Municipalities, Wards and number of households in KAP survey				
District	Municipality/wards	Rural municipality/wards	Sample HH	
Sample HH from each focused district				
Saptari	Kanchanroop Municipality (Wards 3-10)	Rupani Rural Municipality (Ward 2,3,4,6)	405	
Rautahat	Rajdevi Municipality (Wards 1-9)	Durga Bhagwati Rural Municipality	405	
Sarlahi	Malangawa Municipality (Wards 1-5, 7,9,10,12)	Chakraghatta Rural Municipality (Ward 1-9)	405	
Bara	Mahagadimai municipality (Wards 1-4, 6-8, 10)	Baragadhi Rural Municipality (Ward 1-5)	405	
Kapilvastu & Mugu	Shivaraj Municipality (Wards 2, 8)	Chayanath Rural Municipality (Ward 2,3,7)	405	
Sample HH from each non-focused district				
Kavre & Kailali	Dhangadhi Sub-Metropolitan City (Wards 10, others)	Mahabharat Rural Municipality (Ward 6-8)	405	
Total			2430	

A two-stage sampling strategy was applied. In the first stage, wards from districts were selected using the Systematic Probability Proportional to Size (PPS) method. In the

listing operation, the age and gender of each household member aged 18 years and above was collected. Individuals then became the Secondary Sampling Units (SSUs). Big Primary Sampling Unit (PSU) was split into segments containing approximately 300 households starting from the northeast corner block.

After the listing was complete, frames were prepared: an adult male, an adult female, and 25- 25 persons were selected from each group, respectively, using systematic sampling after sorting the frame according to age ascending order. In order to exclude more than one respondent per HH, sampling intervals calculated using the following formula for selecting the respondent:

- 1) The following formula was used for each category calculation:

$$\text{Sampling Interval (SI)} = \frac{N}{n}$$

here N= number of persons listed in the category and n= number of units to be sampled (25)

- 2) We rounded the number obtained in (1) down to get the random start using a table of random numbers. This is the first sample unit.
- 3) To obtain the subsequent samples the following formula was used:

$$\text{Sample } i = \text{Rounded value of (random start} + (i-1) \times \text{ SI})$$

For this purpose, a table of random numbers was used to obtain the random start. To do the sampling, an excel worksheet was provided for the survey enumerators who were equipped with hands-on training and orientation.

Consisting of women and men in each household the survey successfully covered a total of 2,468 households. Sample province, district, municipally and ward wise coverage of samples households by number by percent is presented below in table 9.

Table 9: Coverage of HH- KAP survey samples

Nature	Province	No of and name of districts covered	No of Municipalities covered		No of Wards covered		Total HHs covered	Percent
			Urban	Rural	Urban	Rural		
Focused	Madhesh	4 (Bara, Rautahat, Saptari & Sarlahi)	4	4	16	18	1624	65.8
	Karnali	1 (Mugu)	1	1	0	3	233	9.4
	Lumbini	1 (Kapilavastu)	1	1	2	0	204	8.3
	Bagmati	1 (Kavre)	1	1	0	3	200	8.1

Non-focused	Sudurpaschim	1 (Kailali)	1	1	4	0	207	8.4
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Sampling for qualitative data: The theory of saturation and the grounded theory approach were applied for respondents of the qualitative study (KII, FGD, and SSGI). Applying a purposive sampling approach, a total of 29 key informants were interviewed at the federal, provincial, and district levels. As stated in Tables 1, 2, and 3 these included a number of urban and rural locations. A total of 35 FGDs and SSGIs were conducted covering a total of 545 respondents, applying a gender- and age-stratified random sampling approach in purposively selected municipalities.

3.3. Data collection methods applied, and activities conducted

For the collection and gathering of data and information both secondary and primary sources were explored. Secondary data and information were extracted through in-depth reviews of both project documents and relevant literature. A list of the documents reviewed can be found in Annex 3.

3.4. Data collection methods applied, and activities conducted

For the collection and gathering of data and information both secondary and primary sources were explored. Secondary data and information were extracted through in-depth reviews of both project documents and relevant literature. A list of the documents reviewed can be found in Annex 3. The multiple methods of primary data collection are stated in the following Figure 6:



Figure 6: Multiple methods applied for qualitative and quantitative data collection

Household Sanitation KAP¹⁷ survey: The KAP survey method was applied to generate and collect demographic profile, gender, and age disaggregated qualitative and quantitative data on awareness, behaviours, and perceptions surrounding sanitation. For efficient data collection of comprehensive information the survey included multiple-choice questions in addition to open-ended ones. It also added a household roster to gather demographic information to analyse the data through the equity lenses.

Focus Group Discussion (FGD): Consulted in randomly selected wards/villages in sample municipalities. In order to generate gender-, age-, and vulnerable group-specific ideas and opinions, FGDs were conducted separately with men, women, boys, girls, and members of the LGBTQIA community.

Key Informant Interview (KII): Senior NGO staff engaged with sanitation workers, senior citizens, PWDS in villages, and teachers in schools together with key staff members of relevant government departments at the national, provincial, district, and municipal levels.

Semi Structured Group Interview (SSGI): Conducted with WASH Coordination Committee (WCC) at districts and municipalities.

Direct Observation: Direct observation included household toilets, communal toilets, sanitation, and hand washing facilities at schools, government offices, open defecation sites, water testing labs, tube wells and wastewater drainage, flood resilient tube wells, ponds used for both bathing and cleansing. Based on structures, guide the survey enumerators conducted observation and physical verification of a total of 2,323 household latrines. As part of the qualitative data gathering activities, evaluation team members visited about 100 households and 5 communal latrines. Two other Municipal WASH Plans were also observed.

Province level validation and Lessons learnt session: Consultation in Madhesh Province was done with the provincial WASH coordination committee, chaired by the Chief Secretary of the province. During the session, the evaluation team shared its preliminary observations and findings (on evaluation criteria) about the province, the soliciting of participant feedback, and lessons learned. The validation workshop uncovered the key gaps, which were shared by the evaluation team in relation to inclusive WASH facilities, mobilization of WASH-CCs, and OD practices.

National-level validation session: On 27 June 2022, a national-level validation session was conducted in participation with national WASH-CCs and key programme staff at UNICEF Nepal. In this session, the evaluation team shared its observations and findings (on the evaluation criteria) on the evaluation, the soliciting of participant feedback, and lessons learned.

In addition to conducting quantitative data generation through the HH-KAP survey, as presented in the following Table 10, the evaluation also conducted a total of eighty

¹⁷ Knowledge, Attitude, Practice

(80) qualitative data collection activities through application of the methods stated above.

Table 10: Number of data collection activities conducted

No	Type	Quantity
1	Project briefing meeting with UNICEF Nepal M&E and programme staff	1
2	Hands-on training for survey enumerators	1
3	Household KAP Survey (Covering 2,468 HHs)	1
4	Direct observation of HH latrines (2323+100)	2423
	FGDs	
5	Focus Group Discussion (FGD) with males in the community	4
6	Focus Group Discussion (FGD) with females in the community	8
7	Focus Group Discussion (FGD) with LGBTQIA members in the community	1
8	Focus Group Discussion (FGD) with adolescent boys in the community	4
9	Focus Group Discussion (FGD) with adolescent girls in the community	5
10	FGD with Municipal WASH-CC	3
	KII	
11	Key Informant Interview (KII) at federal Level	5
12	KII with Municipal Chief Executive Officer	1
13	KII with senior citizens in the community	2
14	KII with PWD at the district (Member of District-WCC)	1
	SSGI	
15	Semi Structured Group Interview (SSGI) With National-WCC	1
16	SSGI with District-WCC	3
17	SSGI with Province-WCC	2
18	SSGI with school teachers	4
	Site Document Observation and Review	
19	Site Documents Observation and Review (Municipal WASH Plan)	2
	Direct Observation	
20	Direct Observation of communal latrines	5
21	Direct Observation of School Sanitation Facilities	8
22	Direct Observation of Sanitation Facilities at government offices at provinces, districts, and municipalities	8
23	Observation of open defecation site in communities	2
24	Operation of a community pond used for both bathing and anal cleansing	1
25	Observation of tube wells (including raised platform and platform with ramp) newly installed under water safe community intervention supported by UNICEF	6
26	Observation of water testing lab	1
27	Observation of hand washing facilities at the municipal government offices in response to need for controlling COVID-19	3
28	Province Level Validation and Lessons-learnt Session	1
29	National Level Validation Session	1
30	Post-field lesson consolidation workshop for evaluation team	1

All data quality control measures were adhered to, including a review of the study tools, translation into local language, field practice oriented hands-on training for local enumerators, review of evidence, usage of ICT tools functionality, regular supervision of data collected from survey, etc. The administered tools were checked regularly for correctness, completeness, and consistency.

To ensure data quality, the consultant team prepared and introduced a guide for consolidation that was used by the evaluation team members and survey enumerators. The survey questionnaire and observation checklist for the enumerators were translated into the local language with codification for automated entry purposes. All data tools were finalized after incorporating the feedback received through pre-testing.

An equal number of male and female enumerators who had previous experience was selected. The enumerators were provided with hands-on training on data collection (*in compliance with ethical standards of research*). All evaluation team members and enumerators participated in a 3-day hands-on residential training in which they were thoroughly briefed on the objectives of the evaluation, importance of selecting respondents at various levels in conformity with accuracy, completeness, and the privacy rights of individuals. Additionally, orientation focussing on the following important aspects was provided:

- Voluntary participation and flexibility of individuals regarding privacy rights for participating either partially or completely in this process.
- Maintaining data confidentiality for all individuals.
- Reactions of participants by the researchers.
- Behaviour and attitude of enumerator.

Most data gathering activities involved a group-based approach by multi-stakeholders, which not only eliminates biases but also ensures continued validation, transparency, data authenticity, and reliability.

Furthermore, immediately after completion of data collection, all evaluation team members participated in the Lessons-learnt Workshop where lessons and recommendations were consolidated.

3.5. Compliance to research ethics and risk mitigation measures in primary data collection

To protect the dignity, rights, and welfare of participants and respondents, the evaluation team fully complied with the research ethics and principles, including the *National Ethical Guidelines for Health Research in Nepal*, 2019. Special attention to complying with the ethics of involving children was also adhered to.

All members of the evaluation team and survey enumerators obtained consent for their data collection from all subject/respondent categories. Informed Consent (IC) included a clear and simple invitation to participate, an explanation of what the subject will be expected to do, and reasons why they are being recruited. The purpose of the evaluation was presented in a simple, age, education, and culturally appropriate local

language. IC clearly stated that participation is voluntary, and subject may choose to not respond to any or all questions and may withdraw at any time without consequences. Children from the age group 6-16 years participated in separate FGD sessions and IC was obtained from their guardians. The IC document was prepared in an age- and culturally appropriate manner for them to provide written or verbal consent. IC materials also advised subjects to keep focus group discussions (FGD) confidential and not share with anyone outside the group. All IC materials and activities described protocols for the safety of the subjects throughout data collection, analysis, storage, and dissemination. Data analysis and reporting procedures ensured subject anonymity and security.

In recruiting the study respondents, UNICEF Nepal facilitated the evaluation team by providing information from its roster; privacy and confidentiality was maintained.

While the names of participants were recorded in conducting the KIIs and SSGIs, '*identification of individual subject*' was always omitted in data consolidation and reporting.

Except for a few virtual KII, most data collection activities were conducted in-person and all COVID-19 safety protocols were strictly followed during the data gathering. This included wearing face masks, hand sanitization, and social distancing.

It was well understood by the evaluation team that in the cultural context of Nepal, male evaluators would not be suitable for discussions with girls and women on some topics such as defecation, menstrual hygiene, and management practices. These sensitive interviews and discussions were conducted only by female members of the evaluation team.

The evaluation study did not require information relating to any illegal activities it was applied for the selection of study subjects/respondents. It was thoroughly discussed with the evaluation team members that the study samples were not at risk for issues such as: violence, torture, abuse, kidnapping, sexual exploitation, harassment, prostitution or pornography, female genital mutilation, reproductive or sexual issues, sexual orientation, child, early or forced marriage suicide. Furthermore, no subject of the study was known to be involved in slavery, including the sale and/or trafficking of children, forced labour, servitude, forced recruitment to armed groups, war or armed conflict, illegal activities, production or trafficking of drugs, economic exploitation, work that would be damaging to health or safety, removal of organs for exploitation.

Although the evaluation team understood the probability and magnitude of anticipated harm or discomfort was negligible, the following ordinarily occurring encounters had to be anticipated for defining and applying risk mitigation strategies:

- a. Persons with disabilities might have difficulties with free movement. In hilly and mountainous terrain, elderly people and pregnant women may face difficulties in movement and attending the FGD meeting.
- b. There could be a possibility of real data suppression or instances of false information being provided by interviewees for their own hidden interest. Such suppression of real information might create problems in getting the true picture. Examples of depicting a family who was better off as poor to the

- external enumerators was a common phenomenon in many development interventions in the past. Families who were better off tried to grab the government donation and subsidies allocated for the poor and very poor.
- c. Domination of male over female and upper caste over lower caste may prohibit spontaneous sharing of opinions and ideas by the marginalized. Often gatekeepers prohibit the community members from sharing their frank opinions. These gatekeepers often come up and speak on behalf of the community claiming that they are community representatives themselves.
 - d. Upcoming national election campaigns and rallies may disrupt data gathering activities.
 - e. If a new episode of COVID-19 emerges, planned activities may have to be changed/suspended.

To minimize domination of male over female participants, gender segregated FGD sessions were conducted. In the case of domination by members of the upper caste over lower-caste participants, evaluators had to exercise their freedom to conduct separate interviews with respondents belonging to a lower caste.

Regarding gender, ethnicity, or other demographic characteristics for grouping of subjects, the nature of the sanitation programme did not involve any direct conflict of interest. The contact section of the IC document advises subjects to inform the lead consultant by phone or email in any situation of abuse. This was not mandatory but optional.

To ensure data security, the KAP survey data was collected using a tab-based electronic questionnaire. Once the questionnaire was filled in, it was automatically forwarded to the Kobo depository that had an access control mechanism so that unauthorized access would be denied. Similarly, reports of FGDs, KIIs, as well as notes of observations were prepared in an electronic version which was deposited in a designated password-protected, web-based depository. Appropriate care (E-cloud mechanism) was taken to reduce any risks due to data damage, loss or theft, fire, flooding, or other disasters. Data files were properly archived and saved in a secure place which included a back-up system.

3.6. Data analysis and development of findings

The evaluation team prepared the following criteria-specific points of analysis to serve as a guide for data analysis and development of objectives:

Table 11: Criteria-specific points for analysis

Criteria	Points for analysis
Relevance	<ul style="list-style-type: none"> • Similarities and gaps between needs and planned/implemented programme interventions with special emphasis on the needs of vulnerable groups. • Strengths and weaknesses of programme intervention strategies in terms of sensitivity towards culture, gender, and social inclusion.

	<ul style="list-style-type: none"> • Strengths and weaknesses in addressing emerging needs of climate- and disaster-resilient sanitation.
Effectiveness	<ul style="list-style-type: none"> • Differences in quantity and quality between the intended results and intended output • Merits and weakness of relationship between delivered inputs in creating intended output; contributory and hindering factors • Service-access variations for vulnerable groups such as children, women, PWDs, elderly people, ethnic cultural minorities, members of the LGBTQIA community. • Differential effects created for boys and girls through the programme. • Parity and disparity of quantity/quality in establishing the intended output and reasons behind this. • Strengths and weaknesses of relationship between delivered inputs and creation of intended outputs; contributory and hindering factors. • Parity and disparity of quantity/quality of intended output creation and reasons behind it. • Conformity and discrepancy of equitable access and use of services by vulnerable population groups (i.e., children, women, PWDs, the elderly, economically marginalized, ethnic- and cultural-minorities). • Strengths and weaknesses of relationship between created outputs and creation of intended outcome; contributory and hindering factors • Comparison of baseline and intended value as per indication of KPI (attribution).
Efficiency	<ul style="list-style-type: none"> • Strengths and weaknesses of input delivery in terms of quantity, quality, timely delivery, and coverage. • Comparison of cost – output and probable benefit. • Strengths and weaknesses in finance and human resources.
Sustainability	<ul style="list-style-type: none"> • ODF sustainability status. • Adequacy and inadequacy of sustainability mechanisms have been put in place. • Likelihood of process and outcome sustainability. • Risks and enabling factors for sustainability.
Gender and inclusion	<ul style="list-style-type: none"> • Strengths and weaknesses in gender and inclusion.

To understand the achievements and shortfalls, the analysis examined achievements and accomplishments, which were then compared with the expected outcomes of the programme. In examining the Theory of Change processes, contextual factors, and causality were looked at. From the perspective of a rights-based approach, the analysis also focused on how the project intervention was able to advance the sanitation rights of the targeted population, especially marginalized and traditionally excluded groups.

Quantitative data was generated through household the KAP survey and exported into the Statistical Package for Social Sciences (SPSS) for tabulation. Descriptive statistics including the frequencies, median, Inter Quartile Range (IQR), percentages, and

proportions were used in the analysis. Wherever necessary, cross tabulations were used to measure variations in the information among different groups of respondents.

Regarding the qualitative data compilation report and notes from KIIs, FGDs, interviews and observations, these were synthesized through post-field consolidations and the Lessons-learnt Workshop with the evaluation team. Each of the field teams conducted their presentations using the consolidated FGDs, KII, and SSGI reports. Commonalities and differences in opinions and ideas provided by the different stakeholder categories were reviewed, and lessons/recommendations were drawn up per assessment criteria through participatory discussions.

In order to better understand associations between categorical variables, cross references and co-relations were solicited between the quantities data tables and qualitative opinions/ideas gathered from the various respondent categories and documents. Triangulation of various sets of information eventually confluenced to determine similarities, differences, and general patterns towards drawing lessons, recommendation, and conclusions.

3.7. Limitations

National-level scope may not have been achieved: In Nepal, although Dalits and others in lower caste populations constitute about 20 percent of the total population, only about 40 percent of the respondents in this evaluation study came from the disadvantaged, caste/ethnicity group sector. The findings of this evaluation are therefore mostly relevant to the focused provinces of programme interventions; and do not necessarily convey the national sanitation status of Nepal.

Inadequate number of targeted respondents for KII attending at the federal level: The evaluation intended to have 10 KIIs at the federal level. Targeted key informants were executive staff of the Ministry of Water Supply, DWSSM, Ministry of Education, Science and Technology, Centre for Education and Human Resource Development, Ministry of Federal Affairs and General Administration/Department of Local Infrastructure, and development partners from the sanitation sector, such as UN-Habitat, SNV, FEDWASUN, Helvetas, etc. Most of the targeted key informants (KIIs) attended the introduction meeting held at Himalaya Hotel in Kathmandu for the launch of the data collection. Based on a proposal by the participants, it was decided that a list of key questions would be sent to each participant by email, and they would then revert back to the designated member of the evaluation team. However, only one respondent worked on these questions and sent their responses. 6 KIIs were later conducted, among which 3 were face-to-face and the other 3 were conducted online. Instead of the 10 targeted KIIs, the evaluation team could only reach 9, including KIIs with elderly citizens in the community.

Attendance by LGBTQIA and PWD at the FGDs in communities was low: A separate meeting with 5 people from the LGBTQIA community at Sarlahi District was conducted. There was no access to LGBTQIA persons at the community level FGDs or district and municipal level SSGIs. Despite deliberate efforts to find those in this category during the evaluation mission, only 5 people represented the LGBTQIA community as subjects of the qualitative data collection, while 15 participated in the

household KAP survey. Similarly, very few persons from the PWD community came out to attend the community-level FGDs.

Challenges faced by Team 1 for reaching Mugu: Due to unavailability of flights, not all of the team members in the first attempt could attend. Only one evaluation expert was actually able to fly to Mugu for the evaluation. The rest of the team, led by the Team Leader, waited for a couple of days in Nepalgunj for the second attempt but that flight was also unsuccessful.

No application of Participatory Rural Appraisal (PRA) tools: Although it was not deemed essential, the evaluation team had wished to utilize some of the relevant Participatory Rural Appraisal (PRA) tools¹⁸ for creating visual qualitative data. This, however, was not possible due to a lack of availability of time.

Provincial-level validation and Lessons-learnt Workshops held only in Madhesh Province: Although validation and the Lessons-learnt workshop had been planned for all five sample provinces, it was only conducted in Madhesh Province and not any of the other provinces. Due to a recent changeover to Federal in the unitary governance system, most provincial WASH-CCs were in an inactive state and were yet to have received concrete policy directives and the complete sanitation programme. The provincial WASH-CCs had become non-functional. In this transition phase, the evaluation team had to put in significant efforts to make the event possible in Madhesh Province but doing so was crucial because the four focused districts of the province had been covered in the evaluation sample and the findings from the workshop can be seen as representative of the province. For the other four provinces, one district per province was covered as a sample. Thus, the evaluation team decided not to present and validate the findings to the provincial WASH-CC of these provinces as the gathered information from one district could not be justified as representative of any particular province.

Inability to find and interview LGBTQIA persons living in households and families: Although the evaluation team was able to conduct FGD with a group of LGBTQIA persons in a district office of Blue Diamond Society, none of them were actually living in their homes. Separated from their families, most LGBTQIA persons live in district towns. In order to understand how LGBTQIA persons are treated within their families with regard to sanitation services access, evaluation team members tried their best to find rural LGBTQI persons living with families in order to discuss the situation, but failed to find even one person.

¹⁸ such as matrix scoring, problem tree, bar diagram, pie charts, seasonality analysis, Venn diagrams etc.

4. Findings

4.1. Relevance

The key applied approach of the programme was to make communities (Toles, Wards) Open Defecation Free (ODF). The programme interventions, therefore, had inclusive targeting of all categories of people in the community, including children, women, persons with disability (PWD), elderly, LGBTQIA persons and others in the most vulnerable and marginalized groups.

A major period of the programme was affected by the COVID-19 pandemic. In order to sustain relevance, the programme made timely modifications to some of the interventions.

Behaviour Change Communication (BCC) intervention for safe disposal of child faeces and hand washing was very relevant in addressing the needs of mothers and children.

In Nepal, one-fifth of the population belongs to lower castes. These groups of people and their children are culturally alienated¹⁹. Years of cultural oppression has not only disempowered the lower caste population but also severely lessened their self-confidence in their ability to change the situation. The evaluation finds, in terms of achieving sustainable ODF status, the context of the Dalit and lower caste communities are distinctive thus, warrant integration of intervention for their empowerment. Issues and needs for sustainable sanitation improvement stated by the Dalit and lower caste community members noted are:

- Changing sociocultural norms in order to allow their access to and use of communal water and sanitation facilities.
- Household land ownership (some reported landowners would not allow the toilet to be upgraded).
- Leadership and participation in WASH governance.
- Livelihood and additional income for proper maintenance of sanitation facilities.
- Favourable policy and technical support for enabling them to empty pits of their household toilets that have filled up and proper on-site management of sludge.
- Transforming their oppressed mind-set and raising their collective voice in order to realize their sanitation rights.
- Transforming the mind-set of the upper-caste population so as to stop all forms of discrimination against the Dalit and lower-case communities.

The programme lacked deliberate intervention strategies to address the above-stated issues of empowering Dalits and other lower caste groups.

The evaluation team randomly visited 8 schools in ODF-declared wards and villages to observe the school sanitation situation in areas that had been given the ODF stamp. Except for one primary school supported by UNICEF, there is a massive need even

¹⁹ Shahi, S. (2017). Understanding Vikas: How Dalits Make Sense of Development in Rural Nepal. *Nepalese Journal of Development and Rural Studies*, 14(1-2), 98–111. <https://doi.org/10.3126/njdrs.v14i1-2.19653>

today to improve the school sanitation situation in all of the other seven schools. In a group discussion with the school children, the evaluation team learned that students were not using the toilets because they are filthy and smelled bad. Instead, the students used the back wall of the toilet area as a common urinal. Many defecated in the open just outside the fencing of the school. Please see the plight of school toilets (page 76) as there was a horrible smell wafting throughout the entire place. The plight of the girl students was even more pathetic with many adolescent girls using the doorway of the school toilet for urination and sitting on the floor when relieving themselves. It was nearly impossible to walk inside the toilet for anything because of the strong smell of ammonia, a terribly foul odour. In case of an emergency, the children would go to the bush to defecate. Many adolescent girls used to go home to relieve themselves. In the process, many never returned to school after the sanitation break. In one such instance, at a school in Rautahat, the evaluation team observed that not even a single toilet was in use, nor was there any drinking water or hand washing facilities for more than 2,500 students studying at the higher secondary school. The evaluation team randomly visited the eight schools and found that at all of the schools they visited several needs were yet to be addressed to fulfil the criteria necessary to attain ODF status. This does not mean that the WASH interventions in schools had no ultimate significance – including its value to those affected. However, the interventions were not adequate in terms of addressing the magnitude of needs to be found. Although the emergence of the COVID-19 pandemic from mid-2020 to January 2022 caused severe periodic closures at schools in Nepal, the choice of the three-star approach was absolutely relevant in addressing the needs of school sanitation. Interventions to address the special needs of older persons, PWD, and LGBTQIA persons, however, were definitely inadequate.



Permission was taken from the group to use this photo in the report

The picture shows 5 transgender women who responded to the team's invitation and participated in the meeting at Blue Diamond Society. Blue Diamond Society is an NGO working exclusively for the LGBTQIA in the district of Saptari, in the town of Rajbiraj. According to them, there are 6,000 people who officially identify as LGBTQIA but there are many who have still not publicly identified as such. This is a very high figure and needs to be ascertained in other districts of Nepal as well. Although the social department of the municipality is supposed to maintain all relevant data on the LGBTQIA community, there was no data available from the municipality. It has been reported by LGBTQIA members that they have never been invited to any meeting related to WASH. Moreover, they reported that there are no convenient facilities in any public or private institutions and as a result, they must resort to going to the bushes or forests to relieve themselves. This is a very strong example of negligence against a distinctly prominent group of humans in the municipal township society and it falls short of the UN SDG motto of "Leave No One Behind!" No district can become ODF if 6,000 people still have to relieve themselves in the open, simply due to lack of access to any kind of sanitation facilities. The community also reported they have often been denied access to a male or female public toilets and there is no exclusive toilet built for their use. There have also been incidences where some of them were manhandled and beaten up while using the normal toilets. As a result, they have no other choice but to relieve themselves in the open.

Information on the performance progress shared by UNICEF Nepal mentions that against a target of 40, the program successfully installed basic WASH services in 49 health care facilities. This intervention was also absolutely relevant and based on clear needs.

The evaluation team found out, however, that the programme had no planned and conscious intervention in place to address the crucial need for improving sanitation and hygiene in government offices in the districts and municipalities. During their visits, the evaluation team found that due to poor operation and maintenance, toilets and sanitation facilities in most districts and municipal level offices were in a pathetic state.

The programme's target to develop the WASH plan by integrating strategies and activities related to climate reliance and DRR in sanitation was absolutely relevant to sustainable sanitation outcome needs, however, it would have been better if the planning process had been imputed by findings drawn from the systematically conducted sanitation disaster risk assessment rather than having the evaluation put forward strategies for integrating climate resilient sanitation in the municipal WASH plan. Nevertheless, we've been informed that WASH Plan Development Guidelines issued by the federal government have provided a focus on climate change within WASH, and this includes sanitation. Palika WASH Plans are expected to be updated in the medium term to integrate intervention related to climate resilient sanitation.

The evaluation firmly recognizes that it is not possible for a programme to address all needs within a limited period of time and with a limited range of resources. However, addressing the following needs was possible and that is what makes the programme more relevant:

- Building toilets in homes and public spaces that are adapted to persons with disability (PWD) and involving them in Municipal WASH-CCs to make a clear effort to include their special needs in Municipal WASH plans.
- Building LGBTQIA-designated toilets in public places by developing community awareness and deliberate inclusion into Municipal WASH-CCs.
- Facilitating citizen-led advocacy on land ownership for landless Dalit households, thus encouraging them to build their own household toilets.
- Raising community awareness and technical support for onsite sludge management; especially emptying household toilets that have filled up.
- Introduction of proper maintenance mechanisms for WASH facilities created in the schools. We learned that UNICEF had provided caretaker training to the support staff, but most of the schools that were visited lacked clear policies /management guidelines, finds, and resources for proper maintenance.
- Introduction of MHM material, counselling, and changing facilities in schools.
- Capacity building of municipal WASH-CCs so they could conduct assessments, planning, and implementation of sanitation efforts in their wards.
- Institutional triggering and follow-up toward the improvement of sanitation and hygiene situations at government offices in districts and municipalities.

Strategies and interventions, especially community mobilization, local led approaches, and support within the community were relevant to sustaining ODF status, yet inadequate in making post-ODF community level interventions or addressing issues that lead to slippage from ODF to OD²⁰. These are described in detail in Section 4.4 (Sustainability).

²⁰ As per survey data (table 3.3) 21.85 percent HHs having no functional latrines and again gone back to OD practices.

During a meeting of the Municipal WASH-CC of Malangwa which was declared ODF in 2019. The Mayor and other members were proud of reporting their efforts of making the Municipality ODF. They sent police early morning to protect people going to the bushes and jungles for defecation. The Municipality had used about NPR 5 million on toilet construction and each HH had toilets Anyway, it was reported by the meeting members that due to fill up of household toilet pit and bad condition of communal toilet (provided to them) about 60 percent of Dalit households returned to OD practices. The Mayor and his WASH-CC members are very sad now because the municipality has lost its ODF pride. In his reply on the way to solve this issue the Mayor added "*Dalit is the one who is doing OD and we have to relocate them out of Malanga Municipality.*" It was learnt that silently Dalit households returned to OD but did not come to their municipal government to ask for support and assistance in solving this issue to realize their right to live in ODF environment.

The municipality had used about NPR 5 million on toilet construction and each HH had toilets. In the case of Dalit communities, a majority of super structures were made by plant-based natural products such as bamboo, plant stalks, and so on which could not withstand more than a couple torrential monsoons and were damaged. There was a programmatic gag right after ODF was declared so HHs slowly returned to OD habits. The only solution is to initiate a total sanitation campaign and the only panacea is to create "Water-safe communities" declaration as a follow up action which we have been engaged. However it is not intensive as ODF movement

The evaluation determined that the key issue behind relevance is the lack of intervention strategies for empowering a community and this is crucial in sustaining ODF status. While there is ample evidence that access to safe sanitation infrastructure is ensured, the systematic programme intervention to improve behaviour change and sustainably maintain the infrastructure by the community themselves were rarely seen. The evaluation team conducted FGDs in 19 communities and learnt from participants that after their communities were declared ODF rarely did they get follow-up or facilitation

to assess, plan, and work for the sustainability of the ODF environment. This is also reflected in poor maintenance status of sanitation infrastructure created in schools, public places, government offices, etc. Repair, maintenance, and cleanliness did not seem to be anyone's responsibility. Like the paternalism seen in the traditional development approach, local communities expected everything from the government/outside agencies who helped them to ensure access to sanitation for all. What was lacking was the advanced preparation for households and institutions to be able to maintain the infrastructure by themselves. As a result, the filthy unused facilities are being abandoned in many institutions. It was stated earlier that except for a primary school supported by UNICEF, all the other 7 schools visited showed their reluctance to proper maintenance of existing sanitation facilities. Similarly, survey findings convey that among 37.3 percent of household latrine pits ended up filled in; and 14.5 percent were either deluged, new toilets were built, and the rest were abandoned. Opinions gathered through discussions and interviews with households, schools, and

government offices in districts and municipalities convey that everything including post-construction repair and maintenance was expected to be the government's job. No systematic arrangements were made to prepare local communities to receive sanitation infrastructure and successfully maintain it for their own use. While this did not happen, sanitation infrastructure created with the good intention of ensuring access to safe sanitation turned out to be a potential source of spreading foul odours – an unhygienic, unpleasant example of a failed government initiative. In a truly community-led programme, that is community planned and managed, the ODF monitoring and maintenance mechanism develops naturally. This monitoring structure may or may not follow the same style and system of monitoring as is seen in externally planned monitoring systems. A community-managed monitoring system will have its own uniqueness which is often innovative in the local context. The monitoring and supervision committees that are formed by the community are often much more diverse and non-conventional in nature. For instance, a young housewife may lead the entire monitoring mechanism in which there could be aged, experienced, and powerful men who generally dominate any such village-level initiative. This is a distinct variation from the traditional mechanism whereby control of power is in the hands of older men. However, when monitored by the community, very peculiar and unforeseen indicators might emerge which can often surprise us. Another important gap relating to the relevance of the programme was lack of appropriate intervention strategies for addressing the needs of cross-border issues. The programme had inclusive targets for all categories of people (children, women, PWD, the elderly, LGBTQIA, and those from the most vulnerable and marginalized groups), it overlooked a peculiar and location specific cross-border issue near the Indo-Nepal border which was unique. For example: OD practice was found along the international border in the Terai regions. Friends and relatives of many families live on both sides of the border between Nepal and India along Bihar and Uttar Pradesh (UP) who has strong family relationship living in both sides of the border. Cross border migration (both short- and long-term) between the families is very common during marriages, festivals, and family gatherings. Crossing over to Nepal or India in the Terai belt is not only very common but in many places they share the same property, including croplands, orchards, and livestock grazing areas. There is no fencing or strict border security to prevent such movement because of the good political relationship between the two countries and ethnic and linguistic similarities between the people on both sides. It is very common for these people to visit the neighbouring country in the morning and return home in the evening with harvested grass, tree branches, and leaves for feeding livestock or working as labour for wage earning. In such a scenario, when ODF in many Nepali villages along the border, the practice of OD was still common on the Indian side of the international border. There had been many incidences of conflict when community members in Nepali villages chased people who were visiting their families and relatives on the Nepal side because they were practicing open defecation on Nepali fields. Without asking for a toilet facility the visiting relatives used to go to the field to

relieve themselves in the morning. This practice was not only stopped among locals, but ODF communities would not allow anyone else to defecate in the open either. Such small conflicts along the Indo-Nepal border even reached officials in the local Nepali government, previously called VDCs now wards. Official requests were made by the local government authorities of Nepal to the panchayats in the Indian sides to convince their people to discourage them from practicing OD while visiting their relatives in the ODF villages of Nepal. In fact, the practice of OD was still common in the villages of Bihar and UP along the Nepal border when such practice was completely prohibited in the villages of Nepal. This, of course, influenced some households on the Indian side to construct toilets and stop the practice of OD. Since the availability of work on the Indian side of the border is greater, landless people not only from Terai but also from the mountain regions, come for work during the lean agricultural season. Poor people also visit to collect food like mushrooms, seeds, and to catch fish, etc.

4.2. Effectiveness

The ToR-assigned key evaluation question was “*to what extent did the sanitation programme achieve the intended results and how did it contribute to reducing open defecation in the target areas?*”

The evaluation team did not visit any health care facilities and cannot, therefore, actually judge what the effects created were. With regards to attainment of other output indicators the evaluation team begins with the following brief overview of progress:

- Improving access to basic sanitation services at the household level was satisfactory.
- Prevalence of hand washing behaviour-change programmes was satisfactory.
- Achieving school sanitation services at the three-star standard was medium satisfactory.
- Local government with WASH Plans was highly satisfactory.
- Developing policy guidelines for improving WASH governance was satisfactory.

On one hand, the project has been successful in building thousands of new household toilets but on the other hand, a greater number of previously built toilets have become unusable. This has caused a portion of the population to slip back to OD practices. We also noted that proper maintenance of sanitation facilities by a certain percent of households is lacking and that toilet sludge is being disposed of in open spaces.

Access to basic sanitation services at the household level: In terms of creating access to basic sanitation services, the programme has been satisfactory because by the end of 2021, against a target of 500,000, the programme made a significant achievement by providing access to safe sanitation services for 580,965 people. However, household survey findings show that there are differences in the use of latrines for defecation among various age groups of population. Figure 7 shows that

only 2.6 percent of the population within the age group below 20 years old use latrines for defecation. The highest percentage (23.1 to 27.7) of population groups use latrines is within the age group 20-49. The percentage for population using latrine for defecation again declines starting from the age 50, with only 8.4 percent of the 60+ population use latrine.

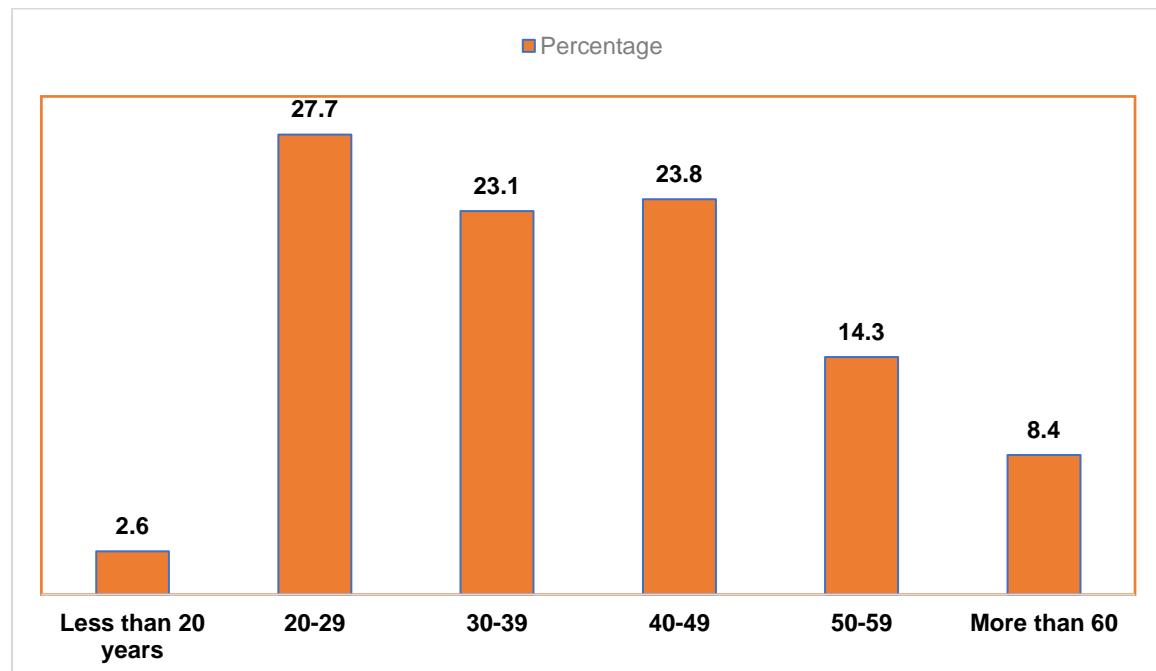


Figure 7: Population's use of latrines for defecation by age group²¹

Further, there are also gender differences in the use of latrine. Figure 8 reveals that in terms of gender categories percentage of population do not use latrine for defecation is at 21.5 percent for males and 22.1 percent for females, while LGBTQIAs ranked at 31.2 percent.

