

Summative Evaluation of Support for WASH Environment Improvement Implemented by Japan Emergency NGO (JEN)

SUMMATIVE EVALUATION REPORT

June 28th 2021



Acknowledgements

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The findings within this document, however, are entirely the responsibility of the technical team of HPRO

June, 2021

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Executive Summary

Background

The project support for WASH Environment Improvement in Guldara village of Chaparhar district of Nangarhar was started on 18 September 2020 and ended on 14th April 2021. The project had two key objectives: firstly, Construct a well and install pipework to continuously supply safe drinking water to beneficiaries. The second objective was to provide hygiene education to improve the awareness of sanitation. Provide hygiene kits so that beneficiaries can practice what they learned and improve their sanitary conditions. The Total of 360 households were covered involving IDPs (179 HH), returnees (82 HH) host community (99HH).

Methodology:

In the summative evaluation 27 beneficiaries were selected from village Guldara (intervention) and 26 were selected from village Shulana (control) in Chaparhar district. For household selection from Guldara village (quantitative data collection), multi-stage sampling was conducted. The non-beneficiary survey has been conducted in Shulana village. The criteria for selection for the Shulana village was: the distance between Guldara village and Shulana village was 10 Km and the village has the same cultural, economic, customs and geographical conditions. Selection of the control village was conducted in close coordination with JEN. In addition to this rigorous impact assessment, participants for KIIs were purposively selected and includes key stakeholders involved in the project such as DACAAR, PRRD, DoRR, WMC and JEN staff. The data collection was conducted from April 17th – 24th 2021

Findings

Demographic profile of the respondents: The marital status was almost similar between women beneficiary (married 81%) and non- women beneficiaries (married 80%). Half of the women in beneficiary group were in age group of 35-45 years (54%) while in non-beneficiary it was within the age group of 25-35 (48%). A small proportion of women from Guldara were employed (8%) as compared to women from Shulana (40%).

Access to drinking water

Large percentage of women from Guldara (intervention) village reported water points constructed by JEN as key source of drinking water (25 out of 27) and the remaining two said they had own piped water in the dwelling or to the neighbour's house. But that water they use for washing cloths and for body wash. They still used water for drinking from the JEN constructed taps. On the contrary the key sources cited by Shulana (control) respondents were either surface water (31%) or unprotected dug well (27%). Out of total beneficiaries, 4/5th mentioned access to drinking water within 500 meters, while 1/5 did not know how much the distance was. For non-beneficiaries 50% mentioned the water source was within 500 meters of their house. For beneficiary households the source of water is either located in their extended family common yard (93%) or at their neighbour's house (7%), whereas for Shulana it was either a communal place or at the neighbour place.

Knowledge, awareness and practices on hand hygiene and sanitation

General Awareness on Hand hygiene and source of information: Beneficiary response to question on purpose of hand hygiene was dispersed throughout the options related keeping hands clean (44%), avoiding diseases (41%), reducing germs (11%) whereas the 4/5th of the Shulana women response was only limited to keeping hands clean and two women didn't

know the purpose of hand hygiene. The awareness on diseases related with poor hygiene received favourable response from beneficiaries for all options linked to communicable diseases including malnutrition and infections. The non-beneficiaries couldn't associate malnutrition and infections to poor hygiene (0%). Beneficiaries stated NGO's (96%) followed by radio (3%) as the key source of information about hygiene. Everyone from beneficiary households in the study confirmed participation in the education session.

Hygiene Practices: The use of soap among beneficiary was 100 percent where as it was only 12 percent among non-beneficiaries. Lack of time and wastage of water was cited as the key reason for not washing by two respondents from Shulana (control) households. Non-beneficiary women highlights soap and use of sanitiser by handful only and half of the women stated using dirt/soil for hand washing. The practice of washing hand before feeding child, attending child after defecation, before serving food and before breast feeding was cited by half of the beneficiaries. The access to water and affordability to buy soap were two interventions stated by respondents for changing hand hygiene habits.

Incidence of Diarrhea among respondent households (outcome): Only 11 percent of beneficiary women stated having experience diarrhea (0-59 months child) in past two weeks during data collection period. The ratio among non-beneficiary was around 61 percent (16 out of 26) for the same. The frequency of diarrhea during day was higher in non-beneficiary reflecting the severity of the cases.

Project Management

Coordination: There is substantial evidence to show that regular coordination meetings held between JEN staff, Provincial department for Rural Rehabilitation and Development (PRRD), Chaparhar district governor, WASH cluster and department of refugees at several occasions. The local level coordination among community shura and JEN staff was also evident from the interviews.

Water management and WMC: DoRR Legal and Advocacy Manager stated that WMC members are well trained to take up any work in future and there will be no need to call someone from outside to fix small plumbing and engineering issues.

Selection of well construction sites: Personnel of JEN and a representative from the rural development in consultation with community elders selected the place/location for the well

Monitoring and Supervision of Project: The project was monitored at two different levels by the directorates, WMC members and local community members. PRRD representative at provincial and district level frequently monitored the sites. The findings from the interviews showed that district governor office, community elders and WMC members were regularly visiting the construction sites.

WASH education session and influence on awareness levels: Four days of health education training was conducted to highlight various aspects of hygiene and its importance. Total beneficiaries of 360 families, which were 360 males and females, were divided into 15-15 teams. Women and men were given choice to select the venue of training. Besides this, some additional people from village voluntarily joined the training.

Complaint Redressal system: Complaint boxes, billboards and complaint banners with the contact details of JEN and other local representatives were put up so that people could share their concerns with.

Impact Evaluation

Practice: The average practice score for practicing appropriate hygiene was 514.37 (SD=96.64) in the intervention group, compared to 233.65 (SD=17.05) in the control group ($p<0.001$). Controlling for employment status, being in an intervention area increased the practice score by 311 points compared to those in the control area.

Knowledge: The average knowledge score was 396.30 (SD:79.57) in the intervention area compared to 234.62 (SD:82.18) in the control area ($p<0.001$). Controlling for employment status, being in an intervention area increased the knowledge score by 169.29 points.

Outcome: 11% of respondents in the intervention area reported a child in their household had diarrhea in the last 2 weeks compared to 64% in the control group (chi-square <0.001). The odds of respondent reporting a child (0-59 months of age) living in their household NOT have diarrhea in the last two weeks if respondent reside in the intervention area is 32 times higher than those in the control area

Project Achievement and LFA: project achieved all the targets as envisaged in the LFA

CHS1: Communities and people affected by crisis receive assistance appropriate and relevant to their needs: The village being a white area had highest population among all the seven priority villages in Chaparhar district and also had large pockets of IDPs, Returnees, was highly relevant to project goal.

CHS2: Communities and people affected by crisis have access to the humanitarian assistance they need at the right time: The impact assessment of the study also highlight the statistical significance of access to clean water in guldara on health indicator such as reduced odds of contracting diarrhea by under five children in the households. It could not be undermined that the project was implemented in the middle of corona outbreak and thus access to clean water has significantly played a key role in the prevention of transmission of corona virus among the families.

CHS3: Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action: The awareness session on hygiene and sanitation along with covid prevention within the community generated awareness and presumably improved the household practices related to WASH. This was also significantly evident from the impact assessment.

CHS4: Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them: Project support for WASH provided many opportunities to household to exercise their rights to stay informed about the water distribution. On other occasions the project supported freedom of choice to select locations for training venues as per the comfort of the families. The hygiene awareness sessions were broad enough to sensitive population on intertwined factors associated with water security.

CHS5: Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints: The two layered complaint redress system was implemented as per discussion with JEN and PRRD. The two mechanisms included JEN installed complaint box, PRRD walk in complaint system and community elders.

CHS6: Communities and people affected by crisis receive coordinated, complementary assistance: Reporting and supervision was part of project management cycle as per information collated through interviews and desk review. The documentary assessment and interview with PRRD, DoRR, DACAAR highlighted that the stakeholders were consistently involved at various stages throughout the project.

CHS7: Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection: The project support for WASH environment made several adjustments and course corrections during execution of the project. Some of the instances narrated by JEN staff was pertaining to defining location for installation of water points considering the demand and future needs of the households.

Value assessment of program intervention: it can be attested that support for WASH environment to IDPs, returnees, conflict-affected households was highly relevant to community needs (CHS1), thus effective (CHS2), exhibited impact on vulnerable population access to clean drinking water (CHS3) and was implemented through coordinated efforts of stakeholders (CHS6). Henceforth, the project was well worthy of implementation.

Recommendations

- In order to strengthen the community resilience towards pandemic and ensure the program support for WASH environment improvement intervention transpires to better health outcome, the emphasis on continuous WASH education awareness sessions has to be prioritised. The education sessions can be imparted by WMC in consultation with PRRD. Future hygiene promotion programs should be adopted based on the findings of this study on the gaps pertaining to hand hygiene occasions to be followed in daily household chores. The pre and post training evaluation should continue to be part of the training assessment.

Table of contents

Acknowledgements	ii
Executive summary	iii
Table of contents	vi
List of tables and figures	Viii
Abbreviations	Vii
1 Introduction	1
1.1 Overview	1
1.2 afghanistan health services and nutrition	1
1.3 Overview of JEN WASH environment support program	3
1.4 Purpose of the study	4
1.5 scope of the study	4
1.6 Structure of the report	4
2 Methodology	5
2.1 Study design	5
2.2 Methodology for data acquisition	6
2.3 Data collection	6
2.4 Data analysis	10
3 Findings	11
3.1 Demographic profile of women	11
3.2 Service Provisioning	11
3.3 Project Management	16
3.4 Challenegs and limitation of Project	18
3.5 CHS compliance	26
3.6 Value assesment of the project	28
4 Recommendations	28

List of Tables and Figures

Table 1: Interviews conducted during the summative evaluation	6
Table 2: Respondents demographic statistics	11
Table 3: Source of drinking water by intervention and control households	12
Table 4: Distance to source of water by intervention and control households	12
Table 5: Location of water in beneficiary and non-beneficiary households	12
Table 6: Respondents response to purpose of hand hygiene questions	13
Table 7: Awareness on diseases linked to poor hygiene among households	13
Table 8: Source of information for hygiene education	13
Table 9: Awareness on Hygiene session conducted by JEN	14
Table 10: Hand washing means among beneficiary and non-beneficiary women	15
Table 11: Hand hygiene practices at critical occasions	15
Table 12: Intervention to make soap a habit among households	16
Table 13: Frequency of diarrhea	16
Table 14: Beneficiary response to questions on complaint management system	20
Table 15: Statistical significance of employment status	23
Table 16: Hygiene Practice score (controlling the employment status)	23
Table 17: Hygiene Practice score (controlling the employment status)	23
Table 18: Response rate of child with diarrhea in intervention and control village	23
Table 19: Odds Ratio-probability of reporting diarrhea	24
Table 20: Project achievements against LFA outputs	25
Figure 1: Summative evaluation data collection methodology	5

Abbreviations

AGP	Anti-Government People
CDC	Community Development Council
CHS	Core Humanitarian Standard (CHS) Framework
DoE	Department of Education
DoPH	Department of Public Health (DoPH)
DoRR	Department of Refugee and Repatriations
DRRD	Department of Rural Rehabilitation and Development
EiEWG	Education in Emergencies Working Group
GoA	Government of Afghanistan
GPS	Global Positioning System
HPRO	Health Protection and Research Organisation
IDP	Internally Displaced Population
JEN	Japan Emergency NGO
JPF	The Japan Platform
KII	Key Informant Interview
LFA	Log Framework Analysis
MoRR	Ministry of Refugees and Repatriation
MOU	Memorandum of Understanding
NGO	Non-Government Organization
OCHA	The United Nations Office for the Coordination of Humanitarian Affairs
ODK	Open Data Kit
PHD	Provincial Health Department
PoRR	Provincial Refugee and Repatriations
PRRD	Provincial Rural Rehabilitation and Development
ToR	Terms of Reference
WASH	Water, Sanitation and Hygiene
WMC	Well Management Committee

I. Introduction

I.1 Overview

Nangarhar is one of the thirty-four provinces of Afghanistan, located in the eastern part of the country and bordering Logar, Kabul, Laghman and Kunar provinces as well as an international border with Pakistan. It is divided into twenty-two districts and has the third highest population of the country's 34 provinces. The city of Jalalabad is the capital of Nangarhar province.

It serves as a regional hub of trade and commerce (Legal and illegal) - due to its strategic location between Kabul and Pakistan. It provides the only regional platform for higher education, vocational training and advanced health care in the east. Its population's historic support for insurgent actors like mujahedin groups fighting the Soviets makes it noteworthy from a security perspective. Additionally, its location as a key supply route from Pakistan to Kabul has made it a desirable military target for any group seeking power in Afghanistan¹.

The Jalalabad plain is one of the principal agricultural areas of Afghanistan. Nangarhar's two rivers create fertile land that is excellent for growing crops year-round in three planting seasons. Nangarhar farmers turn to poppy growing because of the many challenges, including lack of law and order and the economic security acquired through the poppy industry. Poppy is easily grown, transported, and stored, and they bring in significantly more revenue than any other crop of the market².

