STUDY ON
SUSTAINABILITY OF OPEN DEFECATION FREE STATUS OF COMMUNITIES

A Quantified Participatory Assessment (QPA)

FINAL REPORT

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ABBREVIATIONS AND ACRONYMS

CATS	Community Approaches to Total Sanitation
CLTS	Community-led Total Sanitation
CBOs	Community-based organization
CHW	Community health workers
FGD	Focus Group Discussion
GoA	Government of Afghanistan
KPI	Key Person Interview
MDGs	Millennium Development Goals
MHM	Menstrual Hygiene Management
MoE	Ministry of Education
MoPH	Ministry of Public Health
MRRD	Ministry of Reconstruction and Rural Development
NGOs	Non-governmental organizations
O&M	Operation and Maintenance
QPA	Quantified Participatory Assessment
SDG	Sustainable Development Goal
SMC	School Management Committee
SSDA	Society for Sustainable Development Afghanistan
TORs	Terms of Reference
TOC	Theory of Change
WASH	Water, Sanitation and Hygiene

SUMMARY

UNICEF has enlarged its efforts to introduce methods such as Community-led total Sanitation (CLTS) to south Asia to eliminate open defecation by aiming for 100% Open Defecation Free (ODF) communities and associated key behaviours (e.g., washing hands with soap). This research offers an initial effort to systematically collect and analyse evidence of the continued OD, or successful ODF status, of a number of Afghan rural communities in accessible areas.

MAIN FINDINGS

Slippage in communities declared ODF

- Slippage from ODF status: Observation in and around the surveyed communities revealed that around 20% of communities are clearly OD and may have slipped back from the ODF status declared in 2014 - but this cannot be said with certainty since no third-party verification of ODF status has been conducted since then.

Toilet construction and use

- Toilet use: Almost all the households that were using toilets in 2014 were using them in 2016
- Second toilet construction: Nearly half the households reported building a second toilet after ODF declaration, mostly due to large family sizes, growing families, and to have separate toilets for males and females:
- Type of toilet: Most toilets found in communities surveyed were dry toilets
- Quality of toilet construction: Construction quality was mostly rated 'Fair':
- Condition of dry toilets: Half the dry toilets did not have covers and had flies, while some had flies despite covers
- Condition of flush toilets: Most of the 141 household flush toilets surveyed were in good condition
- Waste disposal from flush toilets: Around 40% of flush toilets opened into a drain outside the house

The practice of open defecation

- Household toilet use by members of the household: Some household members (especially boys and girls under 10) defecate in the open even if there is a toilet at home
- Why people do not use their own household toilets: The reasons ranged from functionality (toilet smells, is blocked, or the pit is full) and behavioural (used to going outside):
- Why people defecate in the open: Four main groups of people defecate in the open (those without toilets, adults who have toilets but prefer to go outside, visitors and guests, and children) for different reasons

Household toilet use: motivating and de-motivating factors

- Why people use a toilet: Shame, awareness, convenience and safety were major motivating factors reported:
- Activities encouraging household members to use flush toilets: Buying materials to keep the toilet clean and giving responsibility to family members to keep the toilet clean
- Emptying the toilet pit can be a de-motivating factor for household toilet use: Male farmers empty their own toilet pits but not that of others; the rest pay to get it emptied
- Has using a toilet has become a social norm? No, although more than 80% of the community households know this is the right thing to do, not everyone practices it.

Hand washing After Toilet Use

- Who in the family does not wash hands? Nearly half the boys and girls below 10 years of age, and a third of all other males and females
- Why people do not wash hands with soap after using the toilet: Lack of awareness of the advantages of washing with soap, lack of soap and a lack of a habit of washing with water and soap
- Motivating factors for washing hands with soap and water after using the toilet: Not wanting hands to smell, and doing so because religion and elders say it is the right thing to do; health impacts are a lesser reason
- Factors that helped households improve their hand-washing practices: The fact that it has become a social norm, buying soap regularly, and finding a place to keep the soap
- De-motivating factors: Lack of soap and water to wash and a lack of money to buy soap
- Has Hand Washing with soap after using the toilet become a social norm? No, but there is growing awareness that it is the right thing to do, though not all practice it:

Institutional (School) Toilet Assessments

- Type of toilets: Most school toilet blocks in the 70 communities surveyed had dry toilets
- Construction quality: Most school toilets were rated 'Poor'
- Environmental sanitation: No school toilet opened out into a drain
- Distance from water source: Around half of the school toilets were 100 metres from a water source
- Condition of dry toilets: More than half the dry school toilets had covers and flies: all were dirty and smelly
- Condition of flush toilets: The single flush toilet block was clean, had privacy it did not have light or water

ANALYSIS

- 'Slippage' is low at 20%
- 'Slippage' is not due to household toilet not being used:
- There is growing knowledge, awareness and practice of toilet use and handwashing but needs much more support to establish as social norms:
- The impacts of the high levels of internal displacement and cross-border movement caused by insecurity, on community cohesion and poverty in Afghanistan, also affect toilet use and hand-washing practices.
- Better alignment is needed between 'emergency' and 'development' interventions, as emergency hygiene responses (in case of either war displacement or displacement because of a natural disaster) may not consistently use a CLTS-compatible approach, preferring instead to focus on immediate relief rather than behaviour change.
- CLTS as a method is effective, but the implementation process in the field needs to be more innovative (to trigger change in different groups of household members – rather than follow a 'one-size fits all' approach) and standardized and quality-controlled (since CLTS appears to be implemented differently by some NGOs producing some excellent examples of change, but mostly inadequate).
- Although there is a small and growing awareness of the need to use toilets and wash hands with soap after using toilets, especially among women in the community, many rural people still do not see the need *for everyone* to use toilets *every time.*
- Also, they have not completely internalised the use of latrines and thus consider it natural for small children to defecate in the open, for adult men to defecate in the open on their way to the mosque or to their fields, and for their peers (not only men but elderly women) to do so from habit.
- CLTS however continues to use a 'one-size fits all' approach focused on building toilets and making people use them, and does not have separate long-term and comprehensive behaviour-change strategies for *each* of these groups – to ensure that *everyone* practices these behaviours *every time*.

RECOMMENDATIONS

- Carry out an independent third-party verification of ODF Communities ideally straight-away, but it may be better to do this after modifying the ODF definition and the focus of the CLTS approach, as discussed below.
- Modify the definition of ODF communities to cover small children who defecate in the open while playing, the poor condition of school toilets that drive schoolchildren to defecate in the open, and the major issue of farmers defecating in the field – or taking fresh excreta from their household toilets to spread on their fields (given the lack of access to fertilizers and natural biomass in rural Afghanistan).
- Ensure 100% ODF before CLTS Declaration and withdrawing support with more preparation and quality control among partners, and longer follow-up and support on the field.

- Use differentiated strategies, messages and media for sustained behaviour change of different community groups to address the specific needs of different groups within each household and to encompass the entire village; to cover different types of targeted messaging (e.g., through local mullahs for adult and elderly men; through family health *shura*s and/or health action groups and Community Health Workers (when available) for women; and through formal and non-formal schools for children); and to have variations, including incentive-based campaigns (competitions between communities and institutions such as schools), both face-to-face communication and mass media, particularly radio, which reaches rural communities and is critical to reach the illiterate.
- Develop a conflict-sensitive version of CLTS with stronger and differently calibrated support for communities with high levels of transient populations that is suitable for Afghanistan's challenging circumstances.
- Involve the national and international private sector, donors and local providers to ensure supply chains to provide low-cost soap and water supply by developing a unified approach across rural water supply and school WASH to ensure that water supply is adequately provided, especially for new flush toilets, and for convenient hand-washing with soap after using dry toilets.
- Begin preparing a solid waste, liquid waste and faecal sludge management strategy for rural areas as there could be a growing problem of ground and surface water pollution due to contamination from fresh human faeces from dry toilets and from the improper disposal of faecal sludge from septic tanks attached to flush toilets.

1. INTRODUCTION

1.1 BACKGROUND

South Asia has the largest number globally of people practicing open defecation (OD) and failed to meet the targets of the Millennium Development Goals (MDGs) between 2000 and 2015. In an effort to address this problem UNICEF adopted a strategy called the "Community Approaches to Total Sanitation (CATS)" in 2008, intending to eliminate open defecation by aiming for 100% Open Defecation Free (ODF) communities and associated key behaviours (e.g., washing hands with soap). The CATS approach encouraged ownership and implementation by national partners, including national and sub-national governments, and focused on community participation to introduce and achieve a new social norm of no longer accepting open defecation. CATS strategies included mobilization communities to take collective decisions leading to community implementation and oversight of related activities – including household and school toilet building and use, washing hands with soap, etc. The approach was radically different from conventional efforts focusing on changing household hygiene and sanitation behaviour one at a time, often with heavy subsidies to build toilets.

The UNICEF Global Board commissioned a global evaluation of CATS in 2012-13 and presented the findings in 2014, following which the UNICEF Regional Office in South Asia (ROSA). In 2014 the south Asian country offices decided to study the sustainability of CATS results in south Asian countries, including Afghanistan.

In 2010, a strategy known as Community-Led Total Sanitation (CLTS) was introduced into Afghanistan; the Ministry of Rural Reconstruction and Development (MRRD) of the Government of Afghanistan (GOA) received UNICEF support to implement CLTS. CLTS is claimed to have produced around 1600 open-defecation-free (ODF) communities since 2010, but the difficulties of working in Afghanistan indicate caution in making such claims: there has been speculation about slippage and a return to OD in some communities, although, until this study, there has been no systematic documented evidence of conditions on the ground.

This study forms part of the south Asian regional initiative to evaluate the sustainability of CATS/CLTS. As in other countries in the region, the intention of the study was to find out not only what percentage of rural Afghan communities revert to open defecation, but to identify and explain, as far as possible, the social dynamics associated with sustaining ODF or reverting to less community-friendly hygiene habits.[1] However, Afghanistan differs greatly from its neighbours, which inflects the study in important ways.[2] Most significantly, the country's sanitation and water supplies have suffered heavy war damages leading to poor basic health indicators and limited public health activities, including health education beyond fairly localised emergency messaging.[3] The collection and analysis of big social

[1] Study Terms of Reference are in Annex 1.

[2] See a summary of relevant literature in Annex 2.

[3] Before the Soviet military occupation in 1979, national hygiene education efforts were in place among a population with a higher overall literacy rate than today: "Before the 1980s, hygiene education was in the school curriculum, and government programmes included health education in all clinics, hospitals and in other gathering places. Health inspectors regularly visited schools, and were responsible for hygiene messages" (Masoumyar et al., 2001).

data sets in Afghanistan is also fraught with challenges. Nonetheless, the study attempted to measure behaviours not only through completing questionnaires with accessible communities, but also through close ethnographic observation of what people are actually do. Data were collected and have been disaggregated by age and sex; and the reflections take into account variables such as geography, average income level, displacement/returnee status and community in/security; and other social and political factors to give a textured and descriptive explanation for any slippage or reversals in behaviours.

1.2 PURPOSE

The purpose of the Study is to document the success, or lack of success, in introducing and sustaining changes in community sanitation practices after exposure to the CLTS method in rural Afghanistan, to understand which (disaggregated by sex and age) community members continue to uphold ODF status after triggering, and to begin to explain why some do not; and to contribute more broadly to knowledge on the sustainability of CLTS in Afghanistan, to enhance program implementation and outcomes in the future.

1.3 OBJECTIVES

Specific objectives of the Study are to find out:

- How many communities are still ODF; and if they are not either to concretely identify or surmise from available evidence why they are not;
- The key factors associated with communities remaining ODF or slipping after a minimum of two years after being declared ODF. Here, efforts have been made whenever possible to disaggregate data at a minimum by sex and age; and where possible, to provide information on other social indicators that might inflect the surrounding circumstances of a community's behaviours, including, for example, displacement into or out of a community by armed conflict, etc.
- The key factors (both social and technical) that can explain the success or failure of the CLTS approach in a community context – with the caveat that collecting 'whole-of-community' data in Afghanistan is complicated by the social and security constraints explained above.
- What percentage of people in ODF communities practice hand-washing with soap at critical times, with an effort to disaggregate this information by sex and age wherever possible;
- Key factors at various levels (from community to policy levels) related to government and NGO interventions which *improve* the adherence to new ODF behaviours created by CLTS interventions; or, factors which may be detracting from such efforts, even when these may at first seem 'invisible' because of norms about behaviours based on sex, age, class, etc.

1.4 RESEARCH CONTEXT AND QUESTIONS

As detailed in the Terms of Reference (TORs) in Annex 1, the Study addresses a range of questions (Table 1.1).

Table 1.1: Evaluation questions addressed by the Study

A. How many communities are still ODF?
How many communities are still ODF?
What proportion of households is still using a safe toilet? (Who in the household uses the toilet?)
What proportion of households built a second toilet after ODF verification?
What proportion of households reverted to OD after ODF verification? (If possible, who in the household reverts, and why people of this sex- and age-group do so)
B. What are the key factors associated with communities remaining ODF?
What factors indicate the state of operation and maintenance of toilets? (If possible, who does the maintenance and/or cleaning, and whether this impacts on who uses the toilet)
What is the quality of toilet construction?
What factors motivated (which) individuals to continue using a toilet, or stop using it?
What factors motivated (which) people to build a second toilet after ODF verification?
What actions did people take when their toilet pits filled, and who in the household took action?
C. What are the key factors associated with communities that 'slip'?
What are the common characteristics of households reverting to open defecation? Is it always an entire household that slips? If not, why not?
What factors caused which people to revert to open defecation (any differences by sex and age?)
D. What percentage of people in ODF-communities practices hand washing with soap at critical times (if possible, disaggregated by sex and age)?
What proportion of people has water and soap at a handwashing station in their houses?
What proportion of people has water and soap near their toilets, and if possible, who takes responsibility for supplying a household with soap, supervising handwashing, etc., by sex and age?
E. What key factors, social and technical, might explain the success or failure of the CLTS approach (in a given community context)?
F. What are the key factors related to government and NGO interventions, at various levels (from community to policy), that can improve whole-of-community adherence to new ODF behaviours created by CLTS interventions?
What factors motivate people to practice hand washing with soap after using the toilet? Does this differ by sex and age?
What factors de-motivate people to practice hand washing with soap after using the toilet? Does this differ by sex and age?
What factors are involved in prompting hand washing at critical times by members of the family? Does responsiveness differ by sex and age?
What evidence is there of post-ODF activities that helped households maintain or improve their toilet use and hand washing with soap practices? Does uptake differ by sex and age?
What is the degree to which not practicing open defecation and hand washing with soap after toilet use has become a new social habit/norm?
What factors are related to an enabling environment for sustainable ODF behaviour?
Who should be/are responsible for the post-ODF process – monitoring, motivations, etc.?

1.5 SCOPE

The study covers (at least) 10% of all communities declared ODF in rural Afghanistan at least two years prior to the start of the survey. According to MRRD data, at least 700 communities were declared ODF by February 2014 by all agencies. While the TORs specify that the study should cover 80 communities from the 8 provinces of Badakshan, Bamyan, Daikundi, Kapisa, Laghman, Logar, Nangrahar, and Takhar, subsequent discussions with the WASH Section of UNICEF Afghanistan resulted in an agreement to have a sample size of 70 communities.

1.6 TASKS AND DELIVERABLES

The TORs detail the following tasks for the study (see Annex 1):

Task 1: Inception Phase

Meetings, document gathering, desk review
Conceptual Report, Study Plan, Protocols, Indicators, Approaches and Tools
Selection of geo-areas for the study, Data Collection Plan
Protocols for data cleaning and tabulations
Recruitment and Training of field staff
Obtaining permission for the Study from the relevant authorities by IRB at MoPH
Review of draft Inception Report by UNICEF ROSA, Afghanistan office and the Study Reference Group

Deliverable: Inception Report, including final study protocol and qualitative survey methodology

Task 2: Execution Phase

Training of data collectors
Data collection
Data cleaning, initial tabulations
Analysis and drafting of Country Report

Deliverable: Preliminary Qualitative Analysis

Task 2: Delivery Phase

Preparation and submission of Draft Report
Review of draft Country Report by UNICEF ROSA, Afghanistan office and the Study Reference Group
Preparation and submission of Final Report
Presentation Workshop

Deliverables: Study Report, Presentation Workshop, Workshop Report

After the submission of the initial Draft Report, a third task was introduced: that of deepening the report's analysis of the findings of the ethnographic surveys conducted by each team in the field. At a field-discussion workshop held in Kabul, and through detailed written responses to the more in-depth questions raised in this discussion, the field research team was offered an opportunity to share their overall observations about the ways in which sex and age differences among members of surveyed communities may shape overall community responsiveness to the CLTS approach. This workshop was held

in response to questions raised by reviewers of the draft, but also served the purpose of triangulating data, clarifying the validity of certain observations and understanding the challenges of the field conditions faced by the research teams. These additional observations were used to add ethnographically "thick" evidence to the data reflected in this report.[4] A later review by UNICEF decided that two separate reports should be submitted on the two studies described in the TORs (Annex 1).

1.7 REPORT STRUCTURE

Section 2 covers the sampling methods and methodology, Section 3 presents the main findings of the study, and Section 5 analyses the findings and makes recommendations.

[4] The term "thick description" is applied to a researcher's detailed account of field experiences. Identifying these helps make the patterns of cultural and social relationships explicit, putting them in a context that is not always conveyed by numbers. Such detail is particularly important in difficult research contexts like those in rural Afghanistan as they allow field researchers to make sense of what they saw in ways they are not always able to do while they are in the field (often for reasons of insecurity which shorten research contact time, or make in-field triangulation difficult or impossible).

2. SAMPLING AND METHDOLOGY

2.1 SAMPLING

PROCESS

According to the TORs, the study was to cover at least a 10% sample of all communities declared ODF at least two years prior to the commencement of the study, i.e., by 2014. The latest data verified by both the MRRD and UNICEF show that a total of 606 communities in 8 provinces had been declared Open Defecation Free (ODF) by 2014 (see Table 2.1). Also, as clarified with UNICEF and MRRD, the term 'communities' was understood as referring either to relatively homogenous set of households, e.g., comprising a full village (in which case the name of the village is the same as the name of the community), or part of a village (in which case the name of the village is different from the name of the community. Such a definition meant that the number of households in a community could vary from 60-120 houses in general and, in fact, this size varied from 5 to 1000 in the total list of ODF-declared communities provided by MRRD.

Table 2.1: Number of communities declared ODF by 2014 in Afghanistan

	Province	Number of ODF communities
1	Badakshan	155
2	Bamyan	6
3	Daikundi	40
4	Kapisa	14
5	Laghman	91
6	Logar	79
7	Nangarhar	61
8	Takhar	160
Total		**606**

Source: MRRD, GOA

Two issues complicated the sampling process: First, 7 districts in 4 provinces (containing 96 ODF-declared communities) were under the control of the Islamic State militants and hence were deemed too dangerous to survey (Table 2.2).

Table 2.2: Number of communities and districts in danger zones

Province		District		Number of ODF-declared Communities
1	Badakshan	1	Jurm	25
2	Kapisa	2	Kohband	1
3	Laghman	3	Alingar	28
		4	Alishang	18
4	Nangarhar	5	Dehbala	11
		6	Ghanikhail	5
		7	Mohamandarah	8
Total				**96**

Second, SSDA was the CLTS implementing agency for several ODF-declared communities in Khadir and Miramoor districts in Daikundi Province (Table 2.3) and hence there would have been a conflict of interest if the work in these communities was evaluated by SSDA.

Table 2.3: Communities in Daikundi Province where SSDA implemented CLTS

District		Number of ODF-declared Communities	Number of Communities where SSDA implemented CLTS
1	Khadir	23	20
2	Miramoor	17	13
Total		**40**	**33**

For these two reasons, all these 129 communities were dropped from the sampling universe, reducing it from 606 to 477.

STRATIFICATION

A *simple* 10% random sample drawn from the population of 477 communities (to generate findings at 90% confidence level and 5% sampling error), may have missed out on the relatively small but significant numbers in provinces like Bamyan (6), Kapisa (14) and Daikundi (7), and the relatively small number of houses in over half these communities (the median was 56 houses and the minimum 5 houses). There was, however, no other information on the population of ODF communities, such as proportion of *kuchis*, Internally Displaced People (IDPs) and returnees, or distance of the village from the nearest motorable road and land ownership.

Stratified sampling of 10% of ODF communities, based on province, district and the number of households, thus yielded a more representative sample – since at least one community from each stratum had to be selected in this sampling process. Revising the sampling universe, and yet ensuring through stratification that at least one community was picked from each stratum gave a total sample size of 70, across 32 districts in 8 provinces, which represented nearly 15% of the sampling universe of 477 communities, more than half (241) of which had less than 56 households (Table 2.4).

Table 2.4: Stratified Sample of communities declared ODF

Province	District	Communities			Sample		
		Total	With <56 houses	With >56 Houses	Final Sample Sizes	With <56 houses	With >56 houses
Badakshan	Argo	19	9	10	2	1	1
	Bharak	26	12	14	4	2	2
	Darayam	18	13	5	3	2	1
	Faizabad	28	19	9	3	3	1
	Khash	6	4	2	1	1	0
	Kishm	27	13	14	4	2	2
	Shuhada	6	1	5	1	0	1
Bamyan	Center	6	0	6	1	0	1
Daikundi	Khadir	3	0	3	1	0	0
	Miramoor	4	0	4	1	0	1
Kapisa	Esa Awal Kohistan	7	2	5	1	0	1

Province	District	Communities			Sample		
		Total	With <56 houses	With >56 Houses	Final Sample Sizes	With <56 houses	With >56 houses
	Jabulsaraj	2	2	0	1	0	0
	Kohistan	1	1	0	1	0	0
	Mahmood Raqi	1	1	0	1	0	0
	Said Khil	2	2	0	1	0	0
Laghman	Mehterlam	18	0	18	3	0	3
	Qarghaie District	27	0	27	4	0	4
Logar	Baraki Barak	6	0	6	1	0	1
	Khoshi	6	0	6	1	0	1
	Mohammad Agha	32	12	20	4	2	3
	Pul e Alam	35	10	25	5	1	4
Nangarhar	Baitkot	9	9	0	1	1	0
	Behsood	9	0	9	1	0	1
	Kama	5	5	0	1	1	0
	Khewa	9	8	1	1	1	0
	Rodat	5	5	0	1	1	0
Takhar	Baharak	31	20	11	4	3	2
	Farkhar	22	19	3	3	3	0
	Hazar samuch	32	21	11	4	3	2
	Kalafgan	34	23	11	4	3	2
	Taloqan	21	18	3	3	3	0
	Warsaj	20	12	8	3	2	1
8	**32**	**477**	**241**	**236**	**70**	**35**	**35**

Source: Province and district-wise numbers of ODF communities till 2014 are from Ministry of Rural Reconstruction and Development, Government of Afghanistan. Sample calculations by SSDA

FINAL SAMPLE

The final sample was selected at random, i.e., using a random number generator on the number of communities in each stratum and is thus representative of the communities declared ODF by 2014 in 8 provinces of Afghanistan, given the available background information on the population. The basic statistical characteristics of the sample of 70 communities and the population (i.e., sampling universe of 477 communities) are almost similar, although the maximum number of households in the sample is less than that of (one community in) the population (Table 2.5).

Table 2.5: Sample and population characteristics

Characteristics	Population	Sample
Provinces	8	8
Districts	32	32
Communities	477	70
% of Communities with >56 houses	241	35

Characteristics	Population	Sample
% of Communities with <56 houses	236	35
Total Households	32,755	3,909
Average number of houses	69*	56
Median number of houses	55	54
Minimum number of houses	5	7
Maximum number of houses	1000*	222

*The average and maximum number of houses in the population are affected by the presence of an outlier, a single community of 1000 houses. The median value, however, is not affected.

The final sample of ODF communities surveyed is in Annex 3.

CHARACTERISTICS OF SURVEYED COMMUNITIES

Average number of adults and children: There were, on average, 4 adults and 4 children of both sexes per house in the 70 communities surveyed, although these figures ranged from 3-5 adults per house on average across provinces, and 2-8 children per house on average across provinces (Table 2.6). There was an average of 3 children below 3 per house across the sample, with averages ranging from 1 child in Badakshan and Nangarhar to 5 in Logar, and 1 adolescent per house on average.

Table 2.6: Characteristics of the communities surveyed

Average numbers	Total	Badaksh	Bamyan	Daikundi	Kapisa	Laghman	Logar	Nangarh	Takhar
Adults	4	4	3	5	4	5	5	5	3
Children (per house)	4	3	3	2	2	3	8	6	3
Children below 3 (per house)	3	1	2	2	2	3	5	1	3
Adolescents (per house)	1	1	1	1	1	1	1	1	1
Kuchi households	1			1				1	1
IDP households	1	1		1	1			1	1
Returnee households	1	1		1		1	1	1	1

Kuchi, IDP and Returnee households: There was an average of 1 of each of these types of households, with some provinces having none or very few (average below 0.5) including Bamyan (Table 2.6).