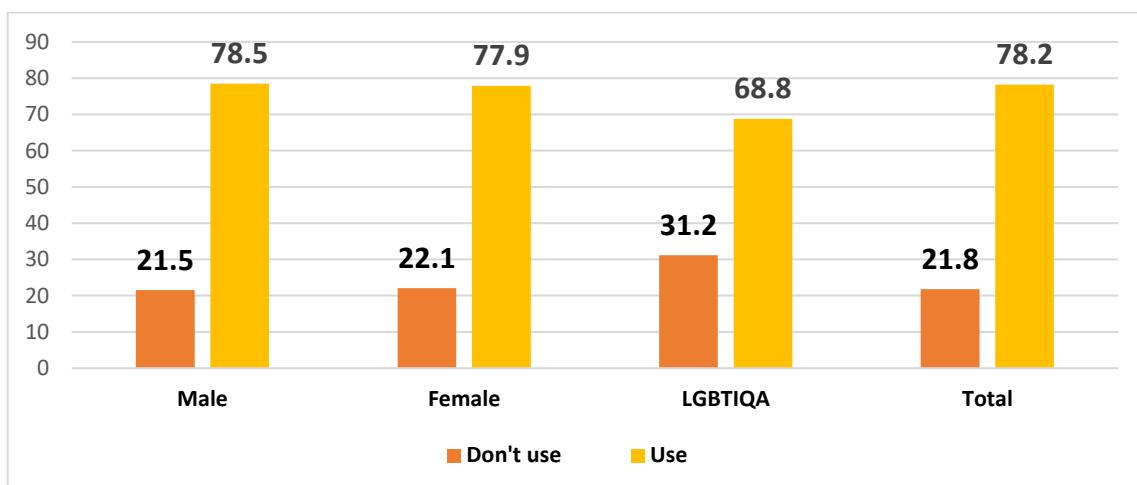


Figure 8: Percentage of population's use of latrines for defecation by gender category²²

²¹ Source: The study survey data 2022. Cross tabulation of age group and gender with OD prevalence method was used.

²² Source: The study survey data 2022. Cross tabulation of age group and gender with OD prevalence method was used.

Information drawn out from the household survey convey that during the time of evaluation: an average of 21.3 percent and 22.7 percent of households in Madhesh Province; 23 percent in Kapilavastu District (Lumbini Province); 20.8 percent in Sudurpaschim District, (Kailali Province); 18.5 percent in Kavre District (Bagmati Province); and 17.6 percent of households in Mugu District (Karnali Province) were practicing open defecation.

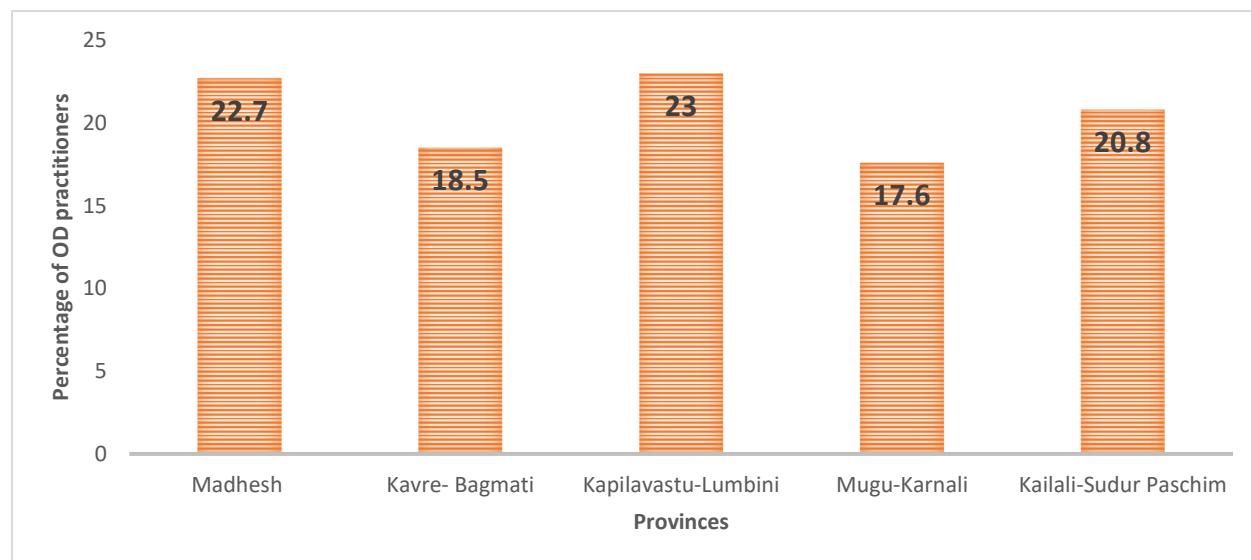


Figure 9: Percentage of HHs practicing OD in different provinces

The findings of the household survey (Table 1.6 in Annex 4) conducted as a part of the evaluation clearly identified that while at the baseline²³ 41.6 percent households in Madhesh Province had no toilets, project interventions were able to reduce this to 22.7 percent. This finding is supported by another UNICEF-commissioned End Line Survey (August, 2022)²⁴ conducted in Madhesh Province, which also shows that the numbers have been further reduced to 12.1 percent.

²³ The baseline data has been taken form the UNICEF commissioned End Line Survey report (August 2022) in Mahesh province, Conducted by Progress Inc. Nepal

²⁴UNICEF commissioned End Line Survey report (August 2022) in Madhesh Province, Conducted by Progress Inc. Nepal

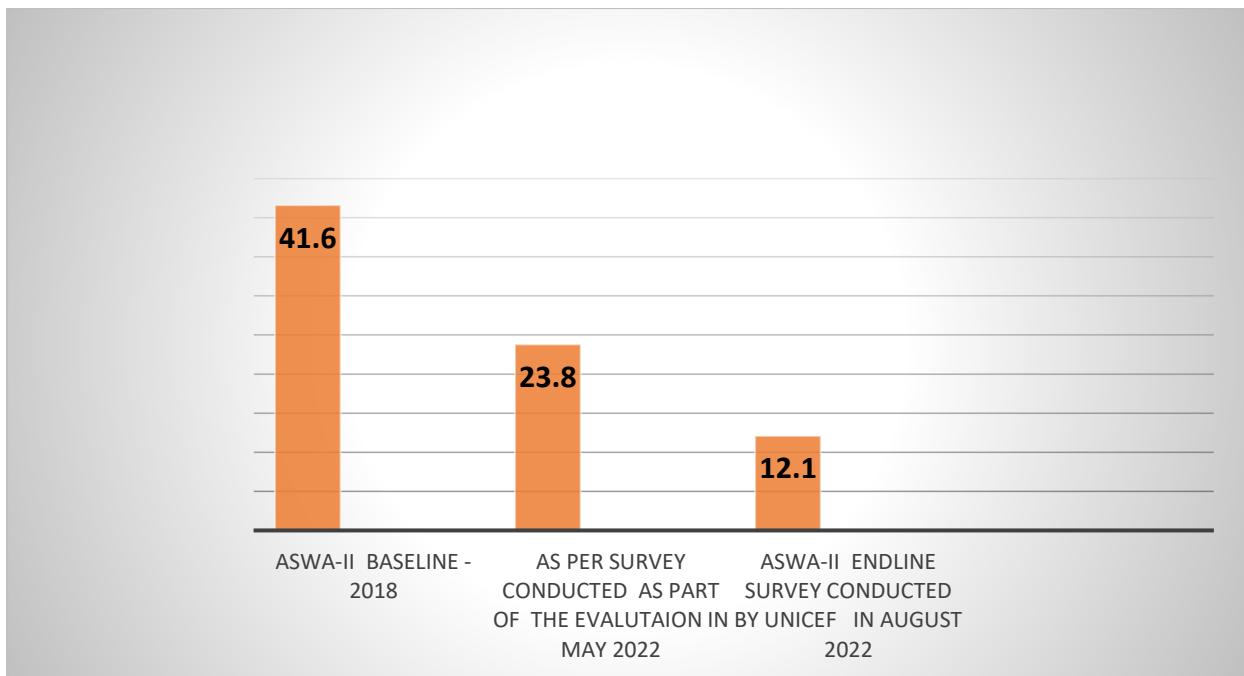


Figure 10: Percentage of households without toilets/not using toilet for defecation

The evaluation confirms that the interventions that were delivered by the project are absolutely credible in increasing access to toilets in accordance with the set output indicators.

Hand washing behaviour-change programmes: Against a baseline of 39 hand washing programs, the project targeted 256; and by the end of 2021, the project reported to have 157 programs total. The triggering and awareness campaign has created positive effects with regard to increased hand washing practices among community members. Findings of the household survey conducted as part of the evaluation (Table 5.2 in Annex 4) clearly identified that project interventions increased the percentage of household toilets with hand washing stations providing water and soap to 67 percent, as opposed to the baseline which had 63.3 percent of household toilets with hand washing stations providing water and soap. This finding is also supported by the end line survey commissioned by UNICEF (August 2022)²⁵ that was conducted in Madhesh Province and found the percentage has further increased to 72.2 percent.

²⁵UNICEF commissioned End Line Survey report (August 2022) in Mahesh province, Conducted by Progress Inc. Nepal

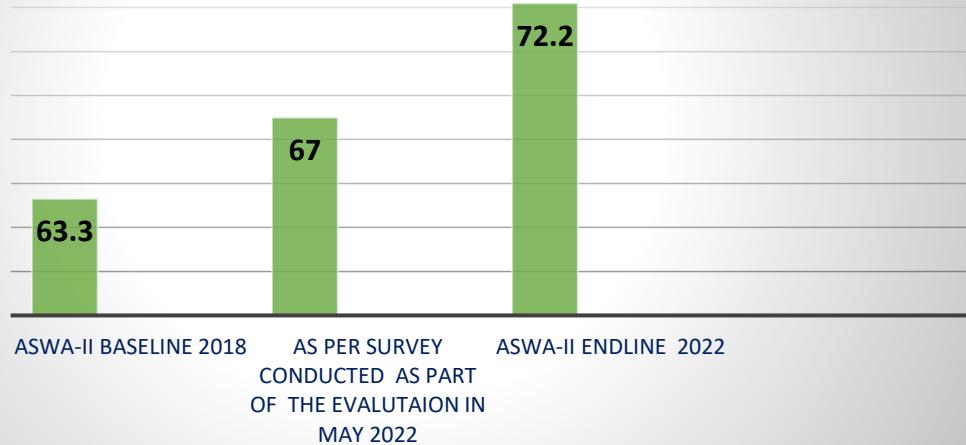


Figure 11: Percent of household toilets with proper hand washing facilities

It seems however, that the increase of hand washing facilities did not equally correlate to an increase in proper hand washing practices among the population. While 60 percent of the population use soap and water for hand washing, 40 percent of the population is hand washing with only water (Table 3.7 in Annex 4).

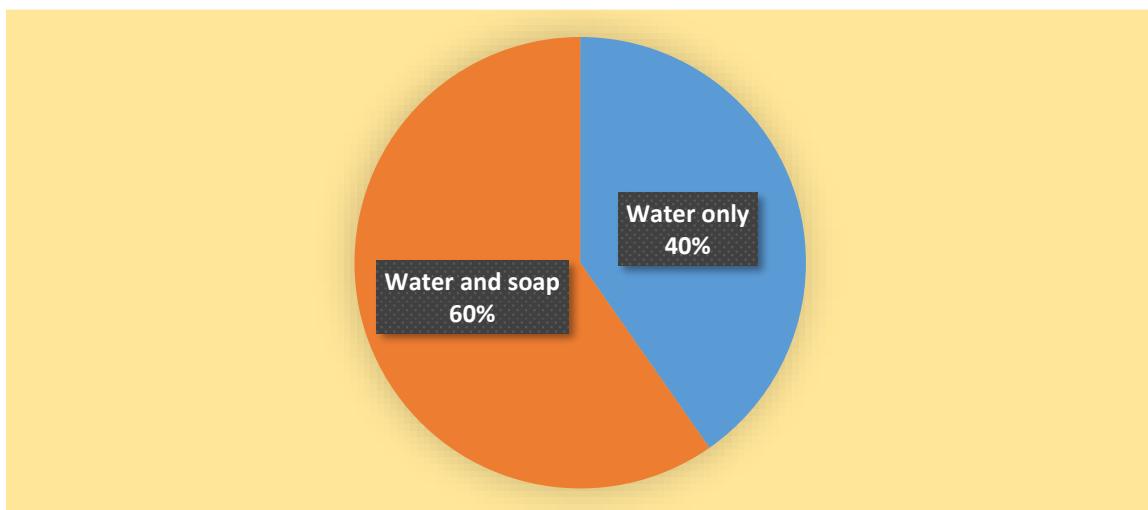


Figure 12: Hand washing patterns of people in the intervention area

The evaluation team observed several hand-washing stations and facilities built at municipal government offices and other institutions for the prevention and control of COVID-19 but most of these were not properly functional. The reasons for this as stated by the key informants (municipal mayor, senior staff at municipal offices, and head teacher of schools) are:

- Lack of person-power to fetch and fill-in water tanks, financial issues around buying soap or paying to maintain cleanliness (O&M).
- There is prevailing perception among the local government that this is an emergency response for the prevention and control of COVID 19. Due to the reduction in COVID-19 cases, keeping hand washing stations functional is not the priority anymore.
- Due to reduction in COVID-19 cases, the importance of hand washing and sanitizing in the minds of the people has also reduced.

School Sanitation: UNICEF Nepal reported that against a target of 288, the project established WASH services in 117 schools that meet the three-star standard, including menstrual hygiene management, by the end of 2021. In August 2022, UNICEF conducted its End Line Survey for the ACCELERATING SANITATION AND WATER FOR ALL (ASWA – II) project. In Madhesh Province, it was determined that against a baseline of 66.7 percent, 90.9 percent of the schools had usable toilets; against a baseline of 0 percent, 30 percent of the schools now have a dedicated budget allocation for school WASH programmes. This is a great achievement indeed but is in contrast with the evaluation findings.

In Madhesh Province, the evaluation team randomly visited 4 primary and 4 secondary schools. Among these, 1 of the primary schools had received support from the programme to build WASH facilities including a hand washing station, separate toilets for boys and girls, and an incinerator for burning waste. A female teacher received orientation training from the project and served as the designated person for the WASH activities at the school. The evaluation team observed school toilets were clean but did not have soap for hand washing. Among the 10 water taps at the hand washing station, 4 taps were broken. These were repaired by the head teacher using his own resources. The incinerator showed no signs of being in use since its installation.

The head and assistant teachers of the school reported that supervised hand washing had not been regular because the school has no budget allocation for buying soap or maintaining WASH facilities. The school had not been supervised by local government

List of Schools Visited

1. Janata Secondary School, Chakraghatta, Sarlahi
2. Saraswati Secondary School, Pipara, Durga Bhagwati, Rautahat
3. Shree Nepal National Secondary School, Belwa Baragadhi , Bara
4. Shree Nepal Adarsha Higher Secondary School, Shivraj Municipality, Kapilvastu
5. Rastriya Adharbhoot School, Kanchanroop, Saptari
6. Adarsha Rastriya Gajendra Primary School, Rupani, Saptari
7. Nepal Rastry Adharbhoot School, Baragadhi, Bara
- 8.. Shree Jana Jyothi Higher Secondary School, Shivraj Municipality, Kapilvastu

institutions or the Municipal WASH-CC. The head teacher requested the accompanying field staff of UNICEF to provide financial support for maintenance of the WASH facilities. No visible excreta were observed in and around the school. In each of the other 7 schools visited (which had not received support from the project) there were very few usable toilets or provisions for MHM. The evaluation team was informed that female students of secondary schools were provided with sanitary pads free of cost by the local government.

Sanitation in Health Care Facilities (HCF): The target of the project was to establish basic WASH services in 49 health facilities. By the end of 2021, a total of 21 HCFs had received these facilities. As the HCFs were not a target sample in the evaluation design, the evaluation team did not visit any HCF and is not in a position to evaluate the effectiveness.

Local government with WASH Plans: At the inception of the project, only two of the Municipal WASH-CCs had a plan for improving WASH in their municipalities. The project intended to develop WASH plans integrating climate resilient development and/or risk management for another 81 municipalities. It has been reported that a total of 58 municipalities had developed their plan for improving WASH by the end of 2021. With regard to initiating a sustainable process and coordinated bottom-up institutional development for WASH, the evaluation team firmly put this across as one of the significant outputs created by the project. The evaluation team visited 12 municipalities and conducted FGDs with each of the Municipal WASH-CCs. While two municipalities shared their documented/printed hard copy of the Municipal WASH Plan with the evaluation team, other municipalities could not because the draft plans yet had to be finalized. Institutionalization of such a bottom-up planning process is complex and takes time to be systematized. In spite of some weaknesses observed (such as the inability of most municipal WASH-CC members to explain their plan and the kind of intervention strategies they decided upon for improving the WASH situation), initiation of the process is certainly a positive effect created by the programme.

Capacity development for effective WASH governance: Regarding the improvement of WASH governance, the outputs created by the project are:

- Development and operationalization of 5 national /sub-national WASH sector policies, instruments and guidelines. (For example: Guidelines on WASH Plan, HCF, Water Quality Monitoring, Water Safe Community, and Sustainability).
- Development and operationalization of 7 WASH sector information and management system MIS.
- Establishment of functioning cluster coordination mechanisms for water, sanitation, and hygiene in humanitarian situations in the provinces and municipalities.

The evaluation team did find, however, that the project would have had a better effect if policies, strategies, and guidelines for sludge management had been developed and rolled out.

Humanitarian response: Another positive output of the project was to provide a humanitarian WASH response to a population of 383,353.

The above findings definitely convey that the interventions of the project created the desired outputs in accordance with the long-term framework of the programme.

Even though the data on access to basic sanitation on a larger scale is promising, drilling down to the status of toilets and their usages reveals a more complex picture. Although 78.8 percent of households now have their individual household toilets, 37.30 percent of those toilet pits are already filled with sludge and have therefore been rendered useless. 15 percent of these households built new latrines but 22 percent went back to the practice of OD. Further, 69.40 percent of households having person(s) with disabilities (PWD) did not build toilets that provide access and services to PWDs. 15 percent of household toilets don't have a drop-hole cover to cover the pit, which led to foul odour and infestation of flies. 36.8 percent of households rarely clean their toilets (Table 4.1; Annex 4) resulting in faeces often being visible in the toilet pan and on the floor. This percentage in the category of unimproved latrines is greater than the national average, as the JMP 2021 estimated that unimproved sanitation facilities in Nepal is 3 percent.

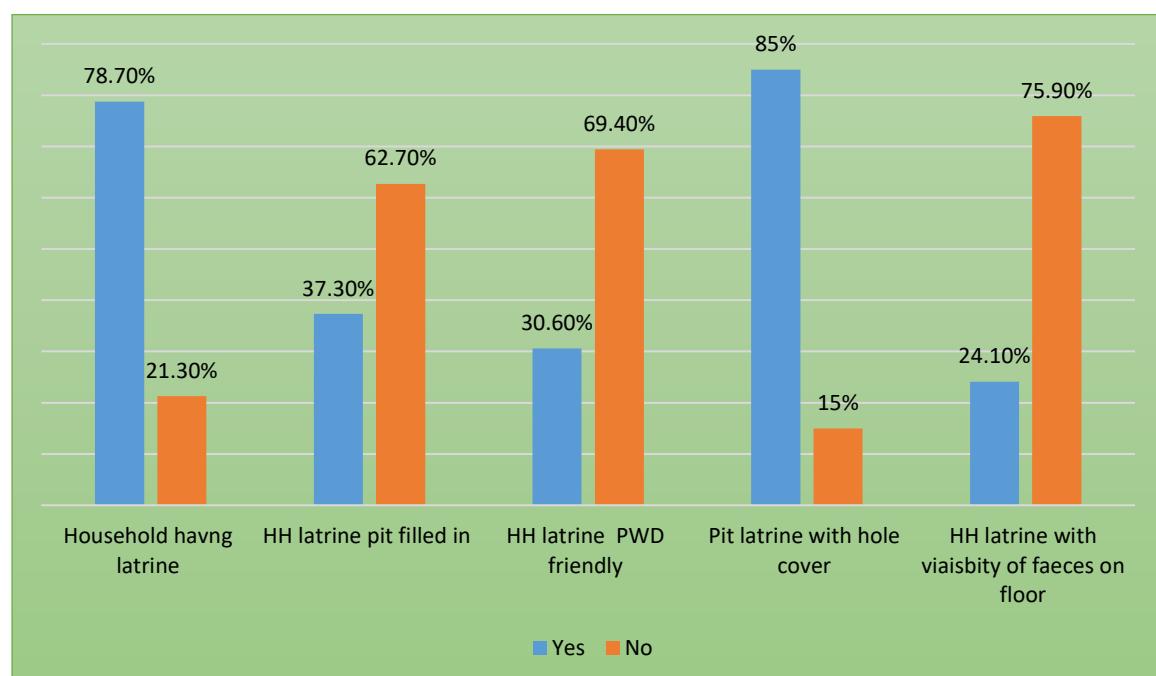


Figure 13: Distribution of the types of latrine at the level of household

Findings of the household survey (Table 3.1 in annex 4) convey that 21.3 percent households do not have latrine facility. In addition 28.9 percent survey respondents (Table 4.6; Annex 4) reported that their toilet²⁶ pit was already filled up and could no longer be used anymore if not emptied. The evaluation team conducted FGDs in 19 wards/communities in ODF-declared municipalities. On completion of each of the FGDs, the team undertook a transect walk and randomly visited some household toilets, hand washing facilities, bushes and jungles, roads/river/canals in and around the communities. Except for four of the communities in Durga Bhagwati, a rural municipality in the Rautahat District of Madhesh Province, in all other 15 communities the evaluation team still observed human excreta in many places: bushes, roadsides,

²⁶ Especially those that were built before and during the period 2018-2019. The survey findings inform 52.5 percent of household toilets were built before 2018.

canals, riversides, filled pit toilets, toilet pans and on the floor. This qualitative observation of the evaluation team co-relate with the survey findings that a certain percent of the population to revert to OD practices, resulting in reducing the percentage of ODF communities.

Although the average percent of households practicing OD is 21.8, it is significantly higher among disadvantaged groups. According to the survey findings, the highest rate (31.2 %) of OD prevails among the disadvantaged non-Dalit Terai population²⁷ , followed by Dalits (28.6), and then religious minorities (27.4 %).

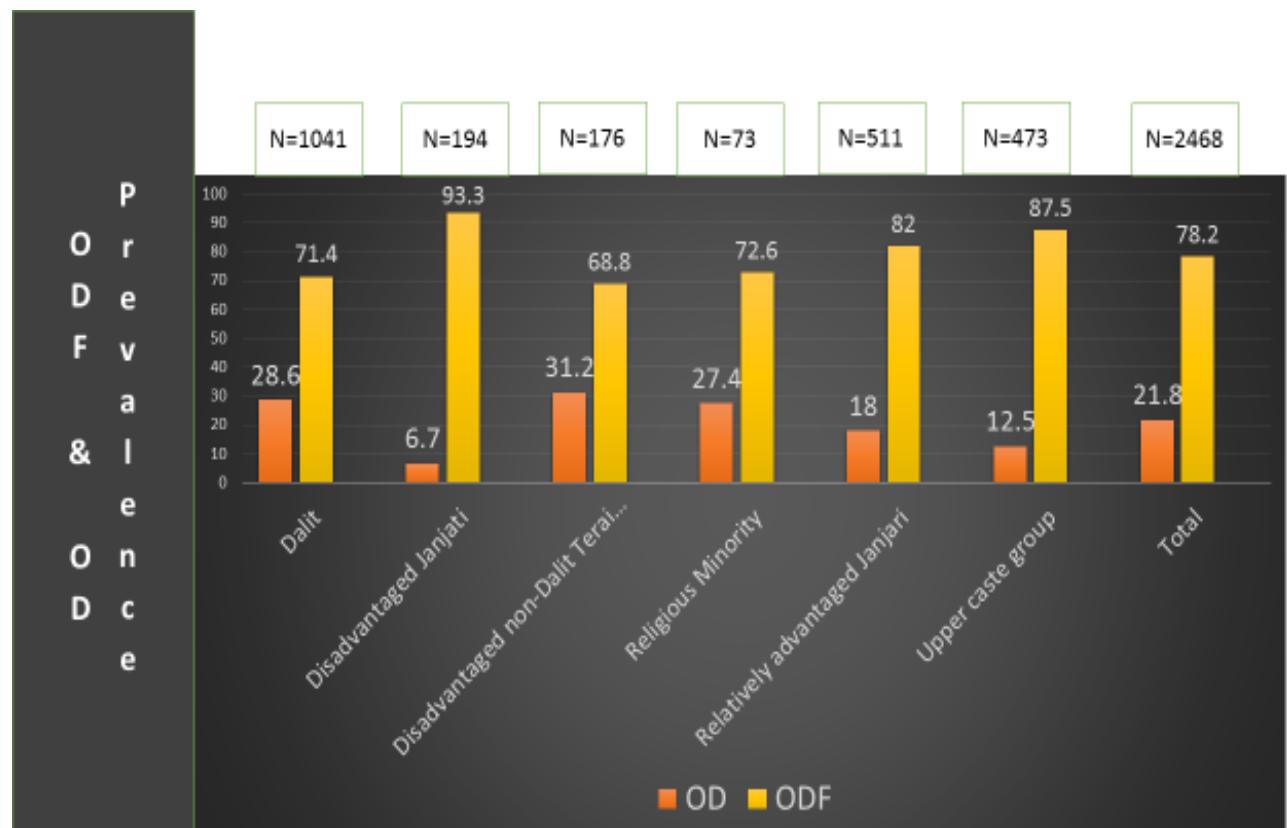


Figure 14: Caste-wise distribution of households practising OD and ODF

Another reason ODF status was jeopardized was disposal of sludge into open fields. The household survey findings revealed that 49 percent of households dispose of toilet sludge in open fields. This practice does not meet ODF criteria.

²⁷ Yadav, Teli, Kalwar, Sudhi, Sonar, Lohar, Koiri, Kurmi, Kanu, Haluwai, Hajam/Thakur, Badhe, Bahae, Rajba Kewat, Mallah, Nuniya, Kumhar, Kahar, Lodhar, Bing/Banda, Bhediya, Mali, Kumar, Dhunia

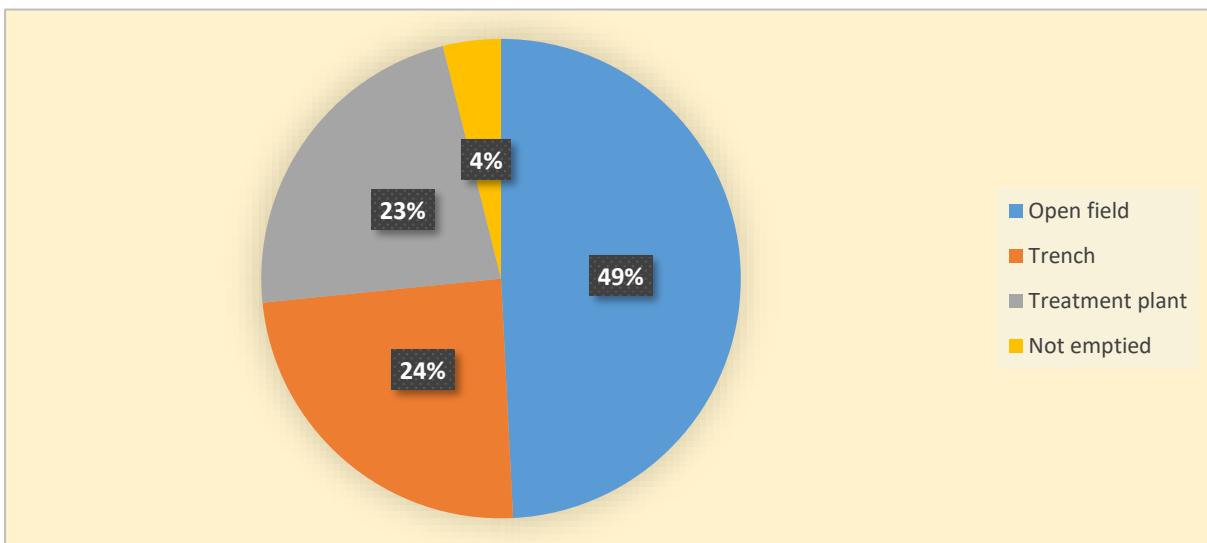


Figure 15: Pattern of disposal for faecal sludge from HH latrines

The evaluation puts across three critical issues that emerged:

- About 20+ percent of households are yet to build their toilets.
- There is a need to de-sludge household pit toilets that have filled up.
- There is a need for proper maintenance and use of household toilets.

Based on the survey findings and notes from the FGDs conducted, the evaluation compiles the following reasons behind the issues mentioned above:

Why 20+ percent of households did not build toilets?

On the multiple response option of the survey (detail in Table 3.4; Annex 4), the highest ranked option stated by respondents is presented in the following figure:



Figure 16: Reasons for not constructing household toilets

Why households did not de-sludge toilet pits that had filled up?

Two main reasons stated by the respondents are lack of finances and an unwillingness to pay (for detail survey Table 3.3; Annex 4).

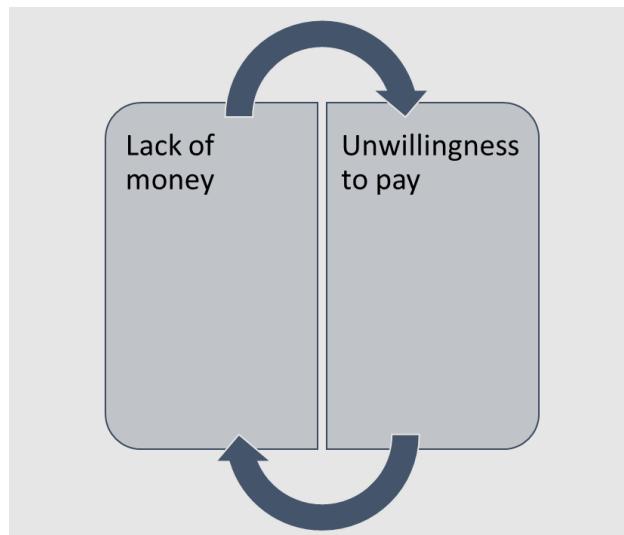


Figure 17: Two main reasons for not evacuating sludge from full household toilets

Why 84 percent of households did not take any action to improve their toilets?

On multiple-response options, the top reasons for not improving the toilets were non-availability of cash, high cost of materials (77.1%), no land to build latrine (40%), no material (22%).

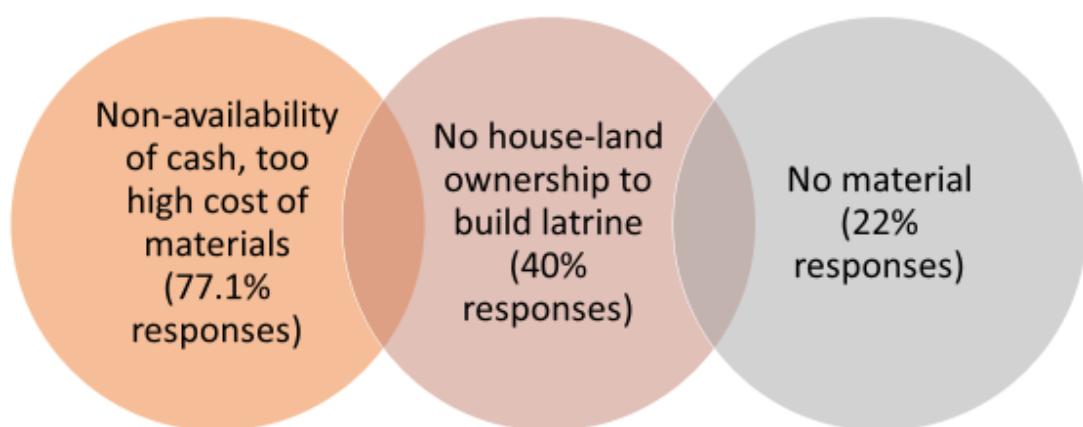


Figure 18: Three main reasons for not improving household toilets. (Details in Annex 4 in Table 3.8)

Other reasons noted through the FGDs are:

- a. Breakage of rings while emptying the filled pit.
- b. Tenants were not allowed to build latrine beside the landlord's home.
- c. Lack of land ownership for Dalit community.
- d. Newly constructed houses did not have money left to build latrines.
- e. Unwillingness of elderly people to break old habits and use toilets.

g. Existing cultural taboos about the father-in-law and his daughter-in-law not using the same household toilet.

Based on the findings detailed above, the evaluation team summarizes that despite the challenges faced by the project due to the emergence of the COVID-19 pandemic and the transition of unitary political administration into federal, the project has successfully created the desired output of creating access to basic sanitation services for a population of 580,956. Although the project made contributions to extending ODF communities and areas, the percentage of ODF communities did not actually increase but decreased due to slippage of previously declared ODF communities. While the household survey findings convey about 22 percent, the population has gone from ODF to OD practices. The evaluation team then visited 19 previously declared ODF communities and observed that 4 communities were retaining their ODF status while 15 communities dropped out. This conveys that about 80% of previously declared ODF communities have failed to retain their ODF status. As it is stated earlier, the household survey result (Table 3.1 in annex 4) inform 21.3 percent HHs do not have latrines thus they are practicing OD.

The programme made remarkable achievements in achieving its intended outputs for developing the capacity of the sector to legislate, plan, and budget for the improvement of WASH systems, including mainstreaming disaster risk management.

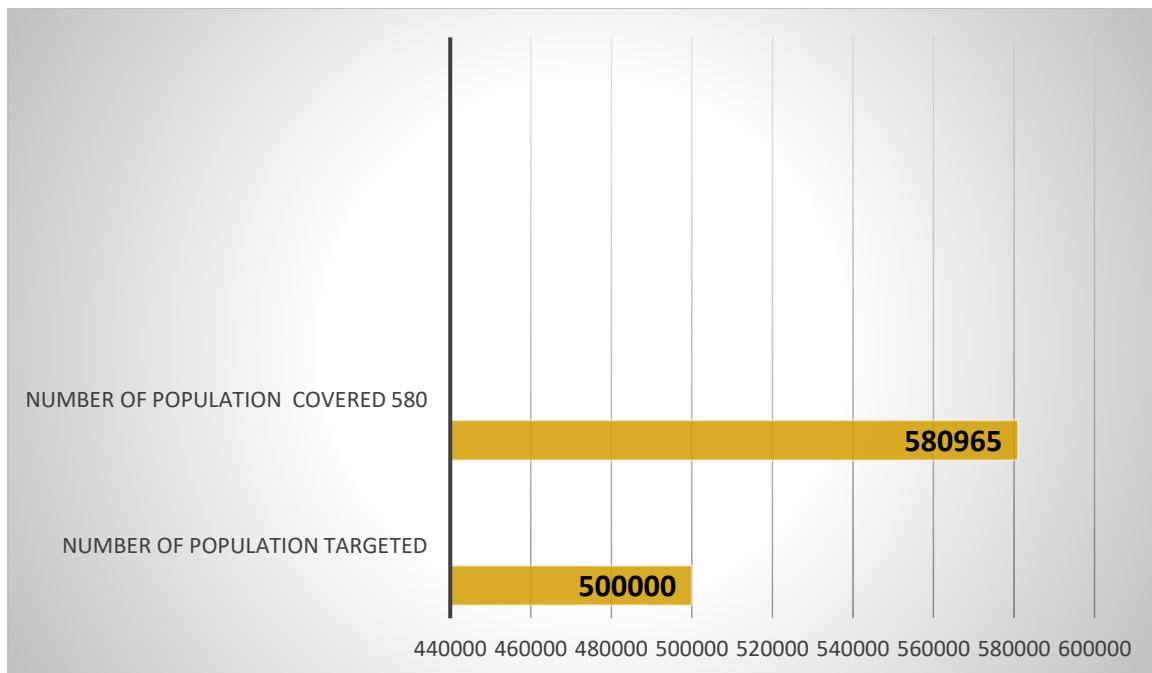
4.3. Efficiency

The efficiency attribute aims to determine the economic cost efficiency, operational efficiency, and timeliness of project interventions. In order to do so, the following key questions were raised:

- To what extent did the inputs and monitoring of the sanitation programme contribute to achieving planned outputs and outcomes in a timely and cost-effective manner?
- Were the programme's financial and human resources sufficient for the implementation of the programme's planned activities?

