Impact Evaluation Study
Of
Hygiene, Sanitation and Water Supply (HYSAWA) Project of the Ministry of Local Government, Rural Development and Cooperatives

Carried out by
Evaluation Sector
Implementation Monitoring and Evaluation Division (IMED)
Ministry of Planning, Government of People's Republic of Bangladesh

Conducted by
Bangladesh Institute of Development Studies (BIDS)

June 2014

Impact Evaluation Study of the Project "Hygiene, Sanitation and Water Supply (HYSAWA) Project of the Ministry of Local Government, Rural Development and Cooperatives"

BIDS Professonals

1. **Dr. S. M. Zulfiqar Ali**
   Senior Research Fellow
2. **Dr. Mustafa K. Mujeri**
   Director General
3. **Badrun Nessa Ahmed**
   Research Associate

With Assistance from,

1. **Nadia Farnaz**
   Research Officer
2. **Md. Faizul Islam**
   Research Officer

IMED Officials

1. **Ms. Salma Mahmud**
   Director General
2. **Mr. Md. Abdul Quiyum**
   Director
3. **Quamrun Nessa**
   Director
4. **Mr. Md. Mosharaf Hossain**
   Deputy Director

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E-17 Agargaon, Sher-e-Bangla Nagar
Dhaka-1207, Bangladesh

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FOREWORD

Ministry of Local Government, Rural Development and Co-operatives (MoLGRD&C) sponsored the project titled "The Hygiene, Sanitation and Water Supply (HYSAWA) project" with the goal of reducing poverty through improved and sustainable public health and environment and reach the MDGs for water and sanitation.The original project was implemented during January 2006 to December 2010 and was financed from the Government of Bangladesh (GoB), Development Partners (DP) and other sources.

Upon request from the Implementation Monitoring and Evaluation Division (IMED) of the Ministry of Planning (MoP), the current evaluation study has been undertaken by the Bangladesh Institute of Development Studies (BIDS). The major objectives of this project were to improve hygiene behavior/practices, promote community-led total sanitation and increase the coverage of safe water supply services. At the same time, strengthen the capacity of government, local government institutions and non-government stakeholders and promote greater devolution of administration and financial authority to local government institutions in regard to hygiene, sanitation and water supply were also the objectives of the study.

The study observes that despite the fact that there have been some bottlenecks in implementing the project activities, it has been successful in creating some significant positive impacts upon its target beneficiaries in respect of access to safe water and access to own and safe sanitary toilet.

I sincerely congratulate BIDS team for conducting the evaluation and successfully completing the report in time. I also thank Ms. Salma Mahmud, DG (Evaluation Sector) along with her professional colleagues for providing guidance and supervisory supports to the BIDS team members throughout the study.

I hope that the findings and recommendations of the study would enrich future management of the HYSAWA Project as well as similar projects of the country.

(Suraiya Begum ndc)
Secretary
IMED, Ministry of Planning

PREFACE

The Evaluation Sector of Implementation Monitoring and Evaluation Division, Ministry of Planning has evaluated "Hygiene, Sanitation and Water Supply (HYSAWA) Project" implemented by Local Government Division, Ministry of Local Government, Rural Development and Co-operatives (MoLGRD&C) from January 2006 - December 2010 with an investment cost of BDT 31631.41 lac. The aim of the project was to demonstrate sustainable hygienic, sanitation and water supply service delivery through local government institutions in consultation with local people.

The evaluation was conducted by the Bangladesh Institute of Development Studies (BIDS). The main objectives of the evaluation study are to i. investigate whether the components of the project were implemented as per DPP; ii. review the present functional status of main inputs/activities; iii. examine whether the provision of PPR-2008 was followed in the procurement process under this project; iv. assess the effects of the project activities and project outcome through employment opportunity of women and v. assess extent of women's participation in development activities.

The findings of the Impact Evaluation Study (IES) were presented in a workshop organized by the evaluation sector of IMED. The workshop was well attended by concerned officials of the ministry, department, agencies and project personnel. Findings of the study indicate that despite some constraints in implementing the project activities, it has some significant positive impacts upon its targeted beneficiaries in ensuring access to safe water and safe sanitary toilet.

I would like to thank BIDS team for conducting the evaluation work and concerned IMED officials for their sincere cooperation to complete the report in time. Thanks are also due to all members of Technical and Steering Committee especially to the Secretary, IMED for providing us valuable advice and guidance I hope that lessons learnt and the recommendations would contribute to improve the quality and effectiveness of the similar projects to be implemented in the near future.

Salma Mahmud
Director General
Evaluation Sector, IMED
Ministry of Planning

ACKNOWLEDGEMENT

The study "Evaluation of the Hygiene, Sanitation and Water Supply (HYSAWA) Project of the Ministry of Local Government, Rural Development and Cooperatives" has been conducted by the Bangladesh Institute of Development Studies (BIDS) for the Implementation Monitoring and Evaluation Division (IMED) of the Ministry of Planning. The study would not have been possible without the active and continuous support from IMED. We are, therefore, thankful to IMED for putting trust on us and for giving us the opportunity to accomplish such an interesting and important assignment. The study team would also like to express its gratitude to the Steering and Technical Committee Members of the study.