2.2 METHODOLOGY

SURVEY TOOLS

A total of seven tools were used for the mixed methods assessment (Table 2.7) using a technique called Quantified Participatory Assessment (QPA: See Annex 4). The tool-wise

listing of topics, questions and issues (listed in the TORs) have been classified and presented in Annex 5, while the Tools themselves are in Annex 6.

Table 2.7: Data collection activities and tools used in the survey

Activity	Tool	Sample details
Key Person Interviews with Province Officials	1	Top Provincial MRRD official
Key Person Interviews with District Officials	2	Top District MRRD official and MoPH official
Focus Group Discussion with male Community Elders	3	Minimum 10 persons including local teacher, imam, *Shura* leader and other elders
Direct Observations	3	The Study team went on a transect walk and noted signs of open defecation while visiting the community's public spaces – and noted them down as part of the re-survey using Tool 3
Social Mapping and Clustering of Households	4	Key Informants suggested by male community elders, who also suggested clustering of community houses into smaller groups of 10-25 houses, for detailed FGDs later
Cluster-level Focus Group Discussions with Male and Female representatives from cluster households (separately)	5	Separate clusters of male & female representatives from every house in the community. Efforts were made to interview (at least) one female, and one male representative from each house
Toilet Assessment in Houses	6	10% of all toilets, as detailed in the FGDs with households. This assessment was most often conducted by women researchers with women in the domain of the household
Toilet Assessment in Institutions (Schools, mosques, health facilities and other public institutions)	7	All schools, mosques, health facilities and other public institutions in the village to which the community belongs (whether a community is part of a larger village or whether the community is the same as the village) – but this was only done for schools

FIELDWORK PROCESS

Province and district level activities

In each of the 8 provinces, the fieldwork by the 4-person team (2 women and 2 men) started with Key Person Interviews (KPIs) with key province-level officials, to explain the context and purpose of the evaluation and to understand their perceptions of the sustainability of ODF status (and slippage) and of the handling, disposal and re-use of human waste. Similar interviews were held with officials in the 32 districts where the study was conducted. Letters of introduction were provided by the MoRD to all senior province and district officials to be interviewed, and all of them happened to be male.

Community-level activities

FGD with Community Elders: At every village - or community within the village – the first exercise was to meet the community elders, explain the context and purpose of the evaluation, ask them about their perceptions about ODF status, slippage and also about human waste handling, disposal and re-use. This meeting was also used to ask for assistance to carry out the various activities planned at the community level. This was an important step to establish a rapport and to obtain formal permission to carry out the evaluation, given that the strong social hierarchies that govern village life in rural Afghanistan dictate that male elders not only have to give permission for strangers to enter a village, especially to collect information. Incidentally, all the community elders who came to meet the study teams happened to be male, reflecting the realities of village life in rural Afghanistan.

The findings from the community-level FGD, however, were supplemented by detailed cluster level FGDs with men and women separately - given that in communities with rigid social hierarchies, especially purdah, men often have very little reliable knowledge about the lives of women and children, including poor knowledge of child-rearing habits (toilet-training of infants and disposal of child faeces, for example) and matters of household hygiene such as the cleaning of the household toilet, handwashing habits and the like. During the thick description phase of the analysis, research teams reflected on the fact that male elders often preferred to give the "right" answer about hygiene habits rather than the "true" answer (the answer that conformed to observations made during the transept walk). In comparison, both women and children would give unmediated responses about what was happening in the household or village with regard to defecation practises and solid waste management.

Transect walk: The teams conducted a transect walk around the village to check whether there was any evidence of open defecation (OD) and to use the opportunity to speak to children about their own hygiene practices, and those of adults. Children tend to be more honest informants and did not attempt to give idealised responses to questions posed by the research teams, and simply showed them to the OD sites. This was important, because teams found that male adults would sometimes try to blame signs of OD on children. This problem was confirmed because, when it was possible to triangulate the responses of adult males with adult females (mothers), they would usually offer the same response as children.

Social mapping and clustering of households: The first activity thereafter was to ask the community elders for Key Informants, almost exclusively males, who could help draw the social map of the village and provide some basic information about the residents of the community. Each house in the community was marked and numbered in the Social Map and information on a range of basic indicators (e.g., number of adult and children in the family, whether or not they have a toilet or own land) was collected from the Key Informants. The next step was to cluster these houses, according to geographical proximity or ethnic group, so that FGDs could be conducted with (male and female) representatives from these clusters. Discussions were held with both Key Informants and other community representatives (e.g., from the clusters) to determine when and where these FGDs could be held, over 2 days.

Cluster-level FGDs: These small cluster-level FGDs were held separately with male and female representatives from each cluster, facilitated by male and female team members respectively. However, cluster-level FGDs with female household representatives were usually held in one family compound, where the female team members would meet them

and hold the FGDs. In some communities, the number of members in each was small, and so these meetings were more like household interviews and informal discussions than formal FGDs.

In these Cluster FGDs, the first step was to cross-check the basic information collected from the Social Mapping exercise. At this point, team members were often able to assess the levels to which community members had been truthful about public hygiene practices in the community, and sometimes noted inconsistencies between what was admitted and what they had actually seen. Thereafter each FGD had two broad parts: first, to collect quantitative information on how many houses had toilets and were using them at the time when ODF status was declared; and how many have toilets and are using them currently. The second part was to collect qualitative information on reasons men and women would admit or give for toilet use and slippage, if any, and also gathered men's and women's perceptions on the handling, disposal and re-use of human waste.

Toilet Assessments in Houses: The information collected in these FGDs (e.g., which houses have toilets) was used to inform the visits of the female research team to houses with toilets, where discussions were overwhelmingly conducted with women. 100% of all houses with traditional toilets and 10% of those with renovated toilets were visited. Here three key issues were assessed: (1) the condition of toilets and women's perceptions on their use by different members of the house – and reasons for non-use, if that is the case; (2) availability of hand washing facilities near the toilets; and (3) women's perceptions of hand washing practices by different members of the house – and reasons for non-practice, if that was reported. The teams also gave women some messages about toilet-use and hand-washing at critical times. While the data collected by women researchers from women householders was discussed during the research team's evening debriefings, time restraints made it impossible to triangulate information with findings from men's visits – and this was left to subsequent data analysis. Study team members did notice discrepancies in what women and men would admit, observing that women (like children) would generally offer different answers about continued OD, which appeared to be overwhelmingly practiced (but denied) by men. Women also appeared to be more reliable informants on the behaviours of elderly individuals (both male and female) who had not managed to internalise or continue to confirm with ODF practices.

Institutional toilet assessment: The final community-level activity, also overwhelmingly conducted by male researchers with male village members, was a visit to schools, mosques, health centres and public institutions in the community (or village) to assess the condition of public toilets. This visit required an initial meeting with the person in charge (e.g., the Principal of the School, the *imam* of the mosque or the person in charge of the health centre), to inform them about the evaluation and to obtain his permission to inspect the public toilets in the institution. The assessment, however, only involved a physical inspection of the toilet blocks without any discussions with users. In practice, however, only schools were assessed.

Final meeting with community elders and other representatives: At the end of the survey, the field team addressed a meeting of community elders and other representatives to inform them about the key findings from their survey (without detailing specific scores or individual responses)

ETHICAL CONSIDERATIONS

The study ensured that appropriate strategies to protect the rights and dignity of the evaluation participants were incorporated into the design of the tools and the methodology, including help/benefit to others, bringing no harm treating people fairly, irrespective of their gender, socio economic status and other characteristics' and respecting individuals' rights to act freely and to make their own choices, while protecting the rights of those who may be unable to fully protect themselves.

The study also took care to minimize the probable risks of disruption to participants' lives and protect them from emotional consequences, safety concerns and social harm.

Furthermore, the study sought 'informed consent' from each individual who took part in the study by reading out a pre-prepared Consent Form (see copy in Annex 7) and by leaving behind a copy of this Form at each data collection event.

QUALITY ASSURANCE

Five checks were put in place to ensure the quality of the information collected.

1. Two rounds of pilot visits during an intensive training program were carried out to ensure that the field research teams were well aware of the basic concepts of open defecation, CLTS, hygiene promotion and the disposal, handling and re-use of human waste, as well as knowing how to facilitate the community-level PRA exercises to collect information (such as Social Mapping, KPIs and FGDs). These trainings were conducted by subject matter specialists from India and Afghanistan. In addition, mock interviews and written tests were carried out, supplemented by pilot visits to villages near Kabul, to ensure that the teams are able to implement the Survey Tools correctly in the field. A final training visit to a village in their own province was carried by each team, at the start of the actual survey.
2. A Supervisor was appointed for all province-level 4-person field teams who was responsible for ensuring that all the information collected and entered into the database was accurate. This information was submitted weekly to SSDA (in exchange for payment), at which point all gaps, inaccuracies or inconsistencies in the (weekly) information collected were assessed and pointed out (in the next week) by the SSDA study coordination team in Kabul.
3. The SSDA team in Kabul telephoned community-level representatives to double-check the information filled in by the field teams, using the telephone numbers collected by the field team during the FGD with male Community Elders.
4. Internal consistency and validity checks were built-into the customized database set up for entering the information collected from the field, so that for instance, information outside the expected ranges (e.g., 0-100 in ordinal questions) could not be entered by Data Entry Operators.
5. SSDA organized workshops for all field staff on 14 December 2016 to discuss data inconsistencies, gaps or errors. This workshop was also used to collect additional insights and observations from the field that may not have been captured in the formats. A second workshop for field Supervisors (and a selected number of female researchers) was conducted on July 20th, after reviews of the initial draft analysis, to clarify ethnographic observations made in the field.

Finally, SSDA offered that UNICEF Afghanistan or the MRRD was welcome to visit any of the surveyed schools and double-check the information collected by the survey teams.

Two additional activities were carried out for quality assurance.

- First, when internal checks revealed that qualitative information collection was incomplete in Tool 3, a re-survey was carried out in late April 2017 to collect the missing data.
- Second, a workshop was held with field staff in August 2017 to collect additional qualitative information to supplement what was recorded in the survey forms.

LIMITATIONS

- No verification of ODF status: ODF had been declared but not verified in all the communities visited, and so it was not conclusively known if these communities were 100% ODF in 2014.

- Security concerns: The security situation in the country meant that the study sample of communities could not include ODF-declared communities in several districts and provinces.

- Limited background information: Across Afghanistan, ongoing insecurity and high levels of suspicion mean that there is limited background information on village communities, including accurate and up-to-date population data (adults and children per house), number of toilets per house, distance from major roads, etc., which makes it difficult to stratify the sampling universe further and thus draw a more representative sample using stratified random sampling techniques.

- Inadequate attention to conflict-sensitivity in survey tool design and field collection: The field research did not build an adequate level of conflict sensitivity into the questionnaire design and the field data collection approach. It was not until the analysis phase that this problem was identified during discussions with field data-collection teams, after which it was decided to incorporate observations on conflict impacts into the final report.

- Limited time for fieldwork in each village: Even when communities were open to research field visits, these had to be conducted quickly to avoid drawing undue attention to the research teams. Field teams were told that two days was the safe limit of time they could spend in a village, after which they would attract the attention of extremists.

3. STUDY FINDINGS

3.1 INTRODUCTION

This Chapter discusses the following six issues:

a. Slippage in communities declared ODF
b. Toilet construction and use
c. The practice of open defecation
d. Motivating and de-motivating factors for continued toilet use
e. Motivating and de-motivating factors for handwashing
f. Institutional (school) toilet assessments.

A final section summarizes the main findings. More detailed findings and reflections are in Annex 8.

3.2 SLIPPAGE IN COMMUNITIES DECLARED ODF

As stated earlier, the CLTS guidelines for Afghanistan base ODF verification define an ODF village as a village where one cannot see (a) human excreta at the fields, around latrines, and (b) unsafe latrines, which translate into the following three criteria: [5]

a. All households (compound) have and use a latrine.
b. No human faeces are visible anywhere in the fields, around latrines and within the community.
c. All latrines have water and soap inside or next to the latrine and handwashing is being practiced.

However, the situation concerning open defecation (OD) is not straightforward to assess and the following five types of situations were found in the communities visited:

1. No human waste visible in the community streets, around houses or fields: The main streets of the settlement are clean and there are no signs of open defecation within the settlement – i.e., behind walls, behind houses, in the streets, etc., no children's faeces in the streets and there is no human waste found in fields. However, human waste (dried or fresh turds) however may be visible in open areas surrounding the settlement, such as near rivers, hillocks and open spaces.

2. Human waste only in fields: there is no human waste visible in the community streets or around houses, but there are signs of human excreta in fields - either because of

[5] 'ODF Village is that village where one cannot see human excreta at the fields, around latrines, and also unsafe latrines' (MRRD (no date) Implementation Manual for implementing Community-led Total Sanitation (CLTS) in the Community. Kabul: National Rural Water Supply, Sanitation and Irrigation Program (Ru-WatSIP), Rural Water Supply and Irrigation Program, Ministry of Rural Reconstruction and Development (MRRD), Government of Afghanistan, p. 23)

human solid waste being collected from toilets and carried to the field or because of farmers prefer to defecate directly in their fields. It is difficult however to distinguish between the two cases, without actual physical observation.

3. Children's faeces thrown in the street: There are no signs of open defecation by adults within the streets of the settlement, but children's faeces are found on the streets (outside houses) of the settlement.

4. Overflow from toilets running through the streets: There were no signs of open defecation in the streets of the settlement, but there is an overflow of urine (and sometimes faeces) from household (flush) toilets onto the streets.

5. Human waste behind house walls and in streets within the public spaces of the settlement: There are clear signs of open defecation by adults in the streets and behind house walls, within the settlement.

For the purposes of this study, therefore, communities falling within the last two cases described above were classified as Open Defecation (OD), but those where one or more of the first four cases were found were classified as Open Defecation Free – differentiated into three stages, defined as follows:

ODF 1: No human waste was visible within the community or in fields (Case 1) - but may be in open areas (hills, valleys, rivers) around the village

ODF 2: No human waste was visible within the community but was present in fields - and in open areas around the community (Case 2).

ODF 3: No *adult* human waste was visible in the community but children's faeces are seen in streets (Case 3).

According to this classification, only 20% of surveyed communities clearly fall into the Open Defecation category and 80% fall into either ODF 1, 2 or 3 (Table 3.1).

Table 3.1: Open defecation status of surveyed villages

Situation		Number of communities	% to total
ODF 1	No human excreta within the community or in fields	10	14%
ODF 2	Signs of human excreta in fields but not within the community	40	57%
ODF 3	Small children's faeces in the streets	6	9%
OD	Human excreta within the community AND/OR toilet waste overflow within the community	14	20%
TOTAL		**70**	**100%**

Slippage from ODF status: Observation in and around the surveyed communities revealed that around 20% of communities are clearly OD and may have slipped back from the ODF status declared in 2014: Most of the surveyed communities (57%) came under ODF 2 while 10 communities (14%) came under ODF 1 and 9% were ODF 3. Since all 70

communities surveyed had been declared ODF in 2014, this suggests that 14 out of 70 (20%) communities have 'slipped back' to ODF. However, given that there is no clear information about the situation prior to declaration of these communities as 'ODF communities', it is difficult to conclude unequivocally that the 20% of surveyed communities where open defecation was found constitute examples of 'slippage'. Discussions revealed that even at the end of the CLTS intervention in a community, the declaration of a community as 'ODF' is based on 80-90% of households using toilets, with others pledging to build and use toilets – but the ODF declaration does not *by itself* mean that every single person in every household in the community *only* defecates in the house toilet every day. It is also important to note that ODF verification (by an independent third party) has not been done in any of the communities declared ODF since 2014. Also, adding the criterion of hand-washing with soap after toilet use, will reduce these percentages, as will the inclusion of institutional toilets in each community – even though the current definition of ODF does not clearly mention the situation in institutional toilets or the disposal of children's faeces.

Discussion

The current definition of 'open defecation' does not specify that signs of open defecation should not be found in open areas surrounding the settlement (where it is difficult to ascertain if it was because of visitors, guests or people from another community) and does not also clearly mention children's faeces. Given this, there is a clear need to re-visit the definition of ODF and to address the practice of male farmers who prefer to defecate in fields or to carry and spread fresh human faeces on fields (to provide fertilizer in a context where chemical fertilizers are expensive and biomass is scarce).

3.3 TOILET CONSTRUCTION AND USE

FGDs with men and women in clusters of households in each community (Tool 5) and detailed assessment of household toilets (Tool 6) showed that the toilets built were being used, that additional toilets were built, most toilets were dry toilets, construction quality was mostly fair and while most of the flush toilets were in good condition, 40% of these flush toilets opened out into the streets.

Toilet use: Almost all the households that were using toilets in 2014 were using them in 2016: While 97% of the 664 household representatives present in the cluster-level FGDs said they were using (working) toilets in 2014, this proportion was the same in 2016. However, the detailed survey of household toilets found that 88% of 517 toilets showed clear signs of being used: 90% of 140 flush toilets and 86% of 387 dry toilets.

Second toilet construction: Nearly half the households reported building a second toilet after ODF declaration, mostly due to large family sizes, growing families, and to have separate toilets for males and females: Between 2014 and 2016, around 22% of the 191-193 households represented in male and female FGDs reported building a second toilet (Table 3.2).

Table 3.2: Households reported to have built second toilets after ODF Declaration

Households building a second toilet after ODF Declaration	Reported in cluster-level FGDs with	
	Male household representatives (191)	Female household representatives (193)
Number of households	40	42
% to total households represented in FGDs	22%	21%

Note: Differences in responses from men and women FGDs were not statistically significant even at the 90% confidence level, using a chi-square test.

Large and/or growing families (e.g., more children), and a felt need to have separate toilets for men and women were the main reasons given, in cluster-level FGDs with male and female household representatives, as to why a second toilet was built (Table 3.3).[6] Less than a quarter felt that having a toilet was a status symbol.

Table 3.3: Reasons for building a second toilet

	Reasons for building a second toilet	Males groups (40)	Female groups (42)
1	Large number of household members, so one was not enough	93%	88%
2	Men and women prefer to use separate toilets	48%	60%
3	Had more children recently and so needed more than one toilet	48%	52%
4	Having more than one toilet is a status symbol in the community	23%	17%

Note: Differences in responses from men and women FGDs were not statistically significant even at the 90% confidence level, using a chi-square test.

Type of toilet: Most toilets found in communities surveyed were dry toilets: Of the 546 household toilets visited by the study team, 74% were dry toilets (395) and the rest (141) were flush toilets. Although there is no baseline data on what kind of toilets were constructed at ODF declaration in 2014, discussions showed that these were mostly dry toilets, although flush toilets with single leach-pits, double-leach pits and septic tanks were also constructed.

Quality of toilet construction: Construction quality was mostly rated 'Fair': Construction quality was rated for 491 household toilets, and only 22% were reported to be 'good', while 60% were 'fair' and 18% were 'poor' (Table 3.4). The construction quality of flush toilets was rated better than dry toilets: only 8% were rated as 'poor' compared to 23% for dry toilets.

Table 3.4: Construction Quality of Dry and Flush Household Toilets

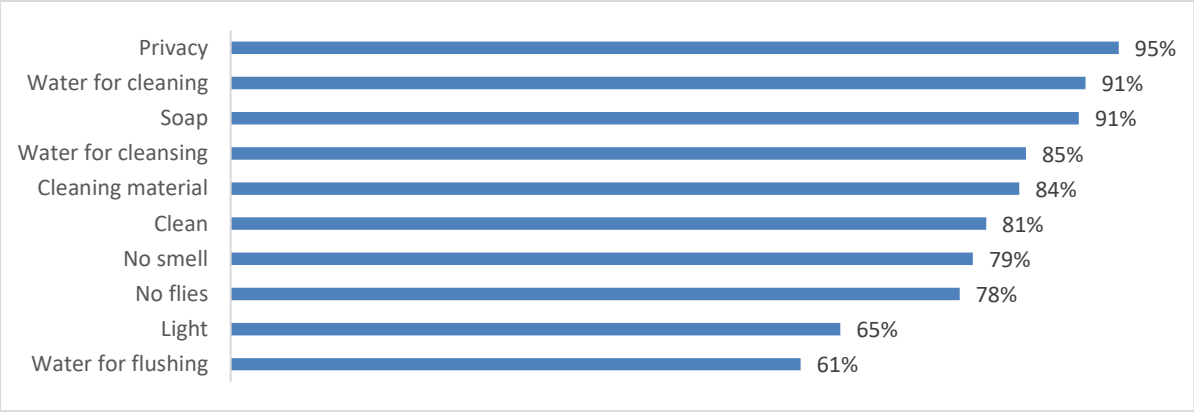
Type of Toilet	Number assessed	Rating of construction quality (%)		
		Good	Fair	Poor
Dry	366	15%	62%	23%
Flush	125	38%	54%	8%
All	**491**	**21%**	**60%**	**18%**

[6] Reasons were taken only from those FGDs where at least one member had built a second toilet.

Condition of dry toilets: Half the dry toilets did not have covers and had flies, while some had flies despite covers: While 47% of 384 dry toilets did not have covers, 49% had flies. Around 20% had covers *and* flies.

Condition of flush toilets: Most of the 141 household flush toilets surveyed were in good condition: According to the field teams that carried out the detailed assessment of 141 household toilets, more than 90% had privacy (functional doors and latches), water for cleaning the toilet and soap, but 20-40% of toilets did not have enough water for flushing, had flies and insufficient lighting (Figure 3.1).

Figure 3.1: Condition of household flush toilets assessed



Waste disposal from flush toilets: Around 40% of flush toilets opened into a drain outside the house: A survey of the outside of the houses with flush toilets found that 39% of these toilets (49 out of 125 surveyed) opened directly into a drain outside the house.

Discussion

The finding that a large proportion of toilets are in use, despite not all of them being in good condition (especially the dry toilets) and there being insufficient water to flush in pour-flush toilets, indicates that there is a strong preference for using toilets. But detailed discussions with male and female household representatives showed that *even in households with toilets that were being used,* some members were opting to defecate in the open.

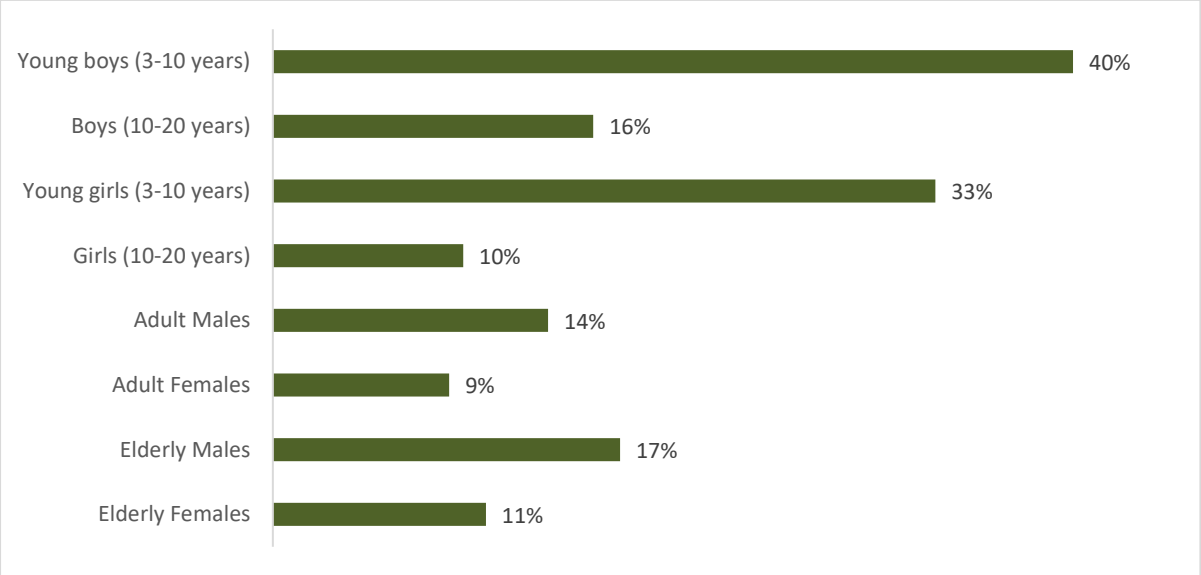
Further, the observation that nearly 40% of flush toilets opened out into a drain outside the house explains the presence of human excreta in the streets from toilet overflows – and why several communities where toilets had been built and were being used are still not ODF (see Situation 4 described in Section 3.2.1).

3.4 THE PRACTICE OF OPEN DEFECATION

Household toilet use by members of the household: Some household members (especially boys and girls aged 3-10) defecate in the open even if there is a toilet at home: From the cluster-level FGDs, households with toilets were identified and visited: male team members visited toilets along with male household representatives, while female team members visited toilets along with female household representatives. In each household, the team first asked who in the family uses toilets – which was expected to be an over-

estimate – and then asked them (especially children), who in the family does *not* use toilets (Figure 3.2).