The evaluation looked at both operational and cost efficiency as well as cost effectiveness. The evaluation team held the view that the project's cost efficiency is high, operational efficiency is above average and the cost effectiveness is low.

Operational efficiency: A review of the achievements against KPI (reported by UNICEF Nepal) shows that in order to *improve sanitation and hygiene behaviour of the community* (Outcome 1) by the end of 2021, against a target of 500,000, the programme made a significant achievement by creating access to safe sanitation services for 580,965 people.



Reference: UNICEF Nepal Report

Figure 19: Targets and achievements in population access to sanitation facilities.

Achievements of the other three target KPIs in Output 2 are presented in Figure 18 and range from 40 to 70 percent. The evaluation acknowledges difficulties in implementation faced by the programme due to COVID-19. Given the current rate of progress, however, there is reason to believe that by the end of 2022 the programme will be able to achieve a 100 percent achievement for targeted KPIs.

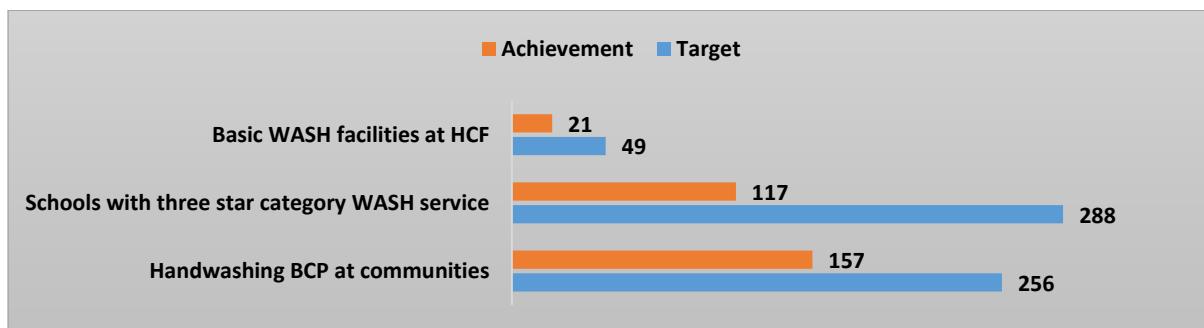


Figure 20: Targets and achievements for associated KPIs to improve sanitation and hygiene behaviour

The original KPI 2018-2022 for the attainment of Output 3 was reviewed and a revised KPI was prepared for the period of 2020-2022. The revised KPI discarded two interventions related to capacity development²⁸ and included KPI for humanitarian WASH services in emergencies with two other KPIs, shown in Fig. 19 and 20 as well. The programme was credible in providing timely humanitarian WASH services to a population of 383,353. Achievement on the other KPIs (shown in Fig. 18 and 19) is also remarkable.

²⁸ Capacity development of the local government body on Three Star Approach to WASH in schools and the development of capacity development masterplans at the national, province and local/municipal government body.

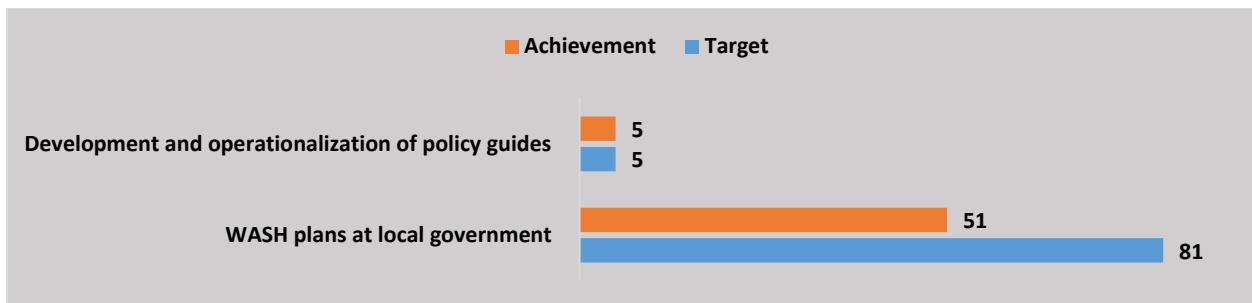


Figure 21: As per 2018-22 CPAP, Target and Achievements of two KPIs for Output 3

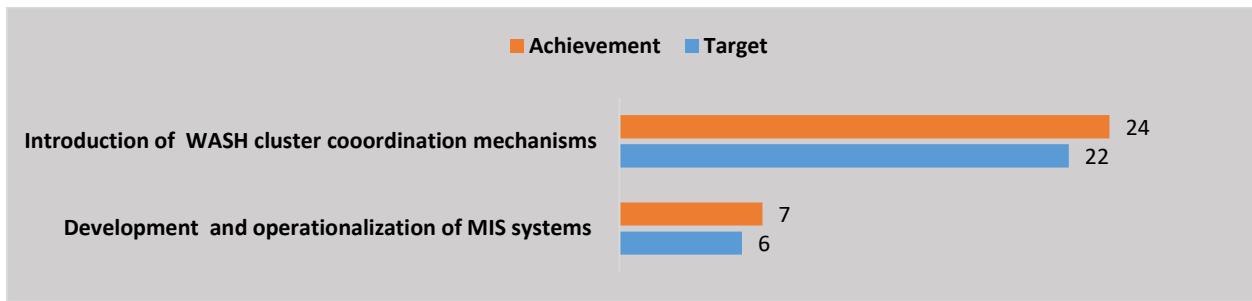


Figure 22: Revised KPI 2020-222, Target and Achievement

The evaluation team was able to visit only one UNICEF-supported primary school (Adarsha Rastriya Gajendra Primary School in Kanchanroop) where the programme has established standard physical WASH facilities, including hand washing stations, separate sanitary latrines for boys and girls, and an incinerator for burning contagious waste. Further, the programme also provided orientation training to school teachers. The school campus and surroundings were observed to be neat and clean without any visible human excreta. Among the 10 taps at the hand washing station, three were found to be broken and repaired by the head teacher with his own money. The head teacher explained that the school was yet to have standard operating procedures and mechanisms for finance, maintenance, supply of required materials and MHM response preparedness at the school for female students. These would enhance utility efficiency of the constructed infrastructure.

For effective and efficient implementation of WASH plans, the Municipal WASH CCs need to develop their capacity for financing, human resources, and programme management. Although replacement of capacity development intervention with emergency WASH response for COVID-19 was an unavoidable need, this could lead to inefficiency in the implementation of municipal WASH plans in the future.

The major gap in the programme's operational efficiency was the absence of systematic internal monitoring. Operational efficiency of any programme largely depends on systematic internal monitoring; designed and conducted based on a well-defined monitoring framework and plan. Of course, there were independent monitoring events conducted by donors (such as DFID), but the key focus of the monitoring was on the results trying to be achieved by the programme rather than on the processes that would actually lead to those results. Monitoring the quality of implementation was also weak. The evaluation finds that even though by the end of 2019 the pits of household toilets started to fill and usage of those toilets started to reduce, the existing monitoring system failed to monitor and provide this information to the programme management so that the necessary actions could be taken in a timely manner. Of course, periodic external study, assessment, review, and evaluation help but they

cannot replace the crucial role of internal programme monitoring, which continuously informs the programme management in order to maintain implementation standards and to take measures needed for rectification. In some areas, being a rush to declare a municipality ODF, some local governments provided subsidized materials to marginalized populations so they could build household toilets. Further, in some municipalities, the local government applied coercive strategies, such as deploying the police to keep watch that people did not defecate in open spaces or cancelling citizenship cards (Nagarik card). All of these would have been prevented if systematic monitoring of implementation processes had been in place. It would also have yielded systemic data and information on the financial, labour, and material contributions by the community, government, and other actors engaged. It was only by the end of the project that a post-project evaluation was finally done (the present evaluation). As a result, there was no scope for any mid-term corrections based on the ongoing project evaluation. The evaluation which is being conducted by CLTS Foundation and Global and Citizen Development Solution seems to be the End of Project Evaluation, where there is no opportunity to incorporate corrective mechanisms for fine-tuning the focus of implementation towards attending to the objectives of the programme. For instance, in this case, whatever recommendations the evaluation team put forward can only be applied to similar such programmes in the future. There is no scope for incorporating the evaluation findings as a means of improving the efficiency and outcome of these projects – simply because the project is now over. The evaluation can only leave recommendations for a future programme, but during the life of this project there was no evaluation whatsoever for improving the efficiency any part of the programme. This deprived it of the opportunity for any changes while it was going on. Many issues which had to be amended at the end of the project could have been identified before the project finished to improve the efficiency and outcome of the project. UNICEF has implemented the project over the last five years and there was no systematic evaluation of the work done by the project.

Cost efficiency: Project Direct Investment (PDI) came to US\$ 2,210,000. In terms of cost vs output creation, the output of 580,965 people getting access to sanitation justifies the high-cost efficiency of the programme. However, the evaluation team recognizes that cost efficiency of a programme cannot be judged only on PDI, but must also take into consideration the amount of money, materials, and time invested by the communities, the government, and all the other actors engaged. The evaluation team was informed by ERG members that for building a household toilet, an approximate cost of US\$100 would need to be invested by the household, which brings the community investment to the approximate amount of (100,000 X US\$100) US\$100,000,000. It was also reported by the community that they received monetary and material donations from people and businesses, which enabled economically marginalized households to build toilets. Partial financing from the relevant government ministries, departments, and local government organizations was also in place. Better judgment on cost efficiency could have been made if the project monitoring had recorded the complete cost data and information on financial, labour, and material contributions made by the community, government, and other actors engaged. Although a better analysis on cost efficiency could have been made if the evaluation team had complete cost data and information on financial, labour, and material contributions made by the community, government, and other actors engaged, the evaluation team would like to designate the programme as high cost efficient. With the project direct investment (PDI) of US\$2,210,000, the programme is

not only credited with providing 580,965 persons access to basic sanitation but also humanitarian WASH services to a population of 383,353. Further, the PDI not only catalysed counterpart financial support by the federal government to Palikas but also catalysed the construction of hundreds of thousands of toilets by community members who invested about US\$100 per toilet.

Cost effectiveness: Unfortunately, in terms of transformation of costs and inputs into sustained outcome, the cost-effectiveness of the programme has diminished. In comparison to the situation that prevailed in the year 2019, the number of ODF communities did not increase but slipped back to OD instead (Figure 24). However, the evaluation firmly recognizes that the policy guides and MIS systems that have been developed and operationalized will have continued utility value in the long term and will thus be a value addition for the money invested.

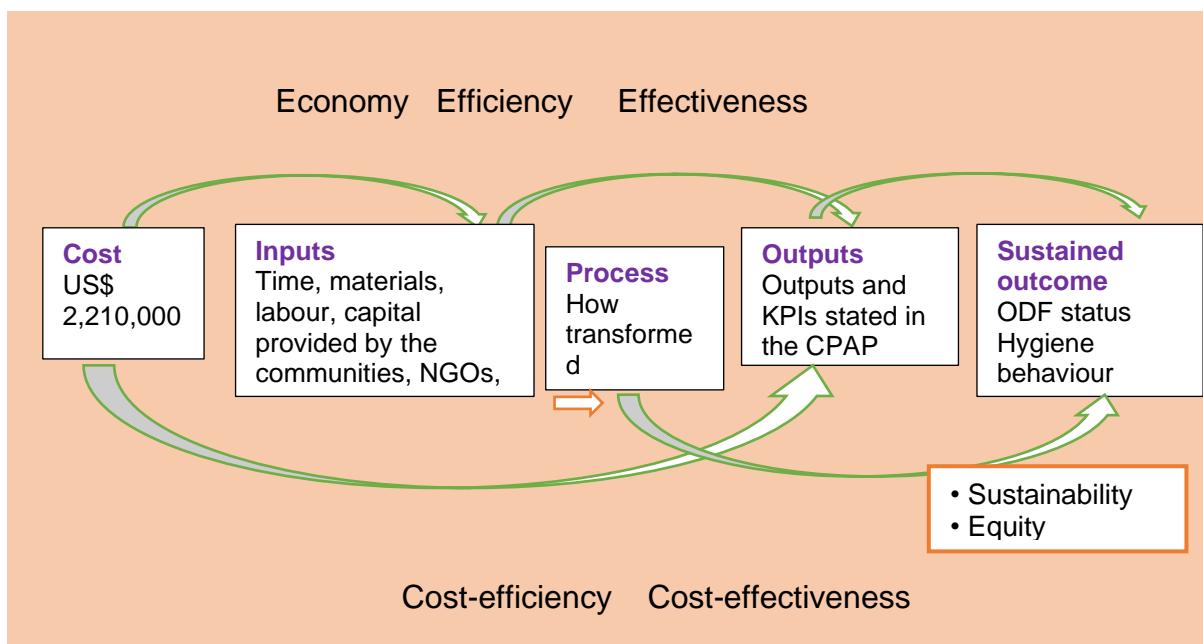


Figure 23: Cost Efficiency and Cost Effectiveness

Several factors contributed to the cost efficiency of the programme. The first – and foremost – factor was the fact that the Government of Nepal has its Sanitation and Hygiene Master Plan in place, whereby multi-stakeholders coordinate institutional structures for planning and implementation. Existence of this institutional structure at federal, province, district, municipality, and ward level helped to plan and implement the programme through targeted tasks that were quickly handled in a coordinated manner.

The second contributory factor was the positioning and involvement of the Municipal Local Government body as the leader and manager of Municipal WASH-CC. Every municipality selected and applied locally relevant appropriate implementation strategies based on their own contexts. They were able to use the same approach for mobilization and delivery of inputs from various stakeholders, including financial and material donations from businesses.

The third contributory factor was the popularization of a focused motto: ***One Household One Toilet***. This motto channelled major efforts and inputs into a one-dimensional direction and achieved fast-tracked coverage.

The fourth contributory factor was the prescribed standard for slab and pan used to build pit toilets at households. Although this factor prohibited the creation of multiple innovations and Pygmalion²⁹ effects regarding ownership, it did reduce time consumption for local innovations.

Contribute Factors for Cost Efficiency

- Multi-stakeholders coordinated institutional structure for planning and implementation
- Positioning and involvement of municipal local government body as the leader and manager of local level planning and implementation
- Popularization of a focused moto “*One Household One Toilet*”.
- Prescribed standard for slab and pan used to build pit toilets at households
- Deployment of police to prohibit open defecation and introduction of sanctions (no toilet no citizenship card). This was facilitated and enforced by the WASHCCs.
- Sustain ODF is the main criteria to select community for water safe community programme
- Fostering access to materials through sanitation marketing
- Engagement of local NGOs as implementing partner
- Direct monitoring and review of programme by UNICEF staff stationed at provinces.
- ODF was a national agenda of the Government of Nepal.

²⁹ The act of falling in love with one's own creation. The term is derived from Greek mythology, in which Pygmalion fell in love with a statue of Aphrodite that he had sculpted. In sanitation if built their own house latrine using their own knowledge technology and creativity then they build affinity with their own creation thus take better care in use and maintenance.

Though it is counterproductive to sustainability of outcomes, the fifth factor that contributed to the efficiency was the deployment of police and youth to prohibit open defecation and to help vulnerable households build toilets.

The sixth contribution to efficiency was positive conditioning, such as making sustained ODF status the main criteria for a community to eventually be eligible to get tube wells and make themselves a water-safe community.

The seventh contribution was fostering access to materials through sanitation marketing.

The eighth factor was the engagement of local NGOs and local government people as implementing partners to create community awareness accretion, implementation, and monitoring of community-level activities.

Next, the direct monitoring and review of the programme by UNICEF staff stationed at province level contributed to efficiency.

Last – but not least – the tenth contributory factor was the Government of Nepal's sincere commitment to improving the country's sanitation situation. This greatly expedited development and operationalization of relevant sector policy guides and systems.

Hindering factors to cost effectiveness: It was stated earlier that cost-effectiveness is the measure of costs and transformation of inputs into a sustainable outcome. In some cases, a contributory factor for cost-efficiency can also be a hindering factor for cost-effectiveness. The key hindering factor to cost efficiency is the unsustainability of ODF communities.

The evaluation concludes that the programme was cost efficient with regard to achieving the stated output and outcomes of the programme, but due to a slippage at previously declared ODF communities, it ultimately failed to increase ODF communities. After 2019, the number of ODF communities started declining as compared to the situation that prevailed up to 2019. This was reflected in the declining personal- and community-level hygiene practices that reduced the cost effectiveness of the programme. Data on the reduction of ODF communities has been presented in the Sustainability section.

4.4. Sustainability

The following evaluation questions have been framed to check the sustainability of the programme:

- To what extent are the targeted locations under the sanitation programme remaining ODF after implementation?
- What internal and external factors affected the sustainability of ODF status?

The following box describes the ODF criteria stated by UNICEF and the Government of Nepal:

ODF Criteria

UNICEF's Global WASH strategy emphasizes ending *open defecation*, which implies halting the incidents of depositing adult or children's faeces (directly or after being covered by a layer of earth) in the bush, open field, mountain slope, or other open areas including the disposal of the same in drainage channels, rivers, or other water bodies as well. Accordingly, the Sanitation and Hygiene Master Plan (Master Plan 2011) of the Government of Nepal describes the following indicators/criteria expected to be present in the following designated areas before declaring the area ODF:

- There is no OD in the designated area at any given time.
- All households have access to improved sanitation facilities (toilets) with every member of the family using it and being responsible for its repair and maintenance.
- All schools, institutions, and offices within the designated areas must have toilet facilities.

In addition, the following aspects should be promoted along with ODF declaration process:

- Availability of soap and a soap case for hand washing in all households.
- General environmental cleanliness, including management of animal waste, solid, and liquid waste management in the designated area.

Retention of ODF communities and location

A good percentage of villages (toles), wards, and municipalities that became ODF during the period 2018-2019 did not retain its status and returned back to the practice of OD. All in ODF declared municipalities, including three Dalit communities the evaluation team visited and intensively observed following 19 communities/ villages (toles) among which while 4 villages in Durga Bhagawati municipality are maintaining ODF status then other 15 villages failed to retain the ODF status as per the criteria stated in the national sanitation master plan. Not all households and members of these communities changed their behaviour in stopping open defecation. Some households in each village were found with no more usable pit latrine and members using open space for defecation, some households found with useable latrine but not all members using it, some households showed visible human excreta around the latrine, there were visible human excreta found in nearby jungles, road /river/canal sides, members of some households using toilets for defecation but not properly washing hands after defecation. Shared communal latrine visited in Dalit communities were not properly maintained and most members of targeted household were not using it but defecating in open spaces.

Table 12: List of intensively observed wards/villages/toles previously declared ODF

Madhesh Province	Other Provinces
<ol style="list-style-type: none"> 1. Kanchanroop; Ward 10 2. Dalit Basti; Ward 10 in Kanchanroop 3. Musahar Basti; Ward 10 in Kanchanroop 4. Ward 3; Makari Tole in Rupani 5. Parariya in Chakraghatta 6. Dalit Basti; Ward 4 in Malangawa 7. Sukumbasi Tole in Durga Bhagawati 8. Ward 10 in Durga Bhagawati 9. Pipara in Durga Bhagawati 10. Bhalohiya in Durga Bhagawati 11. Belawa Tole; Ward 1 in Bara Gadhi 12. Kachahariya Tole in Mahagadi RM 13. Bela Tole in Mahagadi RM 	<ol style="list-style-type: none"> 1. Chandanpur Community, Shivraj Municipality Kapilvastu 2. Nigale Community, Chhayanath Rara Municipality-3, Mugu 3. Chaina Community, Chhayanath Rara Municipality-2, Mugu 4. Bhuiya Ghat, Kailali District Community 5. Ghartichhap Community, Mahabharat Rural Municipality-6, Kavre 6. Khetdanda Community, Mahabharat Rural Municipality-6, Kavre

Population's access and proper use of improved latrines is one of the determinants of ODF. For data comparability and the programme's major focus with Madhesh Province as an example, it was found that while 16.5 percentage³⁰ of households were practicing OD in the year 2019, it increased to 22.7 percent (see Survey Table 1.6; Annex 4) during the period of the evaluation (May 2022); a net increase of 6.2 percent.

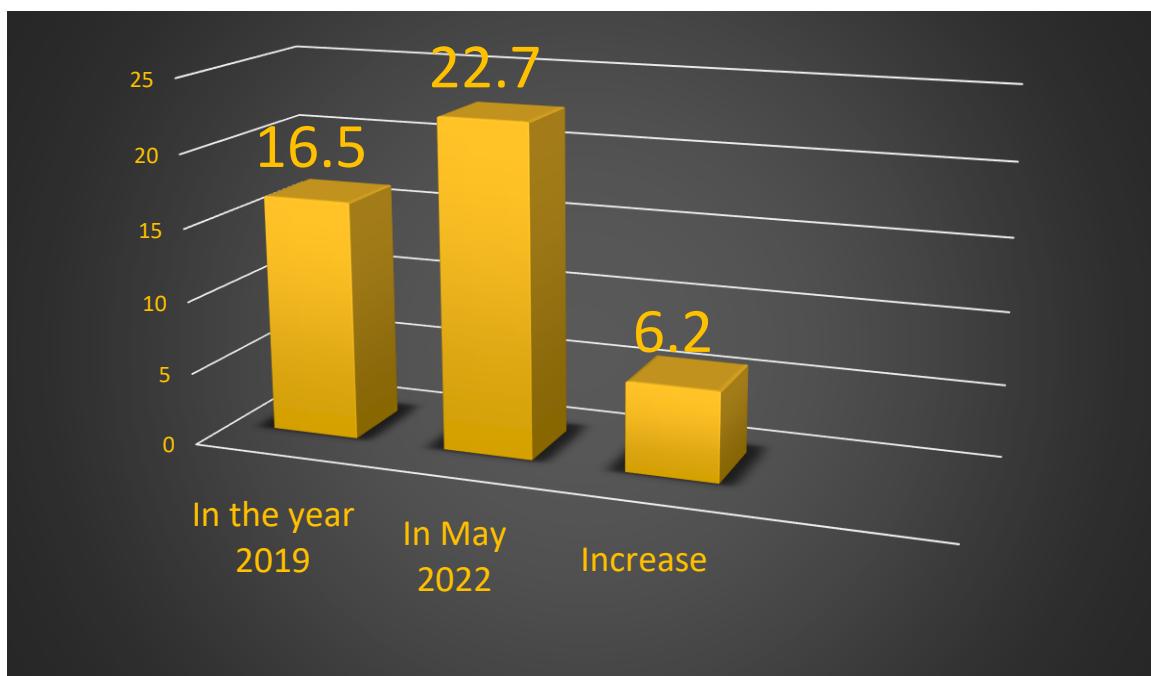


Figure 24: Increase in percent of households defecating in the open in Madhesh Province.

³⁰ Equity Tree: Percentage of household population who defecates in open, 2019. CBS/UNICEF, Nepal MICS Round six , 2019, Kathmandu Nepal

With the exception of Madhesh Province where 4 districts were covered in the household survey, just one district was covered for each of the other 4 provinces. Although a survey that covers only one district as the sample may not be representative of an entire province, findings presented in Survey Data Table 1.6 (Annex 4) show that Lumbini District in Kapilavastu Province has the highest percent (23 percent) of the population practicing OD.

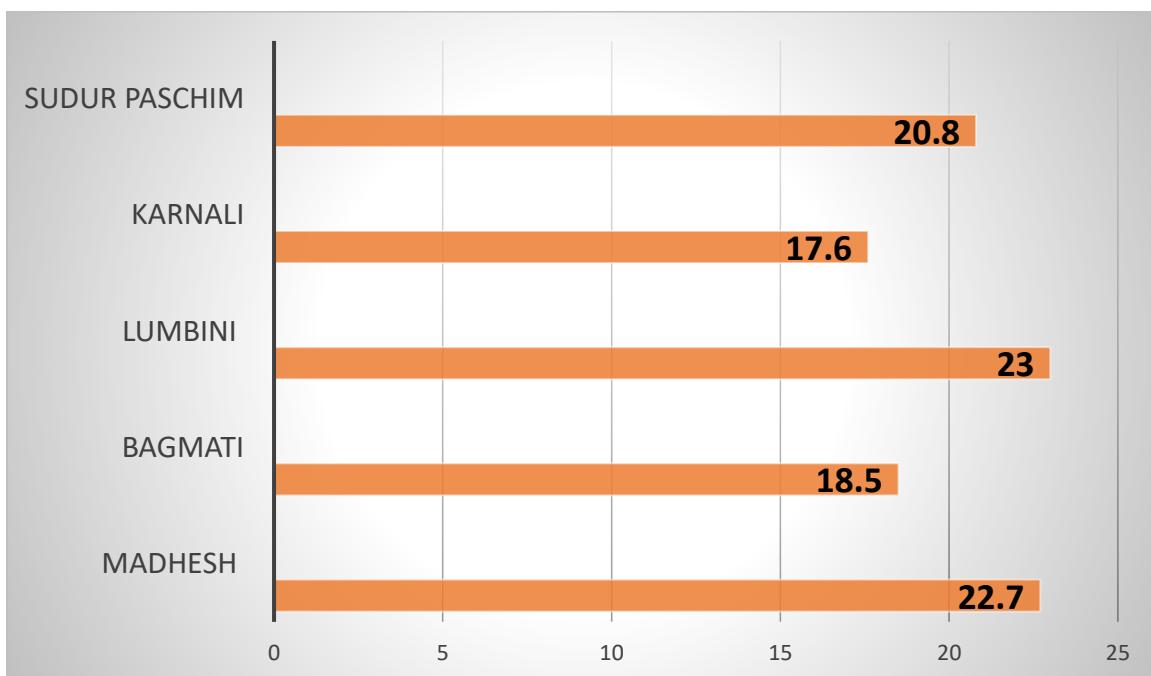


Figure 25: Province-wise percentage of population practicing OD

The increase in the percentage of population practicing open defecation triangulates with the following information table 13 Generated by the household survey.

Table 13: Percentage of population practicing open defecation

No	Indicator	Survey finding	Reference data table in Annex 4
1	Percentage of households without a latrine	21.3	3.1
2	Percentage of households (having latrine) with pit latrine already filled up	37.3	3.3
3	Percentage of households with full pit latrine and constructed a new one	14.5	3.3

4	Percent of households with non-functional/unusable latrine	21.8	3.3
5	Percent of households having toilet but still members practice OD	16.8 ³¹	4.3.
6	Percentages of children in households having latrines but practice OD	19.7	4.3

The above information triangulates by providing reasons for the 6.2 percent increase in OD practices. The table shows that 21.8 percent of households had usable latrines before³² but by the time of the evaluation they have become non-functional/unusable. Members of these households have returned to OD practices, though about 35 percent of these household members reported using a neighbour's or relative's latrine (Survey Data Table 4.6; Annex 4).

Access and use of a latrine is one of the key determinants for ODF but not the only ones. Another determinant of ODF is the proper maintenance of required facilities and hygiene practices. The following information table generated through the survey convey that a certain percentage of households/populations are neglecting to comply with other supportive ODF criteria.

Table 14: Percentage of households neglecting to comply with other supportive ODF criteria

No	Indicator	Survey finding	Reference data table in Annex 4
1	Percentage of households with latrine but it is rarely clean	36.8	4.1
2	Percentage of households (with latrine) using unimproved latrine	22	3.2 & 5.5
3	Percentage of household latrines having human faeces visible on the floor or slab of the latrine	24.1	5.1
4	Percent of household (having toilet) don't have handwashing place inside or just outside/near (within 5 feet) the latrine	19.3	5.2

³¹ ASWA-II projects end line survey (August 2022) inform 2.1 percent.

³² Survey finds 51.5 percent household toilet was built before 2018

5	Percent of toilets have no handwashing facilities with accessible water and soap.	33	5.2
6	Percent of toilet of the household having physically disable member is not accessible for the disabled member	69.4	5.3

The evaluation team understands even having the same percent of population doing OD practices number of OD and ODF villages/ communities/ clusters may vary between two areas/ wards or municipalities.

Why does the number of OD and ODF communities tend to vary despite having the same percentage of the population practicing OD between two wards?

Ward X	Ward Y
Comprised of 10 toles/villages. Each village has the same number of households. In 5 toles/villages all the households defecate in the open. In the other 5 villages, however, all of the households not only use improved toilets but also comply with all ODF criteria. Although 50% of the population in this ward practices OD but 5 communities are ODF.	Comprised of 10 toles/villages. Each village has the same number of households. In each of the villages, 50 percent of the households practice OD and 50 percent are ODF. 50% of the population in this ward practices OD and none of the communities are ODF.

Referencing the MICS 2019 **Equity Decision Tree** and other documents, the evaluation team were able to collect comparable data on the percentage of households/population practicing OD. However, they could not access the percent of clusters / villages / wards that were ODF before the inception of the project.

As stated previously, the evaluation team visited and intensively observed 19 communities in eight sample districts (all in ODF-declared municipalities) and eight schools (all in Madhesh Province). The evaluation team conducted FGDs, visited toilet and hand washing facilities, led transect walks in bushes, gardens, roadsides, riversides, and canal sides, and observed that except for 4 communities in the Durga Bhawati Municipality of Rautahat District, all other 15 communities had failed to retain their ODF status.

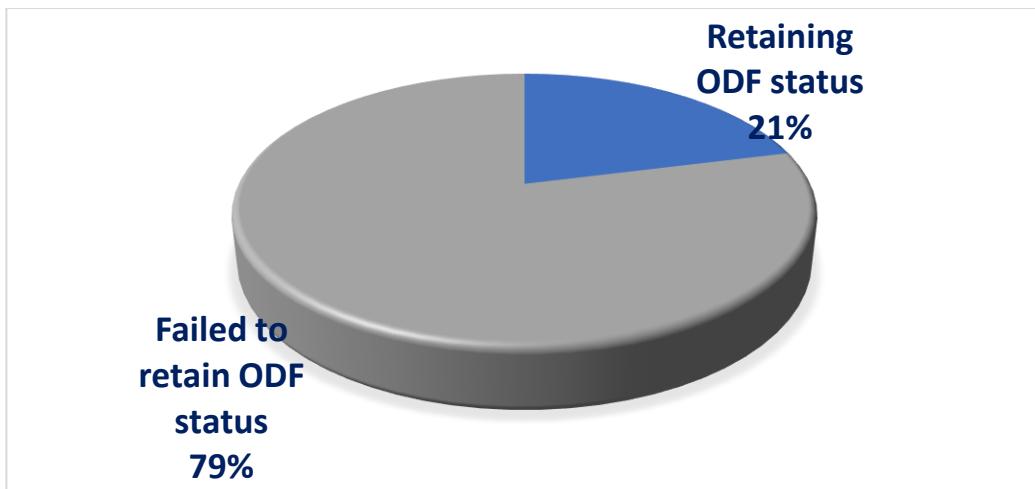


Figure 26: Percent of OD and ODF communities (toles/villages) from the intensive and direct observation of 19 communities

The evaluation team observed open defecation spots, where human excreta was visible, in ODF-declared wards and municipalities. In some municipalities (e.g., Malangwa) communal toilets constructed for Dalits were not adequate nor was there any regular maintenance being done. Construction of most toilets was incomplete and there were no doors. Toilets became filthy and unusable very soon. In such cases, people opted to return to the practice of OD. The practice of OD triangulates with the household survey finding which shows that 64.1 percent of children under the age of 5 were suffering from diarrhoea for the last 15 days from the date of the data collection (Survey data table 2.2: Annex 4), very high in comparison with national data provided by NDHS-2016 and MICS 2019 which is 8 percent and 10 percent respectively. Nonetheless, the household survey findings (table 3.1 in annex 4) inform 22.3 percent household do not have latrines.



Open defecation site in an ODF-declared municipality.

All of the 8 schools in Madhesh Province (4 primary and 4 secondary) were randomly visited. With the exception of one primary school that had received UNICEF support to construct WASH facilities, the sanitation situation in the rest of the other 7 schools was observed to be pathetic. Sanitation facilities created in the schools were not maintained and were totally unusable. Toilet pans were broken and filled with faeces, floors were wet and dirty. Facilities for hand washing with soap and/or potable drinking water were lacking on the school campus. Any tole/village /ward having a school with this kind of pathetic sanitation situation cannot be considered ODF. In order to be considered as an ODF community/ward, all schools in the community or ward must also have proper sanitation situation supportive to be ODF. The evaluation team does, however, recognize that most of the schools visited were being opened after a long closure and this may have been the cause for these negative effects on the overall sanitation situation.

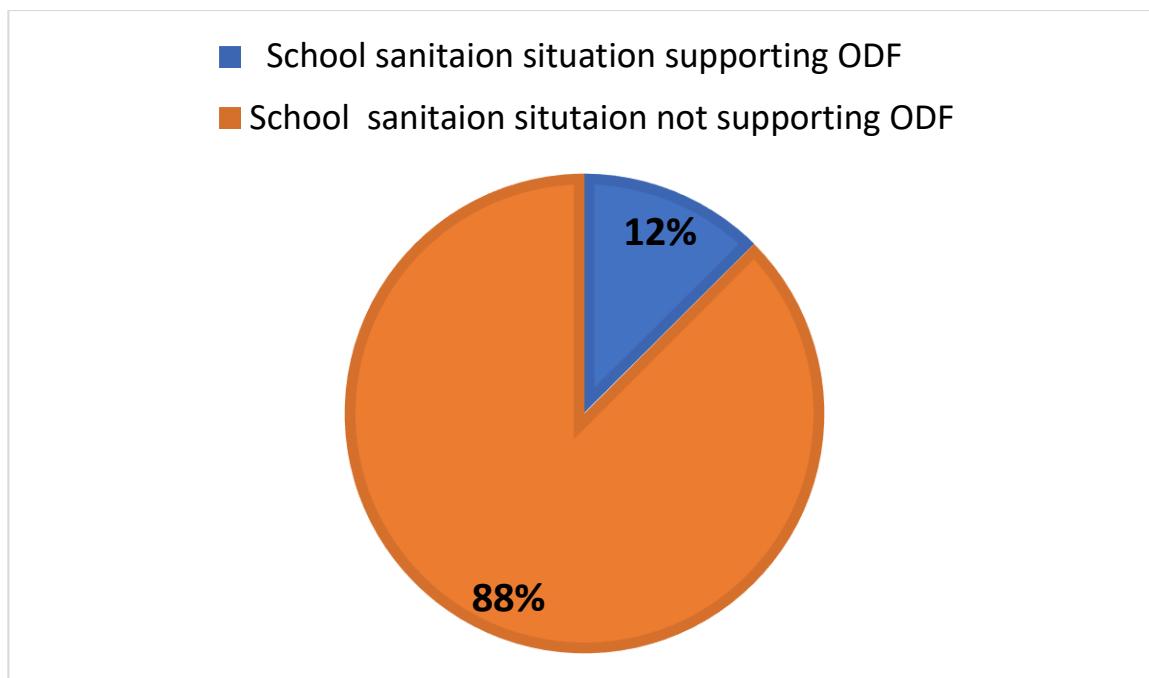


Figure 27: Percent of schools from the 8 randomly visited schools supporting and not supporting ODF status of the community



Toilets at the Saraswati Secondary School in Pipara, Rautahat were not operational over the last two years where the students were compelled to go out into the field to relieve themselves, including open defecation. There were no facilities for hand washing with soap or potable drinking water on the school campus which had 2,500 students.



Plight of sanitation facilities created in the school (visited)

The programme conducted *WASH in Schools* training for teachers and facilitators, and MHM was one segment of the content. While municipal offices distributed sanitary pads free of cost to adolescent girls in all the senior classes free there was no room where they could change the sanitary pads in private. The girls often threw the used sanitary pads outside the window, where they accumulated behind the wall and were burnt openly. As there was no specific changing room in the school, most girls found it very difficult to manage the inconveniences they faced during their menstrual period. It was reported that they had to go to the bush or hide somewhere to change their sanitary pads. Although there was an incinerator found in one of the schools visited, it was non-functional. Through FGD with municipal WASH-CCs, the evaluation team came to know that the procedure for sanitary pad distribution and its management holds the respective local government responsible for making sanitary pads available to the girls. Funding for this comes from the federal government.

Sanitation facilities in the district and municipal offices and institutions were even worse. The evaluation team visited more than 25 toilets in local and district government institutions however, they found that not a single toilet was usable and all were unsafe and unhygienic. There was also no soap or detergent solutions for washing hands.



The picture above shows the plight of toilets in Mahagadimai Municipality, beyond use by any humans. Although sanitation facilities were established, there was no regular maintenance. When this is the deplorable state of standard municipal toilets it is meaningless for that same municipality to be spreading messages of safe sanitation, hygiene behavior, and safe toilet maintenance to its citizens. This municipality was declared Open Defecation Free two years ago.

For the prevention of COVID -19, hand washing facilities were installed at local municipal offices but were no longer in use at the time of the visit.



Non-functional hand washing facilities seen on a visit to a municipal office.

Factors affecting the sustainability of ODF status:

With regards to sustainability, the programme has contributed to making Palika WASH-CCs active and functional by initiating Palika-based planning and implementation systems. Although financing by the federal government is not sufficient for the continuation of proper implementation of Palika's plans for sanitation, the federal government has provided funding directly toward intensifying the sanitation social movement and making Palika areas ODF. The available five frameworks and tools of the WASH sustainability assessment ***International Water and Sanitation Centre*** (IWSC)³³ states that there are five factors for sustainability: 1) financial; 2) institutional; 3) environmental; 4) technical; and 5) social. The evaluation team holds the view that most of the existing assessment frameworks have left out one important factor, which is the *relationship between the outcome and the process*, including the mechanism of sustaining ODF status. Sustainability of ODF status cannot be seen as a one-time static achievement marker. It must be a continuous process of collective action undertaken by the local communities and institutions located in the communities long after the program has ended. Nonetheless, the process of continuous action in order to sustain ODF status is supported when people realize the good impact it has on their life.