Throughout Afghanistan, there are mounting demographic pressures tied to an increased growth rate, youth bulge, the return of refugees from camps in Iran and Pakistan, and significant numbers of IDPs³. In recent times, lakhs of people returned to Nangarhar from Pakistani refugee camps, making it the second-largest returnee province in the country after Kabul. Based on anecdotal evidence, Jalalabad has seen a sharp increase in inhabitants. Young Nangarharis moved to the city hoping for livelihoods that they could not have on their family farms. In the southern part of the province along the Spin Ghar range, the freezing temperatures and the inaccessibility of provincial roads during winter create acute humanitarian needs. With rising temperatures come flash floods that have destroyed valuable farmland and taken lives among the population.

I.2 WASH Situation in Afghanistan

Clean water, basic toilets and good hygiene practices are essential to the survival and development of children. In Afghanistan, diarrhoeal diseases are the second most common cause of death for children under the age of five, after acute respiratory infections. Globally, Afghanistan has the fourth highest diarrheal mortality rate and approximately nine percent of

¹Lawson, B., Kelly, T., Parker, M., Colloton, K., & Watkins, J. (2010). Nangarhar Case Study. In *Reconstruction Under Fire: Case Studies and Further Analysis of Civil Requirements* (pp. 51-80). Santa Monica, CA; Arlington, VA; Pittsburgh, PA: RAND Corporation. Retrieved May 29, 2021, from <http://www.jstor.org/stable/10.7249/mg870osd.12>

²Afghanistan Opium Survey 2018, Islamic Republic of Afghanistan, Ministry of Counter Narcotics

³Humanitarian Response. (2017). *Internal Displacement due to Conflict*

all deaths among children under-five are due to diarrheal diseases. Diarrheal diseases, if not treated, also traps young children in a vicious circle of malnutrition and diarrhoea leading to chronic malnutrition and potential death. In Afghanistan, more than a quarter of all provinces have acute malnutrition rates above 15%⁴, with millions of children who will require treatment for acute malnutrition in subsequent years. One of the most effective ways to save children's lives is by teaching them proper hygiene practices – especially regular handwashing with water and soap – and guaranteeing them clean drinking water and adequate sanitation. Without these, children can suffer from diarrhoea and stunting (which means low weight for age and delayed cerebral development). In Afghanistan, two out of five young children are stunted.

More than 67 percent of Afghans have clean drinking water through 'improved drinking water sources' that are protected from outside contamination – a marked progress from a decade ago when drinking water reached only 20 percent of people. However, although a little more than 80 per cent of families have toilets or latrines, only about 43⁵ per cent are improved and safe – meaning they hygienically separate human waste from human contact. Open defecation continues to be a dangerous challenge in Afghanistan because human waste near waterways and living environments spreads diseases like typhoid, cholera, hepatitis, polio, trachoma, and others quickly and puts children and their families at risk.

The traditional sanitation practice in Afghanistan is the so-called vault toilet. A design that separates urine from excreta. The excreta traditionally is scooped out of the vault at regular intervals and buried for about six months after which it is dug up and used as fertilizer⁶. This is still practiced by many communities where the excreta is regularly mixed with ashes, straw and animal droppings before composting it. Many vault latrines, however, do not meet the minimum standard of an improved latrine – as the vaults are often not properly sealed and excreta is readily visible.

In a country like Afghanistan, a lack of access to water and sanitation affects women disproportionately. Women are often vulnerable to harassment or violence when they have to travel long distances to fetch water, use shared toilets, or practice open defecation in absence of a toilet at home. Recent research in Afghanistan also suggested that a poor water environment was associated with higher maternal mortality. Nearly 25% of all health facilities lack basic services. Recent assessments suggested that access to safe water is lacking in about 23% of health facilities in Eastern Region and in 33%⁷ in the Southern Region. In the same regions, only one third of health facilities have access to a sufficient number of toilets.

1.2.1 WASH in Nangarhar

Based on WASH cluster data, the families of both documented and undocumented returnees, especially those coming from Pakistan, face a higher risk of poor access to improved WASH infrastructure, with more than 60%⁸ of the returnees living in informal settlements with limited or no services. Nangarhar has witnessed the highest gaps in WASH needs for the returnees.

⁴ Afghanistan Humanitarian Situation Report, June 2017, UNICEF

⁵ Joint monitoring program, 2019, WHO/ UNICEF

⁶ National Rural WASH Policy 2016-2020, Islamic Republic of Afghanistan

⁷ UN Children's Fund, WASH cluster, Dec 2020, UNICEF

⁸ IDPs, Returnees, Host Communities WASH need assessment, April 2019, International Medical Corps

Communities living in insecure, remote and hard to reach districts that repeatedly suffer from the impacts of disasters and conflict are often not adequately assisted by humanitarian actors. Those communities hosting considerable numbers of IDPs/returnees suffer severe shortages of basic services unless additional assistance is provided. Conflict, drought and poverty is affecting the capacities of the communities to maintain necessary basic WASH infrastructure in the targeted hard-to-reach areas⁹.

As per the nature of the movement due to conflict the IDPs left in a hurry used whatever transport means available and were unable to carry their belongings. The IDPs currently face, lack of clothing, shelter, hygiene materials and cooking materials. However, the districts have received substantial displacement from within Nangarhar as well as from neighbouring Kunar and Laghman provinces in the recent past. There is pressure building on the existing and overstretched available local housing market, with houses and shelters getting scarce, and rental prices sprang higher¹⁰.

Limited access to potable water is considered the main problem of the households. On the other hand, there are already existing not-functional boreholes due to lack of good maintenance systems in place. Most of the population have to walk around 15-30 minutes to reach the water points, while in some areas, this time is even more than an hour, and people use water tankers to fulfil their needs for potable water. Overall, there is a poor condition of hygiene and sanitation in the province which is one of the main causes of increased water borne diseases among these needy communities. Most of these populations have very limited or no information about safe hygiene and sanitation practices and on the other hand limited access to hygienic latrines and other sanitation facilities keep the population away from safe hygiene practices.

Overall knowledge regarding WASH, personal and environmental hygiene and hygiene promotion is noticed to be at a very lower level among the inhabitants of the camps, settlements, school and hospitals. Hand washing practice and other hygiene activities are not practiced by the majority of the population. Additionally, proper solid waste management systems are a common problem inside the communities and no proper waste collection system is in place. Families are mostly collecting their wastes individually and putting it in an area which is called dumps. Refuse pits, safe collection systems or any other safe practice or system do not exist accounting to communicable and other infectious diseases in the population. Moreover, most of the areas do not have any constructed canalization system for draining wasted water.

1.3 Overview of Support for WASH Environment Improvement

The project support for WASH Environment Improvement in Guldara village of Chaparhar district of Nangarhar was started on 20th September 2020 and ended on 14th April 2021. The project had two key objectives: firstly, Construct a well and install pipework to continuously supply safe drinking water to beneficiaries in the target district in a location they can easily access. Develop a community-based sustainable maintenance and management system. The

⁹Humanitarian needs overview Afghanistan, December 2019,OCHA

¹⁰ Reach Initiative. (2017). Nangarhar Informal Settlements

second objective was to provide hygiene education in an appropriate manner so as to improve the awareness of sanitation among beneficiaries in the target district. Provide hygiene kits so that beneficiaries can practice what they learned and improve their sanitary conditions. The project received funding of JPY 19,169,102 from JPF. The Total of 360 households were covered involving IDPs (179 households = approx. 1,250 persons), returnees (82 households = approx. 570 persons), host community (99 households = approx. 700 persons). As part of the intervention one solar powered well was constructed and water points was installed.

1.4 WASH projects implemented by other organisations and donors

Many organisations have worked in this direction to ensure facilities like sustainable and safe drinking water, proper sanitation and hygiene practices to the community. A project by Japan International Cooperation agency was executed to improve the living environment of the returnees and receiving communities by providing basic infrastructure at community level in Behsud and Surkhrod districts in Nangarhar province. Many deep wells were constructed in the project to ensure fresh water is available to the community. As per the plan road, buildings, irrigation canals were renovated and many new were constructed¹¹. Another project, Strengthening Resilience of Returnees, Afghanistan Project was implemented to improve access to WASH facilities and provision of economic opportunities to returnees in 4 districts of Nangarhar Province-Afghanistan. The project was designed to provide a durable solution for the returnees and IDP families. The priorities of the project were to fill the gaps and to provide resources to the end-beneficiaries who lack adequate water supplies, any kind of sanitation facilities and had a low awareness of important hygiene behaviours. The water facilities selected were particularly appropriate for the multi-use needs of returnee families including their domestic and agriculture-livestock needs¹². However, in Chaparhar district there had been no WASH activities conducted due to the district being in active fight between the government, the ISIS and the Taliban until recently.

1.5 Purpose of the study

To accurately capture information, monitor activities and analyse data on these project activities and to use the outcome of this evaluation for improving the current and future JPF projects and programme.

1.6 Scope of the summative evaluation

This evaluation covered the period (September 2020 – April 2021) of the project with implementation in Chaparhar district of Nangarhar

Objectives of the summative evaluation exercise are:

- To verify and measure actual outputs and if possible, outcomes of the project with the available data.
- To understand the beneficiary's level of satisfaction.

¹¹ The Community Development Project for Returnees and Receiving Communities In Nangarhar Province, Afghanistan, Final Report, June 2013, Japan International Cooperation Agency

¹²Samsor, Akmal. (2015). External Evaluation Report: Strengthening Resilience of Returnees, Afghanistan Project. 10.13140/RG.2.2.29173.47841.

- To determine the value of the project's implementations with all the above and identification of actual measurements of beneficiary's satisfaction.
- To verify that the humanitarian principles and standards including but not limited to CHS are respected.
- To document above achievements and challenges and reports to donors and the public.
- To provide feedback for the future project and programme improvements for both JPF and member NGOs.

2. Methodology

2.1 Study Design

Provision of support to WASH environment improvement services in Chaparhar district of Nangarhar province, made it imperative to use mix methods – quantitative and qualitative methods, and different streams of analysis- for the study. The design of the summative evaluation was informed by the overarching CHS standards and and conclusion was inferred based on JPF value assessment framework.

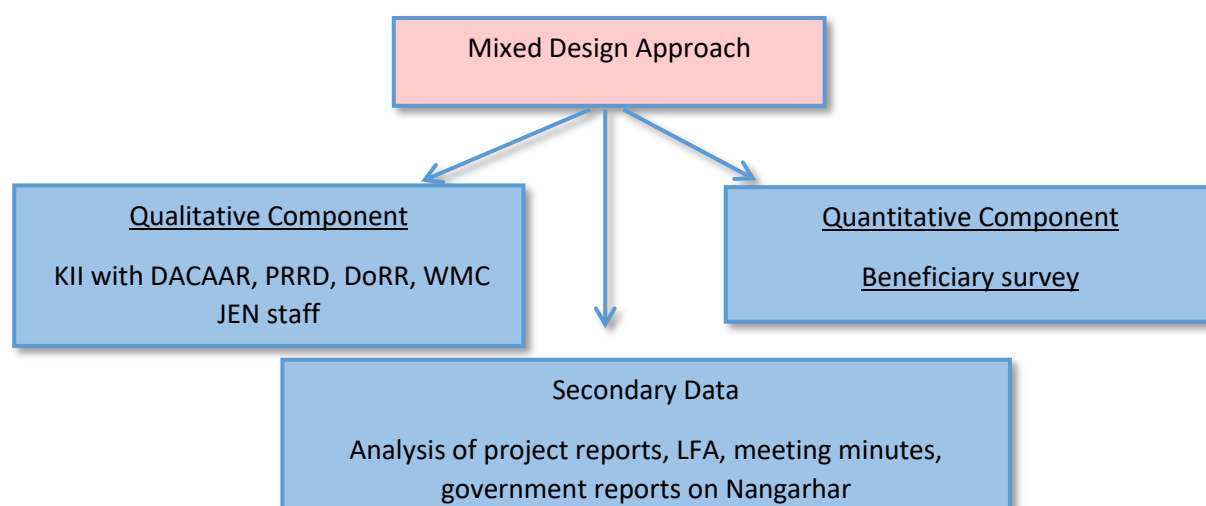


Figure 1: Summative evaluation data collection methodology

2.2 Methodology for data acquisition

In line with the above-mentioned objectives, a mixed design approach was adopted for the evaluation. As a method, this research design focused on collecting, analysing, and mixing both quantitative and qualitative data to provide a better understanding of study objectives. Evaluation design was based on triangulation of primary and secondary information collected during the study.

2.2.1 Sampling

Twenty seven beneficiaries were selected from village Guldara (intervention) and twenty six were selected from village Shulana (control) in Chaparhar district during the summative evaluation exercise. For household selection from Guldara village (quantitative data collection), multi-stage sampling was conducted. The village had more than 300 HHs in lower and middle Guldara which was the target population of JEN project. In the first stage the total villages were divided into three segments and each segment had 100 households. Then one segment was randomly selected for the data collection and in the selected segment 25 HHs were

selected representing lower and middle Guldara wherein every 4th house was randomly selected for data collection.

The non-beneficiary survey has been conducted in Shulana village. The criteria for selection for the Shulana village was

- The distance between Guldara village and Shulana village was 10 Km
- This village has the same cultural, economic, customs and geographical conditions except that Shulana village did not receive any WASH intervention from the JEN project nor from other source.

The total number of HHs in Shulana village was about 200 and stratified into two segments. The same method as mentioned for Guldara village was used for data collection.