Figure 3.2: Household members who do not use a toilet



What is remarkable about Figure 3.2 is that not one group has 100% of its members using a household toilet *even if one is present in their home.* Also, discussions revealed that not everyone who used a toilet *used the toilet every time*. Men, especially, may normally use a household toilet but may defecate outside if they were in the field and working – and felt it was too much trouble to walk back to their houses to use the toilet.

To put it another way, despite a functional household toilet being available in the house, *all household members in every household do not use toilets all the time,* which ought to be the goal of CLTS (rather than just ensuring a functional toilet in each house).

Why people do not use their own household toilets: The reasons ranged from functionality (toilet smells, is blocked, or the pit is full) and behavioural (used to going outside): In the cluster-level FGDs with groups of men (191) and women (193) in the 70 surveyed communities, the top 5 reasons (cited by more than 10% of groups) why people prefer to defecate in the open despite there being a functional household toilet, are the following: (1) the toilet smells; (2) the toilet is used sparingly ((e.g., only for guests or for women or during winter) since there is no one to clean the pit once it is full; (3) the pit is full and there is no one to clean it; (4) the toilet does not work properly (e.g., it gets blocked and there is no one to repair it); and (5) they having been going outside for so long, it feels more comfortable (Table 3.5).

Table 3.5: Reasons why people do not use a household toilet

Reason why people do not use a household toilet	Female Groups (193)	Male Groups (191)
Toilet smells	14%	12%
Toilet is used sparingly	12%	13%
The single pit is full and there is no one to clean it	11%	11%
Toilet does not work properly (e.g., it gets blocked)	10%	9%
Have been going outside for so long, it feels more comfortable	9%	16%

Reason why people do not use a household toilet	Female Groups (193)	Male Groups (191)
No one to collect, carry and pour water into the toilet to flush it	9%	8%
Too much trouble to collect, carry & pour water to flush	6%	7%
Does not feel comfortable to sit inside a small room and go	5%	7%
Convenient: Saves time & effort to do it while walking to fields	4%	7%
Men need to smoke while the defecate, and so prefer to go outside	3%	4%

Note: Differences in responses from men and women FGDs were not statistically significant even at the 90% confidence level, using a chi-square test.

A major reason noted by the teams that assessed 537 household toilets and discussed the issue with household members was a lack of awareness of the advantages of using a toilet – and a preference to go outside, either because it was something they were used to (e.g., adult and elderly men and women who had grown up doing so) or convenient (e.g., farmers, going to their fields, and children less than 10 years old playing outside).

Why people defecate in the open: Four main groups of people defecate in the open (those without toilets, adults who have toilets but prefer to go outside, visitors and guests, and children) for different reasons: Four main types of people who defecate in the open were identified, based on FGDs with male community elders, cluster-level FGDs with men and women, and household-level discussions with male and female representatives (and children) in households with toilets in the 70 communities surveyed.

1. *Adult men and women who do not have toilets in their house* including
    a. Families that have recently come to the village to settle down, e.g., internally-displaced people (IDPs) and newly-returned families from Pakistan (indicating that people who were not part of the triggering or initial CLTS messaging process are difficult to include in a village's hygiene practices at a later stage).
    b. Men who may have committed to building toilets in their houses (e.g., during the triggering process of the community-led toilet sanitation (CLTS) process) but did not actually build toilets either because they remained unconvinced about the need for toilets, or because they do not have the money to build toilets. (The latter challenge is particularly significant in the shrinking economy of Afghanistan, especially in areas destabilised by ongoing armed conflict.)
2. *Adults men and women who may have toilets in their house* but prefer to defecate in the open for various reasons:
    a. *Adult and elderly men and women* not liking the smell inside a toilet and preferring the open space which they were used to prior to building a household toilet.
    b. *Adult men* preferring to defecate in the open, when there is only one household toilet, rather than use a toilet that is also used by women.
    c. *Adult men* refusing or being incapable of using a closed toilet, due to the after effects of conflict (discussed more fully below).
    d. *Farmers*, predominantly men, preferring to defecate in their own fields – either because the field is far away from the house and they cannot come home to use the toilet; or because they prefer to fertilize their fields this way.

3. *Guests and visitors to houses in the community*, especially if the community is located close to towns and a lot of visitors come for business transactions.
4. *Small boys and girls (below 10)* who play and defecate in the streets. This was considered normal by the adult men and women in the household. Children were also reportedly afraid of open pit, dark toilets (lack of light was an issue even in flush toilets: see Figure 3.1).

In the reflection workshop conducted after the completion of the study and initial analysis, researchers offered useful insights into the difficulties faced in villages with, for example, a high number of returnees or persons displaced by war. In more than one village, researchers had observed that men with mental illness/post-traumatic stress disorder found it extremely difficult to defecate in a small, poorly-lit space, or simply wandered around the edges of the village community surviving as best they could. The research team also identified the problem that incomers to a village who had not been present when the initial CLTS triggering process had taken place were not always aware of or committed to changing their hygiene habits to conform to those of the village in which they now lived.

Discussion

A key issue is that many users - ranging from children to adult men and women and elderly men and women - *do not believe in the importance of using toilets, or are not convinced about the advantages of using toilets*. One reason for this is that they have become used to defecating in the open (and seeing others do so) and a second is that they find it convenient (e.g., farmers working in fields or small children playing outside): they have thus internalised any stigma or shame about open defecation. This is an issue that needs more careful research, analysis and action by the CLTS team – *so that different approaches can be worked out to target different members of the household and overcome this reluctance to use toilets*.

Another issue that future CLTS should research, understand and address is the effects of high levels of war trauma – including mental illness. This is an extremely sensitive issue in Afghanistan where, despite high levels of war trauma, recognition of and response to mental illness is largely taboo. In troubled areas, researchers found some correlation between mental illness/trauma and a refusal or incapacity to use a closed toilet (exclusively observed with men).

A third issue to similarly understand and address is why guests and visitors choose not to use household toilets (a sense of shame at sharing a family toilet may have a large role to play).

A fourth issue to address, with more research on women, is that of small children defecating in the open. There is a correlation between the mother's level of education and a child's willingness/knowledge of how to use a household latrine: Women with at least some years of formal schooling are significantly more likely to teach their children about personal hygiene.

3.5 HOUSEHOLD TOILET USE: MOTIVATING AND DE-MOTIVATING FACTORS

A 2013 study of factors affecting the sustainability of ODF status in rural villages following CLTS triggering in four African countries (Ethiopia, Kenya, Sierra Leone and Uganda) divided these

factors into two broad groups: Motivating (and de-motivating) factors – psychological drivers that caused people to keep or abandon their latrine; and Enabling factors (and barriers) - environmental or physical issues that make it harder or easier to build/maintain a latrine (Table 3.6).[7]

Table 3.6: Factors influencing continuing ODF households and those reverting to OD

Factors influencing ODF households	Factors influencing OD Households
Motivating factors	**De-motivating factors**
Health	Financial constraints
Shame, Disgust, Pride	No more (agency or project) support
Privacy, Security	Inconvenience, Discomfort
Convenience, Comfort	Maintenance, Repairs
	Having to share with others
Enabling factors	**Barriers**
Availability of Land, Materials, Labour	Lack of Land, Materials, Labour
Technical Advice, Knowledge	Lack of Technical Advice, Knowledge
Local Soil & Ground Conditions	Local Soil & Ground Conditions
Affordability	Lack of affordability
Availability of Water	Lack of Water

Source: Modified version of Table on p. ix of Tyndale-Biscoe et al., 2013.

In the present case, however, it is difficult to use this analytical framework (useful as it is) in its entirety, for at least two reasons:

1. These factors combine two issues: motivation (or de-motivation) to *build* a toilet and to *use* a toilet. Thus, while some enabling factors or barriers (e.g., availability of land, materials and labour) may affect the decision to build a toilet, the availability of water may affect both the decision to build and to *continue to use* a toilet.

2. Entire households have not reverted to open defecation and, instead, it is only certain members of the household with a functional toilet (that is being used) who continue to, or revert to. defecating outside.

3. The list of motivating and enabling factors (and barriers) can be longer and context-specific. While the Plan International assessment of ODF sustainability developed its own short list for its particular context, the factors relevant in a rural Afghanistan context may be different.

The present analysis, therefore, has focused on who *within the household with a toilet* uses or does not use a toilet – and why. However, both motivating and enabling factors may be identified in both cases, these have been developed with the Afghanistan rural context in mind – and hence awareness, status and social norms are additional motivating factors, while barriers include issues surrounding toilet use (e.g., who cleans the pit or septic tank, and how often).

While de-motivating factors underlying why people prefer *not* to use their own household toilet have been discussed above in the contest of continued open defecation (see Table

[7] Tyndale-Biscoe, P., Bond, M., and Kidd, R., 2013. ODF Sustainability Study [pdf]. Prepared by FH Designs with UK Aid and Australian Aid for Plan International. Available at http://fhdesigns.com.au/Documents/ODF%20Study/Plan%20International%20ODF%20Sustainability%20Study-Final%20Report.pdf

3.4 above), motivating factors and activities for using a household toilet are discussed below – as well as the de-motivating effect on household toilet use of the need to empty the toilet pit.

Why people use a toilet: Shame, awareness, convenience and safety were major motivating factors reported: In cluster-level FGDs with men and women's groups in the 70 communities, participants said they use a toilet because it saves embarrassment of being seen by others, it is a social norm now (everyone knows they should use a toilet), and it is more convenient and safe than going outside (Table 3.7).

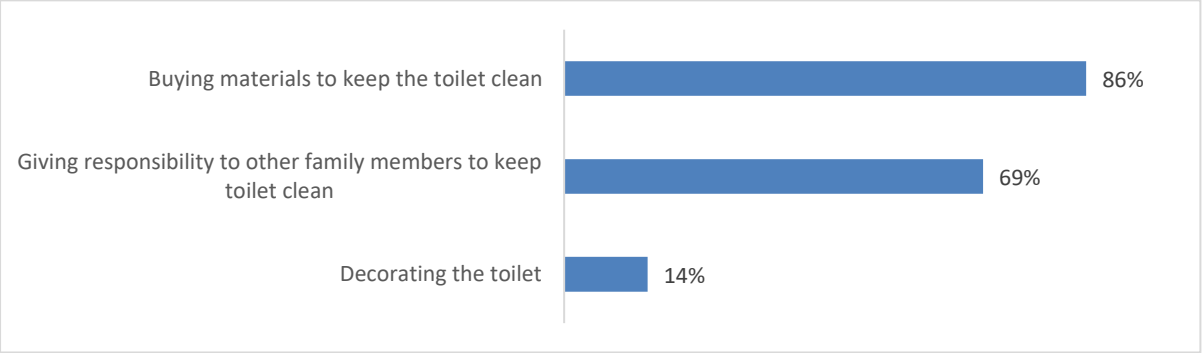
Table 3.7: Reasons why people use a toilet

Reasons why people use a toilet	Female groups (193)	Male groups (191)
Saves embarrassment of going outside and being seen by others	46%	48%
It has become a social norm	25%	24%
Convenient during cold and wet weather	23%	20%
Provides a safer place than outside (animal/insect attacks, bites, etc.)	22%	20%
Provides fertilizer in one place, that is easy to collect & take to field	19%	19%
Status symbol in the community to use a toilet	19%	16%

Note: Differences in responses from FGDs with men and women were not statistically significant even at the 90% confidence level, using a chi-square test.

Activities encouraging household members to use flush toilets: Buying materials to keep the toilet clean and giving responsibility to family members to keep the toilet clean. Discussion with household members during the assessment of (141) household flush toilets brought out that, while decorating the toilet was not a major motivating factor, having materials (such as a broom, and soap and water) that kept the toilet clean and without a smell encouraged household toilet use (Figure 3.3). Giving responsibility to family members, was also seen as an important factor in keeping the toilet clean (and thus encouraging its use) – though responses varied from 'this is the responsibility of all the family' to 'this is the responsibility of the housewife'.

Figure 3.3: Activities encouraging household members to use household flush toilets



Emptying the toilet pit can be a de-motivating factor for household toilet use: Male farmers empty their own toilet pits but not that of others; the rest pay to get it emptied**:** Cluster-level FGDs with male and female representatives in the 70 communities surveyed showed that in the groups where at least one member reported having to empty their toilet pits, most households (82-87%) had emptied the toilet pits themselves (Table 3.8).

Table 3.8: Actions taken when the household toilet pit is filled

What do you do when your toilet pit gets filled	Female groups (86)	Male groups (104)
Empty it yourselves	87%	82%
Get the pit emptied by others	13%	18%

Note: Differences in responses from FGDs with men and women were not statistically significant even at the 90% confidence level, using a chi-square test.

However, in the other cases, the household representatives reported that they had to pay others to empty their pits. They also revealed that while farmers emptied their own toilet pits and took the excreta to fertilize their fields, they would not do it for others – and hence non-farmer households had to pay to get their toilet pits cleaned. Further, while the pit was full and the toilet unusable, the household members were forced to defecate in the open – and hence, emptying the pit proved to be a barrier to the *continued use* of a household toilet, especially in non-farmer households. This did not mean that the toilet was not used, but was used sparingly.

Has using a toilet has become a social norm? No, although more than 80% of the community households know this is the right thing to do, not everyone practices it. An ordinal scoring exercise (the QPA) carried out in the 384 cluster-level FGDs with men and women revealed that more 86% of these respondent groups felt that 'everyone knows it is the right thing to do' (scores of 50 and above in Table 3.6) but only 11% of these groups felt that everyone in their community actually practiced this 'social norm' (Table 3.9). There were no (statistically significant) difference between the responses given by male groups and female groups.

Table 3.9: Perceptions of whether toilet use has become a social norm within the community

Perceived situation	Frequency of respondent scores (%)		
	All Groups (384)	Female Groups (193)	Male Groups (191)
0: No, it has not become a new social habit or norm ***at all***	4%	5%	3%
25: Some people have stopped defecating in the open but it has not become a social habit or norm	10%	10%	10%
50: Yes, everyone knows it is the right thing to do – but not all practice it	35%	32%	39%
75: Yes, everyone knows it and most people practice it, but not all	40%	43%	36%
100: Yes, it has become a new social habit and everyone is practicing it in our community	11%	10%	12%

Note: Differences in responses from FGDs with men and women were not statistically significant even at the 90% confidence level, using a chi-square test.

The issue of real interest, however, is the 11% of groups where they felt the toilet use situation in their community merited a 100 response. The 7 communities where both men's groups and women's groups scored a 100 are mostly in Badakshan (4 communities), with one community in each of the districts of Daikundi, Logar and Nangarhar (Table 3.10).

Table 3.10: Communities where Male and Female FGD respondents felt everyone used a toilet

	Province	District	Village	Community	#HHs
1	Badakhshan	Argo	Nawabad Darkhan	Nawabad Darkhan	50
2	Badakhshan	Darayam	Roee Dasht	Roee Dasht	68
3	Badakhshan	Kasham	Baloch Bala	Masjid Usman Ghani	47
4	Badakhshan	Kasham	Niazabad	Niazabad	50
5	Daikundi	Khaider	Khoshkab	Khoshkab	54
6	Logar	Mohammad Agha	Dak Kali	Dak Kali Ab bazaak	40
7	Nangarhar	Behosood	Janan Khan Banda	Janan Khan Banda	80

These communities are worth studying in detail with 100% assessment of household toilets and checking for open defecation. If indeed they are 100% toilet users, then these communities could become 'model communities' whose case studies should be documented and to which exposure visits can be arranged from other nearby communities, at least within the district if not the province.

Discussion

While there are signs of growing knowledge, awareness and practice of using toilets, future CLTS will need to address the different motivations and de-motivations of different groups of household members in its triggering strategies, and tailor its approach to include *all* members to ensure that *all built toilets are used by all members all the time*.

3.6 HAND WASHING AFTER TOILET USE

Who in the family does not wash hands? Nearly half the boys and girls below 10 years of age, and a third of all other males and females: Discussions with family members (especially children) of households with toilets showed that nearly half the boys and girls aged 3-10 do not wash their hands with soap after using the toilet, while a third of all other adult members (including young boys and girls between 10 and 20 years of age) do not (Table 3.11).

Table 3.11: Family members who do not wash hands after using the toilet

Household members	All Households (474)	Households with dry toilets (345)	Households with flush toilets (147)
Boys (3-10)	45%	50%	32%
Girls (3-10)	46%	51%	34%
Young boys (10-20)	36%	38%	30%
Young girls (10-20)	36%	36%	34%
Adult males	35%	35%	33%

Household members	All Households (474)	Households with dry toilets (345)	Households with flush toilets (147)
Adult females	35%	35%	33%
Elderly men	38%	39%	35%
Elderly women	37%	38%	34%

Interestingly, the discussions also showed that more young boys and girls aged 3 - 10 wash their hands after using a *flush* toilet rather than a dry toilet. Thus, while 50% of boys between 3 and 10 washed hands after using a dry toilet, 68% of them washed hands after using a flush toilet (Table 3.11) – a difference that was statistically significant (at the 99% confidence level, using the chi-square test). The difference between handwashing after using dry and flush toilet use for girls aged 3-10 was also similarly statistically significant.

The suggests either that the CLTS awareness raising on hand washing after using the toilet was effective in reaching children (either directly or indirectly, through their mothers) or simply that children had a fascination for a (new) flush toilet and for washing hands after using it (seen as a 'package'). This issue merits more focused research to understand factors underlying hand washing by children – and how it can be influenced.

Why people do not wash hands with soap after using the toilet: Lack of awareness of the advantages of washing with soap, lack of soap and a lack of a habit of washing with water and soap: Discussions with households during the household toilet assessments revealed that, CLTS notwithstanding, household members of different age groups did not wash hands regularly with soap and water, but for slightly different reasons: Small boys and girls (3-10 years of age) were either defecating in the open/yard, had no awareness of the need to wash hands or did not have soap, and used 'traditional methods' to wash their hands; Young boys and girls (10-20 years) and adult men and women (20-60 years of age) either did not wash regularly, had no habit, or awareness, or could not afford to buy soap or felt that traditional methods (i.e., washing with ash) was enough; Adult men felt, in addition, that daily ablutions (washing 5 times before going to the mosque to pray) were sufficient; while elderly men and women (above 60 years old) sometimes washed with soap, but sometimes did not – feeling it was unnecessary, stemming from a lack of awareness of the need to wash hands (Table 3.12).

The study did not aim to ascertain MHM practices of adult women. Field teams however observed a strong correspondence between positive family hygiene practices and women's level of formal education, a significant finding for health and education policy that merits further research.

Table 3.12: Reasons why people do not wash hands with soap after using the toilet

Group	Age	Main reasons for not washing hands with soap after using the toilet
Small Boys & Girls	3 – 10	Lack of awareness Because they defecate in the streets and open places where they play Soap is not available Using soap sometimes but not all the time Traditional ways/cultural practice Using traditional methods to wash No guidance from parents (who themselves do not wash hands)
Young Boys &	10-20	Aware but not a habit and so do not practice every time

Group	Age	Main reasons for not washing hands with soap after using the toilet
Girls		Aware and wash with water, but no soap (which they cannot afford) or convenient hand-washing facilities (e.g., near the toilet) Lack of awareness of the need to wash with soap - or feel that washing with water or ash is sufficient Feel their daily ablution (5 times) is enough
Adult Males & females	20-60	
Elderly men & women	Above 60	Cannot afford to buy soap Lack of awareness of the need to wash with soap Feel that washing with soap or ash is sufficient Aware and wash with water – and soap, when available, and not regularly

Motivating factors for washing hands with soap and water after using the toilet: Not wanting hands to smell, and doing so because religion and elders say it is the right thing to do; health impacts are a lesser reason. Cluster-level FGDs with groups of men and women in the 70 communities revealed that the major motivating factors for washing hands with soap and water after using the toilet (more than 50% of FGD responses) were (1) that they did not want their hands to smell; and (2) religion and elders say it is the right thing to do (Table 3.13). Awareness through CLTS and others that it could cause illness was mentioned in fewer FGDs with both men and women.

Table 3.13: Motivating factors for washing hands with soap after toilet use

Motivating factors for washing hands with soap after toilet use	Female Groups (193)	Male Groups (191)
I don't want my hands to smell	79%	73%
My religion tells me that this is the right thing to do	67%	70%
My elders tell me that this is the right thing to do	57%	51%
I know from others (not CLTS) that, if I don't, I could fall ill – from the germs in my hands, which will go into my stomach	40%	41%
It has become a social norm	31%	29%
My peers tell me that this is the right thing to do	31%	27%
Because of the CLTS people I know that, if I don't, I could fall ill – from the germs in my hands, which will go into my stomach	30%	32%
The CLTS people told me that this is the right thing to do – but didn't explain why	27%	30%

Note: Differences in responses from FGDs with men and women were not statistically significant even at the 90% confidence level, using a chi-square test.

This finding suggests that (1) there is a relatively small but growing awareness about the health impacts of washing hands with soap after using the toilet – which needs to be encouraged; and (2) using the local religious leaders to reinforce handwashing messages may be an effective way to influence hand-washing behaviour (at least of male members of the household).

Factors that helped households improve their hand-washing practices: The fact that it has become a social norm, buying soap regularly, and finding a place to keep the soap. Discussion with household members during the household toilet assessment reflected the

growing awareness that they were aware that they were expected to wash hands with soap after toilet use (i.e., it was a social norm) and that buying soap regularly and finding a permanent place to keep the soap would help them improve their hand-washing practices (Table 3.14). This, however, seems to be the basic step that they were aware of and thinking about – and that placing a wash basin inside (or just outside) the toilet, or a mirror above the wash basin, were improvements that only a third of these households could contemplate. These were possibly households that already had the soap and water for hand-washing.

Table 3.14: Factors that helped households improve their hand-washing practices

Factors that helped the household improve its hand-washing practices	Households with dry toilets (364)	Households with flush toilets (141)
It has become social norm	86%	90%
Buying soap regularly	66%	77%
Finding a permanent place to keep the soap	52%	60%
Placing a wash basin inside or just outside the toilet	35%	57%
Putting a mirror above the wash basin, to encourage hand washing	32%	40%

De-motivating factors: Lack of soap and water to wash and a lack of money to buy soap: In cluster-level FGDs with groups of men and women in the 70 communities, two factors that were mentioned in more than 50% of these FGDs were (1) the lack of soap to wash hands and (2) the lack of money to buy soap – while lack of water in the toilets was mentioned in slightly less than 50% of these FGDs (Table 3.15).

Table 3.15: De-motivating factors for washing hands with soap after toilet use

De-motivating factors for washing hands with soap after toilet use	Female groups (193)	Male groups (191)
There is no soap in the toilet	57%	55%
It is too expensive to buy soap	54%	56%
There is no water in their toilet	49%	47%
It is difficult to wash hands regularly	32%	30%
Washing hands before going for prayers is sufficient	20%	11%
Lack of awareness (of the need to wash after toilet use - thought it was enough to wash before eating)	17%	18%

Note: Differences in responses from FGDs with men and women were not statistically significant even at the 90% confidence level, using a chi-square test.

The fact that factors such as 'lack of awareness' and 'washing hands before going for prayers is sufficient' were cited in 20% or fewer FGDs suggests that there is a growing awareness about the need to wash hands with soap and water after using the toilet – but poverty is a major hurdle to buying soap for handwashing.

Has Hand Washing with soap after using the toilet become a social norm? No, but there is growing awareness that it is the right thing to do, though not all practice it: In the 384 cluster-level FGDs conducted in the 70 surveyed communities, it emerged that around 65% of these groups felt that it had become a social norm, i.e., people knew this was expected behaviour, but respondents in only 9% of these FGDs felt that everyone in the community was practicing it (Table 3.16).

Table 3.16: Perceptions of whether handwashing after toilet use was a social norm in the community

Scores and Descriptions	Frequency of scores (%)		
	All Groups (384)	Female Groups (193)	Male Groups (191)
0: No, it has not become a new social habit or norm ***at all***	7%	8%	6%
25: Some people have started washing hands with soap after using the toilet but not a social habit or norm	29%	28%	31%
50: Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	37%	37%	37%
75: Yes, it is a social habit in our community: everyone knows it & a majority of people practice it, but not all	17%	18%	17%
100: Yes, it has become a new social habit and everyone is practicing it in our community	9%	9%	9%

Note: Differences in responses from FGDs with men and women were not statistically significant even at the 90% confidence level, using a chi-square test.

As in the case of toilet use, the point of interest in this finding is the 9% of communities where 100% of households were reported to be practising the behaviour. The 5 communities where both men's groups and women's groups scored a 100 are mostly in Badakshan (4 communities), with one community in Nangarhar (Table 3.17).