Figure 28: Process Dynamics in ODF Sustainability

³³ Mapping sustainability assessment tools to support sustainable water and sanitation service delivery (2013) International Water and Sanitation Centre

It was earlier stated that a major percent of villages and wards became ODF during the period 2018-2019 but they were unable to sustain that ODF status. The following internal and external factors affected the retention of ODF status:

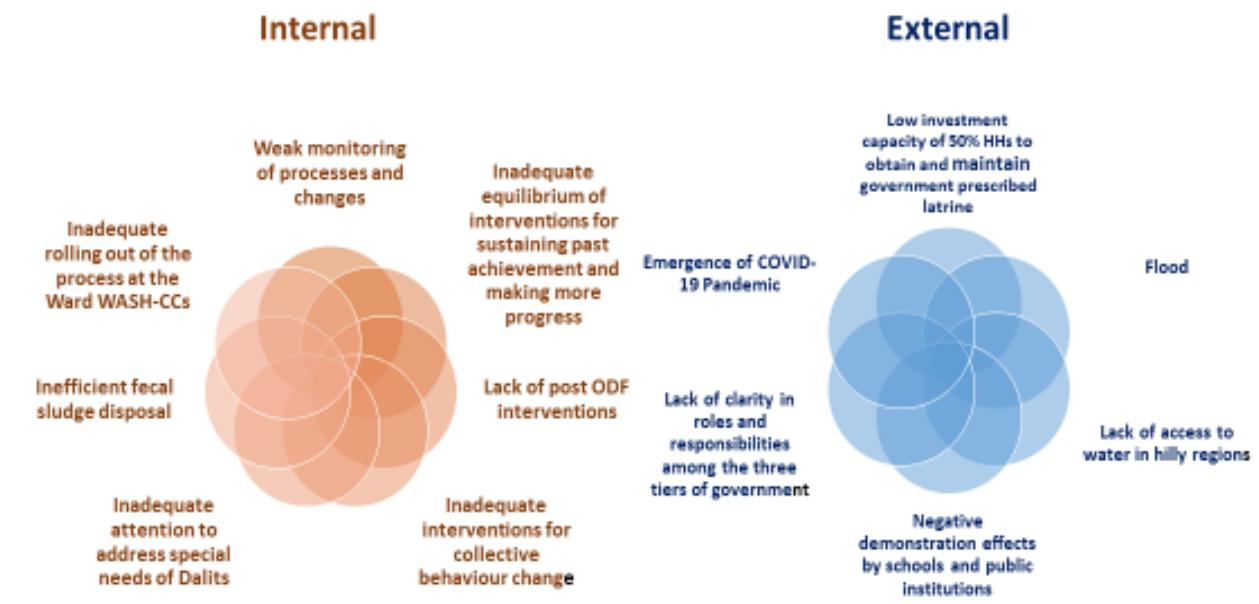


Figure 29: Factors affecting retention of ODF status

Internal factors

Weak monitoring of processes and changes: Sustainability of ODF depends on the way it has been achieved. Application of appropriate tools and processes that make communities realize on an emotional level that becoming ODF and sustaining it, benefits everyone greatly in terms of health, dignity, livelihood, economy, education, and peace. This makes the sustainability potential high. This is where the crucial role of process monitoring comes in to ensure application of the appropriate tools and right processes through which community members realize and take collective self-help actions. As FGDs interacted with community members and Municipal and District WASH-CCs, the evaluation team learned that in most cases triggering and post-triggering follow-up had not been done using the participatory tools and processes. As stated earlier, some municipalities jumped the gun and declared ODF too soon while some municipalities used their own resources to provide subsidies but were not concerned about following the 'do no harm' principles in the course of making the communities ODF. The internal monitoring system of this programme was weak, and thereby could not ensure application of the proper processes for achieving ODF status. Further, internal programme monitoring of changes for the output being created and continuous information feeds to management are also crucial to taking the relevant measures for sustaining ODF. Many household pit latrines constructed before 2018 are becoming full and therefore unusable. The household survey finds that among the portion of households (37.3 percent) whose pit latrine is already filled, the highest

percentage of completely filled latrines was in Mahesh Province in the Terai region, at 66.8 percent (see Figure 30). If an effective internal programme monitoring system had been put in place this change would have immediately been captured and the issue could have been discussed so that relevant measures could have been undertaken.

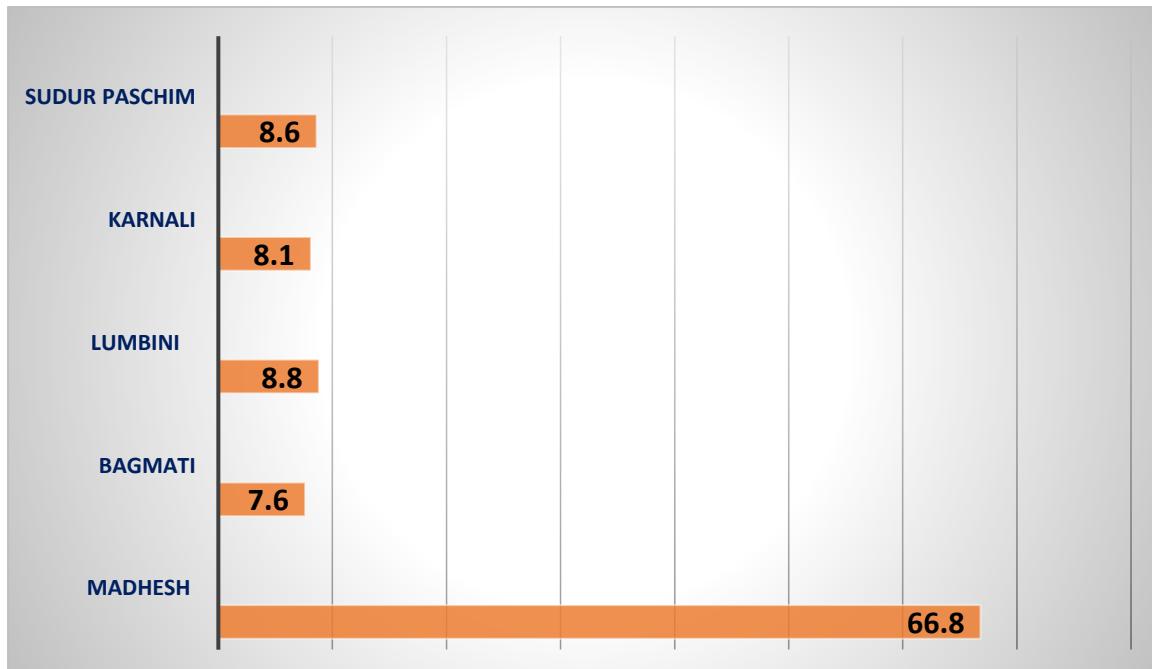


Figure 30: Distribution of filled-in household pit latrines by province shown in percentage

Inadequate intervention equilibrium toward sustaining past achievements and progressing further: Sustaining ODF status demands the application of simultaneous interventions for both sustaining the past achievement and progressing even further onward. This means that besides the delivery of any intervention aiming to extend coverage and access to improved sanitation facilities and services, equal emphasis must be given to delivering interventions that will contribute to sustaining the coverage that has already been achieved and additional progress. These kinds of interventions may include:

- Strengthening Ward WASH-CCs in planning and review; integrating sustainability of already achieved improved sanitation facilities and services.
- Participatory benefit-sharing exercise of having improved sanitation facilities in households, schools, and other public institutions.
- Participatory impact assessment of being ODF.
- Community-based assessment and follow-up of sanitation resource, facilities and services.
- Horizontal sharing of good practices through planned excursions and exchange visits.

Most interventions of the programme were geared towards extending new sanitation facilities and services in households, schools, and health care facilities. Due to a lack of intervention for facilitating and encouraging communities and institutions to maintain

the facilities and services they had already created upright, a certain percentage of households ended up returning to OD practices.

Lack of post-ODF interventions: Sustaining ODF status demands deliberate intervention strategies such as: the formation of a sanitation committee, the building of linkages between relevant stakeholders, support mobilization, marketing facilitating, a participatory sanitation technology development, community-led sanitation marketing, community-led sanitation, disaster-risk reduction, and the promotion of community-based livelihoods and primary health care. The revised KPI of the programme did not include any explicit output or performance indicator on the retention of ODF status for toles, wards, municipalities or districts. A project or programme plan is a logical frame of the means-end relationship. As the programme did not include any explicit KPI for measuring ODF status, it was unable to define and apply intervention strategies³⁴ for ODF sustainability.

Inadequate interventions for collective behaviour change: Although adequate interventions ensure collective behaviour change is the essential element of ODF sustainability, the “One household, one toilet with permanent structure” approach for fast tracking access to sanitation facilities consumed most inputs and efforts for building hardware facilities. As a result, little input and energy were left to strengthen local community participation and sustainable behaviour change.

Inadequate attention to address the special needs of Dalits: Although Nepal’s Census 2021 is yet to provide very detailed data, some documents state that the figure for the Dalit population in Nepal is more than 20% of the country’s population³⁵. For generations Dalits have been treated as untouchable and thus discriminated against and excluded from many spheres of social life. Although the Constitution and laws of Nepal abolished untouchability and other forms of caste-based and cultural discrimination it continues as a deep-rooted tradition even today. Dalits suffer from discrimination and disadvantages across all spheres, including social, cultural, political, economic, and religious aspects of life. They are often denied their basic human rights. Being Dalit is a condition characterized by caste-based discrimination in socio-cultural and economic spheres. Because the society places them in a lower position of society, they have been subject to all kinds of exploitation and intimidation by upper caste categories³⁶. Most Dalits and lower caste households do not have their own land on which to construct a decent house and latrine. Furthermore, Dalit children are commonly exposed to negligence and are ridiculed. As a result, they often drop out of schools and discontinue their education. UNICEF Nepal has stated (<https://www.unicef.org/nepal/education>) that there has been inequity in the education sector as only 12 percent of children from the lowest wealth quintile were developmentally on track in literacy and numeracy as compared to 65 percent from the highest wealth quintile. Thus, children of these communities do not get much from school sanitation. Although sustaining ODF status for the Dalit population requires different needs, no specific intervention strategy was targeted to address these special needs for this marginalized population.

Inefficient faecal sludge disposal: A community, ward, or a municipality cannot sustain its ODF status if untreated faecal sludge is disposed of in the open

³⁴Such as post ODF follow-up, organizational development of sanitation committee, facilitating community based PMEL systems for moving up to sanitation ladder, linkage building of sanitation committee with relevant stakeholders for support mobilization, facilitating Participatory Sanitation technology Development and Community Led Sani Marketing , Community-led Sanitation Disaster Risk Reduction, Linking community based approach to livelihood promotion and primary health care.

³⁵ Sob. D. (2012): THE SITUATION OF DALITS IN NEPAL: Prospects in a new Political Reality. Voice of Dalit, Vol 5, No 1 2012.

³⁶ Upreti, B. C. (2010). DALITS IN NEPAL- Quest for Status and Role. Voice of Dalit Vol. 3, No 1 2010.

environment after being collected from HHs latrine pits. Such inappropriate practices of sludge disposal directly and indirectly jeopardize ODF status for the whole neighbourhood, village, or town. The evaluation found there is no uniform policy to guide households in safe disposal and management of sludge. In some municipalities private groups empty sludge and charge 500 NPR per ring for a pit latrine. The perception of those in economically marginalized households is that having a pit latrine brings an extra financial burden and it is thus better to stick to practicing OD. Different municipalities have taken on different policies and hold different ideas about how to empty household latrines. While one municipality would like to give this service to households free of cost, another has decided to charge money for the service.

Inadequate rolling out of the process at the Ward WASH-CCs after federalization and addressing the legacy of WASH CC has become weak: In most of the municipalities visited in focused districts the Ward-CCs were not active. However, the evaluation team found that in one district (Rautahat), the local NGO partner had facilitated both male and female WASH committees at the ward and tole level in order to monitor and review sanitation-related activities and local actions. As a result, much better performance and eventually ODF status was maintained. This puts across the message that ODF sustainability is directly linked to the presence of functional ward- and tole-level community organizations.

How ODF communities in Druga Bhawani Municipality Retained ODF Status

In Durga Bhawati Municipality of Rautahat district both male and female sanitation committees were formed in wards to help assess, plan, and review sustainability of ODF status and to address any issues which emerged. These sanitation committees mobilized local sources to support vulnerable households to maintain their latrines properly. It is important to note active presence of women committee members who raised their voice to address any issues specific to women and sanitation. Functional male and female ward sanitation committees are systematically connected with the municipal WASH-CC. The municipal WASH-CC then consulted with all these committees and included their suggestions in the development of the Municipal WASH Plan. Durga Bhawati Municipal Government not only covered 50 percent of the budget for the Municipal WASH plan but also provided pit desludging services. Dalits and other vulnerable communities received a special focus and attention for inclusion of their views in the plan. The sanitation programme continued enhancing confidence of the stakeholders on different levels. As Ward WASH-CCs were facilitated, the evaluation found all four of the villages that were visited successfully retained their ODF status.

Inadequate inputs for capacity development: The evaluation put forward that the programme had inadequate input to develop the capacity of ward, municipal, and district WASH-CCs with which the organizations could facilitate and manage the programme in a sustainable manner.

External factors

Low investment capacity of 50% HHs to obtain and maintain government prescribed latrine: The household survey findings revealed that the average expenditure in about 50% of the households was greater than their average monthly income (Survey Data Table 1.4; Annex 4). This population included Dalits and other lower caste people. It was difficult for this category of households to invest, construct, and maintain government-specified models of pit latrines or to properly follow the recommended hygiene practices. The survey data presented below shows that money and material crisis were some of the major reasons for not owning or maintaining latrines properly.

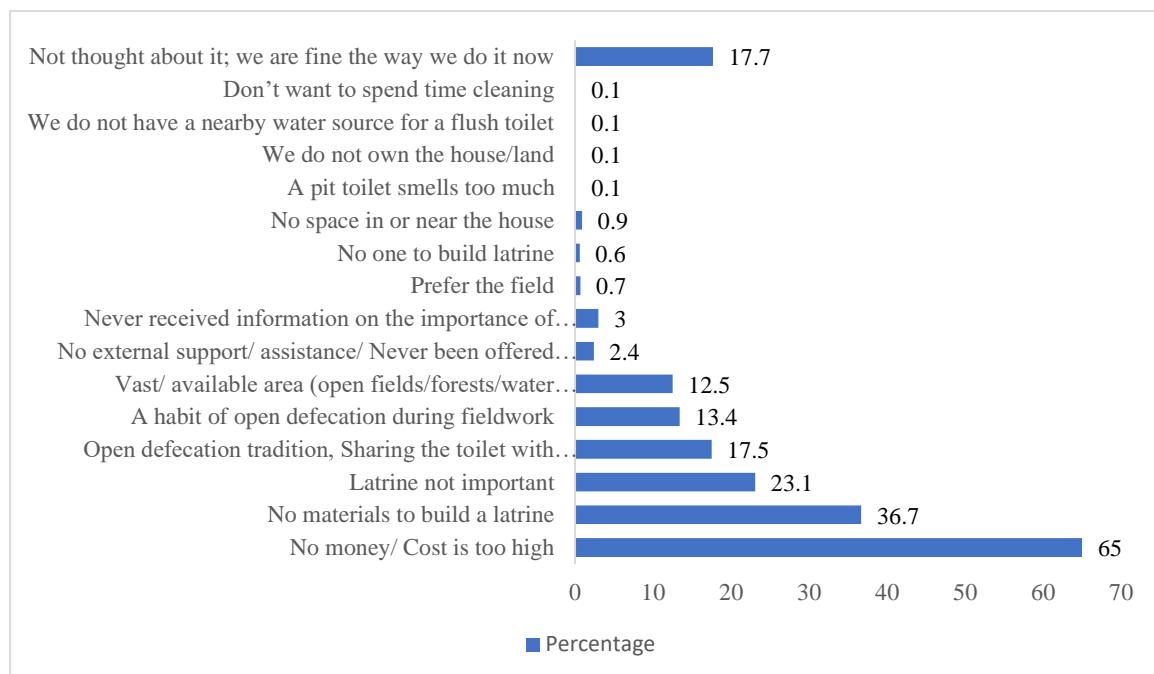


Figure 31: Reasons for not having a household latrine (N=537)

Floods: The household survey findings reveal that 12 % of household latrines were affected by floods (Survey Data Table 3.6; Annex 4). This also adversely affected the population with regard to retaining its ODF status. The evaluation team got an opportunity to validate this survey finding while conducting FGD in a community of Rajdevi Municipality in Rautahat District. Some households of this community are settled in low lying areas and inundated by flood water caused by heavy rainfall which caused pit latrines to collapse. Due to active initiatives of Ward WASH-CC, the households repaired the latrine but did not raise the floor plinth above the flood water level. The programme had inadequate intervention strategies to enable the population to consider flood risk beforehand and build flood resilient latrines.

Lack of access to water in hilly regions: While the population in the Terai Region, which is in the plains, has fairly easy access to water through the installation of tube wells, this is not possible for the hilly regions. A water-sealed pit latrine requires a good volume of water to push excreta through the pit. Fetching water from the river or natural spring is also very hard for the households settled in hilly areas. Difficulties in access to water in hilly areas is also a challenge for sustaining ODF status.

Negative demonstration effects by schools and public institutions: Schools, municipal, and district government offices played the role of change makers in the sanitation social movement. Unfortunately, they themselves could not improve sanitation facilities in schools and institutions, most of which were not functional or well maintained. This unhygienic sanitation situation in institutions and organizations failed to convey any motivational input to the committees on the dire need of sustaining ODF status.

Lack of clarity in roles and responsibilities among the three tiers of government: The master plan suggested systematic joint planning, implementation, and review by VDCs (now ward), municipalities, and districts. However, due to federal transition and lack of clarity about roles and responsibilities among the three tiers of government, the programme did not apply strategies and interventions to link district and municipal WASH-CCs. This reduced the scope of institutionalizing the sustainable process of maintaining ODF status. As stated earlier, after federalization the legacy of WASH-CCs was not addressed and thus, all the district-WASH-CCs that were visited have become inactive. Although under the direct support of the UNICEF programme, targeted municipal WASH-CCs prepared their plan, this did not materialize in non-focused district.

Emergence of COVID-19 pandemic: For a period of about 24 months the programme had to redirect most of its efforts and energies to provide an emergency WASH response for preventing the spread of COVID-19. During this whole period, it was impossible for the programme to conduct in-person meetings at any tier, on-spot follow-ups, or mobilization activities. Further, COVID-19 adversely impacted the livelihood and income of marginalized and disadvantaged groups of the population. All of these factors adversely affected ODF sustainability.

It is clear from the analysis of the sanitation profile for intervention areas that ODF status had been achieved earlier but could not be sustained. Due to several constraints such as access, proper usage, maintenance of facilities, and sustained improved hygiene practices, a significant proportion of the population returned to the practice of OD. Thus, the number of communities that had earlier achieved ODF status declined.

The key factor affecting the sustainability of ODF status is the lack of self-mobilized community participation (Self-mobilisation: People participate by taking initiative independent of external institution to change systems. They develop contacts with external institutions for resources and technical advice they need but retain control over how resources are used. Such self-initiated mobilization and collective action may or may not challenge existing inequitable distribution of wealth and power). Although, community participation is a word used widely for different types and forms of participation, true or genuine participation is different from the lighter forms of participation. Participation could be as ordinary as: see annex 5.

In a genuine or true participation, outsiders do not mobilize or rigorously convince the recipient community (often referred to as beneficiaries) to participate in an outsider driven project. On the contrary, the insiders solely decide whether to participate in a project based on the suitability on their needs and requirements

4.5. Gender

In order to learn how gender has been mainstreamed in the municipal level sanitation programme the evaluation team conducted in-depth consultations with the Municipal WASH-CCs, local NGO partners, male and female groups at wards, teachers, and male and female students at schools. The findings are as follows:

Gender assessment and analysis: The evaluation found that in most cases WASH-CCs conducted informal consultations with both male and female members of the wards/toles to gather ideas and opinions on the felt need for improved sanitation situation in the municipality. For understanding the felt needs at schools and health centers, WASH-CCs did not facilitate any structured consultation but listened to the staff from the education and health engaged as members of the WASH-CC. However, the main gap of the consultation was the lack of focus in trying to understand issues around inequality reasons behind it.

None of the municipal WASH-CCs visited had prepared a socioeconomic profile that gave focus to gender gaps and disparities of the target population. No member of municipal WASH-CCs could share info or give reference to any document that would inform us how many households were headed by males, females, or children.

“While spread of HH toilets exempted us (women) to hold pressure until the daylight goes off, reduced risk of being abused and harassed when defecating open then cleaning and maintenance of toilet, maintaining personal and family level hygiene practices. Frequent hand washing created lots of additional work-load for us. Our male in home “do this and that” but they do not share any work for cleaning children, cleaning toilets and fetching water, or sweeping courtyard.”

- a female member of
Durga Bhawati Municipal WASH-CC

The evaluation suggests that gender assessment and analysis is the first and most important step in identifying gender inequality issues in sanitation as well as determining appropriate interventions to be integrated in the programme plan. Although a consultation was conducted with women and girls on their sanitation needs, the programme did not facilitate WASH-CCs to do systematic gender assessment and analysis. A systematic wellbeing grouping would certainly unpack the facts embedded in the bottom of society. There are issues related to higher and lower caste, landless and marginal farmers, landless living on somebody else's land as tenant or bonded labour/ landowner's mercy. The rules of tenancy/occupation are heavily tilted towards the landowner where the norm of occupancy is determined by the landowner and not by the tenant/occupant allowed to live on mercy. Despite all the social harassment faced by women they have so many other issues to deal with so this becomes a gender compromise for women and children. For example, a landless person has no other option but to defecate on somebody else's agricultural land because he or she has no land to construct a pit latrine even though he/she wants to. In such cases Common Property Resources or local government land, bushes, embankment of rivers and roadsides are used as defecation ground. Often there are unwritten norms set and followed by all those who practice of OD. For example: left side of the road is used by women and the right side is for children.

In the context of Nepal, irrespective of caste and wellbeing categories, any work related to cleanliness in the home is generally the role of women. The programme design lacked interventions to develop new norms, values, and attitudes, changing unjust gender division of labour, develop women's and girls' leadership skills to promote gender equality in sanitation and MHM.

In terms of participation and addressing the felt needs, the programme design did not include deliberate interventions for those who identify as LGBTQIA. Similarly, the Municipal WASH plan has inadequate perspectives and intervention strategies for challenging discrimination that happens as a result of a gender-based power structure between women and men, girls and boys. The programme seems to be mainly designed to improve the conditions by which women and girls can access and practice improved sanitation and hygiene protocols.

Gender in programme implementation, monitoring and evaluation: Despite the lack of systematic gender mainstreaming into the programme cycle, the evaluation finds one of the main strengths of the programme is the active participation of women and girls in promoting improved sanitation and hygiene services in their communities. As one input included addressing the special needs of women, they were consulted before developing the Municipal WASH Plan. Formation and facilitation of women's sanitation groups was one the vital strengths of the programme. Further women triggers, school teachers, and women cooperative members were mobilized to respond to COVID-19. As for weaknesses, women's participation in municipal WASH-CCs is weak. Lack of participation by PWDs, those who identify as LGBTQIA, and seniors was also found to be a weakness. Sanitation facilities created at households and institutions were less responsive to the needs of the elderly, PWD, and LGBTQIA community members. The physical toilet facilities built in schools do not provide adequate privacy provisions for girls so they can tend to their sanitary needs, including MHM. Assessments, monitoring, evaluations and learning processes were not in place for gender and vulnerable group disaggregation. At the municipal level there were no indicators for monitoring Gender Equality and Social Inclusion (GESI) under the M&E system. These were yet to be developed and included in the WASH plan. However, despite lack of systematic gender mainstreaming into the programming cycle, the evaluation found active participation of women and girls in promoting improved sanitation and hygiene services in their communities – this was one of the main strengths.

5. Conclusions and Lessons Learned

Nepal was declared an ODF country in 2019. After two years, as seen during the evaluation, all eight districts where many municipalities had earlier achieved ODF status are now slipping back into the practice of OD. The key lesson the evaluation uncovered is that “an external agency-led social movement coupled with “free or subsidised sanitation hardware/infrastructure-centered approach” to establishing ODF can be successful for the time being, but it may not sustain the necessary collective behavioural change among local communities so that they stay away from the practice of open defecation forever. There are many instances all over the world where sanitation infrastructure created by external agencies remained unused or was used for a different purpose than what it was built for. The intervention areas were no exception to this.



Unused toilets in Sarlahi district

For many reasons, as explained, sustaining the improved hygiene behaviour change among members of the community depends on prevailing conditions, including the wellbeing of the entire community. Inability to cope with time and moving along the sanitation ladder which needs individual investment or support from the government/external agencies is not always accessed by poor families living in remote areas. It appears that it would be extremely difficult to achieve ODF status without empowering the communities in collective action-reflection, along with taking action to improve their sanitation status within their communities. This requires a shift in the role of WASH-CC's from implementer to facilitator, working to empower communities to improve their sanitation and realize the right to live in an ODF environment. In relation to the socio-cultural and institutional context of Nepal, the evaluation presents the

following strategic lessons: consideration of what could make the sanitation programme more effective in creating a sustainable ODF outcome.

Creation of a sustainable sanitation outcome equals emphasis on creating a social movement around sanitation and community empowerment: The Sanitation Social Movement (as applied in Nepal) is a powerful approach to fast-track safe sanitation coverage and population's access to sanitation services. But if the movement is not focused on empowering communities to take care of their own sanitation problems and solve them, it may not guarantee a sustained behaviour change, this was proved again and again in different locations/ ODF communities visited by the evaluation team members though they were not truly within the intervention area. For instance, monitoring the retention of ODF status from outside would not be possible unless the local community decides to do it on their own. This is self-mobilization as explained earlier. For collective behavior change and its sustainability the social movement must have strategies and interventions for local community empowerment. Disadvantaged groups of population in Nepal especially the lower castes reported several socio-cultural, economic and landownership issues in improving their sanitation situation and realizing their rights to sanitation. Resolving these issues will not get proper attention by the relevant government and other duty bearers if they are not empowered to raise their united voice to demand services. Be it a village, community, or school students and teachers or patients of health care facilities without empowerment of these primary stakeholder in demanding appropriate sanitation services from the relevant duty bearers won't make sanitation social moment approach effective enough to have improved and sustainable sanitation outcome. The evaluation put forward a lesson that if the final goal is to promote collective behavior change and its sustainability then a sanitation programme should have equity of intervention strategies that not only enable responsible organizations/duty bearers (relevant departments, WASH-CCs, NGOs) to perform their roles but also to empower community to claim their rights and duties Even if the national or regional policy of the government is totally focused on community empowerment with clearly laid down and written sanitation policy, it may not yield a satisfactory outcome at the community level unless the implementing missionary is trained, exposed, and geared up for performing the same job in a different mode particularly with no subsidy bottom-up participation. A sudden shift from top down, subsidized/ free sanitary hardware focused approach to no subsidy bottom-up approach with full community participation demands massive input on training, capacity building and awareness creation of the implementing missionary at the ground level.

Behavior Change Communication (BCC) strategy must encompass emotional domain of learning; focusing sanitation as Public Good: The survey findings convey that about 85 percent adult members of the communities are aware about bad consequences of OD and good effects of the practice of improved hygiene behaviour. Despite of this awareness many of them are returning to the practice of OD. One of the main reasons being the temporary nature of low-cost latrines build by the poor, very poor and landless during the campaign. However, in course of time these homemade pit latrines soon get filled in with sludge; start collapsing after a few months and years as they were unable to move up along the sanitation ladder in terms of improving the substructure of the toilet, adoption of pro poor improved technology etc. (for example: from homemade pit latrine with ring and slabs, from direct pit latrine to

off-set pit latrine, septic tank, pour flush with septic tank or connecting the toilet with the central sewerage system etc.) the reasons were many. A. Landless and marginal members of the community were allowed by the landlords to construct temporary toilets only and stop the practice of OD. They were not allowed to make any permanent construction with brick, cements etc. in order to avoid any future claim of the land by the user. B. the tenants or temporary/seasonal occupants of the land were not always interested to invest in constructing a permanent toilet on someone else's land. Community awareness raising thoughts and dissemination of messages alone is not enough to change/sustain sanitation and hygiene behaviour without changes in affective/emotional domain of awareness as well as creating supportive conditions to apply their awareness. As seen in many countries the trend of traditional self-help practices of supporting each other to achieve a central goal in this context is an ODF environment which is strengthen by Parma. Parma is the term used for self-help (helping each other in the neighbourhood) for achieving a cross cutting central goal of no open defecation focused towards attaining an outcome focused public health. No matter whether a family has a toilet or not, he/she is not out of danger unless everyone in the community stops the practice of open defecation totally. The chain of faecal oral contamination through different means cannot be eliminated unless the entire village environment is free from open human excreta. If everyone lived in an ODF environment the faecal oral contamination from open defecation and poor hygiene practices comes to an end. This would simply have a significant effect on the clean village environment (no stinks, less flies, visually clean) and a positive health outcome on reduced incidences of diarrhoea and diarrheal diseases, under nutrition, stunting, malnutrition and reduced number of diarrheal patients in the hospitals and health centers³⁷.

Inclusive and equitable sanitation demands for a caste and other vulnerable/ excluded groups (PWDs, older persons, LGBTQIAs) disaggregated strategies: In many parts of Nepal particularly in rural parts of the area the socio-cultural gap between the higher and lower caste, rich and poor, landlord/ landowner/zamindars and tenants etc. are quite prominent where a different political construct primarily governs the rules of engagement of people from different strata. For example: A brahmin and higher caste families generally lives in the best (cleanest and central part of the village) who generally walk to the periphery of the village to defecate in the open in the morning. The poor (could be Dalits, untouchables and other poor minority caste) live around the periphery/outside of the village. While these are the dwelling neighbourhood of the lower caste it is used as defecation area for the rich upper caste. The lower caste families often keep pigs and other scavenging livestock for their livelihood. Often the justification of the rich is that the excreta left behind by the better off is used as food by the pigs. Further, in traditional rural Nepali family in some places the father-in-law would generally avoid using the toilet used by his daughter in law or similar other relation. The preference would always to have an exclusive separate toilet for the use of elders of the family. Physical inability of old people who never used a sanitary latrine might find it difficult to squat on the footrest of a squatting plate and adjust himself/ herself to drop the excreta in the right place. The first-time users of such who practiced open defecation throughout his/her lifetime would find it difficult to get used to a toilet within the four walls of a modern latrine. It takes time for them to get mentally adjusted with the practice which is new to them. In this context inclusive and equitable sanitation

³⁷ <http://resources.cwis.com.s3.amazonaws.com/evidence/files/3-2300-16-1439734509.pdf>

demands for a caste and other vulnerable/ excluded groups (PWDs, older persons, LGBTQIAs) a disaggregated approach. Further due to caste and ethnic stratification achieving and sustaining ODF status of one community to another is very different and diverse in nature. It is difficult to address those with pre-set common intervention of a project/programme without taking participatory planning, review and learning processes down to the community/wards/toles. The Dalits and other lower castes constitute one fifth population of Nepal. A small percentage of school children from the lower caste communities who attends school are affected with the improved appropriate sanitation message and approach taught/ promoted through the schools. The reasons could be many out of which the most important reason is the non-availability of toilets at their homes. While they use toilets at the school and understand the importance of using, not using toilet and stopping the practice of OD, every member in the family including their parents is surprised to hear about such messages from their children. Most of these families are practicing open defecation across generation which is the social norm. This do not mean that the children cannot influence their parents or other members of the family to stop the practice of OD at all.

Cost effectiveness is high if emphasis is equally distributed to collective behaviour change along with sanitary hardware construction: The Local Municipal Government as political entity is more interested in creation of physical facilities than community mobilization and behaviour change. While the municipalities were found to be very focused in making their cities and towns sustainably ODF area they emphasised more on hardware constructions. As explained earlier, if the emphasis is equally distributed to collective behavior change along with sanitary hardware construction it would encompass many who may not be able to construct/afford sanitary latrine outright. In such cases the sharing of latrine, maintaining community latrines clean and dry with shared responsibility and cost sharing are common. It has also been seen that a latrine block with several latrines is maintained properly and kept under lock and key. Families who use a particular latrine knows about it and are responsible for its operation and maintenance. All the user of that particular family maintains or keep a copy of the key to the latrine door. Like this, there could more local example of community managed latrines. Although the counterpart funding by the municipal council is significant in general but major part is spent for water supply and little for sanitation. Most of which is invested for construction of facilities and infrastructure but little for community mobilization and behavior change. For example: India, Bangladesh, Timor Leste, Ghana, Kenya and Madagascar etc. However, there are countries like Kenya there is a separate ministry or directorate exclusively working on Hygiene Behaviour Change and monitoring outcome of sanitation programme as the on public health. Traditionally, the responsibility rests solely on the ministry/directorate which are only concerned with creation of sanitation infrastructure for example: public works, public health engineering etc. in such cases there is often a disconnect between investment on infrastructure and the positive health outcome if the ministry of health is directly involved it is easier for them to monitor the reduction in number of patients suffering from diarrhoea and other enteric diseases reporting in the health centres of ODF areas and the variation in number with non ODF areas.. Having a national policy guide for spending certain percent of the budget for sanitation is often ignored. Again, a municipal council do not have adequate human resource strengths to facilitate community level process of planning and implementation. Therefore, the need for local community participation in supporting the municipal council to manage and discharge

the function of planning and implementation is very important and which needs to be addressed through formation of local community team, training and capacity building of the volunteers who are interested and willing to support the municipality.

The designing of programme must consider the whole sanitation chain in assessing needs and planning: One of the important factors for ODF sustainability commonly reported is the effective and appropriate system of FSM in place; thus, planning must consider the whole sanitation chain.

Deliberate intervention is required to reverse the prevailing perception that sustenance of ODF status is directly dependent on external funding: Although improvement of sanitation situation reduces disease and cost, promotes livelihood, improves health, nutrition and education, common perception prevails among the community members as well as members of WASH-CCs is that sustenance of ODF status and moving up along the sanitation ladder requires fund and resources. There is a need to reverse the prevailing perception that sustenance of ODF status is directly dependent on external funding. There are many instances globally where public contribution, shared responsibility by private sector participation, international donor funding and institutional lending from the financial institutions e.g.: The World Bank, Asian Development Bank, Plan International, World Vision etc. there are examples of joint funding and Private Public Partnership arrangements. Some of these could be explored and appropriately selected by the different municipalities.

Communal sanitation facilities do not serve the purpose if maintenance strategies and mechanisms are not introduced beforehand: Without proper maintenance strategies and mechanisms in place construction and extension of communal sanitation facilities at communities, schools and public institutions soon become non-functional and dirty and unusable thus reducing the efficiency and effectiveness of sanitation programme.

For example: Sulabh Sauchalya in India is a bright example of participation of the user cost sharing, repair and maintenance by the users and the organisations managing them. The system of large scale 'pay and use' toilet facilities was introduced by Sulabh International. Sulabh Sauchalya have crossed the boundary of India and have been adopted by many countries outside.

Integration of Gender Equity and Social Inclusion (GESI) and Climate Change Adaptation (CCA) in Programme design demand for explicitly stated objectives: The overall programme design and WASH plans developed at municipal councils did not include explicit objective, outcome and indicators related to GESI and CCA. Mainstreaming gender and climate resilience in sanitation requires explicit inclusion of objectives outcome and indicators for M&E specific to GESI and CCA; without which integration of gender and CCA in sanitation is non-systematic, anecdotal, and ineffective.

Periodic assessment by externals helps for learning but systematic internal monitoring is essential for damage control: If the programme would have systematic monitoring based on well-defined M&E framework then the SUSTAINABILITY criteria and its indicators would be part of the design and plan. If this were the case, then information related to issues of sustainability would enter into the

project Management Information System (MIS) and then appropriate measures could be undertaken.

6. Recommendations

The recommendations were developed through an analysis of the evidence gathered from the analysis of key findings and conclusions from the evaluation. To ensure utilisation, recommendations were developed with a key focus on what UNICEF could do. Based on the findings and lessons stated earlier the evaluation recommends the following for the future programme to be more effective.

Training and Capacity Building at all levels needs to be based on the principles of collective behaviour change process which does not exclude the outsiders: to initiate the collective behaviour change process amongst the community the outside facilitators should also change the style of communication from a teaching/preaching style to a more participatory mode 'let's do it together mode'. For this to happen the facilitator should also adopt the same attitude and body language as that of the community. Unlike teaching (teacher and student relationship- uppers and lowers) it has to be transformed into participatory training mode. The concept of 'teaching by doing' and 'learning by doing' is crucial here. See the picture below. For example: The Swachh Bharat Mission- Grameen (SBM- G) in India underwent a radical transformation from its focus on sanitary hardware construction during Rural Sanitation Programme in 1986, followed by Total Sanitation Campaign in 1999 and Nirmal Bharat Abhiyan in 2012. The SBM- G was different from previous sanitation programmes as the main focus was on behaviour change process.



In any community meeting outside facilitators should share the same floor with the community in order to avoid the unequal relationship (uppers and lowers). This empowers the local community as equal partners in a project.