Participants from both the intervention and the control group will be purposively selected through matching by socioeconomic indicators such as age, gender, education and marital status. Participants for KIIs were purposively selected and includes key stakeholders involved in the project such as DACAAR, PRRD, DoRR, WMC and JEN staff (table I).

Table I: Interviews conducted during the summative evaluation

Respondents	Number
Village Guldara (intervention)	27
Village Shulana (control)	26
Total	53
KII with DACAAR (Hygiene and Sanitation Supervisor)	1
KII with Irrigation Engineer, PRRD	1
KII with DoRR (Legal and Advocay Manager)	1
KII with WMC (Head of WMC)	1
KII with JEN staff (Acting Head of Office)	1

2.2.2 Secondary data collection

Desk Review: Prior to starting the field work, review of documents regarding the project, a introductory meetings were held with JEN team on the project. Post meeting, a comprehensive review of secondary documents related to the project was conducted. This involved:

- Monthly Reports
- Project Implementation Plan
- Monitoring report

Literature review was first conducted during the tool development. The documents received from the project such as applications and monthly reports were critical for understanding the context for provision of life-saving humanitarian health and nutritional services evaluation. The gathered information was used to inform our data collection tools. The evaluator also reviewed existing peer reviewed journals on the internet for developing the tools. We used the key words (“WASH” or “Nangarhar” or “Nangarhar WASH indicators”) and (“tools” or “questionnaires”) and (“Afghanistan”, “Pakistan”, “India”, “Iran”, “developing countries” or “low- and middle-income countries”). The documents were reviewed in detail and evidence on the evaluation objectives and CHS was extracted. Where possible, evidence was

triangulated. However, analyses were at times constrained by the availability of secondary data.

2.3 Data collection

2.3.1 Selection and Training of Field staff

HPRO mobilized from its pool qualified field supervisor and data enumerators who have been trained on various occasions by HPRO for other studies. The supervisor is a experience in WASH surveys, and the two data enumerators a male and female. The training of provincial supervisor and enumerator for JEN summative evaluation was conducted successfully from April 12-16th 2021 in Jalalabad. The training facilitated by HPRO technical team. Three participants made up of one male and two females, participated in this training. The topics of evaluation approaches, orientation on JEN project, role of HPRO as third party monitor, orientation on conducting a KII, household selection and survey of households in intervention and control village COVID-19 prevention and control measures, research ethics, ensuring confidentiality, role of consent, and data quality presentations were presented to the participants. In addition, the data collection tools were presented separately to the participants who practically worked with the tools on Smart Phones using ODK system. Different methods, such as presentation, group work, questions and answers and practical work were conducted. Finally, the feedback was given by the facilitators regarding filling out the questionnaires and using ODK properly.

2.3.2 Project Discussion meeting with JEN staff

On December 10 2020, a zoom meeting was held between HPRO, JPF, JEN and the advisory group where extensive feedback was provided on the tools and methodology of the summative evaluation and the impact evaluation. Frequency of visits by HPRO to JEN office in Nangarhar and to the field were agreed upon. All the documents including design and data collection tools were updated based on the feedback from the above meeting. The discussion points were:

- Ground operations and areas currently served considering the Covid situation and insecurity of districts.
- Selection criteria for districts
- Coordination and monitoring with PHD and district health department
- Information on community awareness campaigns,
- Issues around sustainability

Continuous discussions were held with JEN staff and JPF over emails regarding the impact evaluation methodology as well as timing of summative evaluation since the project completion date was delayed by 25 days.

2.3.3 Data collection

Data collection was conducted from April 17th – 24th 2021. The beneficiary survey has been conducted in Guldara village and stratified systematic random sampling method was performed as mentioned in the sampling section.

To collect data from control village, Shulana village was selected based on the criteria mentioned in the sampling section. The total number of HHs in this village was about 200 and stratified into two segments. Following same, one of the segment was randomly selected. method as mentioned for Guldara village was used for data collection.

An ODK based cloud mobile data collection platform “Kobotoolbox” was used for the data collection and storage. Digital data collection tools were designed in a manner that ensured receipt of quality data to the system all possible validation measures were considered while designing the tool. Data collectors were sent pop-up alerts when submitting invalid data and they were prevented from submitting incomplete or invalid data. To analyze and visualize the data, a dashboard was designed which also pointed out errors in the data.

The key challenge faced by the data collection team was the insecurity was especially, when the data collectors were conducting the HH survey. The insecurity condition within the province was topsy-turvy since AGP banned the female staff for any activity in this province.

2.3.3 Monitoring and Supervision for quality assurance

The QA team of HPRO were quality checking all the data received in the ODK server on daily bases and provided feedback to the data collectors on daily bases via mobile, what app application. In addition, the Software Automated /Digital Data Collection tools has been designed in a manner that took into consideration all validity measures and skip logics at real-time upon entering data to the system

Quantitative

- All the quantitative data were checked field by field by quality assurance team on daily bases and in case any issues/problem in the data, the feedback have been provided to the data collectors on the spot
- Thoroughly data check conducted to check the relevancy and data logics on the fields

Qualitative

- All the KII interview were reviewed (Audio listening) by the QA team on the receipt bases. As a result, the initially two KIIs on the baselines in Nangarhar were rejected due to poor quality of the interview and Kabul Team re-interviewed the DACAR Team and Provincial Rural Rehabilitation Development (PRRD) staff.
- Translations of all the translators reviewed those which had issue comments passed to the translators for correction. After the correction translation is accepted

2.4 Data management and analysis

2.4.1 Transcription and Translation

Transcription of field notes started as soon as the data arrived in the database. The quality assurance officer reviewed field notes for completeness and made additions to the notes after listening to the audio-recorded interviews. To get an accurate account of data from the interviews, the quality assurance officer, data manager and field supervisor had to review notes and make additions to the field notes. One translator was solely responsible for translating transcripts from Pashto to English. The quality assurance officer translated quantitative information. Verbatim transcripts were created from the recordings using a standardized transcription protocol. Transcripts were translated into English and used for analysis.

2.4.2 Coding of data

The questionnaires were coded with information such as: district name, village name etc. The study team developed coding rules for all the situations and applied them consistently. The

coding issues were pertaining to missing information, ambiguous information and details of responses disconnected from choices selected by respondents. The data files were cleaned for errors. The data manager checked thoroughly the data file to ensure that all responses are within the valid range. Invalid entries were rechecked with the electronic database and based on consensus within the team, observations were replaced with valid numbers. Once questionnaire data was coded, the data was entered into an electronic file of access spreadsheet so that this file that can be easily imported into a data analysis software program.

Qualitative

Some identifiers such as KII interview name used in the study were put in hidden folders since we no longer need this information as we wanted to eliminate the possibility of linking responses on the electronic file to individuals. During the study respondents were given opportunity to provide written comments at the end of the questionnaire. The responses were coded according to the type of comment that was made. The open-ended comments were coded and the data was entered electronically in the access program.

The research objectives and research questions guided data coding for qualitative data. The key themes were developed based on the objectives of the evaluation. The sub-themes were generated using the relevant research questions. These were priori codes that guided the categorization of the data. As new sub-themes emerged, those were also coded as new codes. The quality assurance officer and data manager provided support to the team during transcription of field notes. After the transcription of field notes, a quality assurance officer worked on the organization of field notes. The field notes and transcribed interviews were organised by respondents and type of data collection method (KII). Data was organised by main folder and sub folders and then started coding of data. A deductive thematic analysis was conducted with the transcripts using the qualitative data analysis software. For the coding process, first priori codes were developed based on the existing themes. Priori codes provide a general framework for major themes and subthemes that were generated later through an iterative process. Then, the technical lead had to review transcribed notes multiple times so they could label or group certain areas in the dataset. The quality assurance officer and field coordinator team looked for similar views and opinions and group them together to support a particular theme.

2.4.3 Data analysis

Quantitative

For quantitative data analysis, data was first run for missing values, double entries in STATA 14. Data was recoded for certain values and new variables were generated. During data analysis of quantitative data, data issues of type I and type II errors were assessed. The quantitative information was compiled to generate ratios and figures. In this study only univariate analysis was conducted, mainly in the form of frequencies and percentages.

Qualitative

For analysis of qualitative data, the technical lead used Microsoft excel to generate thematic codes and linking it to research questions. To ensure a link is established between major and sub themes, several analytic themes were grouped under one major theme. Grouping of sub themes took place by reviewing their meaning in relation to the major themes. The major themes were: 1 beneficiary and non-beneficiary Demographics, 2 Knowledge, Awareness and Practices of hygiene. 3. Project Management, 4. Impact Evaluation 5. Project outcome and LFA 6. CHS compliance 7. JPF Framework. Sub themes were generated under each major theme

based on the objectives stated in ToR. The purpose was to group themes in a hierarchical structure. Sub themes were placed under each major theme in a way that supports the major theme.

Eventually, a core set of codes was prepared and used to further support analysis and interpretation of data. After organization and transcription of data, systematic analysis and interpretation of qualitative data followed the analysis process. In addition, when reading text under the themes and adding thoughts and ideas about a particular theme, evaluator tried to identify and assess the relationship between different variables. Similarities and difference between the themes and determined how they interact with each other was assessed. In addition, while presenting views from different respondent groups, “Verbatim” quotes were added to further support a particular theme or argument.

2.4.4 Limitations

There were various limitations to this study, which can be divided into quality, challenges of field, evaluation and duration.

Transcribing and Translation: In order to comply with quality assurance of data, some recorded interviews had to be discarded and repeated interview, transcription and translation again on the KII’s. This delayed the overall analysis.

Duration: This was short term study with overlapping evaluations of other JPF projects. This limited the in-depth data analysis, interpretation, desk review and triangulation of data.

Insecurity: Data collection was challenge in the field as female workers were banned by AGP and overall all the districts were prone to fighting between government and AGP.

3. Key Findings

Sections 3.1 to 3.9 present the findings of analysis against the key thematic areas presented in Chapter 2 (Methodology). Reference was also made to link the findings with the project’s stated outcome and CHS framework. As discussed in Chapter 2 (Methodology), the findings draw primarily from the in-depth analysis performed through an extensive review of WASH documents, project documents and primary data generated from the field.

This section presents the findings under two large themes followed by sub thematic areas. Headline findings are presented as bold (and numbered) statements and the supporting findings are presented as sub sections with additional paragraphed text. Evidence sources are highlighted (mainly through footnotes)

3.1. Demographic Profile of beneficiary and non-beneficiary

All the study participants were women in reproductive age group of 15-49 years. The marital status was almost similar between women beneficiary (married 81%) and non- women beneficiaries (married 80%). Half of the women in beneficiary group were in age group of 35-45 years (54%) while in non-beneficiary it was within the age group of 25-35 (48%). This can be related to number of children below five years was relatively small among beneficiary women (18%) as compared to non-beneficiary women (70%). A small proportion of women from Guldara were employed (8%) as compared to women from Shulana (40%). The data is presented in the table 2 below.

Table 2: Respondents demographic statistics

Respondent	Marital status			Employment		# of Children under five			
	Married	Never Married	Widow	Self employed	Not employed	0	1	2	3
Beneficiary	81%	12%	8%	8%	92%	82%	4%	7%	7%
Non-Beneficiary	80%	8%	12%	40%	60%	31%	35%	31%	4%

3.2 Access to safe drinking water

The access to safe drinking water was assessed on following three parameters:

- Source of water
- Location of source of water
- Distance to source of water

3.2.1 Main source of drinking water at household level

Large percentage of women from Guldara (intervention) village reported water points constructed by JEN as key source of drinking water (27 out of 27). On the contrary the key sources cited by Shulana (control) respondents were either surface water (31%) or unprotected dug well (27%). Understanding any association between sources of water by employment status, we run the chi-squared test and the resulting p-value can be seen as a measure of correlation between these two variables. The result show correlation of 0.003 which is far closer to 1. Hence, no significant association exist between the two variables (table3).

Table3: Source of drinking water by intervention and control households (What is the main source of drinking water for your household?)

Source	Beneficiary (%)	Non-Beneficiary (%)
Taps (water points) constructed by JEN	100%	0.0%
Piped water into dwelling	0.0%	0.0%
Piped to neighbour	0.0%	15.4%
Piped water to yard/plot	0.0%	0.0%
Public tap/standpipe	0.0%	0.0%
Tube well or borehole	0.0%	7.7%
Protected dug well	0.0%	0.0%
Unprotected dug well	0.0%	26.9%
Protected spring water	0.0%	0.0%
Unprotected spring water	0.0%	19.2%
Rainwater	0.0%	0.0%
Tanker truck	0.0%	0.0%
Cart with small tank/drum	0.0%	0.0%
Surface water (river//pond/irrigation channel)	0.0%	30.8%
Bottled water	0.0%	0.0%
Other	0.0%	0.0%

3.2.2 Distance to source of water

Out of total beneficiaries, 4/5th mentioned access to drinking water within 500 meters, while this was for less than 50% of the non-beneficiaries. However, rest of the beneficiaries couldn't be able to respond to the question as they did not know how much the distance

was to the water point (5 out of 27). Nonetheless 3 of these 5 said that the water source was in their extended family's common yard and two said the source was at neighbours' house. Some women from Shulana (1/3rd) have to travel more than 500 m and 1/5th more than one km in order to pitch water for drinking (table4).