Table 3.17: Communities where Male and Female FGD respondents felt everyone washed hands with soap after toilet use

	Province	District	Village	Community	#HHs
1	Badakhshan	Argo	Nawabad Darkhan	Nawabad Darkhan	50
2	Badakhshan	Darayam	Roee Dasht	Roee Dasht	68
3	Badakhshan	Kasham	Baloch Bala	Masjid Usman Ghani	47
4	Badakhshan	Kasham	Niazabad	Niazabad	50
5	Nangarhar	Behosood	Janan Khan Banda	Janan Khan Banda	80

Discussion

The fact that the same communities where everyone was said to be using toilets also report hand-washing by all suggests that CLTS was effective in these communities in bringing about sustained behaviour change. A detailed case study of these communities will be extremely useful in validating these findings, understanding the factors behind the performance, and using these insights in devising effective strategies for other locations. If verified, these communities could also be sites for exposure visits for peer-to-peer learning and discussions for replication in other communities elsewhere in the district and provinces.

On the other hand, the findings also show that the CLTS approach has been applied with different levels of effectiveness by the different NGOs implementing CLTS in rural Afghanistan, and there is an urgent need to standardize the quality of CLTS implementation.

3.7 INSTITUTIONAL (SCHOOL) TOILET ASSESSMENTS

As per the definition of ODF, all institutional toilets (in school, mosque and health centres) in an ODF community also should be functional and not have excreta around them. The study team therefore assessed toilets in all 22 schools found in the 70 communities surveyed.

Type of toilets: Most school toilet blocks in the 70 communities surveyed had dry toilets**:** While 95% of the 23 toilet blocks (22 out of 23) had dry toilets, 5% (one) was a flush toilet with a septic tank (in Badakshan province).

Construction quality: Most school toilets were rated 'Poor': The construction quality of 59% of the school toilets was rated as 'poor', while 32% were rated as 'fair' (Table 3.18).

Table 3.18: Construction quality of school toilets

Construction quality	Dry toilets (22)	Flush toilets (1)
Good	5%	100%
Fair	33%	
Poor	62%	

Environmental sanitation: No school toilet opened out into a drain: Since most (22 out of 23) were dry toilets and the remaining one was attached to a septic tank, none of the school toilets were found to open into a drain (unlike household toilets).

Distance from water source: Around half of the school toilets were 100 metres from a water source: 55% (12 out of 22) of the school toilets, including the flush toilet, were found to be more than 100 metres from a water source (Table 3.19).

Table 3.19: Condition of school toilets

	Dry toilets (22)	Flush toilets (1)
More than 100m from a water source	52%	100%
Cover on hole	57%	Not Applicable
Flies in the toilet	62%	0%

Condition of dry toilets: More than half the dry school toilets had covers and flies: all were dirty and smelly: Apart from the flush toilet, around 62% (13 out of 21) of the dry toilets had flies inside them, although 57% of them (!2 out of 21) had a cover (Table 3.19). All the dry toilets were found to be dirty and smelly.

Condition of flush toilets: The single flush toilet block was clean, had privacy it did not have light or water**:** There were no flies inside the school flush toilet, there was no smell, it had privacy and was clean – but there was no water for flushing, cleaning or washing.

Discussion

The generally poor quality of school toilets found in the schools in the 70 surveyed communities is likely to drive students to defecate in the open (as found in other studies), and thus contributing to open defecation in the entire community. CLTS needs to therefore explicitly address institutional toilets and include these in its community-level triggering work – in addition to its focus on getting individual households to build and use household toilets.

4. ANALYSIS AND RECOMMENDATIONS

4.1 ODF STATUS OF COMMUNITIES

- Slippage is difficult to assess: Given that there is no independent third-party verification of ODF status, and instead a community has only been 'declared' ODF is based on 80-90% of households using toilets (with others pledging to build and use toilets), CLTS declaration alone does not mean that everyone in the household is using household toilets all the time. It is not clear therefore that every community surveyed was clearly ODF in 2014 (as per the definition of ODF) and therefore difficult to conclude unequivocally that all 14 communities assessed to *not* be ODF according to the definition constitute examples of 'slippage'.

- 'Slippage' is low: Based on the current definition of ODF communities, only 14 of the 70 communities surveyed (20%) were assessed to be OD at the time of the survey.

- 'Slippage' is not due to household toilet not being uses: In most of the communities assessed to be OD, almost all the household that had constructed toilets in 2014 continued to use them. Instead, the OD assessment was due to factors such as farmers defecating (or spreading fresh excreta) in the field, waste from flush toilets running on to the streets or small children defecating in the open while playing.

- There is growing knowledge, awareness and practice of toilet use and handwashing but needs much more support to establish as social norms: The better condition and use of flush toilets and the fact that most people were aware that 'washing hands with soap after using toilets' is the right thing to do, are encouraging but the lack of money to buy soap for hand-washing and the lack of support after the ODF triggering teams have withdrawn are key problems affecting the *practice* of these behaviours as social norms.

- External factors affect toilet use and hand-washing: The impact of CLTS has to be seen in the context of internal displacement and other forms of population movement resulting from ongoing political instability, as well as the effects of the continuously declining economic situation that is also a facet of generations of war. The impacts of the high levels of internal displacement and cross-border movement caused by insecurity, on community cohesion and poverty in Afghanistan, also affect toilet use and hand-washing practices. Communities surveyed often felt that incomers did not share their hygiene practices and could not be convinced to change their ways. This makes sense because CLTS triggering (based on a critical mass of people for the behaviour change to work to scale), requires individuals who were triggered together to exert ongoing pressure and thus reinforce positive behaviours *en masse.* It could be that displaced incomers to settled communities are difficult to educate retrospectively, including by settled community members who do not have the skills to undertake CLTS triggering for new people.
- Better alignment is needed between 'emergency' and 'development' interventions: War displacement also leads to very high levels of trauma and mental illness in individuals. More than once, research teams noticed that individuals were unable

to behave in ways followed by the rest of the community; but because Afghanistan has virtually no treatment facilities for war trauma, there is little communities can do to support people who are traumatised, for example, by entering the small dark space of a latrine. Emergency hygiene responses (in case of either war displacement or displacement because of a natural disaster) may not consistently use a CLTS-compatible approach, preferring instead to focus on immediate relief rather than behaviour change.

- CLTS as a method is effective, but the implementation process in the field needs review: Study findings do not point to the lack of effectiveness of CLTS as a method overall but suggests that the *process* being followed in the field needs to be more innovative (to trigger change in different groups of household members – rather than follow a 'one-size fits all' approach) and standardized and quality-controlled (since CLTS appears to be implemented differently by some NGOs producing some excellent examples of change, but mostly inadequate).

- Targeted messaging is necessary: Although there is a small and growing awareness of the need to use toilets and wash hands with soap after using toilets, especially among women in the community, many rural people still do not see the need *for everyone* to use toilets *every time.* Also, they have not completely internalised the use of latrines and thus consider it natural for small children to defecate in the open, for adult men to defecate in the open on their way to the mosque or to their fields, and for their peers (not only men but elderly women) to do so from habit. CLTS however continues to use a 'one-size fits all' approach focused on building toilets and making people use them, and does not have separate long-term and comprehensive behaviour-change strategies for *each* of these groups – to ensure that *everyone* practices these behaviours *every time*.

4.2 RECOMMENDATIONS

- Carry out an independent third-party verification of ODF Communities: This should ideally be done straight-away, but it may be better to do this after modifying the ODF definition and the focus of the CLTS approach, as discussed below.

- Modify the definition of ODF communities: The current definition does not explicitly mention defecation in open areas outside the community and fields – where this study found evidence of open defecation (e.g., near hills, valleys, rivers and open ground). Neither does it explicitly mention children's faeces or the condition of institutional toilets. These appear to have driven the CLTS focus on triggering individual households to construct and use household toilets – while the ODF definition requires a much broader set of interventions. These need to cover, for instance, small children who defecate in the open while playing, the poor condition of school toilets that drive schoolchildren to defecate in the open, and the major issue of farmers defecating in the field – or taking fresh excreta from their household toilets to spread on their fields – given the lack of access to fertilizers and natural biomass in rural Afghanistan.

- Ensure 100% ODF before CLTS Declaration: The implementing partners of the CLTS in rural Afghanistan should ensure that the *entire community is actually ODF* before

ODF Declaration and withdrawing support. This will require more preparation and quality control among partners, as well as longer follow-up and support on the field.

- Use different strategies, messages and media for sustained behaviour change of different community groups: ODF triggering strategies should be differentiated (to address the specific needs of different groups within each household) and broadened (to encompass the entire village). These must also cover different types of targeted messaging, e.g., through local mullahs for adult and elderly men; through family health *shura*s and/or health action groups and Community Health Workers (when available) for women; and through formal and non-formal schools for children. Messaging should be varied, including incentive-based campaigns (competitions between communities and institutions such as schools), both face-to-face communication and mass media, particularly radio, which reaches rural communities – and is particularly important for the illiterate. **The importance of devising messages that reach both women and men cannot be underestimated**, especially since there is a strikingly high correlation between improved hygiene behaviours and women's knowledge: as sole caretakers of both young children and household hygiene, and as influencers of male behaviours. Therefore, enabling women (and girls) to understand and routinely implement improved hygiene remains an under-explored potential cornerstone of successful CLTS in Afghanistan.

- Develop a conflict-sensitive version of CLTS: Stronger and differently calibrated support for communities with high levels of transient populations – perhaps by developing a version of 'CLTS for insecure settings' that is suitable for Afghanistan's challenging circumstances. This should be preceded by a review of discrepancies between 'emergency' and 'development' responses, in case messages given in the former contradict or undermine messages given to populations that are more settled.

- Enable access to soap and water. Involve the national and international private sector, donors and local providers to ensure supply chains to provide low-cost soap, and develop a unified approach across rural water supply and school WASH to ensure that water supply is adequately provided, especially for new flush toilets, and for convenient hand-washing with soap after using dry toilets.

- Begin preparing a solid waste, liquid waste and faecal sludge management strategy for rural areas: There could be a growing problem of ground and surface water pollution due to contamination from fresh human faeces from dry toilets and from the improper disposal of faecal sludge from septic tanks attached to flush toilets. It would therefore be prudent to research this issue, and to begin preparing a strategy to address the problem before it grows to the point that the (scarce) fresh water sources are too polluted to use without expensive treatment.

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ANNEX 1: TERMS OF REFERENCE

SHORT TITLE OF ASSIGNMENT: Study on sustainability of Open Defecation Free status of communities in Afghanistan & Study into safe handling, disposal and reuse of human waste
NATIONAL / INTERNATIONAL: National
LOCATIONS TO BE VISITED: Open Defecation Free Villages in 8 provinces (Badakhshan, Takhar, Nangarhar, Laghman, Kapisa, Bamyan,Daikundi, Logar)

BACKGROUND

Globally, the progress towards the sanitation targets, including those set under the Millennium Development Goals (MDGs) was slow. Many approaches have been tried out in different countries to ensure that people get access to safe sanitation facilities. For decades there has not been a proven, scalable, cost-effective model that gives confidence for rapid further progress. In 2008, UNICEF adopted the Community Approaches to Total Sanitation (CATS) as strategy for its work on sanitation programming. CATS aims at eliminating open defecation; rooted in community demand and leadership, focused on behavior and social change, and committed to local innovation. CATS is an umbrella term that encompasses a wide range of community-based sanitation Programmes, such as Community-Led Total Sanitation (CLTS), School-Led Total Sanitation (SLTS) and Total Sanitation Campaigns (TSC), as well as combinations thereof.

CATS is now used in 50 countries, reaching over 54,000 communities with more than 100 million people. There are major efforts throughout Africa, South Asia, and East Asia. CATS aims for 100% Open Defecation Free (ODF) communities and associated key behaviors (e.g. hand-washing with soap). Implementers are asked to consistently utilize a set of interventions built around a number of CATS principles.

If successful in limiting sanitation related diseases, CATS will have significant direct and indirect impacts on child morbidity and mortality, stunting, education, and other areas. Monitoring data based on a consistent certification/ verification process indicate very high success rates in the use of toilets compared to conventional approaches. Sanitation programmes that apply CATS approaches are fundamentally owned and implemented by national partners; leadership is normally taken by national and sub-national governments but often includes other actors. Community participation is a critical element, setting the stage for the introduction of a new social norm, where open defecation is no longer an accepted practice. Strategies include mobilizing the community to take a collective decision that leads to community implementation and oversight of related activities (household and school toilet building and use, hand washing, etc.). The approach is radically different from conventional efforts that focus on changing the behavior of households one at a time, often with heavy subsidies to build toilets.

Key UNICEF contributions to CATS include policy advocacy, social mobilization, counterpart capacity strengthening, community triggering, monitoring, and limited financial support. UNICEF is not the only organization using and promoting CATS. Globally, there are other major supporters implementing similar approaches which include, but are not limited to, WSP, Plan International and SNV.

South Asia is the region with largest number of people practicing open defecation, and the region did not reach the sanitation MDG target. In this region, UNICEF has been supporting

and promoting the use of CATS in five countries: Afghanistan, Bangladesh, India, Pakistan and Nepal. The nature of UNICEF support in these countries varies significantly, primarily influenced by the extent of Government investments in rural sanitation. As Government budgets for sanitation increase, the nature of UNICEF support moves more from downstream (direct support for CATS implementation) to upstream (support for Government and NGOs to implement CATS strategies).

UNICEF Executive Board commissioned a global evaluation of CATS in 2012-13. This evaluation was carried out in 2013, and the findings and recommendations were presented at a global workshop in February 2014.

I n response to recommendation 2 of this evaluation (specifically in the context of sustainability of the changes in toilet use and handwashing behavior), UNICEF Regional Office for South Asia (ROSA) and the UNICEF Country Offices from South Asia that participated in the global workshop on the CATS evaluation in February 2014 (Afghanistan, Pakistan, India and Nepal), agreed to study the sustainability of CATS results in these four countries. Community Led Total Sanitation (CLTS) was introduced in Afghanistan in 2010 in Afghanistan through a USAID funded project which was later adopted to the Afghan context. UNICEF has been supporting the Ministry of Rural Rehabilitation and Development (MRRD) to implement CLTS and the approach has shown substantial success in converting communities to open defecation free status. The Afghan Context CL TS, in addition to eliminating open defecation also has people upgrade their unimproved latrines and trains community members on hygiene.

Since 2010, CLTS led to about 1600 open defecation free villages. Slippage and conversion to open defecation is happening at varying degrees. In Afghanistan there is no documented evidence on what percentage of communities revert back to open defecation but there are speculations that people in some communities started with open defecating again. This study, part of the regional initiative to evaluate sustainability of CATS/CLTS, is an attempt to find out what percentage of communities revert to open defecation. Moreover, the study will also identify factors associated with sustainability of ODF or slippage.

The Sustainable Development Goal 6 on Water and Sanitation calls for countries to achieve, by 2030, that at least 50% of all human waste is safely managed. Traditionally in Afghanistan, human excreta are composted and used as fertilizer in agriculture. When done adequately with attention to safe handlin g, the re-use of composted human waste as fertilizer is recognized as a form of safely managing human waste. To what extent the re-use of human waste as fertilizer in Afghanistan is still practiced has not been documented as far as we could assess. To our knowledge there are no studies about the knowledge, attitudes and practices of handling, disposal and re-use of human waste in Afghanistan. Anecdotal evidence and field observations show a wide variety of poor handling of human waste and unsanitary conditions around the traditional vault latrines. The outreach required to visit the ODF declared communities under the aforementioned ODF sustainability study offers an efficiency gain when we combine this with a study on handling, disposal and re-use of human waste in Afghanistan, and to address these two studies under one contract.

Methodology

UNICEF will provide the list of all communities declared ODF before February 2014.
Ideally, the agency should carry out In-depth interviews, focus group discussions and observations at the village level as well as key informant interviews and a desk review. A

representative sample model for quantitative data collection should also be proposed by the contractor. The consultancy will produce a country-specific report, with findings, analysis including comparisons, and recommendations.

At least ten percent of the communities declared ODF before February 2014, should be considered as sample for the qualitative data while the contractor should come up with a reasonable sample size for the quantitative data. The main users of the findings and recommendations of this consultancy will be decision-makers in Government, NGOs and UNICEF who are in various ways working on rural sanitation programmes based on CATS/CITS strategies.

This study seeks to determine the following in communities that were certified free of open defecation on or before February 2014:

The proportion of households that is still using a safe toilet
The factors that motivated people to continue using a toilet
The factors that indicate the state of operation and maintenance of the toilets
The proportion of households that reverted to open defecation after ODF verification
The common characteristic of households reverting to open defecation
The factors that caused people to revert to open defecation
The proportion of households that constructed another toilet after ODF verification The factors that motivated household to construct another toilet after ODF verification The actions households took when their toilet pits filled
The proportion of households having water and soap in or near the toilets
The proportion of households having soap for handwashing in their house
The factors that motivate households to practice handwashing with soap after using the toilet The factors that de-motivate households to practice handwashing with soap after using the toilet The factors involved in handwashing at critical times by all members of the family
Evidence of post-ODF activities that helped households maintain or improve their toilet use and handwashing with soap practices
The degree to which not practicing open defecation and handwashing with soap after defecation respectively have become a new social norm/habit
The factors which are related to an enabling environment for sustainable ODF behaviour

The KAP study will collect specific information on knowledge, attitudes, practices and perceptions on:

Use of a toilet facility by different members of the household
Cleaning of household latrines
Emptying household latrine pits, septic tanks and vaults
Facts and beliefs about the collection and use of human and animal waste, related to advantages, risks and (non-) acceptable practices.
Handling and disposal of human waste
Handling and disposal of child feces
Composting of human waste (eg. mixing ash, straw, animal droppings etc. with human waste to aid composting) Reuse of urine for agriculture
Reuse of fresh and/or composted human waste
Different crops, trees and scrubs fertilized with human waste and or urine
The risks and perceptions (health or social) related to handling, disposal or re-use of human waste

About re-use of #own# family waste vs. waste from other families People involved in handling, disposal and re-use of solid waste Commercialization of handling and selling of human-waste based fertilizer

Management of the study:

A Steering Committee will be formed to oversee and steer the overall implementation of the study. The group will provide technical input at different stages of the study and will approve the methodology as part of the inception report, and the draft and final study report. This group will involve members from UNICEF and government ministries including MRRD and MoPH and other relevant agencies/partners.

Task 1

INCEPTION PHASE
Meetings, document gathering, desk review
Conceptual report Study plans, protocols, indicators; approaches and tools, selection of geo-areas for the study (80 communities from 8 provinces); data collection plan, protocols for data cleaning and tabulations. Recruitment and training of field staff
Obtain permission for the Study by the relevant authorities by IRB at MoPH
Review of the draft of the inception report by the UNICEF ROSA and Afghanistan Office and the study reference group
UNICEF feedback, revisions and acceptance of the inception report
Deliverables;
Inception report including final study protocol and qualitative survey methodology
Inception Report, including: Duration: 50 Working Days

Task 2

EXECUTION PHASE Training of data collectors

Data collection
Data cleaning, initial tabulations Analysis and drafting country report Deliverables;
Preliminary Qualitative Analysis
Duration: 45 working days

Task 3

DELIVERY PHASE
Preparation and submission of draft report
Review of draft report by UNICEF ROSA and Afghanistan Office and study reference group
Preparation and submission of final report
Presentation workshop
Deliverables;
Study Report
Duration: 20 working days Presentation Workshop Deliverables;
Workshop report
Duration: 5 working days

BUDGET AND TERMS OF PAYMENTS

The price of proposal for each deliverables should be in attached financial cost schedule annexed to this RFP, include any associated cost to that particular tasks, (i.e., DSA/accommodation, transportation and running costs. Payment modalities:

The payment will be done in three installments as per table shown in the financial cost schedule with following breakdowns:

- The first installment which is 40% will be released upon approval of the Inception Report by the Steering Committee, including the complete research protocol and tools, plan for recruitment and training of field surveyors and the approval from the ethical review board of the MoPH . Output for this instalment is the Inception Report.
- The second payment of 40% will be released upon submission and presentation of draft study report.
- The third instalment which is 20 % will be released after submission and approval by the Steering Committee of the final report, all tools, photographic and recorded materials, and the data sets (in hard and softcopies).

QUALIFICATIONS, SPECIALIZED EXPERIENCE AND ADDITIONAL COMPETENCIES

a. Qualifications for the consulting firm

At least 5 years of experience in carrying out consultancies in water supply, sanitation and/or hygiene behavior change programming

Familiarity or prior work experience for the UN, UNICEF or international development organizations.

- At least 5 years of experience in carrying out field data collection, using household interviews, focus group discussions, and key informant interviews.
- No prior involvement in the programmes/project that are to be evaluated (ODF Villages).

b. Qualifications for the individual experts to be hired

- The study experts must have an advanced university degree in social sciences or related field, preferably related to WASH behavior change;
- The team leader must have proven expertise in leading similar studies or evaluation across several countries, as team leader;
- All experts should have at least 7 years of relevant experience; Excellent English writing and speaking skills;
- Good communication, analytical and facilitation skills;
- Good understanding of the local context and challenges of CLTS programming;
- KAP and C4D expertise including felicity in using tools like Appreciative Enquiry
- Proven capacity to work with multiple partners from governmental and non-governmental institutions;
- The study experts must have at least five years of experience in conducting focus group discussions, key informant interviews, and the supervision and cross-checking of household interviews.
- Mix of male-female and national-international experts

c. Competencies of the personnel deployed for data collection

- At least five years of experience of processing and documentation of qualitative and quantitative of field data collection (FGD, household interviews, key-personnel interviews, questionnaires, etc.).
- Proven experience with relevant Computer-based Statistical data operation and management
- Good English reading, writing and speaking skills.
- Excellent reading, writing and speaking skills in the languages in which the data is collected;
- Good Pashto/Dari reading, writing and speaking skills will be an asset.

The study team should have gender balance. The teams for field data collection must have female interviewers.

The implementing partner should provide the composition of the national evaluation team it is proposing, and include the CVs of all key team members who will be part of implementing the evaluation.

CONDITIONS OF WORK

The contractor will be working from their own offices. UNICEF will cover the financial part as per the agreed deliverables. UNICEF will not provide the office space, computers, include logistics, transport, insurance, security and other related issues. The contractor should have an office in Kabul and must have operating license in Afghanistan.

ANNEX 2: KEY ISSUES FROM A SURVEY OF LITERATURE

Water and Sanitation Status in Afghanistan

Only 27% of Afghanistan's population has access to safe drinking water which falls to a fifth of the population in rural Afghanistan, while an estimated 95% of the Afghan population lacks access to improved sanitation and goes down to 99% for rural areas. While one in five Afghans in rural areas defecates in the open, it is only 1% of the population in urban areas. But given that about 77% of the total country's population lives in rural areas and that a majority of the population in the assessment provinces is rural (see Table A1.1 below) this is of great concern.[8]

Table A1.1: Rural Population and Poverty rates in Assessment Provinces, 2011/12

Provinces	Rural population (%)	Poverty rate (%)
Badakhshan	96.1	62.7
Takhar	87.1	65.4
Nangarhar	85.5	38.2
Laghman	98.9	63.8
Kapisa	99.7	27.7
Bamyan	97.2	40.5
Daikundi	99.2	39.6
Logar	97.9	28.0
National average	**76.5**	**35.8**

Source: World Bank (2014)

In the case of the Kuchis, two-thirds defecate in the open. However, access is not just defined by rural and urban, but also varies across provinces. Therefore, while in Kabul Province 56% of the population, on an average, has access to safe drinking water, in Helmand it is only 5%. Similarly, for sanitation access varies across regions. While only a fifth of the population in the central highlands have access to improved sanitation, the eastern provinces have less than half suffer from poor quality sanitation. Given the overall extremely low coverage of sanitation there are no clear geographical patters of sanitation coverage rates of sanitation in rural Afghanistan. However, there are a few districts where coverage is even less than 1% of the total population (Table A1.1).

Within the 8 provinces to be a part of this assessment, vulnerable districts due to poor WASH facility resulting in less than 50% accessibility to sanitation - resulting in open defecation – were Kharwar in Logar Province (64%) and Rustaq in Takhar Province (59%). Another study (UNICEF and SSDA, 2012) also looked at provinces vulnerable to poor WASH and compounding factors (including disasters, health facilities, access, insecurity and governance), and two of the provinces to be surveyed in the current study, Logar and Laghman, were part of the most vulnerable provinces.

Toilets by type

Around 60% of the existing Afghan population with latrines use *traditional* latrines, usually a vault latrine, while the other common option (especially in rural areas) is to defecate in

[8] CPHD (2011); GoA (2008).

the open – in *deahan/sahrah*[9], open fields and open pits – from where it can also contaminate existing water sources. While vault latrines are better than open defecation, it does not isolate excreta from human physical contact or effectively dispose the waste. Septic tanks, where constructed may also suffer from poor quality construction and result in environmental pollution and ground groundwater contamination. While there are presently no studies that estimate the rate of non-functional facilities, failure rate according stakeholder perception, of sanitation facilities, is around 10%.[10]

A study by USAID in 2012 for its project districts where it was working on improving sanitation facilities and creating ODF in selected communities included a number of the districts included in the present assessment. This study suggests the most popular type of latrines is the vault latrine, followed by the pour flush latrine (Table A1.2).[11] The Percent of population in the project area that built the different type of latrines is given below.