One of the strategic lessons the evaluation draw is the merit of Sanitation Social Movement (SSM) approach in generating enormous inputs towards achieving fast access to sanitation facilities and services. If the dimension of community

empowerment for collective behaviour change process is integrated well then achieving sustainable sanitation outcome would be much more effective and efficient. Until the concerned functionaries are made accountable to ensure collective behaviour change on principle, enhanced sector capacity and extended access to sanitation and hygiene facilities at home and institutions may not necessarily ensure into ODF sustainability. Achieving collective behaviour on a sustainable basis is not possible unless the local participation is high and spontaneous. It is important to mention here that community participation can vary from a most ordinary type to a strong community driven and community owned process. The most ideal form of participation would be self-mobilization meaning that local community will understand the need for collective behavior change and need for ODF environment. If the entire tole (village) is not ODF for some reason or the other some people are exposed to the danger of eating each other's faeces. A highly motivated and aware community would always ensure that everyone including the poor and landless have access to basic sanitation facilities. Otherwise, everybody would be exposed to the danger of faecal oral contamination. Communities sustainably maintaining ODF status across all over the world are taken care of their poor, very poor and disabled on the traditional principle of self-help. For example: Parma in Nepal.

The evaluation highly recommends for developing sector capacity development strategies and deliver interventions based on the principles of collective behaviour change process. If trained and capacitated with the needed knowledge and skill of facilitating multi- stakeholders participatory planning and facilitating village/ward WASH CC/ palika based participatory assessment, planning, implementation and review process the local government organizations at municipalities and districts can act as an effective institution to facilitate the ODF communities to move up along the sanitation ladder. Due to differences in roles capacity development of WASH- CCs needs to be planned and implemented based on systematic needs of WASH- CCs or WASH in institutions whatever the case maybe it would be essential to setup to deal with the institutional mechanism which would act as WASH unit at different levels in full collaboration and cooperation of NSHCC at the national level. The training and capacity building intervention needs to be designed strictly on the outcome of the needs assessment carried out across all levels of WASH-CCs. Any capacity building intervention should have a strong balance with the local needs which might vary in different geographical regions, biophysical and socio-economical context, and time.

Addressing sociocultural variations through Institutionalizing Participatory Assessment, Planning, Implementation and Review (PAPIR) process at the villages/wards as the way forward: Achievement and sustenance of ODF status is very different and diverse between one community to another due to caste and ethnic stratification. It is difficult to address those with one common intervention for all throughout the entire project/ programme "one size doesn't fit all". Challenges of sludge management, establishing equilibrium of interventions for sustaining past achievement and making additional progress, cooperation for sharing local resources for the marginalized households cannot be addressed by the delivery of a common set inputs but by institutionalizing village/ward based participatory assessment, planning, implementation, and review process, as an approach for community empowerment. Hence, it would be essential to institutionalise such a process in all future interventions as the way forward. It is evident that the situation of those village is much better wherever the community level sanitation committee are active e.g.,

Rajdevi of Rautahat. The sanitation status is much better in villages of Rajdevi, Rautahat as compared to similar other villages. The evaluation recommends for ensuring resource provision and support in Palika plans to institutionalize the process of village/community-based assessment, planning and review process through the Ward WASH-CCs. Institutionalization of this PAPIR process will have multiple positive effects for sustainability. First of all, depending on the situation of a community/ward it will decide and implement locally preferred action relevant to both pre and post ODF interventions. Second it will serve as a powerful strategy of action- learning oriented BCC that will encompass emotional domain of learning, focusing sanitation as public good. Third and most importantly, if participatory impact assessment is conducted then people realize the importance of investment in sanitation in reducing household as well as national financial losses, enhancing income and overall national prosperity, which will serve as deliberate intervention to reverse the prevailing perception that sustenance of ODF status is directly dependent on external funding. Fourth for addressing local needs in the relevant context it can generate appropriate actions and innovations out of the box. Improving sanitation by Dalit communities might look as advocacy for securing land ownership. Sixth it will serve as community based informal school hygiene education.

Ensure dedicated budget allocation, action plan and ownership of local government to sustain the already achieved ODF status in Nepal by 2030:

Although the counterpart investment by the palika/ local government is significant in general, major part of the investment goes to water and a very little is allocated for sanitation. For example, Rupani Municipality has allocated 96% for drinking water, 3% for institutional sanitation and 1% for capacity building out of total budget US\$ 632060 for the FY 2020/21.³⁸ Major amount of the investment budget is used for construction of physical facilities and infrastructure but very little goes for community mobilization and behavior change. While facilitating planning ensure the Municipalities allocated dedicated fund for sanitation; include activities for encouraging and fostering community led initiative and rewarding elected local bodies for spearheading successful initiatives.

Encourage local NGOs, CSO, Users Committee, Cooperatives, Women's Self-Help Group etc to get involved in addressing the human resource needs of Municipal WASH- CCs as equal partners: At present Municipal WASH-CCs do not have dedicated human resources capable of facilitating community level participatory process. For addressing human resource constrains and bottlenecks involve local NGOs and other formal and informal entities mentioned above as partners for community facilitation with the local government body.

Intensify interventions through formulation well defined strategies for sanitation facility maintenance and use: Without proper maintenance strategies and mechanisms in place, construction, repair and maintenance of communal sanitation facilities at schools, public institutions and communities become non-functional, dirty and unusable quite soon. Before constructing communal sanitation facilities plan proper repair and maintenance to ensure that the investment in creating public facility is not totally wasted. Stand- alone implementation of sanitary pad distribution or creation of handwashing station does not serve all the purpose of three-star approach

³⁸ Municipal WASH Plan, Rupani Rural Municipality

and MHM in schools. Facility and mechanisms for MHM at schools needs to be established appropriately in consultation with the user groups. In three-star approach there are four indicators related to facility and three each for behaviour and institutionalisation this needs to be built into the strategy itself. If required the experts from the government, UNICEF and CSOs may be invited for consultation and recommendations. CLTS Foundation can also extend necessary help and support in such interactive discussions which has been done in many other countries. Facilitate schools in mobilizing funds for the proper maintenance of continuing WASH facilities in the school. Trigger and follow-up government offices at the municipalities and elsewhere for the proper maintenance of sanitation facilities in office premise. In case of public toilet ensuring proper maintenance is more complex as it is not the responsibility of any one individual or organisation. In other words, it is a facility used by everybody and not maintained by anybody due to lack of any defined and clear accountability. Since the responsibility of maintenance lies on the municipalities, government, or other local bodies, due to lack of availability of recurring expenditure on cleaning, maintenance, and repair. To overcome this challenge, models of user participation and pay and use toilets have been used very successfully. This not only generates revenue for maintenance and repair but generates local employment as well. The huge capital investment in constructing toilet units is not wasted due to lack of maintenance in protecting the toilets from being filthy and dirty. The strategy should also include rural and urban context specific appropriate interventions towards safe onsite and offsite sludge management. The evaluation recommends for formulating strategies through stakeholder consultation.

Adopt a clear and systematic mechanisms for sustaining the service chain whatever is available for managing sanitation services safely: As it is clear from the overall findings of the evaluation that the sanitation infrastructure and technological options available/used by the households are too primitive and meagre for maintaining the ODF status sustainably. However, there is a high level of awareness and interest amongst the sector actors to improve and modernise the checks and balances to systematically monitor the ODF sustainability and its impact on public health. This one area where institutional help and support could be of immense help and be welcomed by the municipalities and other sector players. There were no clear and systematic mechanisms for sustaining the service chain whatever is available for managing sanitation safely. As a result, it was evident that municipalities who have attained ODF status run the risk of losing the status. The following reasons are very important to be addressed by the municipalities or the civil society failing which a very few municipalities would be able to retain their ODF status:

- Although underground sewerage system with appropriate treatment facility is considered as most safe and convenient mechanisms in city life with higher population density deprived from modern technology. It is not used in all the towns and cities of Nepal. While it is one of the most efficient sanitation systems used for big towns and cities including metropolitan cities, this system is expensive and financially dependent on external/government contribution partially. Government contribution is essential for smooth functioning of the sewerage systems. Depending on the efficiency of municipalities the amount collected as tax varies from municipality to municipality. It is generally not easy to collect/expect any tax from poor or very poor settlements within the municipality. Moreover, there are settlements of people who migrated/

displaced or shifted from other places for various reasons. Often the most important reason being wider livelihood options and access to many facilities and welfare support from the government. This is just an example of a government support to extend basic infrastructure and technology to villages and remote areas. This initiative of the government would not be possible unless there is wholehearted cooperation and total participation from the local communities. It has been seen that the level of participation in the government initiatives is remarkably high in ODF villages as compared to other villages. For instance, in the meeting of ward councillors in the mayor's (Mr. Nirpa Odha) office in Dhangadhi (sub metropolitan city) during the evaluation, the ward councillors were represented from 19 wards of the municipalities. They reported that no tax is being collected for sanitation. Due to shortage of land, safe disposal of human waste and waste product remains a constant issue.

- Mechanisms for sustaining the safely managed sanitation services: Enhancing the income of municipality for providing sanitation services to people of municipality. Free sanitation service can only be provided to a certain extent, beyond which it could only be maintained by tax revenue earned, user fees collected and matching contribution from the institutions and agencies receiving municipal services. The unit cost of sanitation service needs to be calculated on at no profit no loss basis. Subsidized services cannot be provided all throughout by the municipality unless the said municipality receives any grant or donation from funding agencies, donors, or the central government. Most municipalities and city corporations in the world have introduced service tax user fees for water supply and other basic services. Traditionally, the basic needs of the people like water, municipal services, repair and maintenance of roads, drains and sewerage systems were the direct responsibility of the government, more and more these services are being provided on cost basis. This is introduced in many towns and cities across the world because of increase in cost and population pressure on the unit area of towns and cities. Moreover, rural urban migration both seasonal and daily visits by people from the suburban areas puts a huge pressure of garbage, solid and liquid waste removal from the busy towns and cities. According to the global forecast of population growth three fourth of the global population would live in towns and cities of the world within a century. Already there are countries in the world where the urban population has exceeded the rural population significantly for example Iran. In Nepal, Eighty-six percent of the migrants are rural-urban migrants. Thirty-five percent of all rural–urban migrants in the country are in KMC (Kathmandu Metropolitan City)³⁹.

³⁹ <https://journals.sagepub.com/doi/abs/10.1177/01171968211017966>

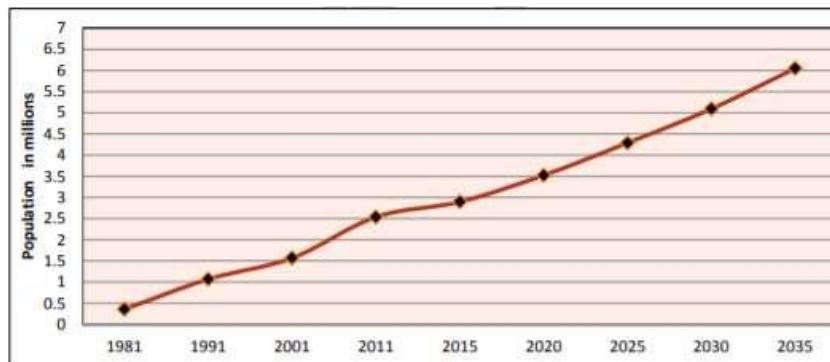


Figure 31: Population growth trend of Kathmandu Valley (Source: Adapted from KVDA, 2016)

- As a result, developing safely managed sustainable sanitation services is a new challenge. Many experiments have been conducted globally to tackle this problem. In-situ disposal of human waste is no longer feasible in towns with rapidly growing population. Periodical emptying of toilet pits and overflow of pits constructed with ring and slab is a most common problem as seen in Nepal. Attempts of engaging private companies for excavating the filled-up toilet pits using suction pumps and tankers found to be useful in some parts of the city but it did not work well in densely populated slum areas. The suction pump mounted tankers could not be moved to dense congested areas to narrow or very narrow roads of towns and cities. It is only the private vendors who come with a portable suction pump and empty the toilet pit by releasing the untreated raw excreta in open ditches and ponds nearby which creates another environmental problem with stink and flies for some time. Even the tankers with suction pipe empty their tanks in the river, khads (manure), open spaces not too far from the towns and cities. This untreated sewerage often gets into the natural water streams and rivers with rainwater and create a health hazard far away down the stream. These are also environmentally dangerous. While construction of treatment plants and treating the raw sewerage before discharging it to the open environment is the only solution, it is a challenge for the municipalities to bear the cost of establishing such a treatment plant. Although a few municipalities informed the evaluation team that they are in the process of receiving grants and loans and subsidized infrastructure for creating such facilities. It still remains a challenge for small municipalities to raise and provide the matching contribution required to create such infrastructure. This again raise the question of public contribution and pay and use system of safely managed sanitation.

Apply the policy of positive discrimination for the gender and inclusion: Upper - lower caste power relations, socio-cultural construct and governance structure in Nepal is controlled and influenced by the upper caste. Discrimination in employment has both direct or intentional and indirect aspects. For example, the low employment rate of Dalits in the government sector can largely be attributed to their low level of education, which again is related to their Dalit status in society. This form of discrimination can, therefore, be seen as indirect discrimination. At the same time, it also has elements of direct discrimination in the sense that the government sector is dominated by 'upper caste' people, who tend to favour candidates belonging to their

own castes when the matter concerns hiring or promoting personnel⁴⁰. Although, the situation is changing it has to go a long way.

In such situation disaggregated approach for inclusive and equitable sanitation is needed with equal participation of all caste and vulnerable/ excluded groups including PWD, older persons and LGBTQIAs etc. The evaluation recommends for the application of policy of positive discrimination to ensure participation of Dalit, PWDs, LGBTQIA and Older persons and any other vulnerable groups. Deliberately include person with disability, Older Persons and LGBTQIAs in the Municipal and Ward WASH-CCs. While facilitating Municipal and Ward WASH planning deliberately include interventions for addressing special needs of these vulnerable groups of population.

Systematize programme monitoring: The governance structure of Nepal is divided into three distinct layers of administration there are 7 provinces, 77 districts and 283 municipalities. There should be a very clearly defined and functional management information system that connects all the three tiers reflecting the status of sanitation at each level. This data would be useful in monitoring the sanitation, SLWM and other important aspects of municipalities. A district or a provincial level monitoring officer/team would be able to categories all the 283 municipalities as Category 1 (cleanest), Category 2 (moderately clean) and Category 3 (not up to the mark) and colour code them with green, yellow and red. In other words, for example if the federal level monitoring board shows eighty-three green, hundred seventy yellow and thirty red (numbers are hypothetical as an example) in the month of July 2022 that means the performance of thirty red municipalities are below standard and not at par with other municipalities. Such poor performance of thirty municipalities pulls Nepal back to a non ODF municipal nation. Logically, the intervention of the district and the federal level should be more at those thirty red municipalities to bring them up to the standard of yellow status and eventually to green status. With the enhanced intervention and interaction with the municipal authorities of these thirty municipalities it might so happen that twenty five out of thirty move up to yellow and green level in the month of August. In other words, they strengthen the municipal administration and improve the sanitation status. For carrying out such monitoring an inter municipality evaluation team along with the members of district and federal level needs to be formed who would periodically visit all the thirty municipalities and review their performance on a commonly agreed list of indicators. As a result, the names of today's red municipality might turn into yellow or green after a couple of months. Therefore, such periodic monitoring visit should be organised by the inter disciplinary inter municipal team from time to time. The result of the evaluation visit should be exhibited at the municipal headquarters at the respective district and the federal level. Kalyani municipality in West Bengal, India is one example where such ward level evaluation chart was presented at the municipal Chairman's office on every month. The performance of the wards continued to change every month as a result of their performance result published in the display board of municipal Chairman's office. During the monthly meeting of all ward councillors this was discussed. Some councillors were very happy some tried to hide their face out of shame but determined to change and improve their status before the next meeting. Such periodic assessment by externals helps in evaluating performance from a neutral perspective and adds value for onward learning

⁴⁰ https://www.ilo.org/wcmsp5/groups/public/@asia/@ro-bangkok/@ilo-kathmandu/documents/publication/wcms_112922.pdf

and technical backstopping. Therefore, a systematic internal monitoring mechanism should be developed in each municipality to sustain their high level of performance. The evaluation recommends for systematization of programme monitoring based on a well-defined framework and plan. Sustainability checking must be a criteria to be included in the M&E framework which should include relevance, effectiveness, efficiency, coherence, Gender Equality and Social Inclusion (GESI). The system should monitor both the processes and outcomes. The programme can explore possibilities of creating and operating a municipal wide digital monitoring dashboard of OD and ODF communities/tols/villages/ward including following categories such as:

- A. *Not triggered and OD continues*
- B. *Triggered but yet to be ODF*
- C. *ODF status achieved and sustained*
- D. *Was ODF could not sustain the status but slipped back to OD again*

Accordingly consolidated structure of the dashboard can be taken up at the province and national level.

In several countries (such as Ethiopia, Ghana) sanitation programme supported by UNICEF applied similar approach of multi-stakeholder coordinated sanitation planning integrating the approach of community self-assessment, monitoring, evaluation and learning. This system prove to be very effective in behaviour change and sustainability of ODF status. UNICEF supported sanitation programme in Nepal may consider self M&E by communities/palikas/ WASH-CCs as a vital strategy in its M&E approach of the programme.

In relation to the introduction of functional information management system, based on well-defined policy and roles of the relevant government entities, the programme should have framework of software that facilitates the collection, storage, organization, and distribution of information to the stakeholders.

Annexures

Annex 1: Evaluation framework

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
Relevance	To what extent did the interventions on sanitation programme address the sanitation needs ⁴¹ of the population in their households and in public spaces?	Has the programme addressed the sanitation needs of each household to become ODF ⁴² and sustain the status as per criteria of the Government of Nepal? Are there gaps between needs and planned/implemented interventions? Can these gaps be addressed?	Compatibility of needs and programme interventions to sustain ODF status of the entire population.	<u>Secondary</u> <ul style="list-style-type: none"> Documents of programme needs assessments Programme plans, progress report <u>Primary</u> <ul style="list-style-type: none"> Survey data Reports of FDGs conducted with community members and leaders/municipal members Reports of KII conducted with the staff of UNICEF, government department 	<ul style="list-style-type: none"> Review of documents Household Survey FGD with community and municipal members KII with the staff of government departments and other support partners/actors involved Direct observation 	<ul style="list-style-type: none"> Commonalities and gaps between needs and planned/implemented programme interventions Ways to address the gaps

⁴¹ For the evaluation a need had been conceptualized as "essential intervention to enabling target population of the programme to reach desired ODF status through accessing improved sanitation facilities and perform proper hygiene behaviour".

⁴² ODF: Open Defecation Free as per definition described in the 'Sanitation and Hygiene Master Plan (2011) of the Government of Nepal'

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
				<p>nts and other stakeholders</p> <ul style="list-style-type: none"> • Notes on direct observation 		
	<p>Has the programme addressed the sanitation needs of schools, health facilities, local government institutions, other public/community buildings and other offices/common places?</p> <p>If there are gaps between needs and planned/implemented intervention, then those gaps can be addressed?</p>	<p>Compatibility of needs and programme interventions to improve sanitation situation in schools, health facilities, local government institutions, other public/community buildings and other public / common places⁴³.</p>	<p>Compatibility of needs and programme interventions to improve sanitation situation in schools, health facilities, local government institutions, other public/community buildings and other public / common places⁴³.</p>	<p><u>Secondary:</u></p> <ul style="list-style-type: none"> • Same as above <p><u>Primary</u></p> <ul style="list-style-type: none"> • Survey data • Report of KII conducted with the staff of government departments and other support partners/actors involved. • Reports of visit /observation and semi structured interview with schools, health facilities, local government institutions , other public/community buildings and public offices. 	<ul style="list-style-type: none"> • KII with the staff of government departments and other support partners/actors involved • Visit, direct observation and semi structured interview with the stakeholders of schools, health facilities, local government institutions , other public/community buildings and public offices. 	<ul style="list-style-type: none"> • Same as above

⁴³ The Sanitation and Hygiene Master Plan (2011) of Nepal state ' Within the designated community, all the institutions including schools, health institutions, VDC/ municipality building, community buildings and other public offices/ places must have hygienic toilets. These toilets should be users friendly in the local context as far as possible. The school toilets must have Child, Gender and Differently abled (CGD) friendly water, toilet and hand washing with soap-station/facilities including menstrual hygiene facilities. Separate toilets for girls in schools may also be provided as appropriate'.

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
				government institutions, other public community buildings and other public offices		
	To what extent the sanitation programme was implemented from 2018 to 2021. Did the programme meet the needs of children, women and their families, persons with disability, and other most vulnerable and marginalized groups?	Has the programme addressed special sanitation needs of children ⁴⁴ , women, PWDs, LGBTQIAs, older persons and ethnic/cultural minorities? To what extent were project strategies sensitive to the culture, gender and social inclusion of men, women, girls, boys, PWDs, older	Compatibility of special sanitation needs of children, women, PWDs, older persons and ethnic/cultural minorities with the programme interventions	<u>Secondary:</u> <ul style="list-style-type: none">Same as above <u>Primary</u> <ul style="list-style-type: none">KAP survey dataSummary report of KII conducted with the staff of UNICEF, government departments and other support partners/actors involvedInformation provided by mothers of children under 5	<ul style="list-style-type: none">Review of documentsHousehold surveyKII with the staff of government departments and other support partners/actors involvedResponses from urban and rural municipalities using FDGs; special interviews with mothers of children under 5	<ul style="list-style-type: none">Commonalities and gaps between needs and planned/implemented programme interventions and ways to address the gapsStrengths and weaknesses of programme intervention strategies in terms of sensitivity towards culture, gender

⁴⁴ Although Article 1 of the United Nations Convention on the Rights of the Child defines 'children' as **persons up to the age of 18**. But According to the Nepal Citizenship Act (1963) and the Children's Act (1992) person below the age of 16 is a child. For this evaluation children under 5 are considered as a subcategory.

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
		persons or senior citizens, LGBTQIA and ethnic minorities If there are gaps between needs and planned/implemented intervention , then those gaps can be addressed?		children under 5, Boys and girls (6-16 years), women, PWDs, LGBTQIA s, older persons and ethnic/cultural minorities	s, older persons and ethnic/cultural minorities • FGD with boys of age range 6-16 • FGD with girls of age range 6-16 •	and social inclusion.
	To what extent has the project adjusted its strategies and activities in addressing changing circumstances and unavoidable emerging needs?	Has the programme addressed the emerging needs of climate and disaster resilient sanitation?	Inclusion of resilient sanitation in Country Programme ToC, plans and intervention strategies. Application of well-defined framework and methodology for integrating climate and disaster resilient sanitation	<u>Secondary:</u> • Documents related to UNICEF Policy ⁴⁵ towards sanitation , Country Programme ToC of UNICEF, National Sanitation and Hygiene plan 2011 of Nepal, Nepal WASH sector Development Plan 2016-	• Review of documents • Household survey • KII with the staff of UNICEF, government departments and other support partners/actors involved.	Strengths and weaknesses in addressing emerging needs of climate and disaster resilient sanitation. Ways to foster strengths.

⁴⁵ Guidance Note: How UNICEF regional and country offices can shift to climate resilient wash programming (2020) UNICEF

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
			facilities in CLTS approach.	2030, comprehensive sanitation plans at province, district, and palika levels <u>Primary</u> <ul style="list-style-type: none">Survey data (on exposure of sanitation facilities with disaster)Summary report of KII conducted with the staff of UNICEF, government departments and other support partners/actors involved		
		Has the programme addressed the newly emerged needs as brought about by the COVID-19 Pandemic	interventions made and resource invested to address COVID-19 IPC	<u>Secondary:</u> <ul style="list-style-type: none">Reports related to COVID-19 responses <u>Primary</u>		Strengths and weaknesses in addressing emerging needs of climate and disaster resilient sanitation.

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
				<ul style="list-style-type: none"> • Survey (<i>sanitation related issues faced due to emergence of COVID-19</i>) • Summary report of KII conducted with the staff of UNICEF, government departments / actors involved • FGD with community members and municipal members • Part of FGDs at urban and rural municipalities; special interviews with mothers of children under 5 women, PWDs, LGBTQIA 		Ways to foster strengths.

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
				S, older persons and ethnic/cultural minorities		
Effectiveness	To what extent did the sanitation programme achieve intended results and how it contributed to reducing open defecation in the target areas?	Has the delivery of inputs ⁴⁶ of focused interventions created intended results in improving overall sanitation and hygiene behaviours practices of the community? What is the contributory and hindering factors? What could make better impact in improving sanitation and hygiene	Number of people gained access to basic ⁴⁷ sanitation services in addition to those benefitted directly through UNICEF programme's support. What are the improved hygiene behaviour practices existing at community (ward) level? What existed and what resulted after the	Secondary <ul style="list-style-type: none">• Programme M&E data, progress reports• Baseline report of prov 2, 2018, MICS, 2014 and 2019, DWSSM and WSSDO reports of the programme Primary <ul style="list-style-type: none">• Survey data• Direct observations• FGD reports• Notes of in-depth	<ul style="list-style-type: none"> • Review of programmed M&E data, progress reports • KAP survey • FGD • In-depth discussion and interview with special vulnerable persons 	<p>Differences in quantity and quality between the intended results and intended output</p> <p>Merits and weakness of relationship between delivered inputs and the results of intended output; factors contributing and hindering the same.</p> <p>Service access variations for the vulnerable groups such as children, women,</p>

⁴⁶ Form the documents shared we could document programme inputs are *Facilitating Go-NGO-CSO Partnership for consensus building and joint planning, *capacity building of actors engaged , * facilitating social mobilization engaging different stakeholders such as CSOs, local networks, journalists, youth group, etc.; * direct monitoring and review of programme by UNICEF staff.

⁴⁷ JMP defined **improved sanitation facilities** are those designed to hygienically separate excreta from human contact. If the excreta from improved sanitation facilities are not safely managed, then people using those facilities are classed as having a **basic sanitation service**. **Safely managed** refers to Use of improved facilities that are not shared with other households and where excreta are safely disposed of in situ or removed and treated offsite
For detail <https://washdata.org/monitoring/sanitation>

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
		behaviours of the community?	programme . Quality, functioning, extent of use, and maintenance of basic sanitation services created this includes hand washing practice.	interview with mother of children Under 5 , PWDs, Older Person, ethnic cultural minority, LGBTQIAs		PWDs, Older Person, ethnic cultural minority, LGBTQIAs. Differential effects the programme reared for boys and girls Comparison of baseline and intended value per indication of KPI
		Has the delivery of inputs of focused programme has created intended effects to enhanced capacity of sector stakeholders to provide access to safe and sustainable sanitation and hygiene facilities at households and institutions?	Number and quality of local government with WASH Plans (including explicit sanitation component) integrating climate resilient development and/or risk management developed	Secondary • Programmed M&E Data, progress reports • MoEST and CEHRD reports, • WASH in School guidelines , CEHRD. Primary • Reports of KII with national/, provincial	• Review of Programmed M&E data, progress reports • KII, FGDs, • Direct observations/visit • Site documents observations	Parity and disparity of quantity and quality of intended output creation and their reasons Merits and weakness of relationship between delivered inputs and creation of intended output; contributory

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
		<p>What is the contributory and hindering factors?</p> <p>What could make better effects in stakeholder's capacity enhancement?</p>	<p>Implementation status of local government WASH Plans</p> <p>Number of schools with WASH services that meet national - Three Star category including menstrual hygiene management and standards.</p> <p>Quality of functions, use and maintenance of WASH/sanitation services in programme targeted schools</p> <p>Number of healthcare facilities (clinics, health centers,</p>	<p>and district level key informant (KI)</p> <ul style="list-style-type: none"> • Reports of FGDs at Palikas/Communities • Note of direct observation/visits and site documents (such as action plan of palika) review • 		<p>and hindering factors.</p> <p>Comparison of baseline and intended value per indication of KPI</p>

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
			<p>hospitals, etc.) with basic WASH services, as a result of UNICEF direct support.</p> <p>Quality of functions, use and maintenance of WASH/sanitation services in programme targeted healthcare facilities</p>			
		<p>Has the delivery of inputs of focused programme has created intended effects to Increase capacity of sector to legislate, plan and budget to improve sanitation systems, including mainstreaming disaster risk</p>	<p>Number of national /sub-national WASH sector policy instruments (WASH Act, WASH Policy, Guidelines on WASH Plan, HCF, Water Quality Monitoring, Water Safe Community, and Sustainability)</p>	<p>Secondary</p> <ul style="list-style-type: none"> Programmed M&E Data, progress reports <p>Primary</p> <ul style="list-style-type: none"> Reports of KII with national/, provincial and district level key 	<ul style="list-style-type: none"> Review of Programmed M&E data, progress reports KII, FGDs Documents observations 	As same as above

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
		<p>management?</p> <p>What is the contributory and hindering factors?</p> <p>What could make better effects?</p>	<p>ty) developed and operationalized.</p> <p>Number of WASH sector information and management system MIS (with N-WASH) developed and operationalized.</p> <p>Existence (Initiating) of functioning cluster coordination mechanism for water, sanitation and hygiene in humanitarian situations (at sub-national level) operationalized. (# Province + # of Palika)</p> <p>UNICEF-targeted</p>	<p>informant (KI)</p> <ul style="list-style-type: none"> • Reports of FGDs at palikas/communities • Notes of direct observation/visits and site documents (such as action plan of Palika)) review 		

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
			population in humanitarian situations accessing appropriate WASH facilities/services (water supply, sanitation, hygiene) in community, schools, temporary learning spaces and other child friendly spaces.			
	How effective were created outputs in the attainment of the programme outcome: 'Irrespective of differences in vulnerabilities among population groups (such as children, Number additional	Number of people living in ODF community environment (number of community become ODF as per Nepal Government Criteria)	Secondary <ul style="list-style-type: none">ODF verification criteria of the governed of NepalProgrammed M&E data and report Primary <ul style="list-style-type: none">KAP survey data	<ul style="list-style-type: none">Review of Programmed M&E data, progress reportsKII, FGDsDocuments observationsIn-depth interview	Parity and disparity of quantity and quality of intended output creation and their reasons Conformity and discrepancy of equitable access and use of services by vulned population	

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
	women, PWDs, Older Persons, economically marginalized, ethnic and cultural monitor, including children and their families a total of 38000 additional people having improved and equitable access to and use of safe sanitation services, and improved hygiene practices? How effective were created outputs in terms of creating education continuity outcome for	people having access to sanitation services by service type steady in JMP sanitation ladder? Equitable access and use of services by vulnerable population groups (such as children, women, PWDs, Older Persons, economically marginalized, ethnic and cultural minority	<ul style="list-style-type: none"> Reports of KIIs with national/, provincial and district level key informant (KI) Reports of FGDs at Palikas/Communities Notes of direct observation/visits 	<ul style="list-style-type: none"> with special vulnerable persons (PWD/LG BTQIA/older person, Widowed) School visit and discussions with teachers and student 	groups (such as children, women, PWDs, Older Persons, economically marginalized, ethnic and cultural monitor.	Merits and weakness of relationship between created outputs and creation of intended outcome; contributory and hindering factors.

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
		the girl's student? What is the contributory and hindering factors? What could make better effects?				
Efficiency	To what extent did the inputs and monitoring of the sanitation programme contribute to achieving planned outcomes in a timely and cost-efficient manner?	Has the programme delivered input as per targeted quantity, defined quality and planned time frame? What is the contributory and hindering factors? Does amount spent per input category justify cost-efficacy in terms of investment	Number input delivery as per detail implementation plan (DIP) of the programme Stakeholder's level of satisfaction on the quality and timely delivery of input. Proper application of core principles and processes of CLTS approach	Secondary <ul style="list-style-type: none"> Financial report /up to date statement of expenditure Financial Audit reports M&E framework Monitoring reports Detail implementation plan DIP of the programme Relevant study reports namely ODF 	<ul style="list-style-type: none"> Document review and observations KIIs FGDs at Palikas Benefit three exercise with male and female community members TimeLine sanitation related diseases prevalence and financial 	Strengths and weakness of inputs delivery in terms of quantity, quality and timely delivery and coverage Comparison of cost – output and probable benefit

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
		made and output/benefit created?	in the targeted communities Creation of intended and unintended output by the delivery of inputs Coverage of target people Existence of functional stakeholder participatory monitoring system to review progress against planned activities. Prevalence of sanitation related disease and household level financial	(sustainability) Study • Field note on CLTS Approach Primary • Reports of KIs with national/, provincial and district level key informant (KI) • Reports of FGDs at Palikas/Communities • Notes of school visit and discussion with teachers , girls and boy students	loss excessive as part of FGD at palikas • School visits and observations • Interview with school teachers • FGD with girls students including benefit tree exercise of school sanitation	

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
			losses caused by those diseases (should we include this in survey questionnaire?)	<ul style="list-style-type: none"> Notes of direct observation/visits 		
	Were the programme's financial and human resources sufficient for the implementation of the programme's planned activities ?	Has the programme employed required human resources?	<p>Well defined staffing /human resource plan of the programme</p> <p>Number of staff at UNICEF dedicated for the programme ?</p> <p>Number of staff dedicated by partner organizations/relevant government departments</p> <p>In relation to CLTS approach plan and</p>	<p>Secondary</p> <ul style="list-style-type: none"> Program plans <p>Primary</p> <ul style="list-style-type: none"> Reports of KIs with national/, provincial and district level key informant (KI) 	<p>Document review</p> <p>KII</p>	Strengths and weaknesses in finance and human resources

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
			<p>application of strategies to engaged natural leaders and community consultants as para-facilitators</p> <p>In relation to CLTS approach human resource plan and allocation of staff /human resource to implement activities related to pre-triggering, triggering, post triggering follow-up and PAML and post ODF facilitation.</p>			

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
		Has the programme allocated and utilized required financial resources for the implementation of planned activities?	Adequate budgetary allocation of fund based on well-defined strategies plan of implementation. Timely financial support with continuity of flow without break. No implementation deficit or delay due to financial shortage	Secondary <ul style="list-style-type: none">Costed Program plansProgramme budget Primary <ul style="list-style-type: none">Reports of KIIs with national/, provincial and district level key informant (KI)		
Sustainability	To what extent are the targeted locations under the sanitation programme remaining ODF after	Are those communities /locations became ODF sustaining their ODF status?	Compliance to ODF verification criteria Application of sustainability as per	Secondary <ul style="list-style-type: none">Programmed M&E dataSustainability check: guidance to design and implement	<ul style="list-style-type: none">Document reviewSurveyKIIFGD	ODF sustainability status

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
	implementation?		UNICEF guide ⁴⁸ Existence of community-led ODF sustainability assessment and action process	sustainability monitoring in WASH (2017) <i>UNICEF HQ Programme Division/WASH, New York</i> Primary <ul style="list-style-type: none"> • Survey data • Reports of KIIs with national/, provincial and district level key informant (KI) • Reports of FGDs at Palikas/Communities • Notes of observations 		
		What internal and external factors can	Strategies and interventions	Secondary <ul style="list-style-type: none"> • Report of ODF 	<ul style="list-style-type: none"> • Documents study and extraction 	Adequacy and inadequacy of

⁴⁸ Sustainably check: guidance to design and implement sustainability monitoring in WASH (2017) *UNICEF HQ Programme Division/WASH, New York*

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
		affect the sustainability of the sanitation programme ?	ns ⁴⁹ have been put in place to sustain ODF status and further moving up the sanitation ladder Motivational factors among the community towards sustaining ODF status Risks of ODF status jeopardy	sustainability study in Nepal (2017), National Sanitation and Hygiene Coordination Committee, <ul style="list-style-type: none"> • Summary Report “Global Sanitation Fund Outcome Study, 2018 • Report of the Study on Sustainability of Open Defecation Free Communities in GSF Supported Program Districts, in Nepal, UN-Habitat 2017 • Lessons from a 	of information <ul style="list-style-type: none"> • FGD and SSI with community level samples • Sustainability assessment of sanitation facilities at households • KAP survey • SWOT on ODF sustainability as part of FGDs with the local government 	sustainability mechanisms have been put in place. Likelihood of process and outcome sustainability. Risks and enabling factors for sustainability.

⁴⁹ Such as post ODF follow-up, organizational development of sanitation committee, facilitating community based PMEL systems for moving up to sanitation ladder, linkage building of sanitation committee with relevant stakeholders for support mobilization, facilitating Participatory Sanitation technology Development and Community Led Sani Marketing , Community-led Sanitation Disaster Risk Reduction, Linking community based approach to livelihood promotion and primary health care.