We are very thankful to project officials of the then HYSAWA who were extremely generous to give their valuable time and input for the study. We also greatly appreciate the cooperation of the Upazilla WatsSan committee members who were extremely cordial and supportive to the study team members. We are also thankful to the Union WatSan committee members for their participation in the discussion at such a short notice.

We are grateful to community members from both program and control villages for being very cooperative. We would also like to thank the local government representatives who participated in this evaluation as individual and also provided valuable information which otherwise would not have been available.

We highly appreciate the efforts and hard work of all the members of the study team especially the enumerators and the facilitators who had taken real trouble of traveling some really remote and inaccessible areas of the country.

While credit goes to all, errors and omissions are entirely of the study team.

Dr. S. M. Zulfiqar Ali
Senior Research Fellow and
Study Coordinator, BIDS

Contents

ABBREVIATION

CDF	Community Development Forum
CHT	Chittagong Hill Tracts
DPP	Development Project Proposal
FGD	Focus Group Discussion
GoB	Government of Bangladesh
HYSAWA	Hygiene, Sanitation and Water Supply
KII	Key Informants' Interview
LGIs	Local Government Institutions
LGSU	Local Government Support Unit
MDG	Millennium Development Goal
MoLGRD&C	Ministry of Local Government, Rural Development and Co-operatives
NGO	Non-government Organization
PNGO	Partner Non-governement Organization
PPR	Public Procurement Rule
UP	Union Parishad
WatSan	Water and Sanitation
WSS	Water Supply and Sanitation

EXECUTIVE SUMMARY

The Hygiene, sanitation and water supply (HYSAWA) project was sponsored by the Ministry of Local Government, Rural Development and Co-operatives (MoLGRD&C) with the goal of reducing poverty through improved and sustainable public health and environment and reach the MDGs for water and sanitation. Besides this goal, the objectives of this project were to improve hygiene behavior or practices, promote community-led total sanitation and increase the coverage of safe water supply services. At the same time, objectives of the study also included strengthening the capacity of government, local government institutions and non-government stakeholders and promoting greater devolution of administration and financial authority to local government institutions in regard to hygiene, sanitation and water supply.

HYSAWA project was implemented in 200 unions of 3 North Western districts namely Najshahi, Nawabgonj, Noagaon and 146 unions of 6 Coastal belt districts namely Noakhali, Feni, Laksmipur, Barisal, Pirojpur and Jhalokathi. The original project was implemented during January 01, 2006 to December 31, 2010. It was revised and extended upto December 31, 2011. Hence the actual completion period of the project was January 01, 2006 to December 31, 2011 and was financed from GoB, PA and other sources. The total cost of the project was 31631.41 lakh taka of which 3707.28 lakh taka came from GoB and 18771.91 lakh taka from PA. The rest 9152.21 lakh taka was financed from other sources. Under this project, more than 3.0 million people received practical training on hand washing, food and waste disposal, sanitation hygiene and water safety against the target of 1.7 million population coverage. More than 50,000 caretakers of tubewells received training on water safety including collection, preservation and consumption aspects of water safety plan. A total of 626 community sanitation schemes were approved by the project of which 620 were completed by November 2011. About 24000 additional water points was the target of HYSAWA project and another 3000 was aimed through incentive funds for UPs who demonstrated good governance. A total of 27,441 water points have been financed through UPs and completed by the end of the project. This additional water points created access to safe drinking water for about 1.8 million people within North-west and coastal district.

The objectives of the present study include investigating whether the components of project were fully implemented/achieved as per DPP, reviewing the present functional status of major inputs/activities, examining whether the procurement process under this project was

done following PPR'08, assessing the intended effects/outcome of project activities and project outcome through employment opportunity of women and women's participation in development activities.

Keeping the objectives in consideration, and following the Terms of Reference, the study selected 20 percent of unions where HYAWA project has been implemented. Hence, a total of 70 unions were selected (out of 346 unions) which covers 10 upazilas of 7 districts (the whole of north-western districts (3 districts) and 4 out of 6 coastal belt districts). In the first place, we have chosen 10 upazilas randomly from the project areas which span over 7 districts as mentioned earlier. In the second stage, almost all the unions of the selected upazilas were taken into consideration which gave us the total of 70 upazilas.
Form previously selected 70 unions, we have chosen 70 villages – one from each union – from which a total of 700 households have been chosen applying systematic random sampling technique. In addition, 35 control villages have also been chosen from the above 70 unions – one from every two unions – from which 375 households have been chosen applying the same technique.

The study observes that project was implemented fully in terms of numbers but, not quite as per the rules and regulations of the project. Its components were implemented without following the rules properly and taking the needs of the community into consideration in many places. Management and monitoring were also weak in most cases as several agencies were involved in implementing the project. There were coordination problems as well. As the project completed four years ago and project office no longer exists, verification on procurement couldn't be made from the project office, however, the team tried to gather information from the filed level on this, and as it has been found, all procurements and purchases have been done following the Public Procurement Rules (PPR)'08.