Table A1.2: Latrine use in 5 project district populations of the of the USAID WASH Project

Province	Percentage of population using a			Percentage of population with no latrine	Total
	Vault latrine	Pit latrine	Pour flush latrine		
Logar	78.9	3.7	13.8	3.7	100
Laghman	42.5	24.7	24.7	8.2	100
Nangarhar	48.9	21.6	15.1	14.4	100
Takhar	45.9	17.8.	14.4	21.9	100
Badakshan	48.6	11.1	20.8	19.4	100

Source: MMRCA (2012)

However, focused attention to create awareness about and demand for sanitation in specific communities has affected overall province figures, suggesting that the project has resulted in the increased coverage of latrines in the project area (Table A1.3).

Table A1.3: Defecation facilities and Practices in Survey District

Province	Type of latrine (%)*					Access to Improved Sanitation (%)
	Flush to sewage	Traditional pit	Open pit	Bush/ field	Others	
Badakhshan	-	34.4	8.4	57.4	-	3.1
Takhar	0.2	48.1	13.1	38.0	0.6	2.0
Nangarhar	13.1	41.5	6.4	40.0	1.3	10.0
Laghman	0.5	48.0	12.7	49.0	0.5	1.2
Kapisa		60.6	1.3	38.1	0.5	0.8
Bamyan	0.5	28.2	0.7	73.3	0.5	0.4
Daikundi	NA	NA	NA	NA	NA	0.4
Logar	0.2	194.1	1.7	4.7	0.6	0.6
Total rural	0.5	52.9	6.4	40.6	3.1	
National average	**2.8**	**59.0**	**6.5**	**32.3**	**2.3**	**8.4**

Source: *MICS 2003 from SIM and SWS, 2012; + World Bank, 2014

[9] Place in or outside house compound where waste, animal manure, ash from fire etc. are disposed.
[10] CPHD (2011); SIM and SWS (2012), GOA (2008)
[11] MMRCA (2012); USAID (2012)

Another important concern is the disposal of children's faeces, specifically those who do not use toilets. In terms of the disposal of children's faeces, a survey of faeces disposal of children under 3 in 2010 suggested that 52% of households were disposing children's faeces unsafely, and of households with improved toilets 20% were also reporting similar unsafe disposal of children's faeces. Furthermore, the safe disposal of children's faeces increased with the wealth of the households – with only 29% of the poorest quantile reporting safe disposal as compared to 76% of the richest quintile. Equally, urban households are more likely to dispose children's faeces properly as compared to rural households at 76 and 42 percent respectively. Clearly this is another area where there is a need for further focus to attain ODF in communities. (UNICEF; World Bank, 2015)

Safe Management of Human Excreta

While data on coverage by sanitation facilities and changes in coverage exist, these data only shows *existing* sanitation infrastructure and changes in habits on where a person or community is likely to defecate – and does not cover issues of safe storage of excreta prior to disposal. Also, as noted in USAID (2012), while cement slabs were recommended by the project, not all households could afford them, and only a minority afforded a ventilation pipes. Thus, the actual quality of the latrine to ensure safe storage of faecal matter may continue to be a concern for poor households without adequate support. Furthermore, with high poverty rates (see Table A1.1), it is likely that safe storage of excreta prior to its disposal may continue to be a challenge. Overall, the proportion of households with access to 'improved latrines'[12] went up to 39% under the project. Also, the 2010 WASH Policy of Afghanistan notes that while about 58% of households use some form of traditional latrines only 5% have access to safe and hygienic latrines. Therefore, while habits may have changed, much more needs to be done to ensure safe disposal of faecal matter and the complete breaking of the faecal-oral contamination route. Furthermore, as Table A1.3 shows, access to safe sanitation is extremely low, and therefore much more may need to be done on the quality of sanitation infrastructure to break the faecal-oral route.[13]

Disposal of human faeces

According to a baseline study for the USAID project on sustainable water supply and sanitation, only about 22% of faeces was safely disposed, and was mainly buried. The rest was either used as fertiliser or poorly disposed of. Five of the USAID project districts, namely, Badakshan, Logar, Laghman, Nangrahar and Takhar are also a part of the current study. The USAID Knowledge, Attitude and Practice (KAP) study for their project suggests that the most frequently used method for disposing old faeces is burying and using the compost as fertilizer. In the 5 districts that are part of the current UNICEF survey and are also part of the USAID study, this proportion is high: 87% (Logar); 78% (Nangarhar); 77% (Takhar); 72% (Badakshan) and 64% (Laghman). Other than in Badakshan, where about 2% of the population reported that somebody collected the old faeces, this was not reported in any other district. The USAID project had introduced the CLTS approach in 2010 in Afghanistan (USAID, 2010 and MMRCA 2012; UNICEF 2016)

[12] Improved latrine includes – a concrete slab that can be cleaned and kept clean, a hole that is safe for children, a cover for the hole, a door or curtain, a window with netting, a ventilation pipe and a secure cover for the hole from which faeces can be removed.
[13] MMRCA (2012); USAID (2012); MRRD (2010)

Creating Improved Sanitation and ODF

According to the HDR 2011, a major cause of low improved sanitation is the lack of demand for sanitation. Social marketing, hygiene education and links between sanitation and health are limited, resulting in inadequate demand for improved sanitation. Another issue identified by a study in 2012 on the water supply and sanitation sector are the technical challenges to identify suitable and acceptable water supply and sanitation solutions. Responding to this concern are approaches like CLTS. Presently, the rural water and sanitation sector in Afghanistan has been shifting towards decentralised, demand responsive and people centred approach. Therefore, presently the government in Afghanistan is becoming a facilitator of rural communities over a direct service provider (CPHD, 2011; SIM and SWS, 2012)

Post-Defecation Hygiene Practices

According to the baseline study for the USAID project on sustainable water supply and sanitation for the USAID's project provinces, 86% of households had a fixed place for washing hands but only 3% had it near the toilet. Similarly, while 77% had soap at home only 2.8% households had soap placed near their washing place. Therefore, it is likely while not all will be washing their hands after going to the toilet, it is even less likely that soap will be used to wash hands every time. Although post project, the overall increase in household with latrines and rate of overall cleanliness increased in latrines was reported to have gone up considerable, the safe disposal of faeces from latrines only went up martially from 38% to 41%, after a year of the project. Post project, which was in 2012 the 87% of households were practicing hand washing post defecation and 52% also washed and after handling child's faeces. Equally, 90% of households reported having toilets (USAID, 2010; MMRCA 2012).

Table A1.4: Post Defecation Hygiene Practice (%)

Province	Washing with				No Hand washing	Others	Total
	Only water	Water and soil	Water and ash	Water and soap			
Badakhshan	95.6	0.3	-	4.8	0.2	0.5	
Takhar	63.3	-	-	38.1	0.9	-	
Nangarhar	57.8	0.7	0.2	40.8	0.8	-	
Laghman	95.2	0.1	0.4	5.2	2.7	-	
Kapisa	84.0	0.50	1.1	28.9	0.3	-	
Bamyan	88.3	-	-	11.0	1.1	-	
Daikundi							
Logar	83.0	0.7	0.6	16.4	0.4	-	
Total rural	85.4	2.8	1.5	23.3	2.9	0.0	
National average	**80.2**	**2.5**	**1.3**	**27.9**	**2.6**	**1.2**	

Source: MICS (2003); SIM and SWS (2012)

Impact of Poor Sanitation in Afghanistan

The multidimensional poverty index of the UNDP suggests 84% of Afghan households as being poor. This index takes into account deprivation in three areas of health, education

and standard of living. The major contributor to this high level of poverty is the lack of access to clean water or improved sanitation, and poor hygiene practices. Apart from also suggesting an urban-rural dimension to poverty, this index also suggests that the Kuchis are the most deprived group among the Afghans, with extremely low access to sanitation[14] and poor access to water supply. (CPHD, 2011)

The lack of access to water and sanitation services in Afghanistan also had a major impact on health. About 23% of under 5 deaths in Afghanistan have been associated with diarrhoea, which is mainly linked to poor access to clean water and improved sanitation. For under 5 children, about 47% of all reported cases in 2006 were related to diarrhoea; and in a survey of 70 hospitals of children of the age of 22 to 59 months, an average of 43% admissions was due to diarrhoea related causes. An estimate also suggests that Afghan children, on an average, suffer 6 episodes of diarrhoeal diseases every year. Apart from diarrhoeal diseases, another concern related to poor sanitation is parasitic infections. A study of 1001 children of the age between 8 and 15 suggested at an approximate 47.2% were infected with at least one type of helminths. (CPHD, 2011; SIM and SWS, 2012)

The burden of diseases, apart from malnutrition, stunting and long term cogitative and physical development deficiencies also impacts household budgets. A study in 2006 suggested that on an average an Afghan home spent 500 AFN for each episode of illness, if they sought health care outside the house. For Afghans below the poverty line (1,255 AFG/month), this is 40% of the monthly income. (CPHD, 2011)

Government of Afghanistan and the Rural WASH Policy

The Islamic Republic of Afghanistan developed a National Rural Water, Sanitation and Hygiene (WASH) Policy in 2010. According to this, the Ministry of Rural Rehabilitation and Development (MRRD) is responsible for rural WSS services, and the Rural Water Supply, Sanitation and Irrigation Programme (RuWATSIP) and the National Solidarity Program (NSP) are to implement this. This Policy provides a roadmap to improve access rural WASH facilities and has a vision from 2010 to 2020, in line with the Afghanistan National Development Strategy. According to this Policy, use of demonstration latrines, subsidies for latrine construction and traditional hygiene strategies have not been successful in triggering behaviour change and resulting in a demand for sanitary latrines on a large scale. However, school programmes have been seen to have bought positive change in children attending the schools. Therefore, children are seen as possible catalysts for creating behaviour change at household and community level. (MMRD, 2010)

This Policy aims at improving the quality of life of people though improved access to safe, convenient, sustainable water and sanitation services and increased adoption of hygiene practices. This Policy has three objectives, one each for rural water supply, sanitation and hygiene. The one pertaining to sanitation is to,

“Make all villages/rural communities in the country 100% ODF free and fully sanitised by 2020; and 50% and 70% by 2014 and 2016 respectively by empowering communities to:

- Improve existing traditional latrines to become safe, hygienic and ensure user privacy;
- Make new latrines as models of safe sanitation in households, schools and clinics;

[14] According to the MRRD RuWatSIP program province profiles Kuchis have 0% access to sanitation facilities, effectively only practicing open defecation, though another study suggest two-thirds defecate in the open (http://www.mrrd-ru-watsip.org/provincial-profile/ accessed 02 September 2016; CPHD, 2011)

- Undertake the safe disposal of solid and liquid wastes."

This Policy has also identified 5 parameters for a hygienic latrine. These are (i) it is fly proof; (ii) it separates excreta from human contact; (iii) it eliminates odour; (iv) it does not contaminate ground or surface water; and (v) it ensures user privacy, especially for women and girls.

This Policy mentions that sanitation facilities are to be resistant to natural disasters, constructed so as to ensure that they do not damage or pollute the environment.

The Policy states that there is to be no upfront hardware subsidy to individual households to construct latrines, though post ODF achievement awards and incentives may be given. The Policy identifying the link between water availability and sanitation suggests adequate operation and maintenance for water supply units to ensure sustainability of safe water and sanitation. It also mentions that hygiene is an essential element of all WSS programmes and therefore focuses on priorities on hygiene also. Further; discussing CLTS, it mentions that this approach shows promise and success in creating lasting behaviour change and creating ODF communities. (MRRD, 2010)

In order to implement its Policy, the MRRD has developed an implementation manual. (MRRD, 2013) According to this manual basic service level for sanitation level facilities are,

- Access to sanitary latrines that can contain human waste in a hygienic manner before final disposal.
- Knowledge through Hygiene and Sanitation Education leading to clear understanding of good hygiene practice and changes in hygiene behaviour.

The RuWatSIP is to implement using the Community Development Councils (CDC) to approach the community. However, where CDCs are not formed Water and Sanitation User Groups would be formed. To support this effort at the provincial level water and sanitation staff would also be available at the Provincial Rural Rehabilitation and Development (RRD) office. Sanitation promotion is to use the CLTS method. While water supply systems would be subsidised with at least 10% cost paid by the community, sanitation is to be borne by the individual households. This strategy, mentioning schools as possible points of influence in the community, says that all schools are to have adequate sanitation facilities. Discussing Kuchis, this strategy also suggests the need to determine a national health, hygiene and sanitation campaign and feasible sanitation strategy or approach for these pastoral communities. In order to ensure sector coordination, the MMRD is to establish the Water and Sanitation Group and also working committees on water, hygiene education and sanitation. (MRRD, 2013)

The main sanitation technologies suggested by the implementation manual are the dry, single or double vault latrine, VIP latrine and the pour flush water seal latrine. However, it also mentions the composting urine diversion toilets and eco-san as other sanitation possibilities. (MRRD, 2013)

Community Lead Total Sanitation in Afghanistan

The Community Lead Total Sanitation (CLTS) approach of MRRD has a total of 10 principles which are to be a part of the Afghan-Style CLTS approach. (MRRD, Ru-WatSIP, nd):

- CLTS focuses on outcomes, not on hardware inputs;

- CLTS emphasis on collective action, mobilizing the community rather than establishing household contacts;
- CLTS suggest local choice, providing a variety of technological options and getting people to access affordable technologies.
- CLTS develop local market, by promoting the availability of sanitary materials and allowing private suppliers to respond to the demand.
- Through CLTS approach, communities construct their own latrines or toilets with their own resources. Those people who are better off help those who are too weak or poor to help themselves.
- In CLTS, no standardized top-down designs are decided for the people. People decide their designs themselves.
- While implementing CLTS, facilitators do not teach or preach. Appraisal and analysis are facilitated. But after triggering, information, media campaigns and encouragement can be provided.
- Through applying CLTS approach, Natural Leaders (NLs) are emerged, when community proceeds towards Open Defecation Free (ODF) status.
- Through applying CLTS approach, local innovations of low cost toilet models using locally available materials are developed.
- In CLTS, community-innovated systems of reward, penalty, spread and scaling-up are followed.

According to the Implementation Manual for CLTS of the MRRD, the CLTS approach has three steps, pre-triggering, triggering and post triggering. The pre-triggering is, includes one or two visits to the selected villages by about two experienced facilitators from the NGO identified to lead the CLTS work in the area. During the pre-triggering phase, the team meets local leaders (such as the religious leaders, village chief and *malik*s), introduces itself and fixes a date when then can meet the whole of the village to understand the village better.

In the second (or triggering) visit, the CLTS team; which consists of both men and women come to the village and meet the men and women in the village separately, and may be in the hujra and pre-determined house respectively. Here a social map of existing sanitation facilities is made to understand the status of open defecation and create an awareness and demand for improved sanitation. After the triggering process; which usually lasts one day, a CLTS committee is identified from the community itself. This is a committee of volunteers who would like to take immediate actions to stop open defecation and would like to improve their own sanitation systems and practices. Of this committee a monitoring team is identified who monitor the commitments of members of the committee.

In the post-triggering period, the NGO undertake regular follow-up visits and monitor and supervise the work. This is a two to four-month period, which is to end with a Clean Village Certification. This Clean Village Certification is to be given once the village is declared ODF. (MRRD, Ru-WatSIP)

UNICEF and WASH in Afghanistan

UNICEF has been working in Afghanistan for over 35 years, and was made the WASH cluster coordinator at its inception in 2008. Though its WASH programme UNICEF; apart

from its water related focus, aims at supporting the installation of sanitation facilities in individual homes and education programmes to highlight the importance of handwashing for disease prevention. UNICEF also focuses on school sanitation and the incorporation of hygiene education in school curricula. UNICEF also supports sanitation activities as a part of emergency humanitarian crisis response. UNICEF's WASH program includes advocacy and support to policy and decision making, influencing policies to improve access in communities and schools, and initiatives in communities and schools. UNICEF supports the scale up of the CLTS campaign in 10 focus provinces, though it has a special focus in south Afghanistan where polio is widespread. It adapted the Community Approaches to Total Sanitation (CATS) as a strategy for its work ion the sanitation programme in 2008. The CATS program aims to eliminate Open Defecation (OD) through community based sanitation programmes such as CLTS, School Lead Total Sanitation (CLTS) and Total Sanitation Campaigns (TSC). UNICEF supports the MRRD to implement the CLTS approach.[15]

UNICEF CLTS Protocols for Afghanistan

In the Afghan context, CLTS aims for ODF, have people upgrade their unimproved latrines and train community members on hygiene. According to the UNICEF CLTS protocols for Afghanistan, ODF is divided into 3 stages, and defined in terms of non-negotiables and desirables for Stage 1 (UNICEF, 2014; UNICEF, 2016) In Stage 1 the non-negotiables are:

- No exposed human excreta within community/household
- All households have access to toilets that does not facilitate the oral-faecal contamination transmission route
- The squat hole should be covered and the floor should be free of faeces and urine
- Superstructure that provides privacy
- All households have a handwashing facility near the latrine

'Desirable' is the use of ash or sawdust over faeces to ensure reduced contact with flies and smell.

In Stage 1: The key indicators are:

- Schools/Health Centres/Public places with functional WASH facilities
- Systems for maintenance of WASH facilities in schools or where teaches and children are involved
- Safe storage/handling of drinking water and point of use water treatment.

In stage 2, the indicators are:

- Community developed system to stop OD in and around village
- Village visible clean (how solid waste or stagnant water)
- Safe storage and handling of food
- Personal hygiene

[15] http://www.unicef.org/infobycountry/afghanistan_7167.html; http://www.mrrd-ru-watsip.org/wash-cluster/; http://ehsanbayatafghanwireless.com/the-unicef-water-sanitation-and-hygiene-wash-program/; UNICEF 2016)

ANNEX 3: SAMPLE OF COMMUNITIES SURVEYED

Province	District	Village		Community	#HHs
Badakhshan	Argo	1	Aziz Abad	Aziz Abad	77
Badakhshan	Argo	2	Nawabad Darkhan	Nawabad Darkhan	50
Badakhshan	Baharak	3	Berdi	Wizraq Berdi	46
Badakhshan	Baharak	4	Hatam Beki	Hatam Beki	43
Badakhshan	Baharak	5	Sartal Kalan	Sartal Kalan	58
Badakhshan	Baharak	6	Toghak	Toghak	70
Badakhshan	Darayam	7	Deh Basi Bala	Deh Basi Bala	40
Badakhshan	Darayam	8	Labi Darya	Labi Darya	57
Badakhshan	Darayam	9	Roee Dasht	Roee Dasht	68
Badkhshan	Faizabad	10	Assi	Assi	89
Badakhshan	Faizabad	11	Khalqjar	Itarchi Hakim Abad	48
Badakhshan	Faizabad	12	Nowabad	Nowabad Itarchi	30
Badakhshan	Kasham	13	Baloch Bala	Masjid Usman Ghani	47
Badakhshan	Kasham	14	Niazabad	Niazabad	50
Badakhshan	Kasham	15	Qarbolaq	NawAbad	70
Badakhshan	Kasham	16	Sary Gardan	Sary Gardan	40
Badakhshan	Khash	17	Khushk Dara	Khushk Dara	33
Badakhshan	Shuhada	18	Ghuzew	Ghuzew (Azzo)	69
Daikundi	Bamyan Center	19	Ajdar Darah	Ajdar	200
Daikundi	Khaider	20	Khoshkab	Khoshkab	54
Kapisa	Miramor	21	Ghochak	Ghockak	32
Kapisa	Hesa-e-Kohistan	22	Ghafar Khail	Ghafar Khail	20
Kapisa	Hesa-e-Kohistan	23	Pana Khail	Pana khail	25
Kapisa	Hesa-e-Kohistan	24	Sarband Payan	Sarband Payan	84
Kapisa	Mahmood raqi	25	Ashor Khail	Ashor Khail	30
Laghman	Mahmood raqi	26	Painda Khail	Painda khail	26
Laghman	Mehterlam Baba	27	Bisram	Bisram	70
Laghman	Mehterlam Baba	28	Ghondai	Ghondai	70
Laghman	Mehterlam Baba	29	Qarargah	Qarargah	70
Laghman	Qarghai	30	Charbagh	Baghban Kocha	76
Laghman	Qarghai	33	Charbagh	Shamshir Abad	71
Laghman	Qarghai	31	Dahander	Dahander	70
Laghman	Qarghai	32	Feroz Abad	Feroz Abad	85
Logar	Khoshi	34	Balawryan	Balawryan	40
Logar	Mohammad Agha	35	Dak Kali	Dak Kali Ab bazaak	40
Logar	Mohammad Agha	36	Qala Mamai	Qala Mamai	40
Logar	Mohammad Agha	37	Sang Sorakh(Hamza Kala)	Sang Sorakh	50
Logar	Mohammad Agha	38	Surkhabad	Surkhabad	50
Logar	Mohammad Agha	39	Waziran AbBazak	Waziran	47
Logar	Pol-e-Alam	40	Malik Sado Khan	Malik Sado Khan	38
Logar	Pol-e-Alam	41	Nesti Coot	Kamal Khil	41
Logar	Pol-e-Alam	42	Qazi Bakhsh Kala	Qazi Bakhsh Kala	45
Logar	Pol-e-Alam	43	Shakar	Shakar	64
Logar	Pol-e-Alam	44	Taghar Hesarat	Taghar Hesarat	45

Province	District	Village		Community	#HHs
Nangarhar	Batikot	45	Lewanyano Kali	Koz Gashni	35
Nangarhar	Behosood	46	Janan Khan Banda	Janan Khan Banda	80
Nangarhar	Kama	47	Land Booj	Malakana	31
Nangarhar	Khewa	48	Abdul Khail	Abdul Khail	36
Nangarhar	Rodat	49	Hesar Shahi	Koza Amlooki	20
Takhar	Baharak	54	Afzal Baig	Afzal Baig Khan	96
Takhar	Baharak	55	Badahshi ha	Masjid Badahshi Kalan	100
Takhar	Baharak	57	Masjid Qurban Baig	Shurato Masjid Qurban Baig	120
Takhar	Farhar	58	Khawaki	Khawaki	50
Takhar	Farhar	50	Masjid Jamey Khafdara	Hafdar Jami Mosque	41
Takhar	Farhar	59	Masjid Baghi Aalum	Masjid Baghi Aalum	40
Takhar	Hazar Samoch	60	Kariz Masjid Jami	Kariz Masjid Jami	59
Takhar	Hazar Samoch	51	Malay Masjid Jami	Malay Masjid Jami	49
Takhar	Hazar Samoch	61	Qashlaq Masjid Logariha	Kosa Qashlaq Masjid Logariha	39
Takhar	Hazar Samoch	62	Sperlik	Sperlik	58
Takhar	Kalafgan	52	Bolak Qishlaq	Bolak Qishlaq	50
Takhar	Kafalgan	56	Masjid Mahkm Tash	Masjid Mahkm Tash	42
Takhar	Kalafgan	63	Masjid Shamsudin (Qazaaq)	Masjid Shamsudin (Qazaaq)	87
Takhar	Kalafgan	64	Qarya Zardaloo Dara	Masjed Naiba	40
Takhar	Kalafgan	53	Qumandan aziz(zardaloo)	Masjid Gumandan Aziz	50
Takhar	Taloquan	65	Bagh-e-Miri	Bagh-e-Miri	61
Takhar	Taloquan	66	Masjid Hassan Baig	Masjid Hassan Baig	44
Takhar	Warsaj	68	Najaran	Najaran	45
Takhar	Warsaj	69	Purawaz	Purawaz	74
Takhar	Taloquan	67	Qazaaq	Qazzaq	50
Takhar	Warsaj	70	Sareshakh	Sareshakh	44
8	32		70	70	3909

ANNEX 4: QUANTIFIED PARTICIPATORY ASSESSMENT

INTRODUCTION

Several methods have been developed in the recent past to address this issue of generating numbers from participatory activities.[16] The Methodology for Participatory Assessment (MPA) [17] was developed in the late 1990s to assess the sustainability of 88 water supply and sanitation projects in 15 countries and used participatory tools to bring out information and then translated this into numbers using a scoring system.[18] The MPA continues to be used as a 'comparative evaluation tool in large domestic water projects and programs'.[19]

The Quantified Participatory Assessment (QPA) was developed from the MPA and used in India in a variety of development projects since 1999 (James, 2003a).[20] Apart from the expansion from the water and sanitation sector to other sectors, notably watershed development, poverty alleviation, rural livelihoods and water resources, the QPA added several other features to the MPA, including peer review of scores, documentation of reasons for scores, use of an MS ACCESS database to store and analyse information, several rounds of stakeholder meetings and a detailed action planning report.