Table 4: Distance to source of water by intervention and control households (How far is the water source from your house? (distance in meter)

Distance	Less than 500m	More than 500m	More than a km	Don't know
Beneficiary	22	0	0	5
Beneficiary (%)	81.5%	0.0%	0.0%	18.5%
Non-Beneficiary	11	9	6	0
Non-Beneficiary (%)	42.3%	34.6%	23.1%	0.0%

3.2.3 Location of source of water

For beneficiary households the source of water is either located in their own house or in the yard, whereas for Shulana households it was either a communal place or at the neighbour place (table5)

Table 5: Location of water in beneficiary and non-beneficiary households (Where is that water source located?)

Location	Beneficiary	Beneficiary (%)	Non-Beneficiary	Non-Beneficiary (%)
In common yard	25	92.6%	5	19.2%
In a neighbour's House	2	7.4%	7	26.9%
At a communal Place	0	0.0%	12	46.2%
Elsewhere	0	0.0%	2	7.7%

3.3 Knowledge, awareness and practices on hand hygiene and sanitation

3.3.1 General Awareness on Hand hygiene and source of information

Awareness on hygiene was measured on the following questions

- What is the main purpose of hand hygiene
- What types of diseases are associated with not washing hands with soap/ash
- From what source do you receive information about hygiene most often

Beneficiary response to question on purpose of hand hygiene was dispersed throughout the options of keeping hands clean (44%), avoiding diseases (41%), reducing germs (11%) whereas the 4/5th of the Shulana women response was only limited to keeping hands clean and two women didn't know the purpose of hand hygiene (table 6)

Table 6: Respondents response to question (What is the main purpose of hand hygiene?)

Purpose	Beneficiary	Beneficiary (%)	Non-Beneficiary	Non-Beneficiary (%)
To reduce germs on the hands	3	11.1%	0	0.0%
To keep hands clean	12	44.4%	23	88.5%
To keep nails clean	1	3.7%	1	3.8%
To keep the hands smooth	0	0.0%	0	0.0%

To avoid diseases	11	40.7%	0	0.0%
Other	0	0.0%	0	0.0%
Don't know	0	0.0%	2	7.7%

The awareness on diseases related with poor hygiene received favourable response from beneficiaries for all options linked to communicable diseases including malnutrition and infections. The non-beneficiaries couldn't associate malnutrition (table 7) and infections to poor hygiene (0%).

Table 7: Awareness on diseases linked to poor hygiene among households (What types of diseases are associated with not washing hands with soap/ash?)

Diseases	Beneficiary	Beneficiary (%)	Non-Beneficiary	Non-Beneficiary (%)
Dysentery	23	85.2%	14	53.8%
Diarrhea	27	100.0%	18	69.2%
Cholera	23	85.2%	3	11.5%
Malnutrition/stunting	4	14.8%	0	0.0%
Pneumonia	4	14.8%	0	0.0%
Ear infections	2	7.4%	1	3.8%
Other	4	14.8%	3	11.5%

Beneficiaries stated NGO's (96%) followed by radio (4%) as the source of information about hygiene. Contrarily only one woman in control household cited radio, one shura and one community volunteer, rest did not receive the information from any source or couldn't respond to the question presumably due to not receiving the information or due lack of knowledge on the source. (See table 8 below)

Table 8: Source of information for hygiene education (From what source do you receive information about hygiene most often?)

Means	Beneficiary (n)	Beneficiary (%)	Non-Beneficiary (N)	Non-Beneficiary (%)
CHW	0	0.0%	0	0.0%
Radio	1	3.7%	1	3.8%
Television	0	0.0%	0	0.0%
Health facility	0	0.0%	0	0.0%
FHA group members	1	3.7%	0	0.0%
Other community- volunteer	0	0.0%	1	3.8%
Health shura	0	0.0%	1	3.8%
Newspaper/ brochures	0	0.0%	0	0.0%
NGOs	26	96.3%	0	0.0%
Other	4	14.8%	0	0.0%
Have not received information	0	0.0%	8	30.8%
No response	0	0.0%	21	80.8%

3.3.2 Awareness on hygiene linked with JEN hygiene education session

The questions pertaining to JEN session were around as follows:

- Has the hygiene education sessions conducted in your village?
- Have you attended any of the hygiene education sessions conducted by JEN?
- Were the sessions participative?

Everyone from beneficiary households in the study confirmed participation in the education session (table9). The findings also highlighted one or two respondents from non-beneficiary households were aware about such sessions depicting awareness spreading to nearby villages

Table 9: Awareness on Hygiene session conducted by JEN

Hygiene practices	Interview Type	Yes (n)	Yes (%)	No (n)	No (%)
Conduction of hygiene education sessions	Beneficiary	27	100.0%	0	0.0%
	Non-Beneficiary	1	3.8%	25	96.2%
Attendance in any of the hygiene education sessions conducted by JEN	Beneficiary	27	100.0%	0	0.0%
	Non-Beneficiary	0	0.0%	1	100.0%
Participative nature of sessions	Beneficiary	26	96.3%	1	3.7%
	Non-Beneficiary	0	0.0%	0	0.0%

3.3.3 Hygiene Practices

Hygiene practices was measured through the following questions

- Use of soap in household chores
- What do you use to was wash hands
- Do you wash your hands daily?
- Chief reasons for not washing hands daily
- What are the occasion for washing hands

The use of soap among beneficiary was 100 percent where as it was only 12 percent among non-beneficiaries, although daily hand washing was practiced by almost everyone in both the intervention and control households. Lack of time and wastage of water was cited as the key reason for not washing by two respondents from Shulana (control) households.

All study respondents from intervention households stated using water and soap (100%) for hand washing, whereas few also responded using ash (10) and sanitiser (6). On the other hand findings from non-beneficiary women data highlights hand washing using water by everyone but soap and use of sanitiser by handful only. On the contrary half of the women stated using dirt for hand washing (table 10)

Table 10: Hand washing means among beneficiary and non-beneficiary women (What do you use to wash your hands?)

Hand washing means	Beneficiary (n)	Beneficiary (%)	Non-Beneficiary (n)	Non-Beneficiary (%)
Water	27	100.0%	26	100.0%
Soap	27	100.0%	1	3.8%
Ash	10	37.0%	2	7.7%
Hand sanitizer	6	22.2%	1	3.8%
Sand	0	0.0%	5	19.2%
Dettol/ disinfectant	5	18.5%	0	0.0%
Earth/ dirt	0	0.0%	13	50.0%

Others	1	3.7%	0	0.0%
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The practice of handwashing at critical stages was significantly higher among beneficiaries as compared to non-beneficiaries. However practice of washing hand before feeding child, attending child after defecation, before serving food and before breast feeding was cited by half of the beneficiaries, highlighting continuous awareness on the same (table 11).

Table 11: Hand hygiene practices at critical occasions during household core activities. (At what times do you routinely wash your hands?)

Practices	Interview Type	N	N (%)
After contact with sticky, oily, smelly materials	Beneficiary	17	63.0%
	Non-Beneficiary	9	34.6%
After coming from the burial field/garden/work	Beneficiary	18	66.7%
	Non-Beneficiary	8	30.8%
First thing when you wake up	Beneficiary	22	81.5%
	Non-Beneficiary	16	61.5%
After eating	Beneficiary	16	59.3%
	Non-Beneficiary	20	76.9%
After attending to a child who has defecated	Beneficiary	16	59.3%
	Non-Beneficiary	6	23.1%
Before preparing food	Beneficiary	19	70.4%
	Non-Beneficiary	10	38.5%
Before feeding a child	Beneficiary	13	48.1%
	Non-Beneficiary	2	7.7%
Before serving food	Beneficiary	13	48.1%
	Non-Beneficiary	3	11.5%
After touching animals	Beneficiary	13	48.1%
	Non-Beneficiary	7	26.9%
After cleaning a dead body	Beneficiary	12	44.4%
	Non-Beneficiary	6	23.1%
After using the toilet/defecating	Beneficiary	15	55.6%
	Non-Beneficiary	5	19.2%
Before eating	Beneficiary	20	74.1%
	Non-Beneficiary	6	23.1%
Before breastfeeding	Beneficiary	13	48.1%
	Non-Beneficiary	0	0.0%
After changing a child's diaper/ cloth	Beneficiary	10	37.0%
	Non-Beneficiary	3	11.5%

Intervention that leads to change in hygiene practices

- What lead to use of soap among women who are washing hands daily

The access to water and affordability to buy soap were two interventions stated by respondents for changing hand hygiene habits (table 12)

Table 12: Intervention to make soap a habit among households (What would need to change to make handwashing with soap a habit for you?)

Changes	Interview Type	N	N (%)
Easy access of water	Beneficiary	27	100.0%
	Non-Beneficiary	23	92.0%
Ability to afford soap	Beneficiary	24	88.9%

	Non-Beneficiary	7	28.0%
Easy access to ash and water	Beneficiary	4	14.8%
	Non-Beneficiary	0	0.0%
Other	Beneficiary	1	3.7%
	Non-Beneficiary	2	8.0%

3.4 Incidence of Diarrhea (outcome)

Only 3 (11%) of beneficiary women stated having experienced diarrhea (0-59 months child) in past two weeks during data collection period. The ratio was around 61 percent (16 out of 26) for the same. The frequency of diarrhea during day was higher in non –beneficiary reflecting the severity of the cases (table 13)

Table 13: Frequency of diarrhea (How many times your child (0-59 months) had diarrhea during the last 2 weeks)

Frequency	Beneficiary N=27	Beneficiary (%)	Non- Beneficiary N=26	Non-Beneficiary (%)
Every day	0	0.0%	0	0.0%
Frequently	0	0.0%	7	26.9%
Sometime	2	7%	7	26.9%
Rarely	0	0.0%	2	7.7%
Never	24	89%	10	39%
Don't know	1	3.5%	0	0.0%

3.5 Project Management

3.5.1 Coordination with key stakeholders

There is substantial evidence to show that regular coordination meetings held between JEN staff, Provincial department for Rural Rehabilitation and Development (PRRD), Chaparhar district governor, WASH cluster and department of refugees at several occasions such as at the time of selection of district and village, monitoring of sites and project closure phase. In another instance, JEN well construction was shared DACAAR, the issue of hard water in the village was discussed and it was decided to dig deeper well to address the same. The local level coordination among community shura and JEN staff was also evident from the interviews. At one point of time provincial health department was also involved in approving the quality of water.

Community shura was involved during selection of village and while executing the project to address the household concerns with the project. JEN representative stated that the coordination meeting with UNOCHA allowed them to understand the service gap and needs assessment in a great way which eventually led to great success of the project.

“Coordination meetings have been held on a regular basis. Such as PDC, PDM and WASH or emergency provincial meetings which they are here. And it is the result of these coordination meetings that we get to know JEN- that who JEN was or how. Whatever coordination meetings there were, they brought us here to help them and improve the project and share the challenges and opportunities.” - Irrigation Engineer, PRRD

3.5.2 Water management and WMC WMC training

WMC key role is in maintenance of water management system during and after the completion of the project. The findings from interviews highlights that r training was conducted wherein various components of the responsibilities were discussed. This gave a sense of ownership to the members. In addition, it would aid the members to keep the project active in future as well. Legal and Advocacy Manager stated that WMC members are well trained on basic plumbing and monitoring of water management system.

“There have been regular trainings. They have agreed to raise a certain amount of money each month. About 42,000 Afghans (500 afis per household from 83 households and 500 from the head of WMC), they have now collected and to work on it. From the beginning of the project when we started installing these pipes or passing them underground. If there is a problem in any place, the members of this committee will solve the problem and remove the problems. They also have the financial means to make ends meet. And with that money, they will be able to solve all the technical problems of the project on their own.” - Irrigation Engineer, PRRD¹³

“WMCs have implemented all the recommendations that were given to them, For example, when you have repairs and where there is a problem, there will be no need to call someone from another place. There are people that have been trained that will look for the problems and solve them immediately. For example, in a normal place where this plaster problem occurs, in the next 10 or 15 years, they will solve the problem on their own, or when there is a need to change the pipe, so the people will come together and take necessary steps to solve the problem.” - Legal and Advocacy Manager

Selection of well construction sites

Principles and criteria for selection of well construction sites were based on the residence of local refugees, displaced people and the host community. Personnel of JEN and a representative from the rural development in consultation with community elders selected the place/location for the well.

“The location chosen for the well and mentioned network was based on the fact that all the areas belong to Guldari or Gulshan Abad village would be reached and to provide safe water, a location should be chosen without any problem. Then in the event that we choose the People's Council, we gathered that if it is your choice where we choose this location for the network.” - Legal and Advocacy Manager

“Location of the well was determined by the consultation of all village people and elders. When personnel of the organization came here and a representative from the rural development was with them so we villagers consulted with each other and decided to select the current placelocation for the well that place belonged to Malik Sahib Shafiq so he donated that placeland for the villagers.” - WMC Head

3.5.3 Monitoring and Supervision of Project

¹³ Future plan is to collect 50Afs/month/HH.

The project was monitored at two different levels by the directorates, WMC members and local community members. PRRD representative at provincial and district level frequently monitored the sites. The findings from the interviews showed that district governor office, community elders and WMC members were regularly visiting the construction sites.