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
				<p>Post ODF Assessment in Nepal. WASH Technical Paper (TP/o2/2018), UNICEF</p> <ul style="list-style-type: none"> • Nepal – SSH4A Results Program me Extension end line brief (2020) SNV • Paschal A. Apanga, Joshua V. Garn, Zoe Sakas and Matthew C. Freeman (2020) Assessin g the Impact and Equity of an Integrated Rural Sanitation Approach : A Longitudinal Evaluatio n in 11 	<ul style="list-style-type: none"> • Direct observations • KII with the staff of UNICEF, relevant government departments and development partners 	

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
				<p>Sub-Saharan Africa and Asian Countries . International Journal of Environmental Research and Public Health</p> <p>Primary</p> <ul style="list-style-type: none"> • Survey data • Report of KII with the staff at UNICEF, relevant government departments and development partners organisations and WASH Coordination Committees at district • Report of FGDs conducted with community 		

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
				City members and municipal and ward level local government		
Gender	To what extent the gender is mainstreamed in the programme?	Has the programme integrated gender in each step of programme management cycle ⁵⁰ ?	Gender disaggregated needs assessment and analysis of the programme? Deliberate interventions to address gender issues in sanitation? Active participation of women and girls in implementation of programmes?	<u>Secondary</u> <ul style="list-style-type: none">• GENDER TOOLKIT Integrating Gender in Programming for Every Child in South Asia (2018) UNICEF Regional Office for South Asia• Programme needs assessment report• Programme proposal and log frame• Project M&E	<ul style="list-style-type: none">• Document s study and extraction of information• Sex desegregated benefit excess mapping as part of FGDs with the male and female community members and Municipal /WASHCC• KIIs with staff at	Strengths and weaknesses of gender mainstreaming

⁵⁰ Needs assessment, planning, implementation, and M&E

Criteria	Key evaluation question	Sub-questions	Indicators	Means of verification/data sources	Data collection methods	Analysis
			<p>Gender-sensitive M&E including gender indicators and using sex- and age-disaggregated data according to mechanisms set out in programme /project design</p> <p>Documentation and sharing of practice generated lessons and learning related to gender and sanitation/ OD & ODF.</p>	<p>framework, report, and data</p> <ul style="list-style-type: none"> • Relevant case stories, study reports <p><u>Primary</u></p> <ul style="list-style-type: none"> • Report of FGDs conducted with male and female community members • Report of KIIs conducted with staff at UNICEF, relevant government departments and development partner organizations 	<p>UNICEF, relevant government departments, development partner organizations and municipal level WASHCC</p>	

Annex 2: Data tools and Informed Consent

2.1: KAP SURVEY QUESTIONNAIRE

Identity of the Interviewee	
Name of Interviewee	
Village	
Municipality	
District	
Province	
Date	

A. DEMOGRAPHIC DATA OF THE HOUSEHOLD

1. Please tell us about the member of your household by sex and age starting from the oldest to youngest.

	Gender [Use code]	Age	Marital status [Use code]	Persons with disability 1=yes- 0=No	Education [Use code]	Primary Occupation [Use code]	Religion
1.							
2.							
3.							
4.							
5.							
6.							

Gender: 1= Male, 2= Female, 3= LGBTIQ

Marital status: 1= Married 2= Single 3= Divorced 4= Stay together 5= Separate 6= Widow/widower

Education: 1=Pre-primary, 2=Primary, 3=Lower secondary, 4=Upper secondary, 5=Higher

Primary Occupation Code: 1 = Selling labour, 2 = Farmer, 3 = Self-employed, 4 = Unpaid family worker, 5= Housewife, 6=Student/too young to work, 7=Retired/ too old to work, 8 = Unemployed, 9= Other specify.....

2. Caste of the HHs (CASTE/ETHNIC GROUPINGS by GoN)

1	2	3	4	5	6
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Dalit	Disadvantaged Janajatis	Disadvantaged non-Dalit Terai caste groups:	Religious Minorities	Relatively advantaged Janajatis	Upper caste groups
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3. Household Asset

1	2	3	4	5
Household land and plot	Agricultural land	Livestock	Machinery/equipment	Other (specify)

4. Livelihood Occupation of HHs Members and Sources of Income

1	2	3	4	5	6	6
Labor	Farming	Livestock and Poultry rearing	Small Business	Job	Dependent on Remittance	Other specify

5. Approximate average monthly income range of the HH (in Thousand Rs.)

1	2	3	4	5	6	7	8	9
5-10	11- 15	16-20	20-25	25-30	31-40	41-45	56-50	51- Above

6. Approximate Average Monthly Expenditure Range of the HH (In Thousand Rs.)

1	2	3	4	5	6	7	8	9
5-10	11- 15	16-20	20-25	25-30	31-40	41-45	56-50	51- Above

7. In case of deficit monthly income of the family what are the support mechanisms?

Remittance of money	1. Yes

	2. No
Essential support (food, medicine, etc.) as and when required	1. Yes 2. No
Support during illness and health emergency	1. Yes 2. No
Loan with interest or without interest	1. Yes 2. No
Support against free labor	1. Yes 2. No
Loan with co-lateral	1. Yes 2. No

B. KNOWLEDGE AND ATTITUDES

8. Open Defection and Its Consequences

8.1	Do you think open defecation practice is a problem?	1. Yes	
		2. No	
8.2	If yes: Why do you think it is a problem? Please check all that apply	1. Pollute the environment	
		2. Cause diseases and malnutrition	
		3. Disgusting: it brings back to shit in our mouth	
		4. Jeopardy privacy and dignity	
		5. Uncomfortable when under the pressure of reliving, rain, and night time	
		6. Risk for women to be sexually abused	
		7. other specify	

8.3	What are the diseases that can be reduced and prevented by stopping open defecation practices? Please check all that apply	1. Diarrhoea	
		2. Worm infections	
		3. Typhoid	
		4. Cholera	
		5. Hepatitis	
		6. Polio	
		7. Trachoma	
		8. Others specify	

9. Open Defecation, Fecal-Oral Contamination, and Diarrheal Diseases

9.1	Do you agree that the human excreta come back home if open defecation continues?	1. Yes	
		0. No	
9.2	If yes, then how does it happen? Please check all that apply	1. Contaminated/ Polluted water that we use	
		2. Flies bring it to our food	
		3. Dry faeces and dust blow in the wind land in our food, nose, and mouth	
		4. Chicken, dogs, and other domestic animals bring them back from the field/bush to our homes	
		5. Vegetables	
		6. Other pathways, specify	
9.3	How does a person get diarrhoea? Please check all that apply	1. No handwashing before eating	
		2. No handwashing after defecation	
		1. No handwashing after cleaning children's bottom and disposal of faeces	

		2. No handwashing before feeding a child	
		4. Drinking untreated water	
		5. Eating stale food and half-cooked food	
		6. Poor and unhygienic kitchen food handlers.	
		7. Improper/ cleaning or washing vegetables before eating	
		8. Don't know	
		9. Others, specify	
9.4	How does diarrhoea spread? <i>DO NOT READ OUT CHOICES. There can be more than one</i>	1. Dirty hands 2. dirty water 3. flies 4. solid and liquid waste 5. Unclean food 6. Dirty latrine 7. Open defecation 8. Through animal faeces 9. Don't know 10. Other, specify	
9.5	What is the best way of reducing the risk of sanitation-related diseases? Please check all that apply	1. Using a safe latrine in one's house regularly 2. Every house in a community has a safe latrine and used by all in the family 3. Everyone in the house practices proper handwashing 4. Drink safe water	

		5. Others, specify	
9.6	Do you have children under 5 in your house? If yes	1. Yes 2. No	Skip to 10
9.7	Did any child under 5 years face diarrhoea in the last two weeks?	1. Yes 2. No	

10. Why should one have own Latrine?

10.1	What are the advantages of owning your latrine? Please check all that apply	1. Improved hygiene/ cleanliness	
		2. Freedom from the filthy environment and bad odour	
		2. Improved health	
		3. More privacy	
		4. More comfortable	
		5. Convenience	
		6. Improved safety	
		7. Improve status/prestige	
		8. Saves time	
		9. Prestige	
		10. Others, Specify	
10.2	What are the criteria for a safe latrine? Please check all that apply	1. Excreta is safely confined and is not seen	
		2. flies cannot enter and sit on excreta	
		3. Having proper handwashing facilities	
		4. Do not spread the foul odour	

		5. Do not cause/pollute the surface and groundwater	
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11. Hand Washing

11.1	In your opinion, when do you think are the critical times to wash your hands? Check all that apply	1. After using the latrine	
		2. After cleaning children's bottom	
		3. Before preparing a meal	
		4. After handling children's faeces	
		5. After defecation	
		6. After touching animals	
		7. After handling animal faeces	
		8. Before feeding others	
		9. After taking care of sick family members	
		10. Before eating	
		11. Don't know	
		12. Others, specify	
11.2	Why is it important for you to wash your hands with soap? Check all that apply	1. Prevents disease	9. Heard from other people
		2. Prevents diarrhoea	10. Heard from radio/TV
		3. Cleans hands/removes dirt	11. Have seen other people do so
		4. Is good hygiene	12. Smells good
		5. Prevents dirt from getting into the mouth	13. Looks/feels clean
		6. Prevents dirt from getting into food	14. Others, specify

		7. Removes germs	
		8. Heard from parents/another family	

C. ACCESS TO FACILITIES

12. Latrine

SN	Questions	Options	Remarks
12.1	Do you have a latrine in your home/house?	1. Yes 0. No	
12.2	If yes: When your house- latrine was built?	1. Before 2018 2. After 2018	
12.3	What kind of latrine do you have in your home/house at present? Note: Also observe and check the appropriate box	<p>Improved</p> <p>1. Flush or pour-flush to sewerage (into the open drain) 2. Flush or pour-flush to sewerage (into treatment plant)</p> <p>2. Flush or pour-flush to a septic tank or pit</p> <p>3. Pit latrine with slab</p> <p>4. Toilet attached to biogas</p>	<p>Unimproved</p> <p>5. Flush or pour-flush to elsewhere</p> <p>6. Open-pit latrine without a slab</p> <p>7. Overhanging latrine</p> <p>8. Defecating while standing in the water</p>

		4. Public or shared latrine (any type)	9. Others
12.4	If the toilet is with pit, how many pits are there?	1. 1 pit 2. 2 pits	
12.5	If 1 pit, has your toilet pit been filled in?	1. Yes 2. No	
12.6	If yes, where is that disposed of of-open field, trenches, treatment plant, not emptied	1. Yes 2. No	
12.7	If not emptied- did you make another toilet- yes/no	1. Yes 2. No	
12.8	If no, mention the reason	1. no money 2. Using other's toilet 3. No willingness 4. Others (Specify)	
12.9	If yes, is the latrine functioning/ usable now?	1. Yes 0. No	
12.10	If not, what are the reasons for non-functioning?	1. No money/ Cost is too high 2. No materials to build a latrine 3. Latrine not important 4. Open defecation tradition Sharing the toilet with other HH 5. Habit of open defecation during fieldwork	

	6. Vast/ available area (open fields/ forests/ water bodies) for open defecation	
	7. No external support/ assistance/ Never been offered toilet facilities	
	8. Never received information on the importance of using the latrine	
	9. Prefer the field	
	10. No one to build latrine	
	11. No space in or near the house	
	12. A pit toilet smells too much	
	13. We do not own the house/land	
	14. We do not have a nearby water source for a flush toilet	
	15. Don't want to spend time cleaning	
	16. Not thought about it; we are fine the way we do it now	
	17. Others, specify	
12.11	Who in the family uses the toilet?	1. Family members 2. Relatives 3. Others (Specify)
12.12	Who in the family member does not use the toilet?
12.13	What is the reason for not using the toilet?

12.14	Was your latrine flooded in the past year?	1. Yes 2. No	
12.15	If yes, have it been damaged?	1. Yes 2. No	
12.16	If yes- have you repaired that?	1. Yes 2. No	
12.17	If yes- what repair work was done?	1. Changed wall, 2. Raised toilet, 3. Changes roof 4. Others (Specify)	
12.18	If no- where are you defecating-	1. Open defecation 2. Neighbour toilet 3. Others (Specify)	
	Only for the household having person(s) with disability (PWD)		
12.19	Is the member with disability of use your house latrine for defecation?	1. Yes 2. No	
12.20	If yes: Can she/he comfortably use the latrine without any complain?	1. Yes 2. No	
12.21	If No: What is the reason?	1. The structure do not allow access and use latrine by her/him 2. She/he does not feel comfortable 3. Alone cannot access and use latrine without help of other member.	

		4. Unable to collect water for her/himself	
		5. Afraid she/she may fall down and end up crawling on the (often filthy) floor of the latrine	
	Only for the household having LGBTQ member		
12.22	Do you recognize any member of the household can be considered as LGBTQ?	1. Yes 2. No	
12.20	If yes: Can she/he equally assess and use the toilet facilities at the house?	1. Yes 2. No	
12.21	If No: What is the reason?	1. He-she does not like to use the latrine	
		2. Other family members do not like him/her to use the latrine	
		3. Other –Please state	

13. Handwashing Facilities

13.1	Does your house latrine have a handwashing facility?	1. Yes 0. No	
13.2	If yes, then what is available? Tick all that applies	1. Only water	
		2. Water and soap	
		3. Others, specify	
13.3	At home, do you have a fixed hand-washing place/station?	1. Yes	0. No
13.4	If yes, does it always have water and soap?	1. Yes	0. No
13.5	If yes, where is it located?	1. Inside the house, specify location:	

	Visit the reported handwashing area for observations	2. Outside the house, specify location: 3. Other, specify location:
13.6	If yes, observe the water and soap availability	1. Water is available 2. Water is not available 3. Soap is available 4. soap is not available
	Only for the household having person(s) with disability (PWD)	
13.7	Is the member with disability of your house usages hand washing facilities at your house?	1. Yes 2. No
12.20	If yes: Can she/he comfortably use the handwashing facilities without any complain?	1. Yes 2. No
12.21	If No: What is the reason?	1. The structure is not friendly for his/her use 2. She/he does not feel comfortable
		3. Alone cannot access and use hand washing facilities without help of other member.
		4. Unable to collect water for her/himself for washing activities
		5. Afraid she/she may fell down and end up crawling on the (often filthy) floor of the latrine
	Only for the household having LGBTQ member	
12.22	Do you recognize any member of the household can be considered as LGBTQ?	1. Yes 2. No

12.20	If yes: Can she/he equally assess and use the toilet facilities at the house?	1. Yes 2. No	
12.21	If No: What is the reason?	1. He-she does not like to use the latrine	
		2. Other family members do not like him/her to use the latrine	

3. Changes in Sanitation Facilities

14.1	Is this your first latrine?	1. Yes	
		0. No	
14.2	If not, how many latrine(s) have you built before?	1. One	
		2. Two	
		3. Three or more	
14.3	How do you compare your present and latrine with the previous one?	1. As same as previous	
		2. Better and improved than that of the previous one	
14.4	If as same as previous: What are your reasons for not improving/ changing your latrine type? (If the current latrine is the same as the previous latrines built)	1. No money/ Cost is too high	
		2. No land to build my latrine	
		3. No materials to build an improved latrine	
		4. No external support/ assistance	
		5. Don't know how to build an improved latrine	
		6. We do not have access to the water supply at home for flushing the toilet	

	7. Satisfied with same latrine type	
	8. No space in or near the house for improved latrine	
	9. No one to build an improved latrine	
	10. Others, specify	

4. Reasons for Having No Latrine
(For Households that have no latrines)

15.1 What are the reasons why you don't have a latrine? Reasons Check all appropriate boxes and then ask to rank given reasons from main to least reason. DO NOT READ OUT CHOICES, CHECK THAT CORRESPOND TO RESPONSES	1. No money/ Cost is too high	
	2. No materials to build a latrine	
	3. Latrine not important	
	4. Open defecation tradition Sharing the toilet with other HH	
	5. Habit of open defecation during fieldwork	
	6. Vast/ available area (open fields/ forests/ water bodies) for open defecation	
	7. No external support/ assistance/ Never been offered toilet facilities	
	8. Never received information on the importance of using the latrine	
	9. Prefer the field	
	10. No one to build latrine	
	11. No space in or near the house	
	12. A pit toilet smells too much	

	13. We do not own the house/land	
	14. We do not have a nearby water source for a flush toilet	
	15. Don't want to spend time cleaning	
	16. Not thought about it; we are fine the way we do it now	
	17. Others, specify	

5. Access to Information, Education & Communication

16.1	In the last year, have you received any messages or visual/reading material on sanitation and hygiene?	1. Yes	0. No
16.2	If yes, what sanitation and hygiene messages do you receive, and in what form?	1. Build a latrine	8. Good food hygiene
		2. Always use a latrine/ stop open	9. Wastewater/stagnant water
		Defecation	management
		3. Safe disposal of infants' faeces	10. Proper solid waste disposal/ management
		4. Wash hands with soap	11. Don't know
		5. Drink safe water	12. Others, specify
		6. Treat drinking water	
		7. Store drinking water safely	
16.3		1. Posters or leaflets in the village	

	If yes, where did you see, hear, receive these messages?	2. At community meetings	
		3. In government offices	
		4. When visiting a health facility	
		5. Material received at your home (handouts, newsletter, etc.)	
		6. In newspapers or magazines	
		7. On TV	
		8. On the radio	
		9. Don't know	
		10. Other, specify	
16.4	If yes, when did you see, hear, receive these messages?	1. Today	7. 6 months ago
		2. Yesterday	8. Don't know
		3. This week	9. Other, specify
		4. Last two weeks	
		5. Last month	
		6. More than a month ago	
7.5	If yes, from whom did you hear/ receive these messages?	1. Village chief	
		2. Commune chief/ council	
		3. Government agency, specify _____	
		4. NGO, specify name _____	
		5. From family members	

	6. From neighbours	
	7. Don't know	
	8. Cannot remember	
	9. Other, specify	

D. PRACTICES

6. Cleanliness of Latrine and Maintenance of Handwashing Facilities

17.1	How often do you/ your family members clean your latrine? Only one answer.	1. Once a day	Remarks
		2. More than once a day	
		3. Once every 2 – 3 days	
		4. Not very often (less than once a week)	
		5. Rarely	
		6. Others, specify	
17.2	What do you do to keep the handwashing facilities upright?	1. No specific handwashing facility available	
		2. The respondent refused to show the place	
		3. Tippy tap	
		4. Bucket with tap	
		5. Jug	
		6. Basin	
		7. Sink	
		8. Hand pump	
		9. Others specify	
17.3	What do you do to control foul odour?	1. Commercial cleaning supplies	
		2. Clean regularly with water	

	3. Burn a candle	
	4. Increase airflow	
	5. Make a DIY air freshener	
	6. Remove mold and mildew	
	7. Sprinkle lime and other disinfectant powders	
	8. Others, specify	

7. Repairing and Reconstruction of Latrine

18.1	What do you do when your latrine is broken/ collapsed/ become unusable?	1. Build a new latrine	
		2. Fix/ repair latrine	
		3. Use neighbour's latrine	
		4. Use relative's latrine	
		5. Use public latrine	
		6. Revert to OD	
		7. Others, specify	
18.2	If the latrine is rebuilt/fixed/ repaired, when Do You re-build/ build new/ fix/ repair your latrine?	1. Immediately/ ASAP	
		2. When have money/ materials	
		3. When receiving external support/ assistance	
		4. After the rainy season	
		5. Others, specify	
18.3	Has your toilet been repaired?	1. Yes 2. No	
18.4	If yes, what type of repair did you do?	1. Roof 2. Wall 3. Door 4. Pan set 5. Filing of the pit	

		6. Others (Specify)	
18.5	What was the cost of repair?	
18.6	How did you manage the cost?	1. Cost is borne my own 2. Loan borrowed 3. Exchange of labour	
18.7	If not, what are the reasons for no repair?	1. No money/ Cost is too high 2. No materials to build a latrine 3. Latrine not important 4. Open defecation tradition Sharing the toilet with other HH 5. Habit of open defecation during fieldwork 6. Vast/ available area (open fields/ forests/ water bodies) for open defecation 7. No external support/ assistance/ Never been offered toilet facilities 8. Never received information on the importance of using the latrine 9. Prefer the field 10. No one to build latrine 11. No space in or near the house 12. A pit toilet smells too much 13. We do not own the house/land 14. We do not have a nearby water source for a flush toilet	

		15. Don't want to spend time cleaning	
		16. Not thought about it; we are fine the way we do it now	
		17. Others, specify	

8. Defecation and Excreta Disposal

19.1	Where do you usually defecate when at home during the daytime? Please, check only one	Dry Season	Wet Season
		1. OD (ground/forest, water body)	1. OD (ground/ forest, water body)
		2. In your latrine	2. In your latrine
		3. In the neighbour's latrine	3. In the neighbour's latrine
		4. In public latrine	4. In public latrine
		5. Others, Specify	5. Others, Specify
19.2	Where do you usually defecate when at home during night time? Please, check only one	Dry Season	Wet Season
		1. OD (ground/forest, water body)	1. OD (ground/ forest, water body)
		2. In your latrine	2. In your latrine
		3. In the neighbour latrine	3. In the neighbour latrine
		4. In public latrine	4. In public latrine
		5. Others, Specify	5. Others, Specify
19.3	Where do you usually defecate when in public places? Please, check only one	Dry Season	Wet Season
		1. OD (ground/forest, water body)	1. OD (ground/ forest, water body)

		2. In the neighbour latrine	2. In the neighbour latrine
		3. In public latrine	3. In public latrine
		4. Others, Specify	4. Others, Specify
19.4	Where do your children usually defecate when in public places? Please, check only one	Dry Season 1. OD (ground/forest, water body)	Wet Season 1. OD (ground/ forest, water body)
		2. In the neighbour latrine	2. In the neighbour latrine
		3. In public latrine	3. In public latrine
		4. Others, Specify	4. Others, Specify
19.5	Where do women usually defecate when in public places? Please, check only one	Dry Season 1. OD (ground/forest, water body)	Wet Season 1. OD (ground/ forest, water body)
		2. In the neighbour latrine	2. In the neighbour latrine
		3. In public latrine	3. In public latrine
		4. Others, Specify	4. Others, Specify
19.6	Where do children of your family usually defecate?	Dry Season 1. OD (ground/forest, water body)	Wet Season 1. OD (ground/ forest, water body)
		2. In your latrine	2. In your latrine
		3. In the neighbour latrine	3. In the neighbour latrine
		4. In public latrine	4. In public latrine
		5. Others, Specify	5. Others, Specify

19.7	Where do children (Girl) of your household usually defecate when at home during night/ rain/ emergency?	Dry Season	Wet Season
		1. OD at the back of your house or neighbour's house (ground/forest, water body)	1. OD (ground/ forest, water body)
		2. In your latrine	2. In your latrine
		3. In the neighbour's latrine	3. In the neighbour's latrine
		4. In public latrine	4. In public latrine
		5. Just outside your house	5. Just outside your house
		6. In a plastic bag which is disposed of outside your compound	6. In a plastic bag which is disposed of outside your compound
19.8	Where do children (boys) of your household usually defecate when at home during night/ rain/ emergency?	Dry Season	Wet Season
		1. OD at the back of your house or neighbour's house (ground/forest, water body)	1. OD (ground/ forest, water body)
		2. In your latrine	2. In your latrine
		3. In the neighbour's latrine	3. In the neighbour's latrine
		4. In public latrine	4. In public latrine
		5. Just outside your house	5. Just outside your house
		6. In a plastic bag which is disposed of outside your compound	6. In a plastic bag which is disposed of outside your compound

		outside your compound	
	7. Others, Specify	7. Others, Specify	
19.9	Where do women of your household usually defecate when at home during night/ rain/ emergency?	Dry Season	Wet Season
	1. OD at the back of your house or neighbour's house (ground/forest, water body)	1. OD (ground/ forest, water body)	
	2. In your latrine	2. In your latrine	
	3. In the neighbour's latrine	3. In the neighbour's latrine	
	4. In public latrine	4. In public latrine	
	5. Just outside your house	5. Just outside your house	
	6. In a plastic bag which is disposed of outside your compound	6. In a plastic bag which is disposed of outside your compound	
	7. Others, Specify	7. Others, Specify	
19.10	Is there an infant in the family Where do you usually dispose of infants' faeces? Please, check only one	Dry Season	Wet Season
	1. Bury	1. Bury	
	2. Throw in forest/ bush/ water body	2. Throw in forest/ bush/ water body	
	3. Throw in your latrine	3. Throw in your latrine	
	4. Throw in the neighbour latrine	4. Throw in the neighbour latrine	
	5. Throw in a public latrine	5. Throw in a public latrine	

		6. Throw in community dumpsite	6. Throw in community dumpsite
		7. Others, Specify	7. Others, Specify
19.7	Are there disabled persons in the household?	1. Yes, adult family members 2. Yes, children	0. No
19.8	If yes adult family members, where do they usually face difficulties?	1. School	
		2. Communities	
		3. Public places	
		4. Others (Specify)	
19.9	If yes, children do experience difficulty in using latrines?	1. School	
		2. Communities	
		3. Public places	
		4. Others (Specify)	

9. Hand Washing

20.1	When do you wash your hands (Please check all that apply)	1. When hands are dirty	7. Before preparing food
		2. When returning to house from work/ from outside	8. After cleaning infant who has defecated
		3. Before eating	9. After touching animals
		4. After eating	10. After disposal of animal faeces
		5. After defecation	11. Others, specify
		6. Before feeding child	

20.2	What do you and other adult members usually use in handwashing? Choose only one.	1. Water only	
		2. Water and soap	
		3. Water with ash	
		4. Others, specify	
20.3	Do your children (1-14 yrs.) have a habit of handwashing?	1. Yes	0. No
20.4	If yes, when do your children wash their hands? Please check all that apply	1. when hands are dirty	7. School/play
		2. when returning to the house from	8. Before preparing food
		3. Before eating	9. After cleaning infant who has defecated
		4. After eating	10. After touching animals
		5. After defecation	11. After disposal of animal faeces
		6. Before feeding child	12. Others, specify
20.5	If yes, what do your children usually use in handwashing? Choose only one.	1. Water only	
		2. Water and soap	
		3. Water with ash	

10. Anal cleansing

21.1	What do you usually use for anal cleansing after defecation? Please check only one.	Dry Season	Wet Season
		1. Water only	1. Water only
		2. Leaves	2. Leaves
		3. Paper	3. Paper
		4. Stone	4. Stone

		5. Wood	5. Wood
		6. Corncob	6. Corncob
		7. Hand	7. Hand
		8. Others, Specify	8. Others, Specify
21.2 What do your children in the HH usually use for anal cleansing after defecation? Please check only one.	Dry Season	Wet Season	
	1. Water only	1. Water only	
	2. Leaves	2. Leaves	
	3. Paper	3. Paper	
	4. Stone	4. Stone	
	5. Wood Hand	5. Wood	
	6. Corncob	6. Corncob	
	7. Mother clean anal of infants with the corner of their saree	7. Mother clean anal of infants with the corner of their saree	
	8. Others, Specify	8. Others, Specify	

11. Sludge Management
Yes/No

22.1 Has your toilet been filled in?	1. Yes	
	2. No	
22.2 If yes, What do you do when your latrine is full?	1. Build a new latrine	
	2. Pump-off latrine	
	3. Use neighbour's latrine	
	4. Use relative's latrine	
	5. Revert to OD	
	5. Use public latrine	

		6. Others, specify	
22.3	What happens to the waste when it is removed?	1. Used as fertilizer	
		2. Dumped in the forest	
		3. Dumped in the river/ pond/ canal	
		3. Empty pit contents in a new hole	
		4. It is transported to trench or treatment plant	
		5. Other, specify	

12. For Representation of the Community

23.1	How many HHs in your village use toilet facilities?	1. All uses toilet facilities 2. About half of the villagers use toilet facilities 3. Most of the HHS use some sort of toilet 4. Everyone uses the toilet 5. Hardly any households use toilets 6. I don't know
23.2	During the last 7 days did you see any human excreta in an open place in your village?	1. Yes 0. No
23.3	If yes, then where?	1. Near latrine of household 2. Bush around residents 3. Other specify

Thank the respondent and close the Interview

- IDP Camp. IRAQ.*
- DRHC. 2010. *National Sanitation and Hygiene Knowledge, Attitudes, and Practices (KAP) Survey Final Report Department of Rural Health Care Ministry of Rural Development Phnom Penh, Cambodia*. Phnom Penh.
- Gomme, Joe, Jamie Skinner, Mary Allen, and Don Brown. 2010. "Methodology for Monitoring and Evaluating Progress in Water Supply, Sanitation and Water Resources Management in West Africa." (October, year???)
- Sibiya, Jerry E., and Jabulani Ray Gumbo. 2013. "Knowledge, Attitude and Practices (KAP) Survey on Water, Sanitation and Hygiene in Selected Schools in Vhembe District, Limpopo, South Africa." *International Journal of Environmental Research and Public Health* 10(6):2285–95. DOI: 10.3390/ijerph10062282.

Others

1. SSH4A Household Questionnaire NEPAL
- 2, Expert suggestions

KOBO tools

Email: ashok1pande@gmail.com

Username: UNICEF sanitation

Password: UNICEF@123

<https://kobo.humanitarianresponse.info/#/fo>

2.2: HOUSEHOLD OBSERVATION GUIDE

(To be used after administering the HH questionnaires)

Name of designated area:

SN	Questions			Observation Notes
1	(For Pit Latrines) – Is there a cover for the hole?	1. Yes	0. No	
2	Is the slab smooth and easy to clean?	1. Yes	0. No	
3	Does the latrine have walls, a roof, and a door?	1. Yes	0. No	
4	Are the latrine roof/ walls/ door well maintained?	1. Yes	0. No	
5	Is there a well-trodden (well-used) footpath/ access path towards the latrine?	1. Yes	0. No	
6	Are human faeces visible on the floor or slab of the latrine?	1. Yes	0. No	

7	Are there flies near/ at the latrine?	1. Yes	0. No	
8	In your opinion, is the general appearance/ condition of the latrine area clean?	1. Yes	0. No	
9	Is there a handwashing place inside or just outside/near to the latrine?	1. Yes	0. No	
10	If yes, please note down what types of handwashing materials			
	Jar and Water	1. Yes	0. No	
	Soap	1. Yes	0. No	
	Ash	1. Yes	0. No	
11	Are there materials to cover the faeces after defecation? What type of materials? It May is not applicable	1. Yes	0. No	
	Ash	1. Yes	0. No	
	Sawdust	1. Yes	0. No	
	Rice husk	1. Yes	0. No	
	Soil/ Sand	1. Yes	0. No	
12	Where is the latrine located concerning the reported regular water source/s?	Distance in meters		
13	(IF THE HOUSEHOLD HAS CHILDREN <5 YEARS) there children's potty/is in the house or around the house?	1. Yes	0. No	
14	If yes, are there observable evidence that the potties are used?	1. Yes	0. No	

15	Is there a Hand-washing facility/ area?	1. Yes	0. No	
16	Is there water at the fixed handwashing facility?	1. Yes	0. No	
17	Can the toilets be considered as "improved sanitation facilities ⁵¹ "? This means either being pit latrines with slab, or ventilated improved pit latrines, flush or pour toilets (connected to a sewer system or a septic tank or pit), or composting toilets?	1. Yes	0. No	
18	Is the average number of toilet users not more than 20 people (5?) per one gender-specific toilet? (Disaggregate the data by gender)	1. Yes	0. No	
19	Are the toilets located less than 50 meters from dwellings (or as locally agreed)?	1. Yes	0. No	
20	Are the toilets regularly cleaned and maintained? (Assess based on interviews with randomly selected users + observations)	1. Yes	0. No	
21	Do the toilets have handwashing facilities (with accessible water and soap) and anal cleansing material?	1. Yes	0. No	
22	Do the toilets respect cultural preferences and are they segregated by gender?	1. Yes	0. No	
23	Are the toilets constructed in a way that does not pose any risk to their users (e.g., risks of collapse; or poor vector control due to missing drop hole cover)?	1. Yes	0. No	
	Is the toilet raised sufficiently during a flood? Was there flood/landslide in the last three years, if yes was the toilet damaged (not usable) If yes have you repaired the toilet?			

⁵¹ An improved sanitation facility is one that likely hygienically separates human excreta from human contact. Improved sanitation facilities include: - Flush or pour-flush to piped sewer system, septic tank or pit latrine, - Ventilated improved pit latrine, - Pit latrine with slab and - Composting toilet However, sanitation facilities are not considered improved when shared with other households, or open to public use. ([https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-using-improved-sanitation-facilities-\(%\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/population-using-improved-sanitation-facilities-(%)))

24	Are the toilets located in a way that minimizes women and girls' exposure to assaults, especially at night?	1. Yes	0. No	
Source: Indikit (Question 17 to 24)				
25	What handwashing materials are observed? Check appropriate box			
	Bar soap	1. Yes	0. No	
	Liquid soap	1. Yes	0. No	
	Powder soap	1. Yes	0. No	
	Ash	1. Yes	0. No	
	Sand	1. Yes	0. No	
	Other specify			
26	Is there a water jar with a bucket?	1. Yes	0. No	
27	Is there a tap on the water container?	1. Yes	0. No	
28	Is there a towel or cloth to dry your hands? It is NA	1. Yes	0. No	
29	Condition of the towel if it is there (clean, dirty, evidence of use) NA	1. Yes	0. No	
30	Is there evidence of having been recently used (wet ground/ cement/ presence of water, etc.)?	1. Yes	0. No	
Prevention of Groundwater Contamination by Faeces				
31	Latrines located at least 30m away from any groundwater source and their pit bottoms being at least 1.5m above the water table- (second question)			
Gender-Segregated Sanitation Facilities in School, Health facility and offices- Need to have info				

32	Are there separate latrines for girls and boys?	1. Yes	0. No	
33	Does the latrine have doors?	1. Yes	0. No	
34	During normal working hours, is the latrine open and operating?	1. Yes	0. No	
35	Is the latrine accessible for people with physical disabilities?	1. Yes	0. No	
Message				
36	Inside the house, in the outside walls, or within the immediate vicinity of the house (on trees, latrines, etc.), are there posters/ signs showing/ encouraging good/ proper sanitation and hygiene practices?	1. Yes	0. No	
37	If yes, what types/ kinds of messages are observed in the posters/ signs? Check appropriate boxes 1. Stop open defecation	1. Yes	0. No	
	2. Consistent handwashing with soap	1. Yes	0. No	
	3. Proper treatment and storage of drinking water	1. Yes	0. No	
	4. Ways to avoid/ prevent diarrhoea	1. Yes	0. No	
	5. Other, specify			
38	Is the latrine is a disability-friendly facility at home?	1. Yes	0. No	
While observing, keep in mind the ODF criteria of Nepal: (source UN-Habitat Survey report 2017) please refer sanitation and hygiene master plan 1) There is no OD in the designated area at any given time. 2) All Households have access to improved sanitation facilities (toilets) with full use, operation, and maintenance.				

- 3) All the schools, institutions, or offices within the designated areas have toilet facilities.
- 4) Availability of soap and soap case for handwashing in all Households. preferred
- 5) General environmental cleanliness including management of animal, solid, and liquid wastes is prevalent in the designated area preferred.

2.3: SUSTAINABILITY OF SANITATION FACILITIES: ASSESSMENT TOOL

Community level (KII with community level)- Sustainability)

- How many households in your community?
- Every household has their toilet. Or is there any shared toilet?
- Do you think every household (even child/ elderly and people with disability) use their toilet?
- Do you see child or other shits in open area?
- Have you seen toilets are upgrading where that were temporary in the time of ODF declared?
- If yes, what were the motivations of people to rebuild or upgrade.
- If not, why?

Hand washing facility Percentage of household

- Do you see every household have hand washing station in your community? If not, why?

LOCAL GOVERNMENT /WASHCC LEVEL-KII

- Your organization has developed WASH plan?
- Monitoring system is in place for sustaining the ODF status in your area.
- Your organization has any strategy for sustaining the ODF status and hygiene promotion (includes promotional activities, continuous monitoring, support, training and incentives etc.).
- How about the service for safely emptying the toilet pit and sludge management? If the service is provided, community people are up taking?
- How about service/payment modality? Is it affordable?
- What are major constraints/challenges to sustain (maintain/upgrade) the ODF status in this area?

Checklist for sustainability-with toilet owners

Objective

The overall objectives of the evaluation are to understand the factors (opportunity, ability, and motivations) for sustainability of sanitation and hygiene facility and behaviours by the people of marginalized group in rural/urban setting.

I. I. General information

Date: _____ District: _____ R/Municipality: _____

Ward: _____ Start time: _____ End time: _____

Participant name: _____ Gender: _____

Name of interviewer: _____ # of people in immediate family: _____

I. II. Introduction

Thank you for taking the time to speak with me today. I've come here from because I've heard that you have a toilet in your household. Is that true? I'd like to discuss your experience with your toilet. Could I record this interview in case I miss any information?

I. III. Rapport Building

To begin, can you tell me your name, your age and how many people live in your house?

How many children do you have? How old are they?

Name:		No of children	
Participant age:		Ages of children:	
# People in house			

Questions

- Now that you have a toilet, do you and the entire family members use toilet regularly
 - If not, who do not use toilet and why?
- Do you have anyone with a disability in your family? (If no, skip to #16)

- If yes, are they using the toilet?
- What are the benefits of toilets and regular use of toilet you and your family?
- How do you clean your toilet? Or what do you use to clean your toilet (probe brush, chemicals water). The materials are available in your area?
- Is there any culture/Social norm to using the same toilet by all family members (father/brother in-law and daughter in-law)?
- Does your toilet ever have any problems?
 - If yes, how did you solve it?
- Is there available of skilled persons to maintain/upgrade the toilet in your neighbour? Sanitation
- Is there available sanitation and hygiene product/materials (brush, cleansing materials, soap etc.)
- Has your toilet pit ever got full?
 - If yes, what did you do?
 - If not, what do you do when pit is full?
- Is there the service provider (government/private sector) for safe management of sludge in the pit?
- Are there any promotional activities on sanitation and hygiene from any community, ward, municipality, or others?
- What are the difficulties to consistent cleaning, maintaining /upgrading their toilets?
- Understand hand washing with soap at critical time behaviour including:
- When do you and your family members wash hand with soap? Can you tell me about the most critical time for washing hands with soap?
- In your opinion, what are the benefits of washing hands with soap and water
- How easy it is to get soap?
- Do you have hand washing station with soap and water? If not, why?
- What are the difficulties to washing hands with soap at critical time?