The QPA was also the basis of the modification of the MPA in Nepal to the NEWAH Participatory Assessment (NPA) by the Gender and Poverty (GAP) Unit of the national NGO, Nepal Water and Health (NEWAH), in Kathmandu, Nepal.[21] The NPA adapted the MPA to suit the geographical, socio-economic and ethnic reality of Nepal, modified the scoring systems to include benchmarks in a flexible 0 – 100 scale, developed additional tools to elicit information on health, hygiene and sanitation issues, and collected additional qualitative information using case studies (James et al., 2003a, 2003b, 2003c).

Qualitative Information Appraisal (QIA) is a generic methodology, developed from the experiences with the MPA, QPA and NPA, which goes beyond the constraints of the term 'Assessment'. The QIA is designed for use in both one-time assessments for baseline, mid-term and overall project impact assessments, as well as for continuous monitoring as part of a project's regular monitoring and evaluation system.

APPLICATIONS

[16] See, for instance, Chambers (2003).
[17] The MPA was developed by Christine van Wijk (van Wijk, 2003) for a Participatory Learning and Action (PLA) project that was a multi-disciplinary and multi-country assessment exercise looking at the factors underlying the sustainability of water supply and sanitation projects (Dayal et al., 1999, Gross et al., 2001).
[18] The scoring system is detailed in James (2000 and 2001) and in Dayal et al. (1999).
[19] Wijk, 2001, p. 2. The revised MPA is described in Mukherjee and van Wijk (2003) while experiences with using the MPA are in van Wijk and Postma (2003), Postma at al., (2003), van Wijk et al., (2002), Paudyal et al. (2002).
[20] This work was done by AJ James who did the statistical analysis of the MPA data for the initial PLA study coordinated by Rekha Dayal of the Water and Sanitation Program. See also, James (2002, 2003b, 2003c, 2003d), James and Kaushik (2002), James et al., (2002), James and Snehalata (2002a and 2002b).
[21] For an account of the pilot MPA and the problems experienced in the field see Paudyal et al. (2002). See James et al., (2003a and 2003b) for a description of the creation of the NPA, and James et al., (2003c) for the details of one application in Nepal.

The QPA has been applied in several applications within India and outside (see Table A2.1).

Table A3.1: QPA Applications from 2000-2016

Funding source	Location	Project	Focus Area	Sample size	Year
Water & Sanitation Program (World Bank)	Global	Participatory Learning and Action (PLA) global study of the World Bank's Water & Sanitation Program	Impact assessment of RWSS projects	88 projects; 15 countries	1997-1999
European Community	India	Doon Valley Integrated Watershed Management Project	Social & environmental impact	16 villages	1999-2000
DFID India	India	APRLP	Water Resources	106 habitations	2001-2002
DFID India	India	WIRFP	Rural Livelihoods	45 villages	2002-2003
World Bank	India	Rajasthan District Poverty Initiatives Project	Project Processes	14 villages, 2 districts	2001-2002
World Bank	India	Analytical and Advisory Activity on Urban Public Health in Tamil Nadu	Performance of Essential Public Health Functions	26 ULBs	2002-2003
Asian Development Bank	Nepal	Community-based Water Supply and Sanitation project preparation	Water Supply, Sanitation & Hygiene	5 regions	2003
Asian Development Bank	Sri Lanka & Vietnam	Evaluation of ADB-funded national Water Supply and Sanitation projects	Water Supply, Sanitation & Hygiene	Sri Lanka 104 sub-projects Vietnam WSS 20 villages; 350 households	2005
UNICEF	India	Independent Evaluation of the Child's Environment Programme (CEP)	Water Supply, Sanitation & Hygiene	117 villages	2004

Funding source	Location	Project	Focus Area	Sample size	Year
Nepal Water for Health (NEWAH)	Nepal	GAP Evaluation	Water Supply, Sanitation & Hygiene	15 villages	2003-2004
Tamil Nadu Water and Drainage Board	India	Change Management Pilots Evaluation	Water Supply, Sanitation & Hygiene	200 habitations	2005-2006
Uttaranchal Livelihood Project in the Himalayas	India	Baseline survey	Rural Livelihoods	140 villages	2007
PATH	India	SureStart (community -level rural health programme)	Strength of partnerships among NGOs	50 rural NGOs	2009-2010
Unicef	India	Impact of Quality Package on Education Quality	Education	18 schools	2007
Uttaranchal Livelihood Project in the Himalayas (ULIPH)	India	Mid Term Evaluation	Rural Livelihoods	140 villages	2008
World Bank	India	Tamil Nadu Integrated Agricultural Modernization and Water bodies Restoration and Modernization (TN IAM WARM) Project	Community-level Assessment of the Impact of Change Management among Rural Development Officials	40 villages	2012
WASTE, the Netherlands	Costa Rica Holland, Benin, Philippines	PSO Learning Trajectory	Organizational Development (of NGOs)	5 international NGOs	2012
UNICEF Afghanistan	Afghanistan	National WASH Vulnerability and Risk Assessment	Rural WASH	33 provinces and districts;66 villages	2012
World Bank, New Delhi	Gwalior & Pune	Gender and Social Exclusion in Urban Water Supply & Sanitation	Urban WASH	100 slums in 2 Indian cities	2012

Funding source	Location	Project	Focus Area	Sample size	Year
UNICEF Afghanistan	Afghanistan	Baseline Survey of Child-Friendly Schools	Education	1500 schools in 10 provinces	2013
UNICEF India	India	WASH to reduce Material Mortality	Health	600 rural health centres in 5 states	2016

KEY COMPONENTS OF THE METHOD

From experience in applying this methodology (in India, Nepal, Sri Lanka and Vietnam), the following arrangements have been found to be optimal:

I. Inception Meeting

A brief meeting (one-day) to clarify the issues to be assessed, the background information available and the logistical arrangements.

II. Methodology and Planning Workshop

This is a vital part of the assessment, where the assessment team discuss and finalise the issues to be assessed, the indicators to be used, the ordinal scales, and thus the QPA field formats. This usually has role plays, mock interviews and field testing to make sure the assessment team practise and develop their PRA and facilitation skills, which is one of the key determinants of the success of the QPA field assessment. This workshop can take from 10 – 14 days depending on the complexity of the issues to be addressed.

Field testing: Although this is usually carried out at the end of the Methodology and Planning Workshop activity, it deserves a special mention. Two rounds of field testing are needed, the first to identify the problems to be rectified in the field formats, and the second to make sure the revised formats are suitable for the survey. Given the size of the assessment team being trained (36 field staff + 3 field coordinators+ 1 field supervisor+2 Research Associates), usually 2 villages are needed for each round of field testing – making a total of 4 villages. None of these villages should be part of the actual survey.

III. Field Assessment

Informing villages about the assessment: Prior information is usually needed for the meetings and focus group discussions – except where it is apprehended that villages may be 'dressed up' for the assessment. If so, the village is informed only a day or two in advance.

Village assessment schedule: In accordance with 'good practice' in participatory assessments, the assessment usually starts with a meeting with village officials (headman, patwari, VAO, etc.), elders, teachers and key informants – to inform them about the purpose of the assessment, to get basic information about the village, and to plan the various focus group discussions (FGDs). Thereafter, a transect walk and social mapping is carried out (to check 'unserved households', etc.), also a water system review. Subsequently, either in the afternoon or evening, FGDs can be held with those who have received training from the project/TWAD Board, women's groups, etc. Finally, a village meeting is held to inform them about the basic findings

of the assessment. Compliance with international 'good practice' is vital for the validity of the participatory assessment.

Assessment time: Assessments take 1 – 4 days per village, depending on the complexity of the field formats. The minimum time is 1 day per village. It is best to have the team debriefing and data entry the very next day, so that field teams remember details of discussions and verify the scores. Entering data in the latter part of the same day will minimise errors and avoid the fatigue (and hence errors) of mass data entry at the end of the assessment. This gives a maximum rate of 3 villages per week (with 1 day off), at which rate, 10 2-person teams can cover 100 villages in 20 days.

Field teams: While field teams have been between 4 – 6 people per village, the ideal combination is a 4-member field teams which can split into two 2-member teams in the field. The minimum, however, is 2-persons per team. Gender balanced teams are highly desirable. To complete 100 villages in 2 weeks, at the rate of 3 villages per week per team will require 18 teams, or 36 field staff.

Field coordinators: Field-level coordination is essential for quality control, especially to check the nature of facilitation during FGDs and to ensure validation of information provided in the FGDs. They are also useful for trouble-shooting field-level problems, including logistics. In addition to the field supervisor, a minimum of 3 Field Coordinators would be necessary for a 100-village assessment.

Focus group discussions: Each FGD takes between 1-2 hours, and more than 2 hours tests participants' patience and could yield biased responses. These have basically to give participants the 'freedom and space' to present their own views, feelings and must adhere to good practice of facilitation (e.g., no leading questions, no prompting, opportunities for all participants to express their views, etc.).

IV. Database, Data Cleaning and Analysis

Database: An ACCESS database is usually created for data entry, so that the computer format matches the paper format exactly and thus minimises data entry errors.

Data cleaning: Even after careful data entry, there is need to 'clean' the data, usually in a joint meeting with the field teams, lasting up to 5 days, depending on the number of villages surveyed and the number of issues covered in the field formats. Basically, this involves scanning the scores and reasons for scores entered in the database, identifying data gaps (e.g., Reason for Score not filled out), and doing some basic calculations (e.g., COUNT, MAX, MIN) to check possible data entry errors. Having the field team at this point is useful for quick cross-verification.

Data analysis: This basically involves generating frequency histograms and user-friendly graphs to present the findings as clearly and intelligibly as possible. This should take around 3 days after data cleaning.

V. Report Writing

Pulling together the methodology, presenting the main findings, and mentioning the quality control efforts of the survey are the key aspects of the report writing exercise, which should take around 6 days in total.

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ANNEX 5: TOOL-WISE QUESTIONS AND ISSUES

Tool	Description
1	**Province-level: FGD with officials**
	Factors motivating people to continue using a toilet
	Factors motivating people to continue build a second toilet after ODF verification
	What do people do after their toilet pit filled?
	Common characteristics of households reverting to open defecation
	Factors that caused people to revert to open defecation
	Factors motivating people to wash hands after using toilet?
	Factors de-motivating people to wash hands after using toilet?
	Factors involved in hand washing at critical times by all members of the family
	Post ODF activities that helped households maintain or improve their toilet use & hand washing with soap
	Has using toilets become a social habit? If not, why not?
	Has hand washing with soap after toilet use become a social habit? If not, why not?
	What is an enabling environment for sustainable ODF behaviour?
2	**District-level: FGD with officials**
	Factors motivating people to continue using a toilet
	Factors motivating people to continue build a second toilet after ODF verification
	What do people do after their toilet pit filled?
	Common characteristics of households reverting to open defecation
	Factors that caused people to revert to open defecation
	Factors motivating people to wash hands after using toilet?
	Factors de-motivating people to wash hands after using toilet?
	Factors involved in hand washing at critical times by all members of the family
	Post ODF activities that helped households maintain or improve their toilet use & hand washing with soap
	Has using toilets become a social habit? If not, why not?
	Has hand washing with soap after toilet use become a social habit? If not, why not?
3	**Community-level: FGD with Elders**
	Factors motivating people to continue using a toilet
	Factors motivating people to continue build a second toilet after ODF verification
	What do people do after their toilet pit filled?
	Common characteristics of households reverting to open defecation
	Factors that caused people to revert to open defecation
	Factors motivating people to wash hands after using toilet?
	Factors de-motivating people to wash hands after using toilet?
	Factors involved in hand washing at critical times by all members of the family
	Post ODF activities that helped households maintain/improve their toilet use & hand washing with soap
	Has using toilets become a social habit? If not, why not?
	Has hand washing with soap after toilet use become a social habit? If not, why not?
	What is an enabling environment for sustainable ODF behaviour?

Tool	Description
4	**Community-level: Social Mapping & Clustering**
5	**Community level: Cluster-level FGDs**
	Toilet? Functional?
	Why have people reverted to OD?
	Motivating factors to wash hands after using toilet?
	De-motivating factors to wash hands after using toilet?
	Do all members of the family wash hands after using toilet? If not, why not?
	Post-ODF actions to maintain/improve toilet use and hand washing practices
	Do all members of the household use the toilet? If not, who does not and why?
	Who cleans the toilets?
	Who empties the toilet pit or septic tank? How? And how frequently?
6	**Toilet Assessment in Houses**
	Quality of construction *Functional? Dirty? Water to flush? Water to clean? Water to wash? Soap?*
7	**Toilet Assessment in Institutions (schools, mosques, health centres & public institutions)**
	Quality of construction *Separate for women/girls and men/boys? Open? Locked? Safe? Lit? Ventilated?* *Functional? Dirty? Water to flush? Water to clean? Water to wash? Soap?*

ANNEX 6: TOOL SET

TOOL 1: KEY PERSONAL INTERVIEW WITH PROVINCIAL OFFICIALS

1.1 CONSENT FOR THE STUDY

Greetings, My Name is _____, I am representative of SSDA, i.e., Society of Sustainable Development of Afghanistan, an NGO working in Kabul. I would like to inform you that UNICEF Afghanistan has entrusted SSDA to study **the sustainability of ODF status and the handling, disposal and re-use of human waste, in selected communities in some provinces**. This study requires collection of information.

Your community has been selected to participate in this study. We will be asking you questions about the various aspects of sanitation and the handling, disposal and re-use of human waste. This information may be used by UNICEF Afghanistan to plan WASH-related infrastructure and service improvements or for conducting further studies.

I assure you that neither your name nor the names of any respondents participating in this study will be included in the dataset or in any report. We request you to participate in this study and help us in collecting the accurate information.

You may refuse to answer any question or choose to stop the interview at any time. However we sincerely hope that you will answer all questions which will benefit the improvement of sanitation and other services provided to the public by UNICEF and the Government of Afghanistan.

If there are questions for which you feel someone else is the most appropriate person to provide the information, please let us know so that we can invite that person to join us.

At this point, do you have any questions about the study?

Do I have your agreement to proceed?

Thank you in advance for your cooperation.

Name of the researcher:

Name of the Supervisor:

Date:

Time of starting assessment:

Community		Village	
District		Province	
Date		Facilitator Name	
Facilitator phone		Facilitator Email	

1.2 ODF COMMUNITIES

1.2.1 How many communities in your province were declared ODF by February 2014?

	District	Number of Communities		District	Number of Communities
1			11		
2			12		
3			13		
4			14		
5			15		
6			16		
7			17		
8			18		
9			19		
10			20		

Please collect the full list of district-wise villages and communities declared as ODF by 2014

1.2.2 How many government officials in the province are involved in ODF work?

	Currently	In 2014
Permanent staff		
Temporary staff		
Contracted staff		
Contracted agencies for CLTS work		
NGO Officials, if any		
Other (if any)		

1.2.3 What are the major achievements and challenges in ODF work in your province?

Achievements	Challenges
1.	
2.	
3.	
Comments and observations	

1.2.4 Who are and should be responsible for maintenance and use of toilets after ODF Declaration?

Who are responsible?	Who should be responsible?
1.	
2.	
3.	
Comments and observations	

1.3 TOILET USE

1.3.1 Why do people in your province continue to use a toilet? *Do not suggest responses, but note all responses that are mentioned*

	Reasons why people continue to use a toilet*		Y/N
1	It saves embarrassment of going outside and being seen by others		
2	It is convenient during cold and wet weather		
3	It provides a safer place than going out – where there could be animal/insect attacks and bites, or other risks		
4	It provides fertilizer in one place, that is easy to collect and take to the field		
5	It is a status symbol in the community to use a toilet		
6	It reduces spread of germs		
7	It has become a social norm		
8	Other reasons (specify)		

1.3.2 Have people in your province built a second toilet after ODF verification? YES/NO

1.3.3 What motivated people to build a second toilet after ODF verification? *Do not suggest responses, but note all responses that are mentioned*

	Reasons why people build a second toilet after ODF verification		Y/N
1	Men and women prefer to use separate toilets		
2	Large number of household members, so one was not enough		
3	Had more children recently and so needed more than one toilet		
4	Having more than one toilet is a status symbol in the community		
5	Other reasons (specify)		

1.3.4 What do people do when their toilet pits get filled? *Do not suggest responses, but note all responses that are mentioned*

	Actions people take when the toilet pit is full		Y/N
1	Empty the pit themselves		
2	Call someone else to empty the pit		
3	Seal the first pit & start using the second pit (only in double-pit or double-vault toilets)		
4	Dig another pit and shift the superstructure		
5	Build another toilet		
6	Go to defecate in the open		
7	Other actions (specify)		

1.3.5 A septic tank collects and treats toilet waste in a sealed tank with two chambers. It is usually constructed with cement under the ground and has a vent pipe on the first chamber to release toxic gases that are released during waste decomposition. How many households in the province have toilets attached to a septic tank? *Circle the right answer*

1. None 2. A few 3. Many 4. All

1.3.6 What did people do when the septic tank was full?

	Actions taken when the septic tank is full		Y/N
1	Stopped using the toilet – and used another toilet		
2	Stopped using the toilet – and defecated in the open		
3	Emptied the septic tank – on their own		
4	Got the septic tank emptied – by someone else		
4	Other actions (specify)		

1.3.7 Generally, who empties the septic tank and how?

	Actions taken when the septic tank is full		Y/N
1	Family members empty the septic tank		
2	Someone else is called and they empty the septic tank manually		
3	Someone else is called and they empty the septic tank with a pump		
4	Other actions (specify)		

1.3.8 Who in the family does *not* use the toilet? And why not?

Family members	Reasons for not using the toilet
Young boys (3 – 20 years old)	
Young girls (3-20 years)	
Adult males (20 - 60)	
Adult females (20 - 60)	
Elderly men (above 60)	
Elderly women (above 60)	

1.3.9 In your opinion, what percentage of households in ODF communities in this province has reverted to open defecation? _____

1.3.10 What type of people revert back to open defecation?

	Type of people revert back to open defecation	Y/N
1	People who commit to build a toilet but do not actually do so	
2	People who build a toilet, but stop using it when something goes wrong with it	
3	People who find it difficult to bring/pour water into the toilet – and hence stop using it	
4	People who do not want to have the problem of emptying the pit	
5	People who are used to going outside and/or cannot sit inside a small closed room	

	Type of people revert back to open defecation	Y/N
6	People who find it difficult to share a toilet with family members of the other sex	
7	People who do not understand (or are not convinced) why it is important to use a toilet	
8	Others (specify)	

1.3.11 Why do people revert back to open defecation?

	Reasons people revert back to open defecation		Y/N
1	The single pit is full and there is no one to clean it		
2	Since there is no one to clean the toilet once it is full, we use it sparingly (e.g., only for guests or for women or during winter)		
3	The toilet does not work properly (e.g., it gets blocked)		
4	The toilet smells		
5	There is no one to collect, carry and pour water into the toilet to flush it		
6	It is too much trouble to collect, carry and pour water into the toilet to flush it		
7	We have been going outside for so long, it feels more comfortable		
8	It does not feel comfortable to sit inside a small room and go (tried it, does not work, so started going out again)		
9	Men need to smoke while they defecate, and so prefer to go outside		
10	It is convenient to go outside, while walking to the fields - saves time and effort (e.g., carrying water to flush)		
11	Other reasons (specify)		

1.4 HAND WASHING

1.4.1 What motivates people to wash hands with soap after using the toilet? *Do not suggest responses, but note all responses that are mentioned*

	Motivation to wash hands with soap after using the toilet		Y/N
1	People don't want their hands to smell		
2	Their religion tells them that this is the right thing to do		
3	Elders tell them that this is the right thing to do		
4	Peers tells them that this is the right thing to do		
5	CLTS people told them that this is the right thing to do – but didn't explain why		
6	Because of the CLTS people they know that, if they don't, they could fall ill – from the germs in my hands, which will go into their stomach		
7	They know from others that, if they don't, they could fall ill – from the germs in their hands, which will go into their stomach		
8	It has become a social norm		
9	Other reasons (specify)		

1.4.2 What de-motivates people to wash hands with soap after using the toilet *Do not suggest responses, but note all responses that are mentioned*

	De-motivation to wash hands with soap after using the toilet	Y/N
1	There is no soap in the toilet	
2	It is too expensive to buy soap	

	De-motivation to wash hands with soap after using the toilet		Y/N
3	There is no water in their toilet		
4	It is difficult to wash hands regularly		
5	They wash hands before going for prayers – and feel that is sufficient		
6	No one told them that they had to wash after going to the toilet – and they thought it was enough to wash before eating		
7	Other reasons (specify)		

1.4.3 Who in the family does *not* wash hands after using the toilet? And why not?

Family members	Reasons for not washing hands after using the toilet
Young boys (3 – 20 years old)	
Young girls (3-20 years)	
Adult males (20 - 60)	
Adult females (20 - 60)	
Elderly men (above 60)	
Elderly women (above 60)	

1.4.4 Has using toilets become a new social habit?

Scores	Descriptions	Score
0	No, it has not become a new social habit or norm ***at all***	
25	Some people have stopped defecating in the open but it has not become a social habit or norm	
50	Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	
75	Yes, it is a social habit in our community: everyone knows it and a majority of people practice it, but not all	
100	Yes, it has become a new social habit and everyone is practicing it in our community	
Reasons for score		

1.4.5 Has hand washing with soap after toilet use become a new social habit?

Scores	Descriptions	Score
0	No, it has not become a new social habit or norm ***at all***	

Scores	Descriptions	Score
25	Some people have started washing hands after using the toilet but it has not become a social habit or norm	
50	Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	
75	Yes, it is a social habit in our community: everyone knows it and a majority of people practice it, but not all	
100	Yes, it has become a new social habit and everyone is practicing it in our community	
Reasons for score		

1.4.6 What activities have helped households maintain or improve their toilet use?

Buying materials to keep the toilet clean	YES/NO
Giving responsibility to other family members to keep toilet clean	YES/NO
Reduction in WASH related diseases	YES/NO
Decorating the toilet	YES/NO
Other (specify)	YES/NO

1.4.7 What activities that helped households maintain or improve hand washing with soap?

Buying soap regularly	YES/NO
Finding a permanent place to keep the soap	YES/NO
Placing a wash basin inside or just outside the toilet, to facilitate hand washing	YES/NO
Reduction in WASH related diseases	YES/NO
Other (specify)	YES/NO

1.4.8 What kind of support is needed to helped households maintain or improve toilet use and hand washing with soap?

Repeated messaging and instruction by the mullah in the mosque	YES/NO
House-to-house inspections by the elders in the village	YES/NO
Community hiring a person to go and repair toilet systems quickly & well	YES/NO
Elderly men and women setting an example for others	YES/NO
Other (specify)	YES/NO

TOOL 2: KEY PERSONAL INTERVIEW WITH DISTRICT OFFICIALS

2.1CONSENT FOR STUDY

Greetings, My Name is _____, I am representative of SSDA, i.e., Society of Sustainable Development of Afghanistan, an NGO working in Kabul. I would like to inform you that UNICEF Afghanistan has entrusted SSDA to study **the sustainability of ODF status and the handling, disposal and re-use of human waste, in selected communities in some provinces**. This study requires collection of information.

Your community has been selected to participate in this study. We will be asking you questions about the various aspects of sanitation and the handling, disposal and re-use of human waste. This information may be used by UNICEF Afghanistan to plan WASH-related infrastructure and service improvements or for conducting further studies.

I assure you that neither your name nor the names of any respondents participating in this study will be included in the dataset or in any report. We request you to participate in this study and help us in collecting the accurate information.

You may refuse to answer any question or choose to stop the interview at any time. However we sincerely hope that you will answer all questions which will benefit the improvement of sanitation and other services provided to the public by UNICEF and the Government of Afghanistan.

If there are questions for which you feel someone else is the most appropriate person to provide the information, please let us know so that we can invite that person to join us.

At this point, do you have any questions about the study?

Do I have your agreement to proceed?

Thank you in advance for your cooperation.