“I have been monitoring the area closely. I have personally gone four times. And whatever problems and difficulties were there we pointed them out and they responded. And very well done on a regular basis.” - Irrigation Engineer, PRRD

“When the committee was created, from the first day to the end of the project all members of the committee were available here and we were informed of every work/activity and we visited every activity/work and we monitored every work/activity and we are informed of it. Personnel of the project informed us about the project progress and activities and also they told us that these activities are included in the proposal so we got informed of it and then we monitored it. We are informed of everything from the start of the project up to the end of the project and we visited and monitored all activities and works of the project.

In my opinion, it was a very transparent process and now MashaAllah the project is submitted for utilization. It is all about the efforts of the WMC or it was the result of our committee members' monitoring. The WMC members monitored the project transparently because this project is for us and we and the village people are the ones who are using the clean water in the future so it was our duty and responsibility to monitor it properly. ” -WMC Head

3.5.4 Access to clean water –evidence from qualitative data

The findings from qualitative interviews highlighted that JEN provided access to clean water within the reach of households and also distributed hygiene kits. Two key tasks were undertaken by JEN as part of the project. One, adjustment in number of water points to be constructed and second, water quality.

Initially, project planned for 20 water points construction, however at the mid stage of the project considering the household large families having many brothers, keeping the distance to within 200-300m in reach of household, addition 63 water points were constructed accommodating the need. During the interview with JEN local staff, it was cited that location of water point in the household premises was also carefully selected considering in future if household members choose to renovate, it will still have access to water supply within 500m.

Secondly, a systemisation process of the water purification was devised in order to ensure quality of water. To ensure water is healthy and fit for drinking, water quality tests were conducted before and after drilling of the well. DACAAR approved the water quality as turbidity was lower than 5 NTU, sustainable as per Afghanistan's National Drinking Quality Standard, Space Standard and WHO. Water quality was systemised by chlorinating wells twice a year with the assistance of UNICEF and the Public health Department.

All stakeholders stated that every selected household got access to 15 litre of clean water per member per day within 500 meters from their houses. Earlier the community had shallow wells with unclean water. Besides this, people used to travel long distances and this time could be now utilized in raising children, economic empowerment or participating in various recreational activities. Head of office, JEN stated that the project understood the importance of water in the life of all villagers. The Pump Test conducted by representatives of Rural

development and immigrants, concluded that the water was enough for the entire Golshanabad. WMC head also highlighted a major point of clean water availability in schools which could help in a big way to regularize school attendances.

“The distance between the farthest stand posts was 200 meters. People have a stand post in their own houses. Also, if you look at water pressure and water capacity, we have a water tank that has a length of 20 meters and a capacity of 20,000 liters of water. We made an automatic system for water, and automatically filled the tank with water 2 or 3 times a day for people’s usage.” - Head of Office, JEN

“Another issue was that before school students didn’t have access to clean water but now the stamp-post (water point) which is constructed for them at school so all students use it properly and now they have access to clean water and all students and teachers of the school are happy and satisfied from it.” - WMC Head

“In areas where there are problems and wars, naturally there is a lack of public awareness.

So the project has provided clean water to the people, especially the sisters and mothers who would find it difficult for them to fetch water, they have to travel distant places to bring unclean and surface water that would cause them different types of diseases. They were prevented by them. Now they are inside the house, protecting their dignity. They can provide water inside if there is wind or rain.” - Hygiene and Sanitation Supervisor

3.5.5 WASH education session and influence on awareness levels

The household interviews findings was evidence of fact that all beneficiaries attended and participated in the education sessions. The interviews with provincial stakeholders, JEN project staff further detailed out that:

Four days of health education training was conducted to highlight various aspects of hygiene and its importance. Total beneficiaries of 360 families, which were 360 males and females, were divided into 15-15 teams. Women and men were given choice to select the venue of training. Besides this, some additional people from village voluntarily joined the training. Details were shared in these training sessions on the following topics:

- a. COVID-19 pandemic and its symptoms
- b. Distinction and sources of clean and unclean water
- c. Methods of cleaning water
- d. Private hygiene/ Environment cleanliness
- e. Diarrhea and emergency care
- f. Proper sanitation practices
- g. Menstrual health of females

“We had 24 clusters, in each cluster we had 15 members. We give them 4 times hygiene education; it means we visit each family 4 times. If we count our additional follow-up that will be much more, but our additional visit was just for 6 clusters because we know that these 6 clusters were a little weak or absent in these training.” - Head Office, JEN

“Important issue was about the women’s period and we didn’t know and we were saying it is okay she is a woman and we were looking at her as a slave but now we realized that we

should care about this issue and we should give her good foods to eat at the time of period and we should help her and let her sleep well.” -WMC Head

As a result of WASH education sessions, not only awareness was created but a sense of belongingness was inculcated within the community. Irrigation engineer, PRRD shared an example how hygiene education has led to a local movement, for instance increased awareness of hygiene generated a campaign that led to removal of sixteen garbage piles in the village. This has invariably positively influenced remotely located villages as well to initiate similar campaign. The enhanced awareness level has also played a key role in controlling corona cases as community took all necessary precautionary measures against corona.

“People cleaned up their community. They harvest their fields. Those liquid and solid wastes that were present everywhere are relocated. Toilets were made and people using the open for defecation are prohibited. Now after this project, these conditions have been prepared and given training and mentality, so of course the problems that were there before have been solved. Now, God willing, live in a healthy environment with clean water.” - Hygiene and Sanitation Supervisor

3.5.6 Complaint Redressal system

All the beneficiaries in the study, coherently stated being aware of complaint management system, using it in case of any issue and contended with functioning of system (table 14)

Table 14: Beneficiary response to questions on complaint management system

Statement	Agree	Agree (%)	Somewhat Agree	Somewhat Agree (%)	Neutral	Neutral (%)	Somewhat Disagree	Disagree
You can complain, in case you face issues with water shortage or poor water quality	26	96.3%	0	0.0%	1	3.7%	0	0
There is a complaint handling mechanism related to water issues	26	96.3%	0	0.0%	1	3.7%	0	0
Complaints are resolved in timely manner	27	100.0%	0	0.0%	0	0.0%	0	0
Contact information of staff for listening to complaints or addressing the complaints are available	27	100.0%	0	0.0%	0	0.0%	0	0
Privacy is maintained while registering complaints	26	96.3%	1	3.7%	0	0.0%	0	0
Feedback or resolution of complaint is shared once its done with complainant	26	96.3%	1	3.7%	0	0.0%	0	0

All the stakeholders agreed that a proper complaint response mechanism was established to address the concern and feedback of the community. Complaint boxes, billboards and complaint banners with the contact details of JEN and other local representatives were put up so that people could share their suggestions for successful implementation of the project. Contact details of the head of the project, representatives of the rural development

department, refugees' department, public health department, MMC/ WMC members and social workers were included. The stakeholders also stated that the organization always approached the problems and suggestions very positively. The concerns shared related to their local, security, traditional, cultural beliefs were very well considered by the officials and incorporated in the project implementation.

"They have fixed banners there in the location of the well. They have fixed a banner on the wall. Along with this, some people don't have access to the telephone so they have put a box here and key of the box was only with the head of the project and they told us in the training if you have any complaint, any opinion, any suggestion, or you have any complaint from us if you can't tell us then it's okay you write it and put it in the box and the key is with the head of the project afterward when we had any complaint so we were writing it and putting it in the box.." -WMC Head

"If they do not share or do not want to share it with the JEN administration, they can apply to the Development Department, Department of Refugees, or the affiliate agencies. They are the people of the area; they are familiar with dress, with the local dialect and the community so the people are free to express their concerns to their colleagues. Because the people in their village are one of them, they are the people in their area, so they can tell them their problem, their colleagues bring up the problem again and they can share the relevant section of the JEN. For the good implementation of the project, I would suggest that the people involved." - Hygiene and Sanitation Supervisor

3.5.7 Community empowerment

Project concluded with the process of enabling the community to increase control over their lives. It provided essential health care, while fostering the development of self-sustaining health care systems. The people were benefited to a large extent wherein they got access to sufficient clean drinking water and toilets within their homes. The sustainability of the project was ensured by deploying WMC members who have received proper maintenance training. People have also been trained to resolve any issue without the need to call anyone from outside. Best health practices, emergency care and hygiene maintenance are other topics the community has been empowered on. Overall, a sense of ownership was elevated in the community.

"From the beginning, the six members of the MWC who monitored the installation of these pipes also learned from them. Where there is a problem that they have to repair that without any delay. And the community is also empowered that men and women have come to JEN trainings. They have received maintenance trainings. Even after the end of the project, they can still consider the project on their own and solve problems on their own." - Irrigation Engineer, PRRD

"We have a committee here by the name of WMC, and every Friday and week the members of the WMC committee monitor the well, water points, and stamp-posts and the members of the WMC committee visit and maintain well and water points so, for this reason, we are believing that it will be not destroyed because every week the members of the WMC committee visit it. Next, the personnel of the JEN organization worked in a good standard and criteria for us. Next, the members of the WMC committee collect money on every stamp-post or water point we collect money because if our project is faced with any problem so in

future we can repair it and we can prevent the destruction of the well, water points, and stamp-posts.” - WMC Head

3.6 Impact Evaluation

3.6.1 Methodology

The impact assessment was measured using three areas, knowledge on hygiene, practice on hygiene and outcome indicator using diarrhea incidence. The questions pertaining to three areas were selected from household questionnaire and was scored 100 for positive and zero for negative. Additional scores were allocated when respondents selected options showing higher knowledge level or practices (annex). The bivariate results were calculated using STATA.

3.6.2 Results

No statistical difference (t-test and chi-square) was found between the intervention and control groups when it comes to age and marital status. There was significant differences in employment status (table 15)

Table 15: Employment status among intervention and control group

Group	Unemployed	Self-employed	Chi-square
Control (N=25)	60%	40%	P <0.01
Intervention (N=26)	92%	8%	

Practice: The average Practice score was 376.66 (SD=168.46). There was a significant difference when it comes to practicing appropriate hygiene between those in the intervention area compared to those in the control area. The average practice score was 514.37 (SD=96.64) in the intervention group, compared to 233.65 (SD=17.05) in the control group (p<0.001). Controlling for employment status, being in an intervention area increased the practice score by 311 points compared to those in the control area (table 16).

Table 16: Hygiene Practice score (controlling the employment status)

Practice-score	Coefficient	Std.Err	T-test	P value
Intervention	310.80	24.45	12.71	0.000
Self-employed (vs. not employed)	41.31	28.81	1.43	0.158
Intercept	205.56	19.83	10.36	0.000

Knowledge: The knowledge score was higher for individuals in the intervention area. The average knowledge score was 396.30 (SD:79.57) in the intervention area compared to 234.62 (SD:82.18) in the control area (p<0.001). Controlling for employment status, being in an intervention area increased the knowledge score by 169.29 points compared to those in the control area (table 17).

Table 17: Hygiene Practice score (controlling the employment status)

Knowledge score	Coefficient	Std.Err	T-test	P value
Intervention	169.29	24.14	7.01	0.000
Self-employed (vs. not employed)	3.53	28.45	0.12	0.902
Intercept	226.59	19.58	11.57	0.000

Outcome: There was a significant difference in the number of respondents who reported a child (0-59 months) in their household had diarrhea in the last 2 weeks. Three (11%)

of respondents in the intervention area reported a child in their household had diarrhea in the last 2 weeks compared to 64% in the control group (chi-square<0.001). The table 18 below highlights the output.

Table 18: Response rate of child with diarrhea in intervention and control village

Group	Had Diarrhea	No Diarrhea	Chi Square
Control (N=25)	64%	36%	<0.001
Intervention (N=27)	11%	89%	

The odds of respondent reporting a child (0-59 months of age) living in their household NOT have diarrhea in the last two weeks if respondent reside in the intervention area is 32 times higher than those in the control area (table 19)

Table 19: Odds Ratio-probability of reporting diarrhea (control vs intervention group)

Positive outcome (no diarrhea)	Odds Ratio	Std.Err	T-test	P value
Intervention	31.90	29.60	3.73	0.000
Self-employed (vs. not employed)	2.87	2.42	1.25	0.212
Intercept	0.36	0.21	-1.78	0.076

3.7 Project Achievement against LFA

Continuous improvements in the project were made on the basis of the feedback or concerns of the community. JEN also course corrected its implementation process so the project could deliver maximum benefit to the residents. Two major amendments that were done are explained:

1. According to the original project, one stamp-post (water point) was to be constructed for 15 to 20 households but when the members of the WMC committee of the village and people of the community came together and told the office (JEN) of their cultural and traditional beliefs that women are not allowed to go outside as well as security concerns, a major change was made and stamp-posts (water points) were made in home. Also considering COVID-19 situation, wherein social distancing is an important component the idea of single water point for above mentioned households was dropped off.

“In the beginning, 20 water points were considered outside of the home for us but with the consideration of the peoples’ problems and based on our village peoples’ suggestions 83 water points are approved to be constructed in peoples’ houses. Before we were facing too many problems (local, security, traditional, cultural, and long distances) so we were facing these problems and now with the construction of the additional water points our problems are resolved.” -WMC Head

2. Some families had issues over training - location or travel. So, as to ensure that there was proper and maximum utilization of these counsellings, separate training for men and women was designed wherein, right to choose the cluster, avenue, place was given to them.