Observation checklist of the toilet when SSI with toilet owner

	Yes	No	Please provide detailed comments as needed
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Foot path: clear pathway, easy for all to walk, looks like it has been used			
Toilet looks like it has been used			
Inside the toilet			
Easy to use for all member of family			
Floor, Pan, Walls looks clean, no marks or smears of faeces			
Presence of water (for pour flush only)			
Presence of cleaning materials for toilet			
Presence of brush/cleaning equipment			
Strong odour of urine or faeces			
Outside the toilet			
Conditions of pipes, junction (are leaking effluent, ground is wet or not)			
Pit is damaged or overflowing			

	Yes	No	Please provide detailed comments as needed
Hand washing station: Within 10 meters of a toilet or in an accessible place in the yard			
Regular presence of water and soap			

2.4 : GUIDELINE FOR PREPARING SUMMARY REPORT OF KII AND SSI

(A report to be prepared according to the federal, province, and district and municipal level)

SUMMARY REPORT OF KII/SSI

Please mention if the KII is conducted at the Federal, Province and District level. Mention the name of the province and district.

Federal	Province	District

Name, designation and contact details of KI

Period of Conducting Interview

RELEVENCE

The interviewer should keep the following questions in mind while conducting the interview. This is just a guideline but may not be asked question by question

Questions

In your view what are the priority issues of sanitation faced by the communities and schools?

What is needed to address those issues?

What are the major gaps in addressing those needs?

In view of existing operational context what strategies do you suggest for addressing those needs?

What are the major strengths and weaknesses do you see in terms of designing the programme based on identified needs?

What are the weaknesses do you see in terms of programme strategies, sensitivity to gender and social inclusion?

To what extent has the project adjusted its strategies and activities in addressing changing circumstances and unavoidable emerging issues?

Summarized answers/findings

EFFECTIVENESS

Questions

In your view what programme interventions were highly effective, moderately effective, and less effective? Why, please explain in brief.

Did you develop a Master Plan for Capacity Development as required in the country programme plan (CPAP)? What are the major gaps noticed?

What is your suggestion for better planning and roll out of Capacity Development Master Plan?

(Specific to DoE & DoHs) Did you develop WASH in schools and WASH in health care facilities guidelines; are those, endorsed and operationalized nationwide?

In your observation and view what changes the program has made in terms of reducing open defecation and promotion of hygiene behavior?

In your views what are the visible and distinct changes in terms of reducing open defecation that has happened as a result of intervention? What suggestions do you have to improve the efficiency of future programmes?

Summarized answers/findings

EFFICIENCY

Questions
In your view what are the major strengths and weaknesses of programme implementation in terms of inclusion, participation as well as application of core principles ⁵² of CLTS/CATS approach?
What challenges were faced in efficient implementation of the programme and how those could be overcome?
How appropriate was the targeting and coverage, timely task delivery coordination, and cohesiveness of the programme? Indicate major strengths and weaknesses.
How the coordination and cohesiveness could be improved and made more efficient?
How effective was M&E and management of the programme?
How participatory was the M&E programme? Was there any participation of the end users in identifying the indicators of change?
In your views what has been the strengths and weaknesses of financing and HR management of the programme? How best this could have been improved?
How strong or weak of documentation, sharing and learning and standardizing the good practice?
Summarized answers/findings

SUSTAINABILITY

Questions
In your view what strengths and weaknesses do you see in terms of strategies and interventions that have been put in place to sustain ODF status? Is the programme's

⁵² CLTS/CATS: Processes involved at each step of Pre-triggering, triggering, post triggering PAML and Post ODF interventions for moving up ladder and sustainability

interventions are appropriate and adequate in relation to Post ODF follow-up of CLTS?

What are the risks that might jeopardized the ODF status which needs to be addressed to?

What are the strengths and weaknesses of the intervention do you see in order to mainstream climate change and disaster risk reduction elements in the programme?

What are the key enablers of sustainability that needs to be strengthened in future?

Summarized answers/findings

GENDER and INCLUSION

Questions

In your view what are the strengths and weaknesses of the *programme needs assessment* in terms of sex and gender disaggregation?

What are the strengths and weaknesses of the programme design in terms of inclusion of interventions to address gender issues in sanitation?

To what extant the sanitation facilities augmented by the program are equally, easily accessed by persons with a disability and LGBTQIA. How do LGBTQ view access to WASH in comparison to other population group?

How do you see the strengths and weaknesses in facilitating active participation of women and girls in implementation of the programmes?

To what extent do you see the gender-sensitivity indicators of M&E included in the programme/project design (e.g., sex and age disaggregated data etc.)?

Summarized answers/findings

Any other Important notes:

Names of team members
conduced KII and SSI

2.5: GUIDELINE FOR PREPARING FGD REPORT

Name of the municipality (Please state Rural or Urban)	Date & Time	Province	District

Facilitator	Content Recorder	Translator (if any)

NUMBER OF PARTICIPANTS		
Male	Female	Total

CHARACTERISTICS PARTICIPANTS (Please briefly described the characteristics of the participants group interns of age, sex, ethnicity including special information such as municipal member, community leader, religious leader, group member, PWD, teachers, forest users group , LGBTIQ etc.)

1. RELEVENCE

1.1. Participants stated most vulnerable groups in the community

[Redacted]

1.2 Participants' stated 5 most important needs of vulnerable groups in the community

[Redacted]

1.3. Participants' expressed priority sanitation needs

[Redacted]

1.4. Participation stated gaps and needs for standard sanitation in schools

Gaps	Needs

1.5. Opinion of the participants: To what extent the project strategies were sensitive to the local culture, gender and social inclusion of men, women, girls, boys, PWDs, older persons or senior citizens, LGBTQIA and ethnic minorities? ?

[Redacted]

1.6. Opinion of the participants: How the sanitation situation, behaviour and practices of community members is affected by the emergence of COVID-19?

[Redacted]

1.7. Opinion of the participants: What kind of services and input they received from the programme for COVID 19 IPC?

[Redacted]

2. EFFECTIVENESS

2.1. Participants' level of satisfaction on the attainment of project outcome		
Intended results	Attainment Satisfaction Score Least 1-2-3-4-5-Higest	Explanation justifying the given score
Proportion of the population practicing open defecation has been reduced from the baseline 10% to 1%		
Access to safe and sustainable sanitation and hygiene facilities in homes and institutions have been increased		
Sanitation and hygiene behaviours practices have been improved		
Municipality have enhanced capacity to provide access to safe and sustainable sanitation and hygiene facilities		

2.2. Participants' recognized project interventions and score on the basis of their preference		
Intervention	Preference score Lest 1-2-3-4-5 highest	Explanation justifying the given score

2.3. Did the municipality developed and roll out sanitation action plan for achieving total sanitation status?

Factors contributed and challenges faced in planning and rolling out

Suggestions for effective planning and rolling out

2.4. Opinions of the respondents: What could make the project more effective?

Observation: did the action plan include strategies and activities related to climate change adaptation and DRR in sanitation (Observe the document at the sight)

2.5. Are the municipal members who attended the FGD are aware about Three Star Approach to WASH in schools? What capacity of your municipality has developed to apply this approach and what activities the Palika implemented in the school in line with this approach?

2.6. Participant's opinions: the changes incorporated in the program to reduce open defecation and improving hygiene behaviour has been reflected distinctly.

What else could have made better changes?

Participants identified other programmes/organizations working in the WASH sector

3. EFFICIENCY

CLTS: Triggering and Post triggering follow-up

3.1. Did participants recall triggering exercise of CLTS? If yes, then what particular events and activities did they remember

3.2. Who participated in the triggering exercise and who could not? Was triggering exercise held in one location of the village involving all members of the community? Or it was organized in separate groups of men women and children/ adults/ children in separate groups? Was the venue of the triggering exercise in someone's house/ courtyard or common place? Who decided the triggering exercise?

3.3. What was participant's opinion about most vulnerable and socially excluded groups in triggering exercise? What were the main constraints for everyone's participation?

3.4. Who did post triggering follow-up/monitoring and how? Was there any committee formed by the villagers?

3.5. What were their plans and actions after the community became ODF to move up along the sanitation ladder? Did they receive post ODF facilitation and guidance from the relevant actors? Did the community report about the involvement of private sector/dealers of sanitation hardware to support the upward movement along the sanitation ladder?
3.6. Participants observation on any changes in diarrhea, dysentery and enteric disease patients reporting to the village quack/ private practitioners, local health post or district hospitals for treatment. Did the number increased, decreased, or did the number remain the same?
3.7. Do the kids Under 5 look healthier now than before? Did the baby ever have diarrhea and dysentery? What percentage of the kids have pot belly?
3.8. Is there any regular BMI checking of babies by the government? If yes, what percentage are malnourished, stunted, and underweight? Does the mother feel any inter relation with underweight and bouts of diarrhea?
3.9. Is their regular scheduled vaccination programme of Under 5 children in the village?
3.10. Are their regular visit by healthcare workers?
3.11. Does the health extension workers' pay house to house visit to advise on pre-natal and post-natal care of the mother and the new born kids including distribution of birth control pills and contraceptives and educate them on safe and hygienic disposal of contraceptives and sanitary products.

4. SUSTAINABILITY

4.1. Participants' views on the possibility of sustaining the ODF status and anticipated challenges in maintaining the same?

Suggestions for overcoming challenges

4.2. Participants' views on the factors responsible for sustaining ODF status and maintain the movement up along the sanitation ladder

Encouraging	Discouraging

4.3. Participants' views about risk of ODF status jeopardy and needs to be addressed

Risks	Needs to be addressed

4.4. Participants' views of key enablers of sustainability that can be strengthened in future

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5. GENDER and INCLUSION

5.1. Participants' views on the strengths and weaknesses of women's participation in community sanitation improvement initiative

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Suggestion for more effective participation

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5.2. Participants' views on the strengths and weaknesses of PWD's participation and access to sanitation facilities

Suggestion for more effective participation

5.2. Participants' views on the strengths and weaknesses of LGBTIQ's participation and access to sanitation facilities

Suggestion for more effective participation

Any other Important notes:

Names of team members
conduced KII and SSI

2.6: INFORMED CONSENT FOR THE RESPONDENT OF KAP SURVEY

INTRODUCTION

Namaskar,

My name is _____ and I am working for the Survey Team of the CLTS Foundation-India and CDS-Nepal currently evaluating the Sanitation Programme of UNICEF and the Government of Nepal.

You are invited to participate in a Knowledge Attitude and Practice (KAP) survey as part of the *Summative Evaluation of Sanitation Programme Outcomes*. This is a programme evaluation commissioned by UNICEF-Nepal and jointly being conducted by CLTS Foundation India and CDS –Nepal. Besides question and answer the survey will also include direct observations of sanitation facilities and there usages in your home and in need audio-video recording and shooting of photographs on the interview and observation will be made. It should take approximately an hours to complete.

PARTICIPATION

Your participation in this survey is voluntary. You may refuse to take part in the study or exit the survey at any time. You are free to decline to answer of any question you do not wish to answer for any reason. You can stop me at any time to ask questions and clarifications. You can also stop the interview if you don't feel like responding. Your participation or refusal will not impact any benefits or services received.

BENEFIT

You will receive no direct benefits from participating in this evaluation study. However, your responses may help us learn more about the strengths and weaknesses of the programme as well as drawing lessons and recommendations for making the programme more effective in future. The information you provide will help your government and international organizations to design and monitor projects that will improve the existing sanitation situations in your community, area and the country. Your honest and responsible answer will enrich the planners and decision-makers of Nepal to plan more effective water and sanitation interventions for the benefit of thousands of villages and towns in Nepal

RISKS

There are no foreseeable risks involved in participating in this study. However, you may find some of the questions sensitive which might cause emotional discomfort. The possible risks or discomforts of the study are minimal. You may feel a little uncomfortable answering some survey questions related to defecation and hygiene practices. For avoiding risk of being exposed with COVID-19, we advise you wearing face mask during the entire period of interview, avoid shaking hands with the evaluation team members/survey enumerators and maintain at least a 1-metre distance between yourself, other participant and the survey enumerators.

CONFIDENTIALITY

Your survey answers will be sent to a web link at KoBo Collect to UNICEF-Nepal where data will be stored in a password protected electronic format. We will not collect identifying information such as your name, email address, or any other contact details. Therefore, your responses will remain anonymous. No one will be able to identify you or your answers. We assure you that any information you provide will remain confidential and will not be used for any reason other than this study.

CONTACT

If you have questions at any time about the study or the procedures, you may contact Dr Kamal Kar; the Lead Consultant of this evaluation study via phone at [number] or via email at [email address]. Please feel free to contact him if you feel you have not been treated according to the descriptions in this form, or that your rights as a participant in research have not been honored during the course of this survey, or you have any questions, concerns, or complaints that you wish to address.

CONSENT

Please select your choice below clicking on the “Agree” or “Disagree” button indicated below

- You have read the above information
- You voluntarily agree to participate

Agree
 Disagree

2.7. INFORMED CONSENT FOR KEY INFOMART INTERVIEW (KII)

INTRODUCTION!

Namaskar,

My name is _____ and I am working for the Evaluation Team of the CLTS Foundation –India and CDS-Nepal currently evaluating the Sanitation Programme of UNICEF and the Government of Nepal.

You are invited to participate in an interview on the *Summative Evaluation of Sanitation Programme Outcomes*. This is a programme evaluation commissioned by UNICEF-Nepal and jointly being conducted by CLTS Foundation India and CDS –Nepal. It should take approximately one to one and half an hours to complete.

PARTICIPATION

Your participation in this interview is voluntary. You may refuse to take part in or exit the interview at any time. You are free to decline to answer any particular question you do not wish to answer for any reason. You can stop me at any time to ask questions and clarifications. You can also stop the interview if you don't feel like responding. Your participation or refusal will not impact any benefits or services received.

BENEFIT

You will receive no direct benefits from participating in this evaluation study. However, your responses may help us learn more about the strengths and weaknesses of the programme as well as drawing lessons and recommendations for making the programme more effective in future.

RISKS

There are no foreseeable risks involved in participating this study. However, you may find some of the questions and direct observation activity to be sensitive which may cause emotional discomfort. The possible risks or discomforts of the study are minimal. You may feel a little uncomfortable answering some survey questions related to defecation and hygiene practices. For avoiding risk of being exposed with COVID-19 we advise you wearing mask during the whole period of interview, avoid shaking hands with the evaluation team members/survey enumerators and maintain at least a 1-metre distance between yourself, other participant and the evaluating team members.

CONFIDENTIALITY

Your responses, opinions and ideas will be noted and inputted into a consolidated report. Therefore, your responses will remain anonymous. No one will be able to identify your answers. We assure you that any information you provide will remain confidential and will not be used for any reason other than this study.

CONTACT

If you have questions at any time about the study or the procedures, you may contact Dr. Kamal Kar; the Lead Consultant of this evaluation study via phone at [number] or via email at [email address]. Please feel free to contact him if you feel you have not been treated according to the descriptions in this form, or that your rights as a participant in research have not been honored during the course of this interview, or you have any questions, concerns, or complaints that you wish to address

CONSENT

Please select your choice below checking on the “Agree” or ‘Disagree’ indicates that

- You have read the above information
- You voluntarily agree to participate

Agree
 Disagree

If agreed then please put your signature beside your name in the format below.

Signature and date:	
Name and designation:	

2.8. INFORMED CONSENT FOR FGD WITH RESPONDENT WITH AGE 16 AND ABOVE

INTRODUCTION

Greetings! (Namaskar),

You are invited to participate in a Focus Group Discussion (FGD) session on - the *Summative Evaluation of Sanitation Programme Outcomes*. Besides discussion the FGD may include participatory exercises such as transact walk, scoring, drawing etc.. Further, in need audio –video recording will be done and photographs will be taken. This is a programme evaluation commissioned by UNICEF-Nepal and jointly being conducted by CLTS Foundation-India and CDS-Nepal. It should take approximately 60 to 90 minutes to complete.

PARTICIPATION

Your participation in this FGD is voluntary. You may refuse to take part in the study or exit the discussion session at any time. You are free to decline to answer any particular question you do not wish to answer for any reason. Your participation or refusal will not impact any benefits or services received.

BENEFIT

You will receive no direct benefits from participating in this evaluation study. However, your responses may help us learn more about the strengths and weaknesses of the programme as well as drawing lessons and recommendations for making the programme more effective in future. The information you provide will help your government and international organizations design and monitor projects that will improve the existing sanitation conditions in your community, area and the country.

RISKS

There are no foreseeable risks involved in participating this study. However, you may find some of the questions and direct observation activity to be sensitive which may cause emotional discomfort. The possible risks or discomforts of the study are minimal. You may feel a little uncomfortable answering some survey questions related to defecation and hygiene practices. For avoiding risk of being exposed with COVID-19 we advise you wearing mask during the whole period of interview, avoid shaking hands with the evaluation team members/survey enumerators and maintain at least a 1-metre distance between yourself, other participant and the evaluation team members.

CONFIDENTIALITY

Your responses, opinion and ideas will be noted and imputed into a consolidated report. Therefore, your responses will remain anonymous. No one will be able to identify your answers. We assure you that any information you provide will remain confidential and will not be used for any reason other than this study. We advise you to keep focus group discussions (FGD) confidential from anyone outside the group.

CONTACT

If you have questions at any time about the study or the procedures, you may contact Dr. Kamal Kar ; the Lead Consultant of this evaluation study via phone at [number] or via email at [email address]. Please feel free to contact him if you feel you have not been treated according to the descriptions in this form, or that your rights as a participant in research have not been honored

during the course of this FGD, or you have any questions, concerns, or complaints that you wish to address.

CONSENT

Please select your choice below checking on the “Agree” or ‘Disagree’ indicates that

- You have read the above information
- You voluntarily agree to participate

Agree
 Disagree

If agreed, then please put your signature beside your name in the format below.

No	Name	Signature

2.9. ASSENT OF CHILD RESPONDENTS OF FGD

We want to tell you about an evaluation study we will be conducting in your area. Please let us know if you would like to participate in the study with your views and responses.

- The name of this study is: '*Evaluation of Sanitation Programme Outcomes*'

If you have difficulty in understanding any of the questions, please let us know we will be happy to explain to you till you fully understand the questions and the responses we would like to have from you.

You are being asked to be in this meeting/discussion session to share your opinions and ideas because those can be more relevant for the children's wellbeing than that of the opinions and ideas only given by the adult members.

Although your parent (guardian) has given their consent for to participate in the discussion, we would still like to have your decision on this. If choose not to participate you can withdraw anytime.

If you decide to be in this discussion, this is what will happen:

- **We will ask you to give your opinions and ideas on the questions we will ask you**
- We will have you do some interesting group exercise such as drawing, scoring , walking together and observe the sanitation situation in your community
- We will listen to your story if you want to share it with us
- If you agree we can also take photographs and do audio –video recording of your discussions
- This discussion will take approximately one hour time

There is a chance that you might feel uncomfortable with the questions we will ask during the discussions. Please don't feel embarrassed or uncomfortable for asking questions about sanitation and personal hygiene.

Wear face mask, maintain at least one meter distance between yourself, other participant, and the evaluation team members for avoiding risk of exposure from COVID-19.

You don't need to answer all questions. Please feel free not to answer any question if you don't like to.

I have read this form or someone has read it to me. If I do not understand something, I will ask the researcher to explain it to me.

Please click on one box:

- YES, I want to be a part of the study.
 NO, I do not want to be in this study.

Child's Name: _____

*Child's Signature
(if he/she can
sign):* _____

Date: _____ *Age :* _____

The following should be completed by the study member conducting the assent process if the child agrees to participate in the study. Click where applicable:

- The child is capable of reading and understanding the assent form**
- The child is not capable of reading the assent form, but the information was verbally explained to him/her.**
- The child had ample opportunity to have his or her questions answered.**

<i>Name of person obtaining agreement:</i>	_____
<i>Signature of person obtaining agreement:</i>	_____
<i>Date:</i>	_____

2.10. PARENT'S/ GUARDIAN/CARETAKER'S CONSENTS FOR CHILD FOR FGD

Your child is invited to take part in a FGD session as part of a study on the *Summative Evaluation of Sanitation Programme Outcomes*. This is a programme evaluation commissioned by UNICEF-Nepal and jointly being conducted by CLTS Foundation India and CDS –Nepal. The FGD session will take approximately 60 minutes to complete and will take place in the suitable place in your ward/community.

If you permit your child to be in this discussion meeting, this is what will happen:

- **He/she will participate in a discussion meeting together with another 8 to 10 children of your community/ward.**
- **We will ask him/her to give opinions and ideas on the questions we will pose related to sanitation programme.**
- He /she may have to do some interesting group exercise such as drawing, scoring, walking together and observe the sanitation situation in your community.
- If you and your child agree then we can also take photographs and do audio –video recording of discussions

PARTICIPATION

Taking part in this research project is voluntary. You do not have to agree to your child's participation, and you can stop them at any time. Your child's participation or refusal will not impact any benefits or services received.

BENEFIT

You or your child will receive no direct benefits from participating in this evaluation study. However, your child's responses may help us learn more about the strengths and weaknesses of the programme as well as drawing lessons and recommendations for making the programme more effective in future.

RISKS

There are no foreseeable risks involved in participating in this study however, you child may find some of the questions and discussion topic to be sensitive which may cause emotional discomfort. The possible risks or discomforts of the study are minimal. Your child may feel a little uncomfortable answering some questions related to defecation and hygiene practices. For avoiding risk of being exposed with COVID-19 we will make sure that your child wear mask, maintain proper distance between him/herself and other participants.

CONFIDENTIALITY

Your child's responses, opinions and ideas will be noted and inputted into a consolidated report. Therefore, his/her responses will remain anonymous. No one will be able to identify his/her answers. We assure you that any information your child provide will remain confidential and will not be used for any reason other than this study.

CONTACT

If you have questions at any time about the study or the procedures, you may contact Dr. Kamal Kar; the Lead Consultant of this evaluation study via phone at [number] or via email at [email address]. Please feel free to contact him if you feel your child have not been treated according to the descriptions in this form, or that your rights as a participant in research have not been honored

during the course of this FGD, or you have any questions, concerns, or complaints that you wish to address.

CONSENT

Please select your choice below checking on the “Yes” or ‘No’ indicates that

- You have read the above information
- You permitted your child to participate

Yes
 No

If yes

Name of the child	Your signature over your name stating your relationship with the child

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Annex 4: Survey Data Tables and Figures

Table and Figure	Page
1. DEMOGRAPHIC	
Table 1.1. Sociodemographic Data on the Survey participants	187
Table 1.2. Respondents by Focused and Non-focused Districts	188
Table 1.3. Household (HH) Demographic data	188
Table 1.4. Household with persons with disability (PWD)	190
Table 1.5. Criteria specific points for analysis	190
Figure 31. Province-wise prevalence of OD	191
Table 1.7. Prevalence of OD by Focused and Non-focused Districts	191
2. KNOWLEDGE AND ATTITUDES	
Table 2.1. Open Defection and Its Consequences	192
Table 2.2. Open Defection and Its Consequences	193
Figure 33 & 34. Advantage of having a HH Latrine and Criteria of a Safe Latrine	196
Figure 35 & 36. Hand Washing	196
3. ACCESS TO FACILITIES and INFORMATION	
Table 3.1. Access to Latrine at Household	197
Table 3.2. Access to Household Latrines by Type	197
Table 3.3. Household Pit Latrines by Type by Present Status	198
Figure 37. Reasons for Not Having Household Latrine	199
Table 3.5. Categories of Members Do Not Use Latrine in HH Having Latrine	199
Table 3.6. Effect of Flood on the access to HH Larine	200
Table 3.7. Access to Handwashing Facilities	200
Table 3.8. Changes in Sanitation Facilities	201

Table 3.9. Access to Information, Education & Communication	202
4. PRACTICES	
Table 4.1. Cleanliness of Latrine and Maintenance of Handwashing Facilities	204
Table 4.2. Repairing and Reconstruction of Latrine	205
Figure 38. Defecation and Excreta Disposal	206
Table 4.4. Hand Washing	206
Table 4.5. Anal Cleansing	210
Table 4.6. Sludge Management	211
Table 4.7. Participants observation on the use of latrines by his/ her community members	211
5. DIRECT OBSERVATIONS OF HOUSEHOLDS	
Figure 40. Latrine Status Observed	213
Table 5.2. Hand Washing Facilities Observed	213
Table 5.3. Accessibility Observed	214
Table 5.4. Location of Latrine Observed	214
Table 5.5. Toilet Standard Observed	214
Table 5.6. Awareness Creation Messages Observed	214

1. DEMOGRAPHIC

Table 1.1. Sociodemographic status of the survey participants

Study participants (N= 2468)	Number	Percent
Province-wise study participants		
Madhesh	1624	65.8
Bagmati	200	8.1
Lumbini	204	8.3
Karnali	233	9.4
Sudurpaschim	207	8.4
District-wise study participants		
Bara	407	16.5
Kailali	207	8.4
Kapilavastu	204	8.3
Kavre	200	8.1
Mugu	232	9.4
Rautahat	404	16.4
Saptari	404	16.4
Sarlahi	410	16.6
Municipalities/Rural municipalities wise study participants		
Baragadhi RM (Ward 1-5)	201	8.1
Chakraghatta Rural Municipality (Ward 1-9)	200	8.1
Chayanath Rural Municipality (Ward 2,3,7)	232	9.4
Dhangadhi Sub-Metropolitan City (ward 10, others)	208	8.4
Durga Bhagwati Rural Municipality	201	8.1
Kanchanroop Municipality (Ward 3-10)	201	8.1

Mahabharat RM (Ward 6-8)	200	8.1
Mahagadimai municipality (Ward 1-4, 6-8, 10)	204	8.3
Malangawa Municipality (Ward 1-5, 7,9,10,12)	211	8.5
Rajdevi Municipality (Ward 1-9)	204	8.3
Rupani Rural Municipality (Ward 2,3,4,6)	202	8.2
Shivaraj Municipality (Ward 2,8)	204	8.3

Table 1.2. Respondents by Focused and Non-focused Districts

	Frequency	Percentage
Non focused (Kavre and Kailali)	407	16.5
Focused (Bara, Kapilavastu, Mugu, Rautahat, Sarlahi, Saptari)	2061	83.5
Total	2468	100.0

Table 1.3. Household (HH) Demographic data

Demographic data (N= 2468)	Number	Percent
Gender		
Male	1602	64.9
Female	851	34.5
LGBTQIA	15	0.6
Age in years: Median: 40; IQR: 19 (Minimum age: 14 years & Maximum age: 90 years		
Less than 20 years	56	2.3
20-29 years	434	17.6
30-39 years	618	25.0
40-49 years	627	25.4
50-59 years	420	17.0
60 and above years	313	12.7

Demographic data (N= 2468)	Number	Percent
Marital status		
Married	2232	90.4
Single	135	5.5
Divorced	3	0.1
Widow/widower	98	4.0
Education		
Pre-primary	1527	61.9
Primary	388	15.7
Lower secondary	229	9.3
Upper secondary	202	8.2
Higher	122	4.9
Primary Occupation		
Selling labor	877	35.5
Farmer	970	39.3
Self-employed	277	11.2
Unpaid family worker	10	0.4
Housewife	144	5.8
Student/too young to work	55	2.2
Unemployed	54	2.2
Other	81	3.3
Religion		
Hindu	2213	89.7
Buddhist	102	4.1
Christian	31	1.3
Muslim	122	4.9
Caste of the HHs (caste/ethnic groupings by GoN)		

Demographic data (N= 2468)	Number	Percent
Dalit	1041	42.2
Disadvantaged Janajatis	194	7.9
Disadvantaged non-Dalit Terai caste groups	176	7.1
Religious Minorities	73	3.0
Relatively advantaged Janajatis	511	20.7
Upper caste groups	473	19.2

Table 1. 4. Household with persons with disability (PWD)

Disability status (N= 2468)	Number	Percent
Yes	159	6.4
No	2309	93.6

Table 1.5. Household Asset and Income

HH assets (N= 2468)	Number	Percentage
Livelihood Occupation of HHs Members and Sources of Income		
Labor	1184	48.0
Farming	1235	50.0
Livestock and poultry rearing	343	13.9
Small business	320	13.0
Job	138	5.6
Dependent on remittance	143	5.8
Other specify	40	1.6
Approximate average monthly income range of the HH (In Rs.)		
Median: 12536; IQR: 5000 (Min: 1300 & Max: 200000)		
Approximate Average Monthly Expenditure Range of the HH (In Rs.)		

Median:9315; IQR: 5685 (Min: 1000 & Max: 220000)		
Supporting mechanisms while deficit monthly income (Multiple responses)		
Remittance of money	1315	53.3
Essential support (food, medicine, etc.) when required	1369	55.5
Support during illness and health emergency	1566	63.5
Loan with interest or without interest	933	37.8

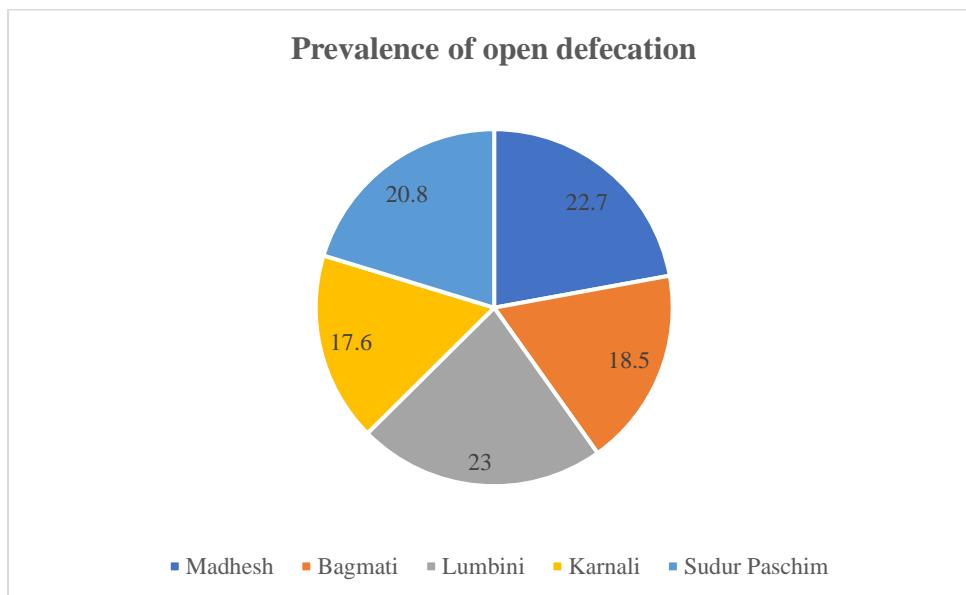


Figure 32: Province-wise prevalence of OD (N=537)

Table 1.7. Prevalence of OD by Focused and Non-focused Districts

Districts	Number	Percentage
Focused (Bara, Kapilavastu, Mugu, Rautahat, Sarlahi, Saptari)	457	22.2
Non focused (Kavre and Kailali)	80	19.7
Total	537	21.8

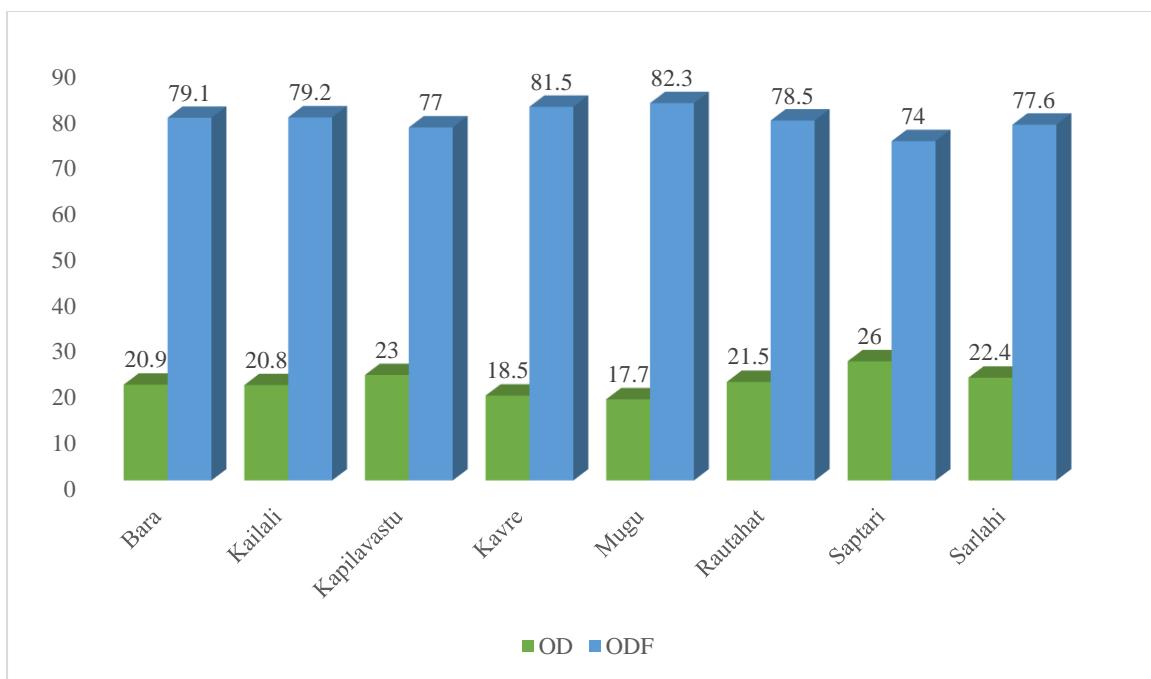


Figure 33. District-wise prevalence of OD (N=2468)

2. KNOWLEDGE AND ATTITUDES

Table 2.1. Open Defection and Its Consequences

Knowledge and attitudes	Frequency	Percentage
Do you think open defection practice is a problem? (N=2468)		
Yes	2075	84.1
No	393	15.9
*Why do you think it is a problem? (N=2075)		
Pollute the environment	1846	84.1
Cause diseases and malnutrition	1600	74.8
Disgusting: it brings back shit in our mouth	1363	64.8
Jeopardy privacy and dignity	1200	57.8
Uncomfortable when under the pressure of reliving, rain, and nighttime	1210	53.8
Risk of women being sexually abused	1073	51.7

Others	19	0.9
*What are the diseases that can be reduced and prevented by stopping open defecation practices? (N=2468)		
Diarrhea	2316	93.8
Worm infections	1787	72.4
Typhoid	1548	62.7
Cholera	1834	74.3
Hepatitis	1114	45.1
Polio	1025	41.5
Trachoma	1028	41.6
Others (parasitic infestation)	43	1.7

*Multiple responses

Table 2.2. Open Defecation, Fecal-Oral Contamination, and Diarrheal Diseases

	Frequency	Percentage
Do you agree that the human excreta come back home if open defecation continues? (N=2468)		
Yes	2210	89.5
No	258	10.5
If yes, then how does it happen? (N=2210)		
Contaminated/ Polluted water that we use	2044	82.8
Flies bring it to our food	324	13.1
Dry feces and dust blow in the wind and land in our food, nose, and mouth	62	2.5
Chicken, dogs, and other domestic animals bring them back from the field/bush to our homes	29	1.2
Vegetables	8	0.3

Other pathways	1	0.0
How does a person get diarrhea? (N=2468)		
No handwashing before eating	2250	91.2
No handwashing after defecation	1744	70.7
No handwashing after cleaning children's bottoms and disposal of feces	2011	81.5
No handwashing before feeding a child	1557	63.1
Drinking untreated water	1309	53.0
Eating stale food and half-cooked food	1516	61.4
Poor and unhygienic kitchen food handlers.	1057	42.8
Cleaning or washing vegetables before eating	1159	47.0
Don't know	25	1.0
Others	18	0.7
*How does diarrhea spread? (N=2468)		
Dirty hands	2163	87.6
Dirty water	1998	81.0
Flies	2081	84.3
Solid and liquid waste	1455	59.0
Unclean food	1662	67.3
Dirty latrine	1539	62.4
Open defecation	1531	62.0
Through animal feces	1291	52.3
Don't know	55	2.2
Other	1	0.01
*What is the best way of reducing the risk of sanitation-related diseases? (N=2468)		

Using a safe latrine in one's house regularly	2360	95.6
Every house in a community has a safe latrine and is used by all in the family	1950	79.0
Everyone in the house practices proper handwashing	1768	71.6
Drink safe water	1524	61.8
Others	42	1.7
Do you have children under 5 in your house? (N=2468)		
Yes	1131	45.8
No	1337	54.2
Did any child under 5 years face diarrhea in the last two weeks? (N=1131)		
Yes	725	64.1
No	406	35.9

Note: Prevalence of Diarrhea is 339 per 1000 under 5 population (Source: DoHS, Annual Report 2078/79)

*Multiple responses

Advantage of having Latrine

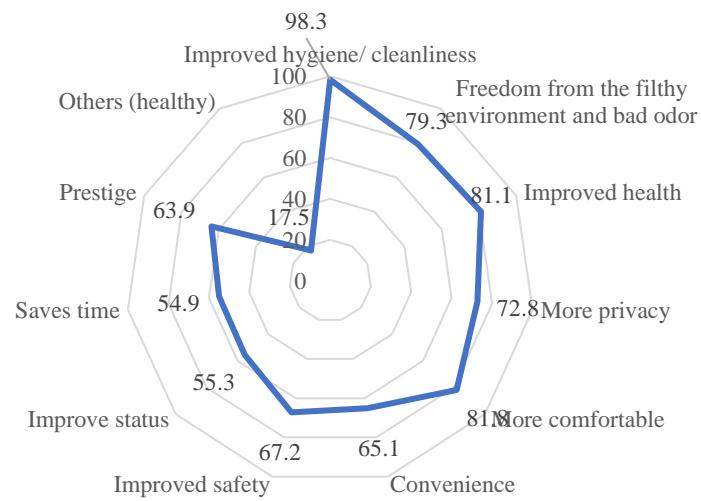


Figure 34. Advantages of having latrine (N=2468)