Name of the researcher:

Name of the Supervisor:

Date:

Time of starting assessment:

Community		Village	
District		Province	
Date		Facilitator Name	
Facilitator's Phone		Facilitator's Email	

2.2 ODF COMMUNITIES

2.2.1 How many communities in your province were declared ODF by February 2014?

	Names of Communities
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	

Please collect the full list of district-wise villages and communities declared as ODF by 2014

2.2.2 How many government officials in the district were or are involved in ODF work?

	Currently	In 2014
Permanent staff		
Temporary staff		
Contracted staff		
Contracted agencies (e.g., for CLTS work)		
NGO Officials, if any		
Other (if any)		

2.2.3 What are the major achievements and challenges in ODF work in your district?

Achievements	Challenges
1.	
2.	
3.	
Comments and observations	

2.2.4 Who are and should be responsible for maintenance & use of toilets after ODF Declaration?

Who are responsible?	Who should be responsible?
1.	
2.	
3.	
Comments and observations	

2.3TOILET USE

2.3.1 Why do people in your district continue to use a toilet? *Do not suggest responses, but note all responses that are mentioned*

	Reasons why people continue to use a toilet*		Y/N
1	It saves embarrassment of going outside and being seen by others		
2	It is convenient during cold and wet weather		
3	It provides a safer place than going out – where there could be animal/insect attacks and bites, or other risks		
4	It provides fertilizer in one place, that is easy to collect and take to the field		
5	It is a status symbol in the community to use a toilet		
6	It reduces spread of germs		
7	It has become a social norm		
8	Other reasons (specify)		

** These suggested responses (also for subsequent questions) will be revised after training & piloting*

2.3.2 Have people in your district built a second toilet after ODF verification? YES NO

2.3.3 Why motivated people to build a second toilet after ODF verification? *Do not suggest responses, but note all responses that are mentioned*

	Reasons why people build a second toilet after ODF verification		Y/N
1	Men and women prefer to use separate toilets		
2	Large number of household members, so one was not enough		
3	Had more children recently and so needed more than one toilet		
4	Having more than one toilet is a status symbol in the community		
5	Other reasons (specify)		

2.3.4 What do people do when their toilet pit gets filled? *Do not suggest responses, but note all responses that are mentioned*

	Actions people take when the toilet pit is full	Y/N
1	Empty the pit themselves	
2	Call someone else to empty the pit	
3	Seal the first pit & start using the second pit (only in double-pit or double-vault toilets)	

	Actions people take when the toilet pit is full		Y/N
4	Dig another pit and shift the superstructure		
5	Build another toilet		
6	Go to defecate in the open		
7	Other actions (specify)		

2.3.5 A septic tank collects and treats toilet waste in a sealed tank with two chambers. It is usually constructed with cement under the ground and has a vent pipe on the first chamber to release toxic gases that are released during waste decomposition. How many households in the province have toilets attached to a septic tank? *Circle the right answer*

2. None 2. A few 3. Many 4. All

2.3.6 What did people do when the septic tank was full?

	Actions taken when the septic tank is full		Y/N
1	Stopped using the toilet – and used another toilet		
2	Stopped using the toilet – and defecated in the open		
3	Emptied the septic tank – on their own		
4	Got the septic tank emptied – by someone else		
4	Other actions (specify)		

2.3.7 Generally, who empties the septic tank and how?

	Actions taken when the septic tank is full		Y/N
1	Family members empty the septic tank		
2	Someone else is called and they empty the septic tank manually		
3	Someone else is called and they empty the septic tank with a pump		
4	Other actions (specify)		

2.3.8 Who in the family does *not* use the toilet? And why not?

Family members	Reasons for not using the toilet
Young boys (3 – 20 years old)	
Young girls (3-20 years)	
Adult males (20 - 60)	
Adult females (20 - 60)	
Elderly men (above 60)	

Elderly women (above 60)	

2.3.9 In your opinion, what percentage of households in ODF communities in this district has reverted to open defecation? _____

2.3.10 What type of people revert back to open defecation?

	Type of people revert back to open defecation	Y/N
1	People who commit to build a toilet but do not actually do so	
2	People who build a toilet, but stop using it when something goes wrong with it	
3	People who find it difficult to bring/pour water into the toilet – and hence stop using it	
4	People who do not want to have the problem of emptying the pit	
5	People who are used to going outside and/or cannot sit inside a small closed room	
6	People who find it difficult to share a toilet with family members of the other sex	
7	People who do not understand (or are not convinced) why it is important to use a toilet	
8	Others (specify)	

2.3.11 Why do people revert back to open defecation?

	Reasons people revert back to open defecation	Y/N
1	The single pit is full and there is no one to clean it	
2	Since there is no one to clean the toilet once it is full, we use it sparingly (e.g., only for guests or for women or during winter)	
3	The toilet does not work properly (e.g., it gets blocked)	
4	The toilet smells	
5	There is no one to collect, carry and pour water into the toilet to flush it	
6	It is too much trouble to collect, carry and pour water into the toilet to flush it	
7	We have been going outside for so long, it feels more comfortable	
8	It does not feel comfortable to sit inside a small room and go (tried it, does not work, so started going out again)	
9	Men need to smoke while they defecate, and so prefer to go outside	
10	It is convenient to go outside, while walking to the fields - saves time and effort (e.g., carrying water to flush)	
11	Other reasons (specify)	

2.4 HAND WASHING

2.4.1 What motivates people to wash hands with soap after using the toilet? *Do not suggest responses, but note all responses that are mentioned*

	Motivation to wash hands with soap after using the toilet	Y/N
1	People don't want their hands to smell	
2	Their religion tells them that this is the right thing to do	

3	Elders tell them that this is the right thing to do		
4	Peers tells them that this is the right thing to do		
5	The CLTS people told them that this is the right thing to do – but didn't explain why		
6	Because of the CLTS people they know that, if they don't, they could fall ill – from the germs in my hands, which will go into their stomach		
7	They know from others that, if they don't, they could fall ill – from the germs in their hands, which will go into their stomach		
8	It has become a social norm		
9	Other reasons (specify)		

2.4.2 What de-motivates people to wash hands with soap after using the toilet *Do not suggest responses, but note all responses that are mentioned*

	De-motivation to wash hands with soap after using the toilet		Y/N
1	There is no soap in the toilet		
2	It is too expensive to buy soap		
3	There is no water in their toilet		
4	It is difficult to wash hands regularly		
5	They wash hands before going for prayers – and feel that is sufficient		
6	No one told them that they had to wash after going to the toilet – and they thought it was enough to wash before eating		
7	Other reasons (specify)		

2.4.3 Who in the family does *not* wash hands after using the toilet? And why not?

Family members	Reasons for not washing hands after using the toilet
Young boys (3 – 20 years old)	
Young girls (3-20 years)	
Adult males (20 - 60)	
Adult females (20 - 60)	
Elderly men (above 60)	
Elderly women (above 60)	

2.4.4 Has using toilets become a new social habit?

Scores	Descriptions	Score
0	No, it has not become a new social habit or norm ***at all***	

Scores	Descriptions	Score
25	Some people have stopped defecating in the open but it has not become a social habit or norm	
50	Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	
75	Yes, it is a social habit in our community: everyone knows it and a majority of people practice it, but not all	
100	Yes, it has become a new social habit and everyone is practicing it in our community	
Reasons for score		

2.4.5 Has hand washing with soap after toilet use become a new social habit?

Scores	Descriptions	Score
0	No, it has not become a new social habit or norm ***at all***	
25	Some people have started washing hands after using the toilet but it has not become a social habit or norm	
50	Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	
75	Yes, it is a social habit in our community: everyone knows it and a majority of people practice it, but not all	
100	Yes, it has become a new social habit and everyone is practicing it in our community	
Reasons for score		

2.4.6 What activities have helped households maintain or improve their toilet use?

Buying materials to keep the toilet clean	YES NO
Giving responsibility to other family members to keep toilet clean	YES NO
Reduction in WASH related diseases	YES NO
Decorating the toilet	YES NO
Other (specify)	YES NO

2.4.7 What activities that helped households maintain or improve hand washing with soap?

Buying soap regularly	YES NO
Finding a permanent place to keep the soap	YES NO
Placing a wash basin inside or just outside the toilet, to facilitate hand washing	YES NO
Reduction in WASH related diseases	YES NO
Other (specify)	YES NO

2.4.8 What kind of support is needed to helped households maintain or improve toilet use and hand washing with soap?

Repeated messaging and instruction by the mullah in the mosque	YES NO
House-to-house inspections by the elders in the village	YES NO
Community hiring a person to go and repair toilet systems quickly & well	YES NO
Elderly men and women setting an example for others	YES NO
Other (specify)	YES NO

TOOL 3: FOCUS GROUP DISCUSSION WITH COMMUNITY ELDERS

3.1 CONSENT FOR STUDY

Greetings, My Name is _____, I am representative of SSDA, i.e., Society of Sustainable Development of Afghanistan, an NGO working in Kabul. I would like to inform you that UNICEF Afghanistan has entrusted SSDA to study **the sustainability of ODF status and the handling, disposal and re-use of human waste, in selected communities in some provinces**. This study requires collection of information.

Your community has been selected to participate in this study. We will be asking you questions about the various aspects of sanitation and the handling, disposal and re-use of human waste. This information may be used by UNICEF Afghanistan to plan WASH-related infrastructure and service improvements or for conducting further studies.

I assure you that neither your name nor the names of any respondents participating in this study will be included in the dataset or in any report. We request you to participate in this study and help us in collecting the accurate information.

You may refuse to answer any question or choose to stop the interview at any time. However we sincerely hope that you will answer all questions which will benefit the improvement of sanitation and other services provided to the public by UNICEF and the Government of Afghanistan.

If there are questions for which you feel someone else is the most appropriate person to provide the information, please let us know so that we can invite that person to join us.

At this point, do you have any questions about the study?

Do I have your agreement to proceed?

Thank you in advance for your cooperation.

Name of the researcher:

Name of the Supervisor:

Date:

Time of starting assessment:

Community		Village	
District		Province	
Date		Facilitator's name	
Facilitator's phone		Facilitator's email	

3.2 TOILET USE

3.2.1 Why do people in this community continue to use a toilet? *Do not suggest responses, but note all responses that are mentioned*

	Reasons why people continue to use a toilet*		Y/N
1	It saves embarrassment of going outside and being seen by others		
2	It is convenient during cold and wet weather		
3	It provides a safer place than going out – where there could be animal/insect attacks and bites, or other risks		
4	It provides fertilizer in one place, that is easy to collect and take to the field		
5	It is a status symbol in the community to use a toilet		
6	It reduces spread of germs		
7	It has become a social norm		
8	Other reasons (specify)		

3.2.2 Who are & should be responsible for maintenance & use of toilets after ODF Declaration?

Who are responsible?	Who should be responsible?
1.	
2.	
3.	
Comments and observations	

3.2.3 Has anyone in the community built a second toilet after ODF verification? YES/NO

3.2.4 Why motivated people to build a second toilet after ODF verification? *Do not suggest responses, but note all responses that are mentioned*

	Reasons why people build a second toilet after ODF verification		Y/N
1	Men and women prefer to use separate toilets		
2	Large number of household members, so one was not enough		
3	Had more children recently and so needed more than one toilet		
4	Having more than one toilet is a status symbol in the community		
5	Other reasons (specify)		

3.2.5 What do people do when their toilet pits get filled? *Do not suggest responses, but note all responses that are mentioned*

	Actions people take when the toilet pit is full	Y/N
1	Empty the pit themselves	
2	Call someone else to empty the pit	

	Actions people take when the toilet pit is full		Y/N
3	Seal the first pit and start using the second pit (only in double-pit or double-vault toilets)		
4	Dig another pit and shift the superstructure		
5	Build another toilet		
6	Go to defecate in the open		
7	Other actions (specify)		

3.2.6 A septic tank collects and treats toilet waste in a sealed tank with two chambers. It is usually constructed with cement under the ground and has a vent pipe on the first chamber to release toxic gases that are released during waste decomposition. How many people in the community have toilets with a septic tank? *Circle the right answer*

3. None 2. A few 3. Many 4. All

3.2.7 What did people do when the septic tank was full?

	Actions taken when the septic tank is full		Y/N
1	Stopped using the toilet – and used another toilet		
2	Stopped using the toilet – and defecated in the open		
3	Emptied the septic tank – on their own		
4	Got the septic tank emptied – by someone else		
4	Other actions (specify)		

3.2.8 Generally, who empties the septic tank and how?

	Actions taken when the septic tank is full		Y/N
1	Family members empty the septic tank		
2	Someone else is called and they empty the septic tank manually		
3	Someone else is called and they empty the septic tank with a pump		
4	Other actions (specify)		

3.2.9 Who in the family does *not* use the toilet? And why not?

Family members	Reasons for not using the toilet
Young boys (3 – 20 years old)	
Young girls (3-20 years)	
Adult males (20 - 60)	
Adult females (20 - 60)	

Elderly men (above 60)	
Elderly women (above 60)	

3.2.10 In your opinion, what percentage of households in ODF communities in this community has reverted to open defecation? _____

3.2.11 What type of people revert to open defecation?

	Types of people who revert to open defecation	Y/N
1	People who commit to build a toilet but do not actually do so	
2	People who build a toilet, but stop using it when something goes wrong with it	
3	People who find it difficult to bring/pour water into the toilet – and hence stop using it	
4	People who do not want to have the problem of emptying the pit	
5	People who are used to going outside and/or cannot sit inside a small closed room	
6	People who find it difficult to share a toilet with family members of the other sex	
7	People who do not understand (or are not convinced) why it is important to use a toilet	
8	Others (specify)	

3.2.12 Why do people revert to open defecation?

	Reasons people revert back to open defecation	Y/N
1	The single pit is full and there is no one to clean it	
2	Since there is no one to clean the toilet once it is full, we use it sparingly (e.g., only for guests or for women or during winter)	
3	The toilet does not work properly (e.g., it gets blocked)	
4	The toilet smells	
5	There is no one to collect, carry and pour water into the toilet to flush it	
6	It is too much trouble to collect, carry and pour water into the toilet to flush it	
7	We have been going outside for so long, it feels more comfortable	
8	It does not feel comfortable to sit inside a small room and go (tried it, does not work, so started going out again)	
9	Men need to smoke while the defecate, and so prefer to go outside	
10	It is convenient to go outside, while walking to the fields - saves time and effort (e.g., carrying water to flush)	
11	Other reasons (specify)	

3.3 HAND WASHING

3.3.1 What motivates people to wash hands with soap after using the toilet? *Do not suggest responses, but note all responses that are mentioned*

	Motivation to wash hands with soap after using the toilet		Y/N
1	I don't want my hands to smell		
2	My religion tells me that this is the right thing to do		
3	My elders tell me that this is the right thing to do		
4	My peers tell me that this is the right thing to do		
5	CLTS people told me that this is the right thing to do – but didn't explain why		
6	Because of the CLTS people I know that, if I don't, I could fall ill – from the germs in my hands, which will go into my stomach		
7	I know from others that, if I don't, I could fall ill – from the germs in my hands, which will go into my stomach		
8	It has become a social norm		
9	Other reasons (specify)		

3.3.2 What de-motivates people to wash hands with soap after using the toilet *Do not suggest responses, but note all responses that are mentioned*

	De-motivation to wash hands with soap after using the toilet		Y/N
1	There is no soap in the toilet		
2	It is too expensive to buy soap		
3	There is no water in their toilet		
4	It is difficult to wash hands regularly		
5	They wash hands before going for prayers – and feel that is sufficient		
6	No one told them that they had to wash after going to the toilet – and they thought it was enough to wash before eating		
7	Other reasons (specify)		

3.3.3 How many people in your community do you think do *not* wash hands at critical times? *Circle the right answers*

Before eating food	None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All
After defecation	None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All
Before cooking food	None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All
Before feeding children	None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All

3.3.4 Who in the family does *not* wash hands after using the toilet? And why not?

Family members	Reasons for not washing hands after using the toilet
Young boys (3 – 20 years old)	
Young girls	

Family members	Reasons for not washing hands after using the toilet
(3-20 years)	
Adult males (20 - 60)	
Adult females (20 - 60)	
Elderly men (above 60)	
Elderly women (above 60)	

3.3.5 Has using toilets become a new social habit?

Scores	Descriptions	Score
0	No, it has not become a new social habit or norm ***at all***	
25	Some people have stopped defecating in the open but it has not become a social habit or norm	
50	Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	
75	Yes, it is a social habit in our community: everyone knows it and a majority of people practice it, but not all	
100	Yes, it has become a new social habit and everyone is practicing it in our community	
Reasons for score		

3.3.6 Has hand washing with soap after toilet use become a new social habit?

Scores	Descriptions	Score
0	No, it has not become a new social habit or norm ***at all***	
25	Some people have started washing hands after using the toilet but it has not become a social habit or norm	
50	Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	
75	Yes, it is a social habit in our community: everyone knows it and a majority of people practice it, but not all	
100	Yes, it has become a new social habit and everyone is practicing it in our community	
Reasons for score		

3.3.7 What activities have helped households maintain or improve their toilet use?

Buying materials to keep the toilet clean	YES NO
Giving responsibility to other family members to keep toilet clean	YES NO
Reduction in WASH related diseases	YES NO

Decorating the toilet	YES NO

3.3.8 What activities that helped households maintain or improve hand washing with soap?

Buying soap regularly	YES NO
Finding a permanent place to keep the soap	YES NO
Placing a wash basin inside or just outside the toilet, to facilitate hand washing	YES NO
Reduction in WASH related diseases	YES NO
Other (specify)	YES NO

3.3.9 What kind of support is needed to helped households maintain or improve toilet use and hand washing with soap?

Repeated messaging and instruction by the mullah in the mosque	YES NO
House-to-house inspections by the elders in the village	YES NO
Hiring a community-level person to go and repair toilet systems quickly & well	YES NO
Elderly men and women setting an example for others	YES NO
Other (specify)	YES NO

TOOL 4: SOCIAL MAPPING AND CLUSTERING OF HOUSEHOLDS

4.1 CONSENT FOR THE STUDY

Greetings, My Name is _____, I am representative of SSDA, i.e., Society of Sustainable Development of Afghanistan, an NGO working in Kabul. I would like to inform you that UNICEF Afghanistan has entrusted SSDA to study **the sustainability of ODF status and the handling, disposal and re-use of human waste, in selected communities in some provinces**. This study requires collection of information.

Your community has been selected to participate in this study. We will be asking you questions about the various aspects of sanitation and the handling, disposal and re-use of human waste. This information may be used by UNICEF Afghanistan to plan WASH-related infrastructure and service improvements or for conducting further studies.

I assure you that neither your name nor the names of any respondents participating in this study will be included in the dataset or in any report. We request you to participate in this study and help us in collecting the accurate information.

You may refuse to answer any question or choose to stop the interview at any time. However we sincerely hope that you will answer all questions which will benefit the improvement of sanitation and other services provided to the public by UNICEF and the Government of Afghanistan.

If there are questions for which you feel someone else is the most appropriate person to provide the information, please let us know so that we can invite that person to join us.

At this point, do you have any questions about the study?

Do I have your agreement to proceed?

Thank you in advance for your cooperation.

Name of the researcher:

Name of the Supervisor:

Date:

Time of starting assessment:

Community		Village	
District		Province	
Date		Major Ethnic Group	

4.2 SOCIAL MAPPING

- *With Key Informants, draw a rough social map of the community, showing <u>all</u> houses & <u>all</u> private and community water points & toilets.*
- *Form clusters of nearby households by circling each Cluster on the map and give it a number (e.g., Cluster 1, Cluster 2, Cluster 3 …)*
- *Number each house on the map and, for each Cluster, fill the House Number and information into the Table below (use extra sheets if necessary).*

Cluster Number	House Number	Head of Family			Household Members		Type of household (✓*the right one*)					Toilet?	Farm Land?
		Name	M/ F	Father's name	Adults	Children	General	Special group				Y/N	Y/N
								IDP	Returnee	Kuchi	Other *		
	1												
	2												
	3												
	4												
	5												
	6												
	7												
	8												
	9												
	10												

**Codes will be given for these after the pilot testing at province levels. During the survey, household types not coded will be entered directly*

Use more sheets if necessary

4.3 IDENTIFYING CLUSTERS OF NEARBY HOUSEHOLDS

- *Two Group Discussions will be held in each Cluster, one with the males and one with the females (facilitated by a male or female Team Member)*
- *After discussion with community representatives, fix the timings for Group Discussion with each cluster into the Table below*

Cluster Number	Group Discussion Details				
	With	Date	Time	Location	Facilitator's Name
1	Females				
	Males				
2	Females				
	Males				
3	Females				
	Males				
4	Females				
	Males				
5	Females				
	Males				

TOOL 5A: FOCUS GROUP DISCUSSIONS WITH CLUSTERS OF HOUSES

5.1 CONSENT FOR THE STUDY

Greetings, My Name is _____, I am representative of SSDA, i.e., Society of Sustainable Development of Afghanistan, an NGO working in Kabul. I would like to inform you that UNICEF Afghanistan has entrusted SSDA to study **the sustainability of ODF status and the handling, disposal and re-use of human waste, in selected communities in some provinces**. This study requires collection of information.

Your community has been selected to participate in this study. We will be asking you questions about the various aspects of sanitation and the handling, disposal and re-use of human waste. This information may be used by UNICEF Afghanistan to plan WASH-related infrastructure and service improvements or for conducting further studies.

I assure you that neither your name nor the names of any respondents participating in this study will be included in the dataset or in any report. We request you to participate in this study and help us in collecting the accurate information.

You may refuse to answer any question or choose to stop the interview at any time. However we sincerely hope that you will answer all questions which will benefit the improvement of sanitation and other services provided to the public by UNICEF and the Government of Afghanistan.

If there are questions for which you feel someone else is the most appropriate person to provide the information, please let us know so that we can invite that person to join us.

At this point, do you have any questions about the study?

Do I have your agreement to proceed?

Thank you in advance for your cooperation.

Name of the researcher:

Name of the Supervisor:

Date:

Time of starting assessment:

Cluster Number		FGD With? *Males/Females/Adolescents*		Facilitator	
Community				Village	
District				Province	
Date				Major Ethnic Group	

5.2 CLUSTER TOILET ACCESS AND USE

- *For each household in the Cluster, copy the information from Table 4.1 (Social Mapping) and then check if the information for that household is correct*

Cluster	Head of the Household			Household Members		Type of household (✓*the right one*)					Toilet?	Farm Land?
	Name	M/ F	Father's name	Adults	Children	General	Special group					
House Number							IDP	Returnee	Kuchi	Other *	Y/N	Y/N
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

**Codes will be given for these after the pilot testing at province levels. During the survey, household types not coded will be entered directly*

5.3 CLUSTER-WISE HOUSEHOLD INFORMATION

Cluster	Household Representative Present			Children		Situation at ODF Declaration			Current situation*			
	Name of Representative	Y / N	Name of representative in the other (M/F) Group	Number of children below 3 years	Number of adolescent children	Did your house have a toilet?	Was it working?	Did you use it?	Does your house have a toilet?	Is it working?	Do you use it?	Did you build a 2nd toilet after ODF?
House Number						Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												

** All houses that currently have a working toilet have to be visited and assessed using Format 6. Therefore make a separate list of such houses to be visited*

5.4 TOILETS AND THEIR USE

5.4.1 How many of you in this group use a toilet? *Ask them to raise their hands, and count: _____ (note the number)*

5.4.2 How many people in your community do you think use a toilet?

None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All

5.4.3 Why do people in this community continue to use a toilet? *Do not suggest responses, but note all responses that are mentioned. Ask them to raise their hands & count all those who give that reason*

	Reasons why people continue to use a toilet*	Number saying Yes
1	It saves embarrassment of going outside and being seen by others	
2	It is convenient during cold and wet weather	
3	It provides a safer place than going out – where there could be animal/insect attacks and bites, or other risks	
4	It provides fertilizer in one place, that is easy to collect and take to the field	
5	It is a status symbol in the community to use a toilet	
6	It has become a social norm	
7	Other reasons (specify)	

5.4.4 Did anyone in this group build a second toilet after ODF verification? YES NO
Circle the right answer

5.4.5 If YES, what motivated you to build a second toilet after ODF verification? *Do not suggest responses, but note all responses that are mentioned*

	Reasons why people build a second toilet after ODF verification		Y/N
1	Men and women prefer to use separate toilets		
2	Large number of household members, so one was not enough		
3	Had more children recently and so needed more than one toilet		
4	Having more than one toilet is a status symbol in the community		
5	Other reasons (specify)		

5.4.6 Has the toilet pit become full – in the toilets of anyone in this group? *Ask them to raise their hands, and count: _____ (note number)*

5.4.7 What do people do when their toilet pits gets filled? *Do not suggest responses, but note all responses that are mentioned*

	Actions people take when the toilet pit is full	Y/N
1	Empty the pit themselves	
2	Call someone else to empty the pit	
3	Seal the first pit and start using the second pit (only in double-pit or double-vault toilets)	
4	Dig another pit and shift the superstructure	
5	Build another toilet	
6	Go to defecate in the open	

7	Other actions (specify)		

5.4.8 A septic tank collects and treats toilet waste in a sealed tank with two chambers. It is usually constructed with cement under the ground and has a vent pipe on the first chamber to release toxic gases that are released during waste decomposition. How many of you have a toilet with a septic tank? *Ask them to raise their hands, and count: _____ (note number)*

5.4.9 If at least one person has a toilet with a septic tank, has the septic tank ever become full? YES NO *Circle the right answer*

5.4.10 If YES, what did you do when the septic tank was full?

	Actions taken when the septic tank is full		Y/N
1	Stopped using the toilet – and used another toilet		
2	Stopped using the toilet – and defecated in the open		
3	Emptied the septic tank – on your own (		
4	Got the septic tank emptied – by someone else		
4	Other actions (specify)		

5.4.11 If at least one person has a septic tank that was full, have you seen the septic tank emptied? YES NO *Circle the right answer*