“Some families were saying that we do not take training there, or we don't go there, we want to take training in another place and so on. So, first of all, we have to take separate training for men and women and give them back the right to choose, which cluster, which avenue, which place they choose, they are free to choose and they can come to training.” - Head of Office, JEN

Table 20: Project achievements against LFA outputs

To improve the awareness among people, including internally displaced people, returnees, and people in the host communities whose lives and living conditions are particularly harsh or precarious, of sanitation and provide access to a minimum amount of safe water without hurting their dignity.				
Aims (at completion of the project)	Target value (index to measure the result) and confirmation method	Achievement status as per end-line	Activities for achievement	Achievement status as per end-line
1. Make safe drinking water continuously available at a location easily accessible by beneficiaries in the target district.	<ul style="list-style-type: none"> Establishment of one well and 20 water points (within 500 m) that satisfy Sphere Standards (15 L/person/day) Water quality that satisfies Sphere Standards Target number of beneficiaries: Total of 360 households Breakdown: IDPs (179 households = Approx. 1,250 persons), returnees (82 households = Approx. 570 persons), host community (99 households = Approx. 700 persons)	<ul style="list-style-type: none"> Achieved one well, 83 standpoints. 15L/person/day within 500m Water quality achieved 	1-1 Construction of deep well from which water is pumped up by solar power and installation of pipework 1-2 Organization of WMC, delivery of maintenance tools after providing training on public health, well-maintenance and management, and financial management 1-3 Handover of water supply facilities to the WMC with the attendance of relevant authority officials	1-1 100% 1-2 100% 1-3 100%
2. Provide hygiene education in an appropriate manner & hygiene kits to the beneficiaries	<ul style="list-style-type: none"> Number of beneficiaries who received hygiene education (a total of 720 persons, one each of male and female of the 360 households) 80% of the people who received hygiene education scored high on the KAP Survey¹⁴ and 20% a medium-range score by the end of the project Number of beneficiary households that received hygiene kits (360 households) 	<ul style="list-style-type: none"> Achieved 720 persons Achieved 80% with high score Achieved 360 HH 	2-1 Grouping of beneficiaries 2-2 KAP Surveys before and after the project 2-3 Provision of hygiene education 2-4 Distribution of hygiene kits 2-5 Monitoring of hygiene kit usage and establishment of hygiene education	2-1 100% 2-2 100% 2-3 100% 2-4 100% 2-5 100%

3.8 Core Humanitarian Standards

CHS1: Communities and people affected by crisis receive assistance appropriate and relevant to their needs.

Nangahar suffers from insurgency of ISIS, Taliban and other anti-government bodies (AGB), over the top are natural disasters, increasing returnees from Pakistan, and IDPs from other provinces. The Chaparhar district selected by PRRD was a conflict affected district and was under military operations to clear from AGB before initiation of JEN project. Chaparhar easy access geographically was another factor why the district was selected for the JEN project. Guldara village was selected out of seven prioritised villages by Department of Rural Development, the Department of Refugees, as well as the Department of Public Health. The village being a white area (absence of any type of health facilities) had highest population among all the seven villages and also had large pockets of IDPs, Returnees. In terms of access to clean water, the village had limited open dug well and inhabitants of the Guldara grapples with severe water shortages. The study respondents cited instances of injuries while travelling to a distance as far as 5km for collecting water. Guldara village also provided a flat terrain required for construction of well and hence logistically suited best for the project. The support for WASH environment improvement provided basic right to access to clean drinking water in white area of Chaparhar district.

CHS2: Communities and people affected by crisis have access to the humanitarian assistance they need at the right time.

In the wake of the high demand for clean drinking water, the installation of water distribution system was timely. The project covered 360 families in both low and middle locations of guldara village. The upper guldara could not be provided with water points being a steep area had the challenge of water pumping. The impact assessment of the study also highlight the statistical significance of access to clean water in Guldara on health indicator such as reduced odds of contracting diarrhea by under five children in the households. It could not be undermined that the project was implemented in the middle of corona outbreak and thus access to clean water has significantly played a key role in preventing transmission of corona virus among the families.

CHS3: Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action.

The awareness session on hygiene and sanitation along with covid prevention within the community generated awareness and presumably improved the household practices related to WASH. This was also significantly evident from the impact assessment wherein knowledge and practices related to WASH was three fold as compared to control village. Although the household quantitative findings did reflect some of the gaps in hand hygiene practices such as low awareness on few hand washing moments among beneficiaries while performing daily household chores. A well trained, informed and involved WMC members also signifies a step towards sustainability of project and community ownership. WMC member's formulation and then involvement right at the inception of the project does contribute towards a resilient

community. The overall WASH model comprising of availability of clean water supply along with imparting of hygiene awareness among residents and distribution of hygiene kit (soap) was significantly effective in empowering households for ensuring right to WASH is enforced.

CHS4: Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them.

Project support for WASH provided many opportunities to household to exercise their rights by staying informed about the water distribution. On other occasions the project supported freedom of choice to select locations for training venues as per the comfort of the families. The hygiene awareness sessions was broad enough to sensitive population on intertwined factors associated with water security. This findings from the study hints towards significant contribution of JEN project in generating awareness on WASH and thus overall community empowerment. The spill over effect of awareness on solar powered water management system , which was a unique model itself was also visible in nearby villages. Not to mention the overall project model combining awareness and soap distribution along with water distribution

CHS5: Communities and people affected by crisis have access to safe and responsive mechanisms to handle complaints.

The two layered complaint redress system was implemented as per discussion with JEN and PRRD. The two mechanisms included JEN installed complaint box, PRRD walk in complaint system and community elders. The complaints were resolved locally with the facilitation from community leaders. The informal structure functions well in a traditional system like Afghanistan. The findings from the study reflects on the malleable JEN project management system accommodating the needs from the community. The increased water points from 20 to 83 is the best example certifying a responsive project.

CHS6: Communities and people affected by crisis receive coordinated, complementary assistance

The Memorandum of Understanding (MoU) of the project has been signed with the PRRD. Reporting and supervision was part of project management cycle as per information collated through interviews and desk review. The documentary assessment and interview with PRRD, DoRR, DACAAR highlighted that the stakeholders were consistently involved at various stages throughout the project. Approval and guidance at different stages were sought with PRRD, governor office especially during increased conflict and covid lockdown. District counter parts of PRRD closely monitored the construction of well and water points with JEN.

CHS7: Communities and people affected by crisis can expect delivery of improved assistance as organisations learn from experience and reflection.

The project support for WASH environment made several adjustments and course corrections during execution of the project. Some of the instances narrated by JEN staff was pertaining to defining location for installation of water points considering the demand and

future needs of the households. The advice and guidance from DACAAR and PRRD had helped project team in executing water management system efficiently within the budget. The high adaptability of project w.r.t accommodating community needs and requests contributed in achieving community satisfaction with the project.

CHS8: Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers.

CHS9: Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically.

The HR competency assessment, resource assessment is not covered under the scope of summative evaluation. However, the functional and active involvement of various district authorities in monitoring and supervision is a sound example of good management and efficiency as reflected in CHS8 & 9.

3.9 Value assessment of program intervention

Assessing project intervention using JPF value assessment framework, it can be attested that support for WASH environment to IDPs, returnees, conflict-affected households was highly relevant to community needs (CHS1), thus effective (CHS2), exhibited impact on vulnerable population access to clean drinking water (CHS3) and was implemented through coordinated efforts of stakeholders (CHS6). Henceforth, the project was well worthy of implementation.

Recommendation

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The JEN model addressed multitudinal factors under WASH. The environment and economical solar powered water distribution system was complemented with community WASH awareness sessions. The distribution of hygiene kits not only reduced initial financial barrier to access soap but also allowed households to experience newly acquired knowledge on WASH thus ensuring behavior and sustainability. The model prove to be a scalable solution for improving water security.

Program specific recommendations

- Emphasis on continuous WASH education awareness sessions has to be prioritised. The education sessions can be imparted by WMC voluntarily in consultation with PRRD.
- Water pump, Pipes, Taps and Solar panels may not last more than 2-3 years and needs to be replenished. WMC is required to allocate fund and budget line to replenish these.
- Community to continue support WMC trained members for maintenance of the Water system

Annexure A: Demographic Details of Respondents (in numbers)

Age (years)	Respondent Type	Female	Marital Status			Employment Status		Frequency of children <5 years			
			Married	Never Married	Widow	Self employed	Not employed	0	1	2	3
15-25	Beneficiary	5	2	2	0	0	5	5	0	0	0
	Non-Beneficiary	4	2	2	0	3	1	2	2	0	0
25-35	Beneficiary	5	5	0	0	0	5	4	0	1	0
	Non-Beneficiary	12	12	0	0	3	9	0	6	5	1
35-45	Beneficiary	14	13	0	1	1	13	10	1	1	2
	Non-Beneficiary	4	4	0	0	1	3	1	0	3	0
45-55	Beneficiary	1	1	0	0	0	1	1	0	0	0
	Non-Beneficiary	4	1	0	2	3	1	3	1	0	0
55-65	Beneficiary	1	0	0	1	1	0	1	0	0	0
	Non-Beneficiary	1	1	0	0	0	1	1	0	0	0

Annexure B: Impact Assessment detailed Methodology and Results

Scoring (methodology)

Practice score (0-700)

Q200. Do you use any soap for any chores in your household? (Highest score 100)

Yes=100

No=0

Q201. Do you wash your fruit or vegetables before you cut it or afterwards?(Highest 100)

Cut before washing=0

Wash before cutting=100

Both depending on the situation=0

No response= missing

Q202. At what times do you routinely wash your hands? (highest score 150)

100 if all core routines were selected (i.e., After eating, before preparing food, before serving food, after touching animals, after using the toilet/defecting, before eating), and reduce 14.29 points for each missing core.

For remaining hygiene practices add a 7.14 score for each selected practice.

Q203. What do you use to wash your hands? (highest score 350)

Water=50

Soup=100

Ash=0

Alcohol/hand sanitizer=100

Sand=0

Dettol/disinfectant=100

Earth/dirt=0

Knowledge score (0-550)

Q212. What is the main purpose of hand hygiene? (Highest score 100)

To reduce germs on the hands =100

To keep hands clean=100

To keep nails clean=100

To keep the hands smooth=0

To avoid diseases=100

Q213. What types of diseases are associated with not washing hands with soap/ash? (Highest score 450)

Dysentery=100

Diarrhea=100

Cholera=100

Malnutrition/stunting=50

Pneumonia=50
 Ear infections=50

Outcome—No Diarrhea

Q214. Has your (0-59 months) child had diarrhea in the last 2 weeks?

No=1
 Yes=0

Results (Stata output)

```

log type:    smcl
opened on:   6 Jun 2021, 09:28:29
1 . do "/var/folders/2_/l0mc3_3n3tgfvjqlbx0s429c0000gn/T//SD23679.000000"
2 . ttest age, by(intervention)

Two-sample t test with equal variances

+-----+-----+-----+-----+-----+-----+
| Group | Obs | Mean | Std. Err. | Std. Dev. | [95% Conf. Interval] |
+-----+-----+-----+-----+-----+-----+
| 0     | 25  | 34.36 | 1.96713   | 9.835649  | 30.30004 38.41996 |
| 1     | 26  | 34.96154 | 1.819958 | 9.280003  | 31.21326 38.70981 |
+-----+-----+-----+-----+-----+-----+
| combined | 51  | 34.66667 | 1.325368 | 9.465023  | 32.00459 37.32875 |
+-----+-----+-----+-----+-----+-----+
| diff   |     | -.6015385 | 2.676784 |           | -5.980738 4.777661 |
+-----+-----+-----+-----+-----+-----+

diff = mean(0) - mean(1)                t = -0.2247
Ho: diff = 0                            degrees of freedom = 49

Ha: diff < 0                            Ha: diff != 0                            Ha: diff > 0
Pr(T < t) = 0.4116                       Pr(|T| > |t|) = 0.8231                       Pr(T > t) = 0.5884
    
```

interventi on	Maritalstatus			Total
	1	2	3	
0	20	2	3	25
1	21	3	2	26

Total	41	5	5	51
-------	----	---	---	----

4 . tab intervention maritalstatus, chi

interventi on	Maritalstatus			Total
	1	2	3	
0	20	2	3	25
1	21	3	2	26
Total	41	5	5	51

Pearson chi2(2) = **0.4049** Pr = **0.817**

5 . tab intervention employment, chi

interventi on	employment		Total
	0	1	
0	15	10	25
1	24	2	26
Total	39	12	51

Pearson chi2(1) = **7.3935** Pr = **0.007**

6 . tab intervention watersoure, chi

interventi on	watersoure						Total
	1	3	6	7	9	11	
0	0	4	0	2	7	5	26
1	1	1	25	0	0	0	27

Total	1	5	25	2	7	5	53
-------	---	---	----	---	---	---	----

interventi on	watersoure	Total
0	15	2
1	8	6
1	0	2
1	0	7
Total	8	5
		3

Pearson chi2(6) = **49.7989** Pr = **0.000**

7 . sum practice_score

Variable	Obs	Mean	Std. Dev.	Min	Max
practice_score	53	376.6604	168.4574	51	754

8 . do "/var/folders/2_/l0mc3_3n3tgfvjqlbx0s429c0000gn/T//SD23679.000000"