Criteria for a safe latrine

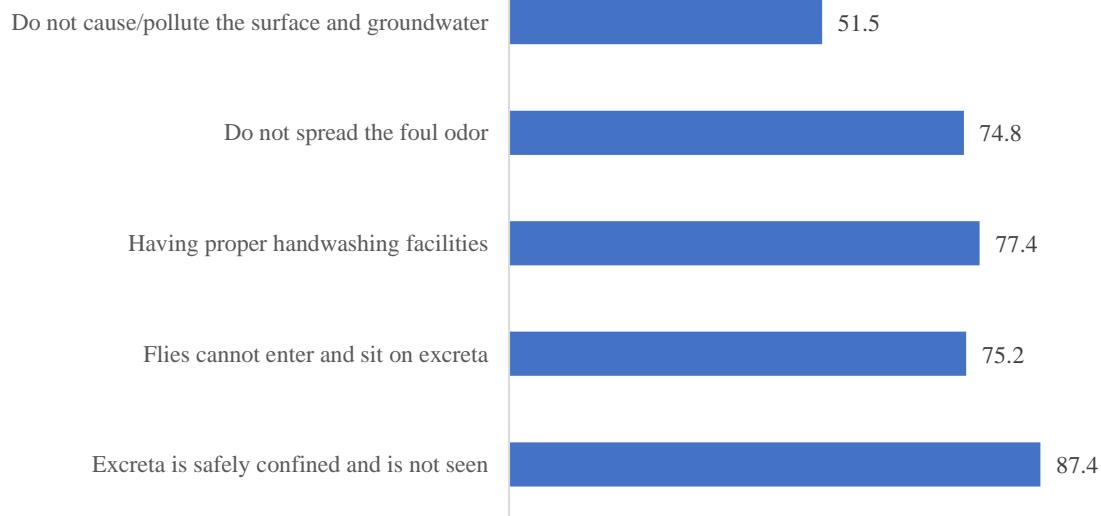


Figure 35. Criteria of safe latrine (N=2468)

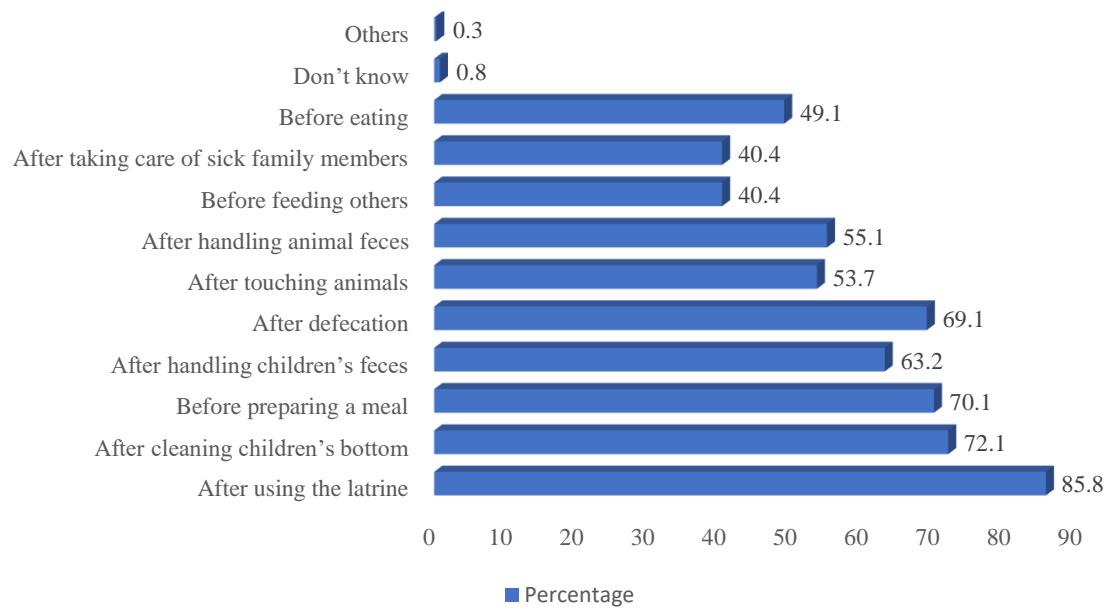


Figure 36. Hand Washing

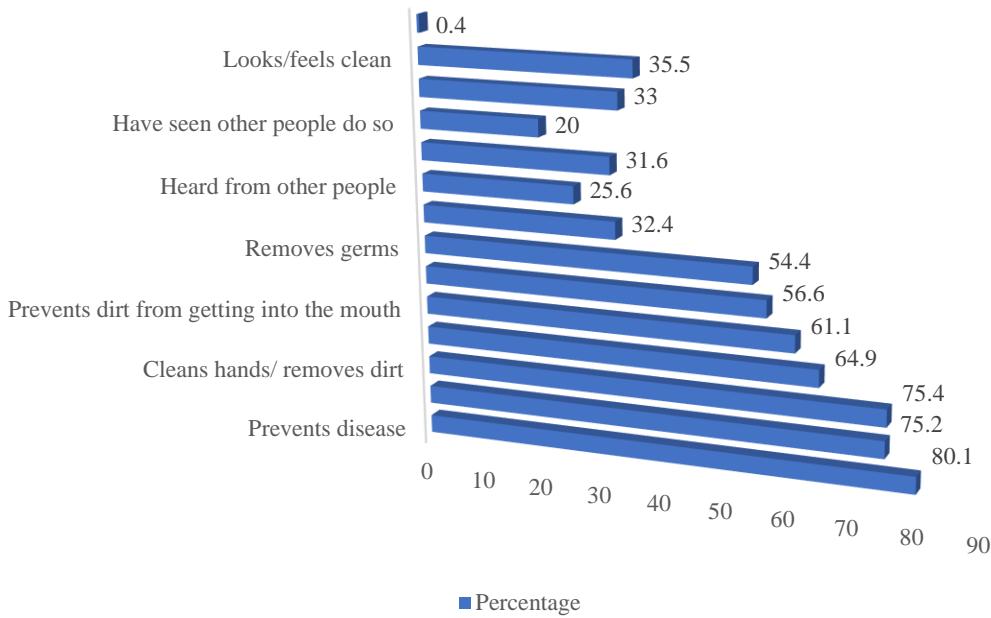


Figure 37. Importance of washing hands with soap

3. ACCESS TO FACILITIES and INFORMATION

Table 3.1. Access to Latrine at Household

	Frequency	Percentage

Do you have a latrine in your home/house? (N=2468)			
Yes		1943	78.7
No		525	21.3
If yes: When your house- latrine was built? (N=1943)			
Before 2018		1000	51.5
After 2018		943	48.5

Table 3.2. Access to Household Latrines by Type

What type of latrine do you have in your home/house at present? (N=1943)					
Improved	F	P	Unimproved	F	P
Flush or pour-flush to sewerage	87	4.5	Flush or pour-flush to elsewhere	302	15.5
Flush or pour-flush to sewerage (into treatment plant)	53	2.7	Open-pit latrine without a slab	112	5.8
Flush or pour-flush to a septic tank or pit	1014	52.2	Public or shared latrine (any type)	3	.2
Pit latrine with slab	329	16.9	Defecating while standing in the water	31	1.6
Toilet attached to biogas	12	0.6			
Total improved	1495	76.9	Total unimproved	448	23.1

Table 3.3. Household Pit Latrines by Type by Present Status

	Frequency	Percentage
If the toilet is with a pit, how many pits are there? (N=1943)		
1 pit	1584	81.5
2 pits	359	18.5
If 1 pit, has your toilet pit been filled in? (N=1584)		

Yes	591	37.3
No	993	62.7
If yes, where is that disposed of (N=993)		
Of-open field	291	49.2
Trenches	143	24.2
Treatment plant	134	22.7
Not emptied	23	3.9
If not emptied- did you make another toilet (N=993)		
Yes	144	14.5
No	849	85.5
If no, mention the reason (N=849)		
No money	260	30.6
Using other's toilet	30	3.5
No willingness	325	38.3
Others (Specify)	234	27.6
Do you have a latrine with functioning/ usable now? (N=2468)		
Yes	1931	78.2
No	537	21.8

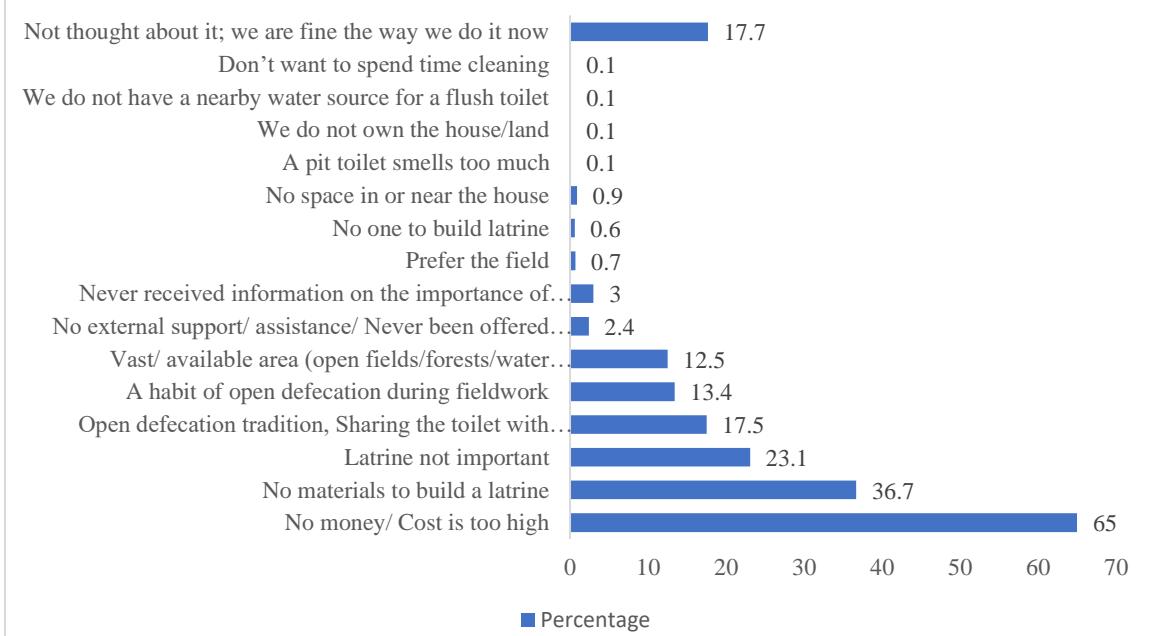


Figure 38. Reasons for not having household latrine (N=537)

Table 3.5. Categories of members do not use latrine in HH having latrine

Who in the family member does not use the toilet? (N=623)		
Children	335	62.6
Young age people	177	33.1
Older people	111	20.7

* Multiple responses

Table 3.6. Effect of flood on the access to HH latrine

Was your latrine flooded in the past year? (N=2468)	Frequency	Percentage
Yes	305	12.4
No	2163	87.6
Yes, have it been damaged? (N=305)		
Yes	184	60.3
No	121	39.7
If yes- have you repaired that? (N=305)		

Yes	154	50.5
No	151	49.5
*If yes- what repair work was done? (N=151)		
Changed wall	115	74.7
Raised toilet	83	53.9
Changes roof	28	18.2
Others	8	5.2
If not, where are you defecating? (N=151)		
Open defecation	93	61.6
Neighbor toilet	14	9.3
Others (Using plastic, bottles)	44	29.1

* Multiple responses

Table 3.7. Access to Handwashing Facilities

	Frequency	Percentage
Does your house latrine have a handwashing facility? (N=2468)		
Yes	1118	45.3
No	1350	54.7
If yes, then what is available? (N=1118)		
Only water	451	40.3
Water and soap	667	59.7
At home, do you have a fixed hand-washing place/ station? (N=2468)		
Yes	1376	55.8
No	1092	44.2
If yes, does it always have water and soap? (N=1376)		
Yes	1260	91.6

No	116	8.4
If yes, where is it located? (N=1260)		
Inside the house	530	42.1
Outside the house	730	57.9
If yes, observe the water and soap availability (N=1260)		
Water is available	1052	83.5
Water is not available	34	2.7
Soap is available	160	12.7
Soap is not available	14	1.1

Table 3.8. Changes in Sanitation Facilities

	Frequency	Percentage
Is this your first latrine? (N=2468)		
Yes	2083	84.4
No	385	15.6
If not, how many latrine(s) have you built before? (N=385)		
One	250	64.9
Two	115	29.9
Three or more	20	5.2
How do you compare your present and latrine with the previous one? (N=385)		
As same as previous	245	63.6
Better and improved than that of the previous one	140	36.4
*Reasons for not improving/ changing your latrine type? (N=245)		
No money/ Cost is too high	189	77.1
No land to build my latrine	98	40.0

No materials to build an improved latrine	54	22.0
No external support/ assistance	32	13.1
Don't know how to build an improved latrine	24	9.8
We do not have access to the water supply at home for flushing the toilet	4	1.6
Satisfied with same latrine type	5	2.0
Others (No one to build an improved latrine)	65	13.7

*Multiple responses

Table 3.9. Access to Information, Education & Communication

	Frequency	Percentage
In the last year, have you received any messages or visual/reading material on sanitation and hygiene? (N=2468)		
Yes	2183	88.5
No	285	11.5
*If yes, what sanitation and hygiene messages do you receive, and in what form? (N=2468)		
Build a latrine	1638	75.0
Always use a latrine/ stop open defecation	1427	65.4
Safe disposal of infants' feces	1070	49.0
Wash hands with soap	1218	55.8
Drink safe water	1021	46.8
Treat drinking water	887	40.6
Store drinking water safely	764	35.0
Safe and hygienic food	732	33.5
Wastewater /stagnant water management	677	31.0
Proper solid waste management	625	28.6
Don't know	290	13.3

Others, specify	87	4.0
*If yes, where did you see, hear, and receive these messages?		
Posters or leaflets in the village	1318	60.4
At community meetings	1371	62.8
In government offices	1051	48.1
When visiting a health facility	939	43.0
Material received at your home (handouts, newsletter, etc.)	463	21.2
In newspapers or magazines	406	18.6
On TV	510	23.4
On the radio	530	24.3
Don't know	294	13.5
Other	81	3.7
If yes, when did you see, hear, and receive these messages? (N=2183)		
This week	148	6.8
Last month	737	33.8
For more than a month	483	22.1
6 months or years ago	815	37.3
*If yes, from whom did you hear/ receive these messages?		
Village chief	1333	61.1
Government agency	1197	54.8
NGO	994	45.5
From family members	686	31.4
From neighbors	637	29.2
Don't know	299	13.7

Cannot remember	91	4.2
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*Multiple responses

4. PRACTICES

Table 4.1. Cleanliness of Latrine and Maintenance of Handwashing Facilities

	Frequency	Percentage
How often do you/ your family members clean your latrine? (N=2468)		
Once a day	511	20.7
More than once a day	189	7.7
Once every 2 – 3 days	591	23.9
Not very often (less than once a week)	134	5.4
Rarely	907	36.8
Others	136	5.5
*What do you do to keep the handwashing facilities upright? (N=2468)		
No specific handwashing facility is available	596	24.1
The respondent refused to show the place	98	4.0
Tippy tap	259	10.5
Bucket with tap	548	22.2
Jug	561	22.7
Basin	127	5.1
Sink	30	1.2
Hand pump	738	29.9
Others	40	1.6
*What do you do to control foul odor? (N=2468)		
Commercial cleaning supplies	1325	53.7
Clean regularly with water	1171	47.4
Burn a candle	84	3.4

Increase airflow	356	14.4
Make a DIY air freshener	200	8.1
Remove mold and mildew	365	14.8
Sprinkle lime and other disinfectant powders	280	11.3
Others	171	6.9

*Multiple responses

Table 4.2. Repairing and Reconstruction of Latrine

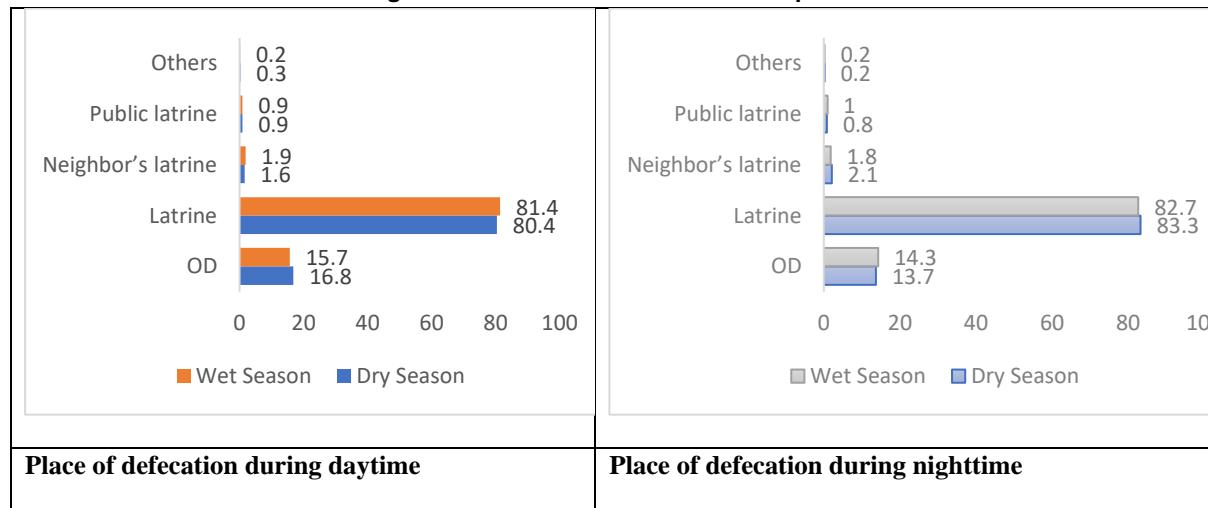
	Frequency	Percentage
*What do you do when your latrine is broken/ collapsed/ become unusable? (N=2468)		
Build a new latrine	1070	43.4
Fix/ repair latrine	1290	52.3
Use neighbor's latrine	453	18.4
Use relative's latrine	318	12.9
Use public latrine	262	10.6
Revert to OD	212	8.6
Others, specify	236	9.6
If the latrine is rebuilt/fixed/ repaired, when do you re-build/ build new/ fix/ repair your latrine? (N=2468)		
Immediately/ ASAP	1063	43.1
When have money/ materials	1100	44.6
When receiving external support/assistance	53	2.1
After the rainy season	15	0.6
Others, specify	237	9.6
Has your toilet been repaired? (N=2468)		
Yes	693	28.1
No	1775	71.9

If yes, what type of repair did you do? (N=693)		
Roof	197	28.4
Wall	214	30.9
Door	127	18.3
Pan set	54	7.8
Filing of the pit	81	11.7
Others (Specify)	20	2.9

What was the cost of repair? (N=693)		
Median: 4000; IQR: 4000 (Min: 0 & Max: 150,000)		
How did you manage the cost? (N=693)		
Cost is borne by my own	572	82.5
Loan borrowed	121	17.5

*Multiple responses

Figure 39. Defecation and Excreta Disposal



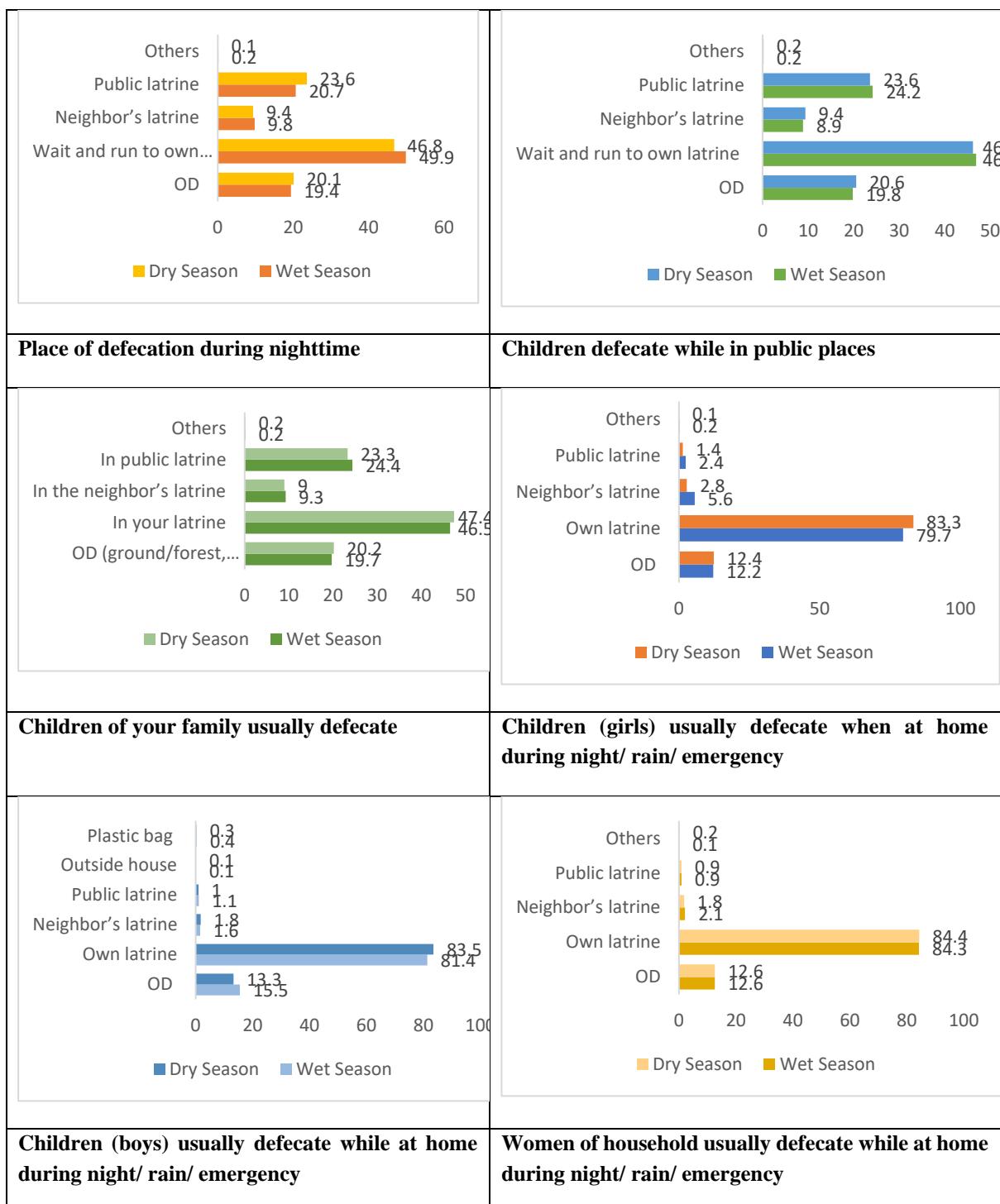


Table 4.4. Hand Washing

	Number	Percentage
*When do you wash your hands (N=2468)		
When hands are dirty	1884	76.3
When returning to the house from work/ from outside	1653	67.0
Before eating	1701	68.9

After eating	1643	66.6
After defecation	1708	69.2
Before feeding child	1236	50.1
Before preparing food	1287	52.1
After cleaning an infant who has defecated	1143	46.3
After touching animals	1010	40.9
After disposal of animal feces	1090	44.2
What do you and other adult members usually use in handwashing? (N=2468)		
Water only	764	31.0
Water and soap	1584	64.2
Water with ash	118	4.8
Others, specify	2	0.1
Do your children (1-14 yrs) have a habit of handwashing? (N=2468)		
Yes	1591	64.5
No	877	35.5
If yes, when do your children wash their hands? (N=1591)		
When hands are dirty	1507	94.7
While returning to the house	1141	71.7
Before eating	1318	82.8
After eating	1280	80.5
After defecation	1292	81.2
Before feeding child	922	58.0
School/play	1024	64.4
Before preparing food	844	53.0
After cleaning an infant who has defecated	755	47.5

After touching animals	662	41.6
After disposal of animal feces	686	43.1
Others, specify	1	0.1
If yes, what do your children usually use in handwashing? (N=1591)		
Water only	242	15.2
Water and soap	1326	83.4
Water with ash	23	1.4

Cross tabulation between gender and no hand washing practices

Gender	Male (N=1602)		Female (N=850)		LGBTIQA (16)		Total (N=2468)	
	N	%	N	%	N	%	N	%
While returning to the house	511	31.9	300	35.3	4	25.0	815	33.0
Before eating	479	29.9	282	33.2	6	37.5	767	31.1
After eating	508	31.7	310	36.5	7	43.8	825	33.4
After defecation	465	29.0	289	34.0	6	37.5	760	30.8
Before feeding child	756	47.2	469	55.2	7	43.8	1232	49.9
Before preparing food	718	44.8	456	53.6	7	43.8	1181	47.9
After cleaning an infant who has defecated	807	50.4	509	59.9	9	56.2	1325	53.7
After touching animals	941	58.7	509	59.9	8	50.0	1458	59.1
After disposal of animal feces	902	56.3	467	54.9	9	56.2	1378	55.8

Table 4.5. Anal Cleansing

	Dry Season		Wet Season	
	Number	Percentage	Number	Percentage
What do you usually use for anal cleansing after defecation? (N=2468)				

Water only	1707	69.2	1721	69.7
Leaves	33	1.3	19	0.8
Paper	5	0.2	5	0.2
Stone	3	0.1	2	0.1
Wood	3	0.1	3	0.1
Corncob	0	0.0	1	0.0
Others	1	0.0	1	0.0
Do not say	716	29.0	716	29.0

What do your children in the HH usually use for anal cleansing after defecation? (N=2468)

Water only	1730	70.1	1733	70.2
Leaves	9	0.4	10	0.4
Paper	6	0.2	3	0.1
Stone	3	0.1	2	0.1
Wood	3	0.1	3	0.1
Others	1	0.0	1	0.0
Do not say	716	29.0	716	29.0

Table 4.6. Sludge Management

	Number	Percentage
Has your toilet been filled in? (N=2468)		
Yes	714	28.9
No	1754	71.1
If yes, what do you do when your latrine is full? (N=2468)		
Build a new latrine	164	23.0
Pump-off latrine	356	49.9

Use neighbor's latrine	54	7.6
Use relative's latrine	18	2.5
Revert to OD	26	3.6
Use public latrine	96	13.4
*What happens to the waste when it is removed? (N=2468)		
Used as fertilizer	1368	55.4
Dumped in the forest	670	27.1
Dumped in the river/ pond/ canal	697	28.2
Empty pit contents in a new hole	375	15.2
It is transported to a trench or treatment plant	147	6.0

*Multiple responses

Table 4.7. Participants observation on the use of latrines by his/ her community members

	Number	Percentage
How many HHs in your village use toilet facilities? (N=2468)		
All use toilet facilities	721	29.2
About half of the villagers use toilet facilities	219	8.9
Most of the HHS use some sort of toilet	433	17.5
Everyone uses the toilet	30	1.2
Hardly any households use toilets	123	5.0
I don't know	942	38.2
During the last 7 days did you see any human excreta in an open place in your village? (N=2468)		
Yes	16	0.6
No	2452	99.4
If yes, then where? (N=16)		
Near latrine of household	6	37.5

Bush around residents	10	62.5
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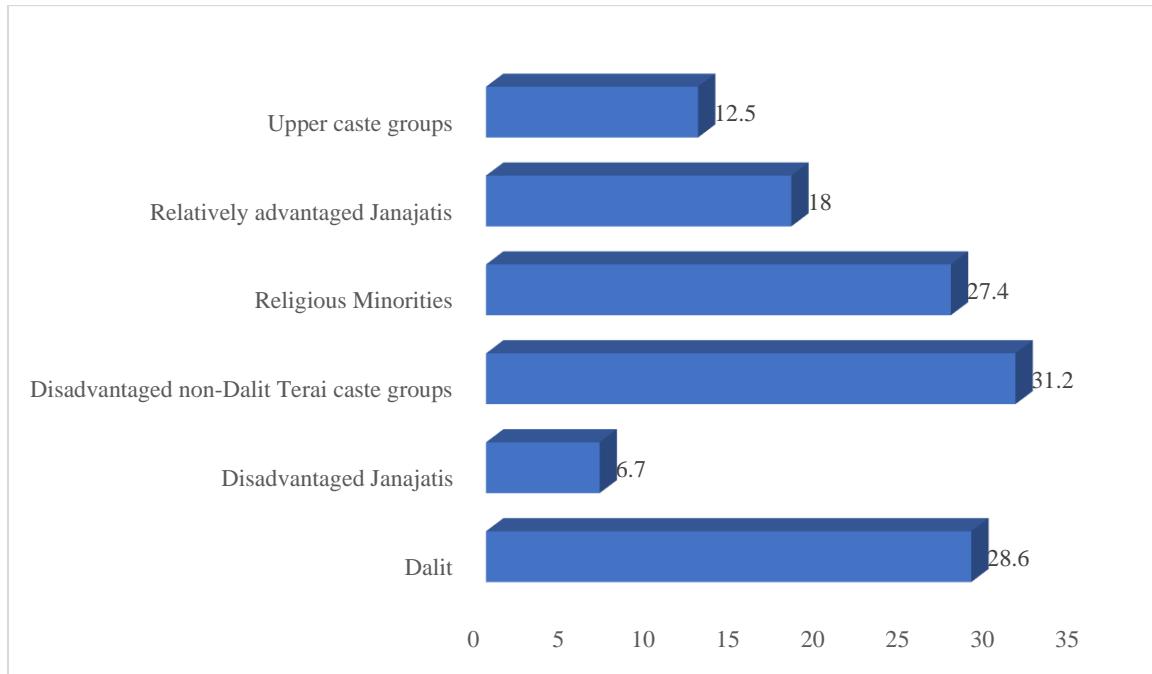


Figure 40. Prevalence of OD and ODF by Caste (N=2468)

5. DIRECT OBSERVATIONS OF HOUSEHOLDS (N=2323)

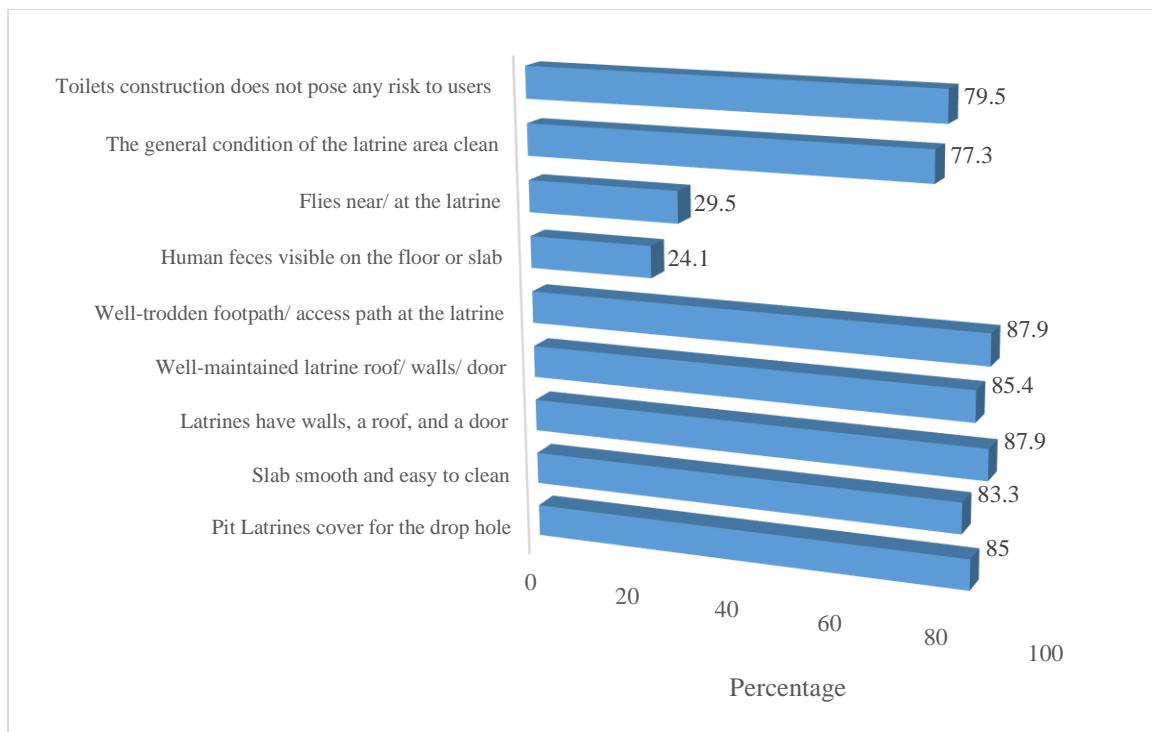


Figure 41. Latrine status

Table 5.2. Hand Washing Facilities Observed

Hand washing facilities	Yes	%	No	%
Is there a handwashing place inside or just outside/near the latrine?	1875	80.7	448	19.3
Do the toilets have handwashing facilities (with accessible water and soap) and anal cleansing material?	1556	67.0	767	33.0
Is there water at the fixed handwashing facility?	1997	86.0	326	14.0
What handwashing materials are observed				
Bar soap	1831	78.8	492	21.2
Liquid soap	459	19.8	1864	80.2
Powder soap	583	25.1	1740	74.9
Ash	795	34.2	1528	65.8
Sand	457	19.7	1866	80.3
Is there a towel or cloth to dry your hands?	668	28.8	1655	71.2
Condition of the towel if it is there (clean, dirty, evidence of use)	649	27.9	1674	72.1
Is there evidence of having been recently used (wet ground/ cement/ presence of water, etc.)?	1728	74.4	595	25.6

Table 5.3. Accessibility Observed

Access for the persons with disability	Yes	%	No	%
Is the latrine accessible for people with physical disabilities?	710	30.6	1613	69.4
Gender considerations				
Are the toilets located in a way that minimizes women and girls' exposure to assaults, especially at night?	1571	67.6	752	32.4
Do the toilets respect cultural preferences and are they segregated by gender?	926	39.9	1397	60.1
Facilities for the children				
(IF THE HOUSEHOLD HAS CHILDREN <5 YEARS) there children's potty/is in the house or around the house?	648	27.9	1675	72.1
If yes, is there observable evidence that the potties are used?	493	21.2	1830	78.8
Number of users				
Is the average number of toilet users not more than 20 people?	1912	82.3	411	17.7

Table 5.4. Location of Latrine Observed

Locations of latrines
Where is the latrine located concerning the reported regular water source/s? Distance in meters: Median: 8 meters; Interquartile Range: 11 meters; Minimum: 0 meters to Maximum 300 Meter

Are the toilets located less than 50 meters from dwellings (or as locally agreed)?	1764	75.9	559	24.1
Latrines located at least 30m away from any groundwater source and their pit bottoms being at least 1.5m above the water table?	1746	75.2	577	24.8

Table 5.5. Toilet Standard Observed

Improved or unimproved facility	Yes	%	No	%
Can the toilets be considered "improved sanitation facilities"? This means either being pit latrines with slab, or ventilated improved pit latrines, flush or pour toilets (connected to a sewer system or a septic tank or pit), or composting toilets?	1820	78.3	503	21.7

Table 5.6. Awareness Creation Messages Observed

Messages	Yes	%	No	%
Inside the house, on the outside walls, or within the immediate vicinity of the house (on trees, latrines, etc.), are there posters/ signs showing/ encouraging good/ proper sanitation and hygiene practices?	1395	60.1	928	39.9
If yes, what types/ kinds of messages are observed in the posters/ signs?				
1. Stop open defecation	980	42.2	1343	57.8
2. Consistent handwashing with soap	107	4.6	2216	95.4
3. Proper treatment and storage of drinking water	945	40.7	1378	59.3
4. Ways to avoid/prevent diarrhoea	910	39.2	1413	60.8

Annex 5: Typology of participation

Typology of participation: How people participate in development programmes and projects. (Priyanka take it as annex as commented) Source: Pretty (1994), adapted from Adnan et al. (1992):

TYPE	CHARACTERISTICS OF EACH TYPE
1. <i>Passive Participation</i>	People participate by being told what is going to happen or has already happened. It is a unilateral announcement by an administration or project management without any listening to people's responses. The information being shared belongs only to external professionals.
2. <i>Participation in Information Giving</i>	People participate by answering questions posed by extractive research using questionnaire surveys or similar approaches. People do not have the opportunity to influence proceedings, as the findings of the research are neither shared nor checked for accuracy.
3. <i>Participation by Consultation</i>	People participate by being consulted and external agents listen to views. These external agents define both problems and solutions and may modify these in the light of people's responses. Such a consultative process does not concede any share in decision making, and professionals are under no obligation to take on board people's views.
4. <i>Participation for Incentive</i>	People participate by providing resources, for example labour, in return for food, cash, or other material incentives. Much on-farm research falls in this category, as farmers provide the fields but are not involved in the experimentation or the process of learning. It is very common to see this called participation, yet people have no stake in prolonging activities when the incentives end.
5. <i>Functional Participation</i>	People participate by forming groups to meet predetermined objectives related to the project, which can involve the development or promotion of externally initiated social organization. Such involvement does not tend to be at early stages of project cycles or planning, but rather after major decisions have been made. These instructions tend to be dependent on external initiators and facilitators, but may become self-dependent.
6. <i>Interactive Participation</i>	People participate in joint analysis, which leads to action plans and the formation of new local institutions or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple perspectives and make use of systemic and structured learning processes. These groups take control over local decisions, and so people have a stake in maintaining structures or practices.
7. <i>Self-Mobilization</i>	People participate by taking initiative independent of external institution to change systems. They develop contacts with external institutions for resources and technical advice they need, but retain control over how resources are used. Such self-initiated mobilization and collective action may or may not challenge existing inequitable distribution of wealth and power.