5.4.12 If YES, who emptied it and how?

	Actions taken when the septic tank is full		Y/N
1	Family members emptied the septic tank		
2	Someone else was called and they emptied the septic tank manually		
3	Someone else was called and they emptied the septic tank with a pump		
4	Other actions (specify)		

5.4.13 How many of you have reverted back to open defecation? *Ask them to raise their hands, and count: _____ (note number)*

5.4.14 How many people in your community, do you think, practice open defecation today?

None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All

5.4.15 Why do people revert back to open defecation? *Do not suggest responses, but note all responses that are mentioned*

	Reasons people revert back to open defecation	Y/N
1	The single pit is full and there is no one to clean it	
2	Since there is no one to clean the toilet once it is full, we use it sparingly (e.g., only for guests or for women or during winter)	
3	The toilet does not work properly (e.g., it gets blocked)	
4	The toilet smells	
5	There is no one to collect, carry and pour water into the toilet to flush it	

6	It is too much trouble to collect, carry and pour water into the toilet to flush it		
7	We have been going outside for so long, it feels more comfortable		
8	It does not feel comfortable to sit inside a small room and go (tried it, does not work, so started going out again)		
9	Men need to smoke while the defecate, and so prefer to go outside		
10	It is convenient to go outside, while walking to the fields - saves time and effort (e.g., carrying water to flush)		
11	Other reasons (specify)		

5.5 HAND WASHING

5.5.1 How many people in your community do you think do *not* wash hands at critical times? *Circle the right answers*

Before eating food	None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All
After defecation	None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All
Before cooking food	None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All
Before feeding children	None	Few (<10%)	Some (~ 25%)	Many (50-75%)	All

5.5.2 What motivates you to wash your hands with soap after using the toilet? *Do not suggest responses, but note all responses that are mentioned*

	Motivation to wash hands with soap after using the toilet		Y/N
1	I don't want my hands to smell		
2	My religion tells me that this is the right thing to do		
3	My elders tells me that this is the right thing to do		
4	My peers tells me that this is the right thing to do		
5	The CLTS people told me that this is the right thing to do – but didn't explain why		
6	Because of the CLTS people I know that, if I don't, I could fall ill – from the germs in my hands, which will go into my stomach		
7	I know from others that, if I don't, I could fall ill – from the germs in my hands, which will go into my stomach		
8	It has become a social norm		
9	Other reasons (specify)		

5.5.3 What de-motivates you to wash hands with soap after using the toilet *Do not suggest responses, but note all responses that are mentioned*

	De-motivation to wash hands with soap after using the toilet		Y/N
1	There is no soap in the toilet		
2	It is too expensive to buy soap		
3	There is no water in their toilet		
4	It is difficult to wash hands regularly		
5	They wash hands before going for prayers – and feel that is sufficient		
6	No one told them that they had to wash after going to the toilet – and they thought it was enough to wash before eating		
7	Other reasons (specify)		

5.5.4 Has using toilets become a new social habit?

Scores	Descriptions	Score
0	No, it has not become a new social habit or norm ***at all***	
25	Some people have stopped defecating in the open but it has not become a social habit or norm	

Scores	Descriptions	Score
50	Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	
75	Yes, it is a social habit in our community: everyone knows it and a majority of people practice it, but not all	
100	Yes, it has become a new social habit and everyone is practicing it in our community	
Reasons for score		

5.5.5 Has hand washing with soap after toilet use become a new social habit?

Scores	Descriptions	Score
0	No, it has not become a new social habit or norm ***at all***	
25	Some people have started washing hands after using the toilet but it has not become a social habit or norm	
50	Yes, it has become a social habit in that everyone knows it is the right thing to do – but not all practice it	
75	Yes, it is a social habit in our community: everyone knows it and a majority of people practice it, but not all	
100	Yes, it has become a new social habit and everyone is practicing it in our community	
Reasons for score		

TOOL 6: HOUSE TOILET ASSESSMENT

6.1 CONSENT FOR STUDY

Greetings, My Name is _____, I am representative of SSDA, i.e., Society of Sustainable Development of Afghanistan, an NGO working in Kabul. I would like to inform you that UNICEF Afghanistan has entrusted SSDA to study **the sustainability of ODF status and the handling, disposal and re-use of human waste, in selected communities in some provinces**. This study requires collection of information.

Your community has been selected to participate in this study. We will be asking you questions about the various aspects of sanitation and the handling, disposal and re-use of human waste. This information may be used by UNICEF Afghanistan to plan WASH-related infrastructure and service improvements or for conducting further studies.

I assure you that neither your name nor the names of any respondents participating in this study will be included in the dataset or in any report. We request you to participate in this study and help us in collecting the accurate information.

You may refuse to answer any question or choose to stop the interview at any time. However we sincerely hope that you will answer all questions which will benefit the improvement of sanitation and other services provided to the public by UNICEF and the Government of Afghanistan.

If there are questions for which you feel someone else is the most appropriate person to provide the information, please let us know so that we can invite that person to join us.

At this point, do you have any questions about the study?

Do I have your agreement to proceed?

Thank you in advance for your cooperation.

Name of the researcher:

Name of the Supervisor:

Date:

Time of starting assessment:

6.2 HOUSEHOLD SELECTION

- *Using Table 5.2 in Format 5, list in Table 6.1 below, all households in the Cluster that confirmed having and using a working toilet.*
- *Visit each such house, confirm the information in Table 6.1 below, and fill in the information mentioned in Section 6.2 of this Format*

Cluster	Household Representative Present			Situation at ODF Declaration			Current situation			
	Name	Y/N	Name of representative in the other (M/F) Group	Did your house have a toilet?	Was it working?	Did you use it?	Does your house have a toilet?	Is it working?	Do you use it?	Did you build a 2nd toilet after ODF?
House Number				Y/N	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
1										
2										
3										
4										
5										

House Number		Name of House Representative	
Community		Village	
District		Province	
Date		Facilitator	

6.3 HOUSEHOLD TOILET ASSESSMENT

Use one set of formats for each house

6.3.1 Condition of the waste disposal system of the toilet (*outside the house*)

Circle the right option

Type of Toilet	Dry toilet (no water poured inside)	YES NO
	Pour flush (water is poured inside)	YES NO
	EcoSan toilet	YES NO
Type of waste disposal system	Single pit or vault	YES NO
	Double pit or vault	YES NO
	Septic tank	YES NO
	Other (specify)	YES NO
If septic Tank	Is there a vent pipe?	YES NO
	If yes, is the vent pipe on the first chamber of the septic tank?	YES NO
	Is the septic tank outlet connected to a soak pit?	YES NO
Construction Quality	Good (no cracks or leaks anywhere)	YES NO
	Fair (some problems, but overall functional)	YES NO
	Poor (major problems, smell and leaks evident)	YES NO
Environmental protection	Is the pit/vault or septic tank more than 100m from the nearest water source?	YES NO
	Is waste from the toilet being released into an open drain?	YES NO
	Are there flies around or on the toilet system?	YES NO
Animal waste	Is animal or other waste also being mixed with the human excreta?	YES NO

6.3.2 Does the toilet show clear signs of being used as a toilet?

YES NO

6.3.3 If it is a dry toilet, is there a cover over the hole? YES NO

6.3.4 If it is a dry toilet, are there flies inside the toilet? YES NO

Comments and observations

6.3.5 Condition of the flush toilet *Circle the right answer*

1	**Flies:** Are there flies in the toilet?	YES NO
2	**Smell:** Is there a dirty smell inside the toilet?	YES NO
3	**Cleanliness:** Is the pan and floor free from excreta and excreta smears?	YES NO
4	**Light:** Is there a working light inside the toilet?	YES NO
5	**Privacy:** Is there a door with a latch that can be fastened securely from the inside?	YES NO
6	**Cleaning material:** Is there a broom or brush to clean the toilet?	YES NO
7	**Water for cleaning**: Is there water to clean the toilet?	YES NO
8	**Water for flushing:** Is there water for flushing the toilet?	YES NO
9	**Water for cleansing:** Is there water for anal cleansing?	YES NO
10	**Soap:** Is soap available for washing hands inside or near the toilet?	YES NO
Comments and observations		

6.3.6 Who in the family uses the toilet and washes hands after using the toilet?

	Family members	Using the toilet	Washing hands with soap after using the toilet
1	Young boys (3 – 20 years old)	YES NO	YES NO
2	Young girls (3-20 years)	YES NO	YES NO
3	Adult males (between 20 and 60)	YES NO	YES NO
4	Adult females (between 20 and 60)	YES NO	YES NO
5	Elderly men (above 60)	YES NO	YES NO
6	Elderly women (above 60)	YES NO	YES NO
Comments and observations			

6.3.7 Who in the family does *not* use the toilet? And why not?

Family members	Reasons for not using the toilet
Young boys (3 – 20 years old)	
Young girls (3-20 years)	
Adult males (20 - 60)	
Adult females (20 - 60)	
Elderly men (above 60)	
Elderly women (above 60)	

6.3.8 Who in the family does *not* wash hands with soap after using the toilet? Why not?

Family members	Reasons for not washing hands with soap after using the toilet
Young boys (3 – 20 years old)	
Young girls (3-20 years)	
Adult males (20 - 60)	
Adult females (20 - 60)	
Elderly men (above 60)	
Elderly women (above 60)	

Comments and observations

6.3.9 Activities that helped households maintain or improve their toilet use practices?

Buying materials to keep the toilet clean	YES NO
Giving responsibility to other family members to keep toilet clean	YES NO
Decorating the toilet	YES NO
Other (specify)	YES NO

6.3.10 Activities that helped households maintain or improve hand washing with soap practices?

It has become social norm	YES NO
Buying soap regularly	YES NO
Finding a permanent place to keep the soap	YES NO
Placing a wash basin inside or just outside the toilet, to facilitate hand washing	YES NO
Putting a mirror above the wash basin, to encourage hand washing	YES NO
Other (specify)	YES NO

TOOL 7: INSTITUTIONAL TOILET ASSESSMENT

Use one format for each institutional or public toilet (school, mosque, health centre etc.)

Community		Village	
District		Province	
Type of institutional toilet (School/Mosque/Health Centre/Other (specify)			
Date		Facilitator's name	
Facilitator's phone		Facilitator's email	

7.1 CONSENT FOR STUDY

Greetings, My Name is _____, I am representative of SSDA, i.e., Society of Sustainable Development of Afghanistan, an NGO working in Kabul. I would like to inform you that UNICEF Afghanistan has entrusted SSDA to study **the sustainability of ODF status and the handling, disposal and re-use of human waste, in selected communities in some provinces**. This study requires collection of information.

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I assure you that neither your name nor the names of any respondents participating in this study will be included in the dataset or in any report. We request you to participate in this study and help us in collecting the accurate information.

You may refuse to answer any question or choose to stop the interview at any time. However we sincerely hope that you will answer all questions which will benefit the improvement of sanitation and other services provided to the public by UNICEF and the Government of Afghanistan.

If there are questions for which you feel someone else is the most appropriate person to provide the information, please let us know so that we can invite that person to join us.

At this point, do you have any questions about the study?

Do I have your agreement to proceed?

Thank you in advance for your cooperation.

Name of the researcher:

Name of the Supervisor:

Date:

Time of starting assessment:

7.2 MEETING WITH INSTITUTIONAL HEAD

7.2.1 Type of institution: School Mosque Health centre *Circle the right one*

Other (specify): _____

7.2.2 Name of institution: _____

7.2.3 If school, type of school *Place a tick in the right cell*

Primary (1-6 class)		Secondary (7-9)		Higher secondary (10-12)	

7.2.4 Name of Institutional Head: _____

7.2.5 Average numbers of daily users of the public toilet:

7.2.6 Toilet availability

	Boys (Students)	Girls (students)	Male Teachers/users	Female Teachers/users
Is there a separate toilet for …?	YES NO	YES NO	YES NO	YES NO
Number of toilet seats				
Is there water supply to the toilet for …?	YES NO	YES NO	YES NO	YES NO

Comments and observations about the toilets toilets

7.3 INSTITUTIONAL TOILET ASSESSMENT

Visit the toilets and assess them first from outside and then from inside. Use one Format for a Toilet Block

7.3.1 Condition of the waste disposal system of the toilet (*outside the school*)

Circle the right option

Type of Toilet	1	Dry toilet (no water poured inside)	YES NO
	2	Pour flush (water is poured inside)	YES NO
Type of waste disposal system	3	Single pit or vault	YES NO
	4	Double pit or vault	YES NO
	5	Septic tank	YES NO
	6	Other (specify)	YES NO
If septic Tank	7	Is there a vent pipe?	YES NO
	8	If YES, is the vent pipe on the first chamber of the tank?	YES NO
	9	Is the septic tank outlet connected to a soak pit?	YES NO
Construction Quality	10	Good (no cracks or leaks anywhere)	YES NO
	11	Fair (some problems, but overall functional)	YES NO
	12	Poor (major problems, smell and leaks evident)	YES NO
Environmental Protection	13	Is the pit/vault or septic tank more than 100m from the nearest water source?	YES NO
	14	Is waste from the toilet being released into open drains?	YES NO
	15	Are there flies around or on the toilet system?	YES NO
Animal waste	16	Is animal or other waste also being mixed with the human excreta?	YES NO

Comments and observations about the toilet system (from the outside)

7.4 DETAILED TOILET ASSESSMENT

Fill up one sheet for every toilet visited

7.4.1 Does the toilet show clear signs of being used (as a toilet)? YES NO

7.4.2 If it is a dry toilet, is there a cover over the hole? YES NO

7.4.3 If it is a dry toilet, are there flies inside the toilet? YES NO

7.4.4 Condition of the flush toilet *Circle the right answer*

1	**Flies:** Are there flies in the toilet?	YES NO
2	**Smell:** Is there a dirty smell inside the toilet?	YES NO
3	**Cleanliness:** Is the pan and floor free from excreta and excreta smears?	YES NO
4	**Light:** Is there a working light inside the toilet?	YES NO
5	**Privacy:** Is there a door with a latch that can be fastened securely from the inside?	YES NO
6	**Cleaning material:** Is there a broom or brush to clean the toilet?	YES NO
7	**Water for cleaning**: Is there water to clean the toilet?	YES NO
8	**Water for flushing:** Is there water for flushing the toilet?	YES NO
9	**Water for cleansing:** Is there water for anal cleansing?	YES NO
10	**Soap:** Is soap available for washing hands inside or near the toilet?	YES NO

Comments and observations about the toilet (from the inside)

8 Field Observations by the Study Team

8.1 Did you see any human excreta in the open while visiting the community? YES NO

8.2 **If YES, where did you see it? _____** (write a short description)

8.3 **Please define where you saw it:**

Near/in Fields Along the road Traditional open defecation area

8.4 **Do you feel this practice takes place daily in this community?** (even if only a few are doing it)

8.5 **Do you feel a lot of people are defecating in the open in the community?** YES NO

8.6 **If Yes, is this because**

You saw a lot of excreta in the open?	YES	NO
People you spoke to mentioned it?	YES	NO
Other (specify)	YES	NO

8.7 **Do you feel that community members are aware that open defecation is happening?** YES NO

ANNEX 7: CONSENT FORM

Consent Form

Greetings, My Name is _____, I am representative of SSDA, i.e., Society of Sustainable Development of Afghanistan, an NGO working in Kabul. I would like to inform you that UNICEF Afghanistan has entrusted SSDA to study **the sustainability of ODF status and the handling, disposal and re-use of human waste, in selected communities in some provinces**. This study requires collection of information.

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I assure you that neither your name nor the names of any respondents participating in this study will be included in the dataset or in any report. We request you to participate in this study and help us in collecting the accurate information.

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At this point, do you have any questions about the study?

Do I have your agreement to proceed?

Thank you in advance for your cooperation.

Name of the researcher:

Name of the Supervisor:

ANNEX 8: SUMMARY OF FINDINGS AND REFLECTIONS

1. ODF Status

ODF Declaration and Slippage

- In 15 communities out of the 70 surveyed (21%), there were no signs of OD by adults or children either within the settlement or outside the settlement and also no signs of toilet waste overflow – and these are hence taken to be Open Defecation Free (ODF) - although the situation of farmers' defecating directly into their fields cannot be ruled out.
- Since all 70 communities surveyed had been declared ODF in 2014, 55 out of 70 communities can be said to have 'slipped back'.

Those defecating in the open today – and why

Five main types of people who defecate in the open were identified:

- Adults who do not have toilets in their house including
    - Families that have recently come to the village to settle down (e.g., internally-displaced people (IDPs) and newly-returned families, e.g., from Pakistan)
    - People who may have committed to building toilets in their houses (e.g., during the triggering process of the community-led toilet sanitation (CLTS) process) but did not actually build toilets either because they are not convinced about the need for toilets, or because they do not have the money to build toilets
- Adults who may have toilets in their house but prefer to defecate in the open for various reasons, including the following:
    a. The toilets in the house not working properly
    b. The toilet pits are full and house owners do not want to empty the pit
    c. There not being enough toilets in the house
    d. Men not wanting to use household toilets that are also used by women;
    e. Users not liking the smell inside a toilet and preferring the open space (especially the older men and women) which they were used to.
    f. Users do not believe in the importance of using toilets – or are not convinced about the advantages of using toilets
    g. Farmers who may have toilets in their house but prefer to defecate in their own fields – either because the field is far away from the house and they cannot come home to use the toilet; or because they prefer to fertilize their fields.
    h. Guests and visitors to houses in the settlement, especially if the community is located close to towns and a lot of visitors come for business transactions.
    i. Small children who play and defecate in the streets.

Who tends to not use a toilet at home? And why?

- Young children who run and play outside and defecate outside when they feel like it
- Elderly men and women who have been used to defecating in the open for a long time and cannot get used to defecating inside the confined space of a toilet
- Adult farmers who either prefer to defecate in the open on the way to their fields, or to defecate in their own fields – or who do not wish to come back to their house toilet to defecate once they have reached their fields

The main reasons given for not using the toilets varied across age groups of family members: from lack of awareness (of the benefits of using toilets, and the problems of open defecation) and being 'comfortable defecating in the open' (especially for boys) among small boys and girls (3-10 years old); and, being used to open defecation, their families not using toilets and feeling 'shame' while using a toilet at home, among young boys and girls (10-20 years old); to feeling 'comfortable' outside and hence preferring open defecation to using a toilet, being far away in their fields and hence not being able to return home every time they needed to use the toilet, and defecating in the open on their way to early morning prayers in the mosque, for adult men and women; and most elderly men and women not having the habit of using toilets, and feeling used to defecating in the open.

When there was only one toilet in the house, it is used by women and men continued to go outside. Clearly, therefore, the messages to begin the process of behaviour change have to be different, targeting the specific reasons why different age groups do not use a toilet.

2. Household toilet use

Why people continue using a toilet

The over-riding reason why people continue to use a toilet was that it 'saved embarrassment of going outside and being seen by others'. This was followed by safety against animal or insect attacks or bites. Interestingly, 'toilets being a status symbol' scored relatively low among community elders (selected only in 27% of the 70 community FGDs) - lower than 'provides fertilizer in one place that is easy to collect and take to the field' (39%) and 'convenience during cold and wet weather' (30%). Also, the reason 'it reduces the spread of germs' did not score high, suggesting that key CLTS lessons did not last long.

Is it a social norm now?

In most cases, everyone knows that using toilets is the right thing to do but not all practice it. It has not become a new social norm though in a small minority of communities (10%) elders felt using toilets 'has become a new social habit and everyone is practising it'.

What helps households to maintain or improve their toilet?

Buying materials to keep the toilet clean and giving responsibility to other family members to keep the toilet clean helped households maintain/improve their toilet. But the understanding of 75% of province officials that perceptions of reduced WASH-related diseases would help households improve toilet use was supported only in 30% of the FGDs with community elders.

Building a second toilet

Around half the communities reported that individuals had built a second toilet after ODF verification.

Large family size, men and women preferring to use separate toilets and more children being born are the main reasons for building a second toilet after ODF verification

Emptying toilet pits

When toilet pits are full, most people empty the toilet pit themselves or hire someone else to empty it

Septic tanks

Houses with toilets attached to septic tanks are concentrated in a few districts such as Argo (Badakshan), Khadir (Daikundi), Hesa Awal Kohistan (Kapisa), Mehertam and Qarghai (Laghman), Behsud (Nangarhar) and Takhar province.

When the septic tank is full, people generally got it emptied by someone else – although elders felt that people would stop using the toilet and either use another toilet or defecate in the open.

Generally, family members empty the septic tank while some reported calling someone else to manually empty the septic tank – rather than with a pump.

3. Hand washing

Why people wash hands after using the toilet

Key motivations for people to wash their hands with soap after using the toilet were:

(1) religious belief (that this was the right thing to do)
(2) the fear that their hands would smell; and
(3) elders' instruction (that this was the right thing to do).

Only 30% of groups felt it was because of CLTS messages about health impacts of not washing hands – although 75% of province officials seemed to think so.

Why people do not wash hands after using the toilet

The lack of soap and water in toilets were the key de-motivations for people to wash their hands with soap after using the toilet: The fact that it is too expensive to buy soap – although the lack of water in toilets was also mentioned in nearly 50% of the FGDs with community elders. There was also the perception that 'it is difficult to wash hands regularly' and that washing hands before going for prayers was enough – although this was reported only by 20% or fewer of the FGDs.

Who do not wash hands after using the toilet

Small boys and girls and elderly men and women tend not to wash hands with soap after using the toilet while more of the adult men and women (20-60 years old) do so. In Kapisa, however, the perception is that very few wash hands – while in Logar, the perception is that most wash hands.

Why people do not wash hands after using the toilet

Defecating in the open, lack of awareness and lack of soap and water in the toilet were key reasons why people do not wash hands with soap after using the toilet: Most of the family members responding to the house toilet survey said that young boys and girls (3-20

years of age) did not wash with soap after using the toilet because they were either defecating in the open/yard, or had no awareness of the need to wash hands or did not have soap and water or used 'traditional methods' to wash their hands, while young men and women (20-60 years of age) had no habit, or awareness, or soap and water to wash; and elderly men and women (above 60 years old) sometimes washed with soap, but sometimes did not – feeling it was unnecessary, or easier not to wash, stemming from a lack of awareness of the need to wash hands, CLTS notwithstanding.

Most people know that washing hands with soap after using the toilet is the right thing to do, few practice it and so it has not become a new social norm although a small minority (6% of the 70 communities surveyed) felt that 'it has become a new social habit' in the community and 'everyone is practising it' (score of 100). The most common reasons for low scores were – the low awareness among the people about the practices required for cleanliness; the fact that soap and washing facilities are not available near the toilet; and because people do not feel that it is important to wash hands.

What helps people improve hand washing habits?

Buying soap regularly was the one key activity that helped households maintain/improve their hand washing with soap although the realization or expectation of a reduction in WASH related diseases, placing a wash basin close to the toilet (to facilitate hand washing) and finding a permanent place to keep the soap, were also activities that helped.

Repeated messaging and instruction by the mullah was the main support perceived as necessary to help households improve/maintain toilet use and washing hands with soap while elderly men and women setting an example for others and house-to-house inspections by elders in the village (to check hand washing facilities) were also mentioned as useful support.

4. Institutional and Household Toilet Assessments

Most household toilet were dry toilets, with a single pit, the rest being pour flush (no eco-san): Of the toilets with septic tanks, only 27% had a vent pipe, and only 9% were connected to a soak pit.

Most (93%) institutional toilets were also dry toilets, but relatively more were double-pit toilets (14%) and connected to septic tanks (22%), and all the septic tank toilets had vents in the correct locations and were connected to soak pits.

Around 55% of house toilets visited in Nangarhar communities were flush toilets, while all were dry toilets in Daikundi, the other provinces having between 5% (Badakshan) and 31% (Takhar). Also, around 38% of toilets in Nangarhar were connected to a septic tank, followed by 23% in Bamyan.

Most household toilets had 'fair' to 'good' construction quality but most (59%) were less than 100m from a water source, 25% had toilet waste being released into an open drain and nearly half of them had flies around or on the toilet system.

More than half of the institutional toilets were 100 metres or more away from water sources, but more than half of them had poor construction quality (88% had problems and smells), released toilet waste into open drains (52%) or had flies (63%). Most house toilets in Logar (71%) had good construction, while most toilets in Laghman (78%) and Logar (76%) were more than 100 meters from a water source and none of the toilets in Logar were discharging into an open drain or had flies.

Most household toilets showed clear signs of being used but only 38% had a cover over the hole, and a third had flies inside the toilet.

Only half the institutional toilets showed clear signs of being used and, although most (63%) had a cover over the hole, a majority (61%) had flies inside the toilet.

Only few household and institutional toilets had animal or other waste mixed with the human excreta - although the average number of household toilets where this was the case varied from 4% in Bamyan to 74% in Nangarhar.

Household flush toilets were much better maintained than institutional flush toilets: The best household toilets were found in Nangarhar, while those in Logar and Daikundi were among the worst. Across provinces, the institutional toilets in Badakshan were comparatively better, while those in Laghman and Takhar were among the worst.