9 . ttest practice_score,
by(intervention) Two-sample
t test with equal variances

Group	Obs	Mean	Std. Err.	Std. Dev.	[95% Conf. Interval]	
0	26	233.6538	17.05547	86.96617	198.5274	268.7802
1	27	514.3704	18.59833	96.63975	476.141	552.5998
combined	53	376.6604	23.1394	168.4574	330.2278	423.093
diff		-280.7165	25.2857		-331.4797	-229.9534

diff = mean(0) - mean(1) t = -11.1018
 Ho: diff = 0 degrees of freedom = 51
 Ha: diff < 0 Ha: diff != 0 Ha: diff > 0
 Pr(T < t) = **0.0000** Pr(|T| > |t|) = **0.0000** Pr(T > t) = **1.0000**

11 . tab intervention employment, chi row

interventi on	employment		Total
	0	1	
0	15 60.00	10 40.00	25 100.00
1	24 92.31	2 7.69	26 100.00
	39 76.47	12 23.53	51 100.00

Pearson chi2(1) = **7.3935** Pr = **0.007**

12 . ttest knowledge_score, by intervention

Two-sample t test with equal variances

Group	Obs	Mean	Std. Err.	Std. Dev.	[95% Conf. Interval]	
0	26	234.6154	16.11717	82.18179	201.4214	267.8093
1	27	396.2963	15.31389	79.57329	364.8182	427.7744
combined	53	316.9811	15.70451	114.3306	285.4677	348.4945

diff	-161.6809	22.21859	-206.2866	-117.0752
------	-----------	----------	-----------	-----------

diff = mean(0) - mean(1) t = -7.2768

Ho: diff = 0 degrees of freedom = 51

Ha: diff < 0 Ha: diff != 0 Ha: diff > 0

Pr(T < t) = 0.0000 Pr(|T| > |t|) = 0.0000 Pr(T > t) = 1.0000

13 . tab outcome_nodiarrhea intervention, chi ro

outcome_no	intervention		Total
	0	1	
Diarrhea			
-			
0	16	3	19
	84.21	15.79	100.00
1	9	24	33
	27.27	72.73	100.00
Total	25	27	52
	48.08	51.92	100.00

Pearson chi2(1) = 15.6592 Pr = 0.000

14 . tab outcome_no diarrrhea intervention, chi col

Outcome	intervention		Total
	0	1	
No			
Diarrhea			
0	16	3	19
	64.00	11.11	36.54
1	9	24	33
	36.00	88.89	63.46

Total	25	27	52
	100.00	100.00	100.00

Pearson chi2(1) = 15.6592 Pr = 0.000

15 . tab intervention outcome_nodiarrhea, chi ro

interventi on	outcome_noDiarrhea		Total
	0	1	
0	16	9	25
	64.00	36.00	100.00
1	3	24	27
	11.11	88.89	100.00
Total	19	33	52
	36.54	63.46	100.00

Pearson chi2(1) = 15.6592 Pr = 0.000

16 . reg practice_score intervention employment

Source	SS	df	MS	Number of obs	=	51
				F(2, 48)	=	87.58
Model	1141095.32	2	570547.658	Prob > F	=	0.0000
Residual	312688.841	48	6514.35085	R-squared	=	0.7849
				Adj R-squared	=	0.7760
Total	1453784.16	50	29075.6831	Root MSE	=	80.712

practice_s~e	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
intervention	310.8047	24.44969	12.71	0.000	261.6453	359.9641
employment	41.3098	28.81424	1.43	0.158	-16.62511	99.24472
_cons	205.5561	19.83471	10.36	0.000	165.6757	245.4364

17 . reg knowledge_score intervention employment

Source	SS	df	MS	Number of obs	=	51
				F(2, 48)	=	28.37
Model	360474.51	2	180237.255	Prob > F	=	0.0000
Residual	304917.647	48	6352.45098	R-squared	=	0.5417
				Adj R-squared	=	0.5227
Total	665392.157	50	13307.8431	Root MSE	=	79.702

knowledge_~e	Coef.	Std. Err.	t	P> t	[95% Conf. Interval]	
intervention	169.2941	24.14396	7.01	0.000	120.7494	217.8388
employment	3.529412	28.45393	0.12	0.902	-53.68105	60.73987
_cons	226.5882	19.58668	11.57	0.000	187.2066	265.9699

18 . logit outcome_nodiarrhea intervention employment, or

Iteration 0: log likelihood = **-33.111666**

I Form

Beneficiary Interview

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Beneficiary Verbal Informed Consent

Instructions for the Interviewer: *The following is to be read verbatim to the client prior to the consultation and interview. If the client then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line. In case of minors (children or adolescents <age 18 years), the consent text will be read to parent or guardian accompanying the client and informed consent to be sought from the parent/guardian*

Purpose of the Study

This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. We would like to ask you some questions about access and availability of safe water, hygiene and sanitation at your home. This information will help the JPF project and its partner NGO's in improving their project work. However, there is no immediate or direct benefit to you for participating.

I.1.1

I.1.2 Procedures

I.1.3 To obtain the necessary information, you have been chosen randomly to participate from among the beneficiary of this project in your village. If you agree, we will ask you to answer several questions availability of water, access to safe drinking water at your home, hygiene and sanitation status at your home. We will ask you these questions in another room, without the presence of any health worker

I.1.4 Risks /Discomforts

The questions will take less than 45 minutes to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

I.1.5 Confidentiality

I.1.6 During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you or your family member. We will not tell any community member, or household member about the information you provide. All the information collected will be stored in a locked area.

I.1.7 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence. If you decided not to participate, you or your family member will get the same care that he or she would otherwise receive.

I.1.8 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? Yes No

Signed by interviewer after subject has verbally consented

1 IDENTIFICATION

Province Name:|_____| Province Code: |_|_|_|

District Name: |_____| District Code: |_|_|_|

Village (Health post) Name:|_____|Code: |_|_|_|_|_|

Questions on water

Safe water access, water storage and usage at household

#	Description	Answer	Answer Code	Skip pattern
---	-------------	--------	-------------	--------------

100	<p>What is the main source of drinking water for your household?</p> <p>[Interviewer: one response only please.]</p>	<p>1.....Piped water into dwelling 2.....Piped water to yard/plot 3.....Piped to neighbor 4.....Public tap/standpipe 5.....Tube well or borehole 6.....Protected dug well 7.....Unprotected dug well 8.....Protected spring water 9.....Unprotected spring water 10.....Rainwater 11.....Tanker truck 12.....Cart with small tank/drum 13.....Surface water (river/dam/lake/pond/stream /canal/irrigation channel) 14.....Bottled water 15.....Other (specify): _____</p>		
101	<p>Where is that water source located?</p>	<p>1.....In Own house 2.....In Own Yard/Plot 3___ Well constructed by JEN 4..... Taps (water points) constructed by JEN 5.....Elsewhere (specify)): _____</p>		
If using well/ tap constructed by JEN				
102	<p>How far is the water source from your house? (distance in meter)</p>	<p>1. Less than 500m 2. More than 500m 3. More than a km 99. Don't know</p>		

103	How long does it take to reach to water source?	Minutes _____		
104	How long does it take to stand in que (if there is any), fetch water	Minutes _____		
105	How long does it take to bring water to your home once you have fetch it? Travel time	Minutes _____		
106	<p>What do you do to the water to make it safe to drink for everyone in your family?</p> <p>[Circle all that are spontaneously mentioned – PLEASE DO NOT READ LIST]</p>	<p>1.....Boil</p> <p>2.....Add bleach/chlorine</p> <p>3.....Strain through a cloth</p> <p>4.....Use water filter (ceramic/sand/composite/etc.)</p> <p>5.....Solar disinfection</p> <p>6.....Let it stand and settle</p> <p>7.....Other (specify)</p> <p>9.....Don't know</p> <p>_____</p>		
107	<p>How do you usually store your drinking water?</p> <p>[Circle single best answer spontaneously mentioned – PLEASE DO NOT READ LIST]</p>	<p>1.....Covered container (bucket, bottle, clay pot)</p> <p>2..... Uncovered container (bucket, bottle, clay pot)</p> <p>3.....Roof tank</p> <p>4.....Cistern</p> <p>5.....No storage</p> <p>6.....Other (specify)</p> <p>_____</p>		

Questions on hygiene and sanitation

I would now like to ask a few questions about what you do every day and see places within your house where you do certain tasks. Will this be all right?

#	Description	Answer	Answer Code	Skip pattern
200	Do you use any soap for any chores in your household?	1.....Yes 2.....No		
201	Do you wash your fruit or vegetables before you cut it or afterwards?	1.....Cut before washing 2.....Wash before cutting 3...Both depending on the situation 8.....No response		
202	At what times do you routinely wash your hands? [Interviewer: Circle all that are spontaneously mentioned – PLEASE DO NOT READ LIST]	1....After contact with sticky, oily, smelly materials 2....After coming from the burial field/garden/work 3....First thing when you wake up 4....After eating 5.....After attending to a child who has defecated 6....Before preparing food 7.....Before feeding a child 8.....Before serving food 9.....After touching animals 10....After cleaning a dead body 11....After using the toilet/defecating 12.....Before eating 13.....Before breastfeeding 14....After changing a child’s diaper/ cloth 15....Other (specify): _____		

203	<p>What do you use to wash your hands?</p>	<p>1.....Water 2.....Soap 3.....Ash 4.....Alcohol/ hand sanitizer 5.....Sand 6.....Dettol/ disinfectant 7.....Earth/ dirt 8.....Other (specify): _____ 88.....No response</p>		
204	<p>If you do not wash your hands daily, what are the main reasons for not doing so?</p> <p>[Interviewer: Circle all that are spontaneously mentioned – PLEASE DO NOT READ LIST]</p>	<p>1....No water available immediately 2....No soap or ash available immediately 3.....No time 4.....It is waste of water 5....It is waste of soap 6...Other reason (Specify) _____ 9....Don't know</p>		
205	<p>What would need to change to make handwashing with soap a habit for you?</p>	<p>1.....Easy access of water 2.....Able to afford soap 3.....Easy access to ash and water 4...Other (specify) _____</p>		

206	<p>What kind of toilet facility do members of your household usually use?</p> <p>[Interviewer: Select single best answer.]</p>	<p>1.....Flush or pour flush toilet</p> <p>2.....Flush to piped sewer system</p> <p>3.....Flush to septic tank</p> <p>4.....Flush to pit latrine</p> <p>5.....Flush to somewhere else</p> <p>6.....Flush, don't know where</p> <p>7.....Ventilated improved pit latrine</p> <p>8.....Pit latrine with slab</p> <p>9.....Pit latrine without slab/open pit</p> <p>10...Composting toilet</p> <p>11...No facility/bush/field</p> <p>12...Other (specify):</p> <p>_____</p> <p>99...Don't know</p>		
207	<p>Has the hygiene education sessions conducted in your village? Data collector: briefly describe the hygiene education</p>	<p>1.....Yes</p> <p>2.....No</p>		<p>If "No" go 218</p>
208	<p>Have you attended any of the hygiene education sessions conducted by JEN NGO?</p>	<p>1....Yes</p> <p>2....No</p>		
209	<p>Were the sessions participative?</p>	<p>1....Yes</p> <p>2....No</p>		
210	<p>Please explain</p>			

<p>211</p>	<p>From what source do you receive information about hygiene most often?</p> <p>[Interviewer: Circle all that are spontaneously mentioned – PLEASE DO NOT READ LIST]</p>	<p>1.....CHW 2.....Radio 3.....Television 4.....Health facility 5.....FHA group members Other community-level volunteer 6.....Health shura 7.....Newspaper/ brochures 8.....NGOs 9.....Other (specify): _____ 10.....Have not received nutrition information 88.....No response</p>		
<p>212</p>	<p>What is the main purpose of hand hygiene?</p> <p>[Interviewer: circle one best response, please do not read list.]</p>	<p>1.....To reduce germs on the hands 2.....To keep hands clean 3.....To keep nails clean 4.....To keep the hands smooth 5.....To avoid diseases 6.....Other (Specify) _____ 9.....Don't know</p>		
<p>213</p>	<p>What types of diseases are associated with not washing hands with soap/ash?</p> <p>[Interviewer: Circle all that are spontaneously mentioned – PLEASE DO NOT READ LIST]</p>	<p>1.....Dysentery 2.....Diarrhea 3.....Cholera 4.....Malnutrition/stunting 5.....Pneumonia 6.....Ear infections 7.....Other (specify): _____</p>		

214	Has your (0-59 months) child had diarrhea in the last 2 weeks?	1.....Yes 2.....No		If no (2), go to 311.
215	How many times your child (0-59 months) had diarrhea during the last 2 weeks	1....Every day 2....Frequently 3....Sometime 4....Rarely 5....Never 6....Don't know"		

Core Humanitarian Standard (CHS)

#	Description	Answer	Answer Code	Skip pattern
	Enumerator reads the statement and respondent selects the right answers and also ask explanation for the answer			
300	Construction of well is utmost necessity of this village ensuring safe water availability to residents	1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree		
301	Please explain your choice			
302	water point constructed by JEN are within reach (within 500m for their household) to all village members?	1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree		
303	Please explain your choice			
304	Some people have to wait near the water point to get the water or some are given preference for accessing water from well?	1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree		
305	Please explain your choice			

Summative Evaluation Report JEN

306	Women can access water without any discomfort like privacy issues, long wait or que	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
307	Please explain your choice			
308	People usually fight while accessing water , or while standing in que for water near water stand point?	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
309	Access to safe drinking water is your and everyone right	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
310	In case you face issues with water shortage or poor water quality, do you complain?	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
311	Please explain your choice			
312	There is a complaint handling mechanism related to water issues	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
313	Please explain your choice			
314	Complaints are resolved in timely manner	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
315	Please explain your choice			
316	Do you have contact information of staff for listening to complaints or addressing the complaints	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
317	Please explain your choice			
318	Privacy is maintained while registering complaints	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		

319	Please explain your choice			
320	Feedback or resolution of complaint is shared once its done with complainant	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
321	Please explain your choice			
Well Management Committee (WMC)				
400	WMC is formulated and functioning well	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
401	Please explain your choice			
402	Can you narrate the role of WMC members?			
403	How many members are currently in WMC?			
404	WMC members are well trained and competent in their job	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
405	Please explain your choice			
Counter factual scenario : before well/water points were not constructed				
500	There were high cases of diarrhea among children in a particular season	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
501	Please explain your choice with examples from past, point out month, season , year and dates			
502	There was lack of access to drinking water and women has to travel long distance to fetch water	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		

503	Please explain your choice with examples from past, point out month, season , year and dates			
504	There was lack of access to drinking water and women /man has to travel long distance to fetch water which means missing daily wages	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
505	Please explain your choice with examples from past, point out month, season , year and dates			
506	The water available through various sources was unfit for drinking	<ol style="list-style-type: none"> 1. Agree 2. Somewhat agree 3. Neutral 4. Somewhat Disagree 5. Disagree 		
507	Please explain your choice with examples in the village houses			

Thank You

2 Form

Key Informant Interview- WMC, Member Male & Female

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Verbal Informed Consent

Instructions for the Interviewer: *The following is to be read verbatim to the client prior to the consultation and interview. If the client then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line.*

Purpose of the Study

This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. We would like to ask you some questions about the WASH activities conducting by JEN. This information will help the JEN project staff in improving their project work. However, there is no immediate or direct benefit to you for participating.

2.1.1

2.1.2 Procedures

2.1.3 To obtain the necessary information, you have been chosen randomly to participate from among the beneficiary of this project in your organization. If you agree, we will ask you to answer several questions availability of water, access to safe drinking water at the community, hygiene and sanitation status at community. We will ask you these questions in another room, without the presence of any person.

2.1.4 Risks /Discomforts

The questions will take less than 45 minutes to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

2.1.5 Confidentiality

2.1.6 During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you. We will not tell to any project staff or community member, or household member about the information you provide or your name, which will not be recorded. All the information collected will be stored in a locked area.

2.1.7 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence.

2.1.8 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? Yes No

Signed by interviewer after subject has verbally consented

1. Job title

2. Sex

3. Age

4. Contact Number

I. Well Management Committee (WMC)

I01. How selection of WMC members was conducted? Probe for : nomination basis or voting, is it a participatory process, selection and participation of women in the process, how community was involved in the process

I02. what are the duties of each member of WMC, please state

I03. Does WMC members received training on well and water point management?

1. YES

2. NO

In either case provide explanation with details

I04. Do you think WMC members played active role in successful execution of this project?

3. YES

4. NO

a. If YES, describe.

b. If NO, describe

2. Well Construction

201. How the location of well was determined? What role did you played?

202. How frequently you monitored the construction process?

- a. Once a week
- b. Once a month
- c. Once in three months
- d. Visited the site once
- e. Didn't visit at all

203. What criteria did you followed while visiting the construction of well and water points ? Please state

- 1. _____
- 2. _____
- 3. _____

204. Is the construction is adequate as per requirement of households (15 litre per person per day) ?

- 1. YES
- 2. NO

If YES, describe.

If NO, describe deficiency

3.WASH

301. How the location of water points was determined? What role did you played?

302. Is water points number and location as per constructed by JEN helpful for the school ? (Probe: access within 500m , availability of water, queuing, safe and secure for women) Give examples

303. Is there a protocol for Operation and Maintenance (O&M) of well and water points after construction?

- 1. YES
- 2. NO

A. If yes, please explain briefly

B. If no, why, please explain briefly

305 How will you overall rate the construction of well and water points by JEN

- a) Good
- b) Adequate
- c) Inadequate
- d) Poor

306 Please explain your option 'why you opted for good/adequate/inadequate/poor?.

e) _____

4. Training

401. Have you received any training on hygiene and sanitation in ?

- 1. Yes
- 2. No

If yes, please explain when , duration, what all subjects covered in the training?

5.CHS

501 Could you tell me how much is community involved in the project:

Prob: Is community involved in planning, execution of project?

Is community involved in monitoring of the project?

Is community informed of the findings?

Is the community actively sharing concerns and feedback?

502. Is complaint redressal is functioning?

503. Who are the identified staff to answer issues from community?

504. How long does it to take to address ay complaint?

505. Is the complaint mechanism accessible, effective, confidential and safe for their use?

6. Overall

601. Are you confident in managing well and water points after JEN leaves?

1. Very confident
2. Confident
3. Cant say
4. Less confident
5. Not confident at all

Please explain your choices and challenges with the same

506 What are your recommendations that how this project can be further improved?

—

***Thank you for your time ***

Confidential for research purpose only

3 Form

Key Informant Interview- JEN Project Manager

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Verbal Informed Consent

Instructions for the Interviewer: *The following is to be read verbatim to the client prior to the consultation and interview. If the client then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line.*

Purpose of the Study

This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. We would like to ask you some questions about the WASH activities conducting by JEN. This information will help the JEN project staff in improving their project work. However, there is no immediate or direct benefit to you for participating.

3.1.1

3.1.2 Procedures

3.1.3 To obtain the necessary information, you have been chosen randomly to participate from among the beneficiary of this project in your organization. If you agree, we will ask you to answer several questions availability of water, access to safe drinking water at the community, hygiene and sanitation status at community. We will ask you these questions in another room, without the presence of any person.

3.1.4 Risks /Discomforts

The questions will take less than 45 minutes to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

3.1.5 Confidentiality

3.1.6 During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you. We will not tell to any project staff or community member, or household member about the information you provide or your name, which will not be recorded. All the information collected will be stored in a locked area.

3.1.7 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence.

3.1.8 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? Yes No

Signed by interviewer after subject has verbally consented

Participant characteristics				
Job title				
Organization				
Sex				
Age				
Contact number				
3.1.8.1.1 Section 2: Relevance and Project Outcomes				
202	How would you describe the selection of village for the project? <i>Probe: What was the laid out criteria for selection? Is it documented somewhere? Please share the document</i>			
203	To what extent do you think project outcome and output targets were achieved under LFA?	Not Achieved	1	
		Partially achieved	2	
		Achieved	3	
	Are the set targets and goals rational and plausible?	Yes	1	
		No	2	
		Dont Know	97	
	Please comment on the status of targets of 1. Establishment of one well and 20 water points (within 500 m) that satisfy Sphere Standards (15 L/person/day), • 2. Water quality that satisfies Sphere Standards for target number of beneficiaries: Total of 360 households • 3. hygiene education (a total of 720 persons, one each of male and female of the 360 households)			
204	What were the major factors influencing the achievement of the indicators? List three a. b. c.			

205	What were the major factors influencing the non-achievement of the objectives? List three a. b. c.			
206	Is water quality test conducted ?	Yes No Dont Know	1 2 97	
207	what does SoP on water quality states on frequency, sampling and reporting			
208	How it is in line with SOP's			
209	Is the constructed water point will be able to meet the need of 15L per person per day need of household ?	Yes No Dont Know	1 2 97	
210	No or Yes, share details			
211	If No, what is the provision undertaken to meet the demand of households			
Section 3: Project Management				
301	Is procurement conducted as per timeline?	Yes No Dont Know	1 2 97	
302	If No , share what could have been improved			
303	Is monitoring of well construction conducted timely?	Yes No Dont Know	1 2 97	
304	If No , share what could have been improved			
305	Is necessary supportive supervision is provided to JEN staff timely by DoRR, DRRD?			
306	If No , share what could have been improved			

307	Is necessary supportive supervision is provided to JEN staff timely by JPF?			
308	If No , share what could have been improved			
Section 4 : Coordination				
401	Did JEN staff participated in meetings at DoRR/ DRRD which led to constructive inputs for project	Yes No Dont Know	1 2 97	
402	If yes state two such instances a. b.			
403	Are monitoring visits by DoRR/DRRD conducted with feedback to project staff	Yes No Dont Know	1 2 97	
404	If yes state two such instances a. b.			
405	Are WMC meetings held?	Yes No Dont Know	1 2 97	
407	If yes state main key points discussed in last meeting a. b.			
408	Are the coordination meeting between JEN local staff and JEN tokyo staff held regularly	Yes No Dont Know	1 2 97	
409	If yes state discussion points of last two meetings a. b.			
410	Does the DoRR/DRRD able to provide timely direction and	Yes	1	

	guidance to JEN staff, state examples	No Dont Know	2 97	
411	If yes state two examples a. b.			
412	Does the JEN tokyo staff able to provide timely direction and guidance to JEN local staff, state examples	Yes No Dont Know	1 2 97	
413	If yes state two examples a. b.			
Section 5: Sustainability				
501	Is the Project Sustainable	Yes No Dont Know	1 2 97	
502	How community is empowered and what are the provision after project completion? a. b.			
503	How the coordination between different stakeholder was effective , state few examples a. b.			
504	What changes are made to improve project efficiency and over implementation ? How challenges were overcome , what is the evidence			
506	List three challenges during the project which team overcome a. b. c.			
507	List three changes which could have made project more efficient b. c.			

Thank you for your participation in the interview

4 Form #

Key Informant Interview- Government DoRR, DRRD

Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan

Conducted by: Health Protection and Research Organization (HPRO);

Supported by: Japan Platform

Beneficiary Verbal Informed Consent

Instructions for the Interviewer: *The following is to be read verbatim to the client prior to the consultation and interview. If the client then agrees to participate, you must sign on the line marked at the end of this form. Also mark the date on the appropriate line.*

Purpose of the Study

This is with respect to Third-party Project Monitoring & Evaluation of JPF Funded Projects in Afghanistan. We would like to ask you some questions about the WASH activities conducting by JEN/JPF. This information will help the JPF project in improving their project work. However, there is no immediate or direct benefit to you for participating.

4.1.1

4.1.2 Procedures

4.1.3 To obtain the necessary information, you have been chosen randomly to participate from among the beneficiary of this project in your organization. If you agree, we will ask you to answer several questions availability of water, access to safe drinking water at the community, hygiene and sanitation status at community. We will ask you these questions in another room, without the presence of any person.

4.1.4 Risks /Discomforts

The questions will take less than 45 minutes to complete. If there are any questions you do not want to answer, you may refuse to answer them without consequence. None of the information obtained will be identified with you or your family in any way.

4.1.5 Confidentiality

4.1.6 During the question period, I will write down the information you tell me. The record of this interview will not have any information that can be used to identify you. We will not tell to any project staff or community member, or household member about the information you provide or your name, which will not be recorded. All the information collected will be stored in a locked area.

4.1.7 Voluntary Consent

It is your decision whether or not to be in this study. You may stop participating in the study at any time without consequence.

4.1.8 Whom to Contact

If you have any questions now, I will answer them. If you have questions later, you can contact

Dr. Farooqi @ telephone no. 0781675290

Do you agree to participate in this study? Yes No

Signed by interviewer after subject has verbally consented

Participant characteristics	
Job title	
Organization	
Sex	
Age	
Contact number	

1. Q for stakeholders (not JEN): Can you tell me how much you are informed of the JEN/JPF WASH project? (probe: project scope, status, completion, outcome and impact? selection of site?
2. Gulshan Abad Village in the Chaparhar District, was selected for well and water point construction? What was the basis for selection of this village? Has the WASH situation improved among households after the start of the program and now completion of program. If so, how? If not, why not?
3. Is coordination meetings conducted regularly with JEN active participation? when was the last meeting held and what was discussed?
4. How this coordination meetings helped JEN in successful implementation of project?
5. In your view was it a efficiently implemented project with a success? (Probe: what gaps do you see in the project and what would you recommend to improve it)?
6. How often monitoring visit by department officials were conducted? What were the findings of last visit? Were the findings shared with JEN and how the recommendations were incorporated in the project? Please share report if you have.
7. In your view does JEN has system of feedback / complaint and improving project management based on feedback. How far community is involved in planning and monitoring of project implementation? Please state examples
8. What are the initiatives taken under project to bring sustainability? Please share your ideas and inputs?

9. In your view is SMC members are competent and well trained? Please share inputs in detail
10. Do you think establishment of well and water points will be able to meet the water requirement of 15l per person per day ? Yes or No please explain. If no, what are the other strategies adopted by the department to meet this requirement?
11. How community is empowered and what are the provision after project completion ?

Thank you for your participation in the interview