Most of the cases UP and Union WatSan Committee did not show active and functional interest to perform project activities. The UP Chairperson and members, who are the major responsible actors at the local levels,have not been able to demonstrate their performance effectively on this that are needed for successful implementation of the project. In some of the unions PNGOs have also lacked direction and experience for implementing hygiene promotion activities as well. The study observes that, there is a prevalence of significant gaps between the desired and actual performances of the Upazila level actors. They did not play

the facilitating roles towards enabling the watsan committees to assess, plan and implementproject activities properly.

Despite the fact that there have been some bottlenecks in implementing the project activities, it has been successful in creating some significant positive impacts upon its target beneficiaries in case of access to safe ware, access to own toilet facility and safe sanitary toilet and increasing awareness related to hygiene practice.

The present initiative of community management in water supply is an innovative process that combined good outcomes with some challenges. The project has been an important intervention to facilitate access to safe water and sanitation and promote good hygiene practices. It has also contributed significantly towards achieving some of it. In order to extract the fuller benefit of it, a modified version of it may be implemented in some of the same and other areas based on proper need assessment. HYSAWA needs to review its pro poor strategy to ensure that it is relevant, effective and meets the needs of the Hardcore Poor. At the same time it needs to ensure the local socio-economic and political context into consideration for proper implementation of this kind of project. For strengthening the local government, capacity building training can be provifed to UPs in procurement and financial management of such kind of big project with efficiency and there should be robust systems for monitoring the activities of UPs compliance to financial and procurement guidelines. Besides, a Strategic Monitoring Manager Officer or Investment Manager should be added to HYSAWA staffing structure for long term strategic montoring of the project. The person recruited would take responsibility for all HYSAWA investments once made. To justify the effectiveness of this kind of project, utilisation of user satisfaction checklist can be filled out/completed and signed by the user of project component after completion of the project. For overall implementation of this kind of project, preparation of a defaulters list of contractors and their exclusion from further short-listing or participation in subsequent tendering procedure needs to be incorporated. At the same time, forwarding the cases of UP default to the HYSAWA Board, Ministry for their advice/action could ensure the proper implementation and further expansion of this kind of project.

Evaluation of the Hygiene, Sanitation and Water Supply (HYSAWA) Project of the Ministry of Local Government, Rural Development and Cooperatives

CHAPTER ONE: INTRODUCTION

1.1 Background

Hygiene, water supply and sanitation in Bangladesh are characterized by a number of achievements and challenges. The share of the population with access to an improved water source was estimated at 98% in 2004 which is a very high level for a low-income country.This has been reached to a large extent through the building of hand pumps with the support of internal and externaldonors. Conversely, in 1993 it was revealed that groundwater which is the source of drinking water for 97% of the rural population and a significant share of the urban population, is in many circumstances naturally contaminated with arsenic.On the other hand, surface water is usually polluted and needs treatment. Taking arsenic contamination into account, it was estimated that in 2004 still 74% of the population had access to arsenic-free drinking water.

Again there is problem of the low level of cost recovery due to low tariffs and poor economic efficiency, particularly in urban areas where revenues from water sales do not even cover operating costs.In rural areas, users contribute 34% of investment costs, and at least in piped water schemes supported by the Rural Development Academy recover operating costs. Hygiene and sanitation faces its own set of challenges, with only 56% of the population estimated to have had access to adequate sanitation facilities in 2010. A new approach to improve sanitation coverage in rural areas, the community-led total sanitation concept that has been first introduced in Bangladesh, is credited for having contributed significantly to the increase in sanitation coverage since 2000.

1.2 Hygiene, Sanitation and Water Supply (HYSAWA) Project

Given this context, the Government of Bangladesh, with support from development partners has undertaken the "**Hygiene, Sanitation and Water Supply (HYSAWA) Project"** in the country.The Government of Denmark through Danida provided assistance since 1972 to the Government of Bangladesh (GoB) in the Water supply and Sanitation (WSS) sector. This technical and financial support was channeled through various agencies and projects; Since June 1999, Danida supported the sector in a more holistic and comprehensive way through the first phase of the Water Supply and Sanitation Sector Programme Support (WSSPS-1). A Second phase, WSSPS-II was planned for a further five-year period starting from January 2006. WSSPS-II had three Components: the Policy Support Component, the WSS Component and the Sector Capacity Building Component. Under WSSPSII, HYSAWA is the part of WSS component which is comprised with Local Government Support Unit (LGSU) and HYSAWA fund[1]. WSS Component and Sector Capacity Building Component consisted of 7 projects and overall programme management (NPD Office). WSSPS-II supported a WSS project in the Chittagong Hill Tracts (CHT), titled the CHT HYSAWA Fund. The present 'Hygienic Promotion, Sanitation and Water Supply Project (HYSAWA project) was project under the WSS Component of the WSSPS-II. The HYSAWA project promoted Union Parishad (UP) based investments focusing on the poor, un-served and under-served areas. Funding for the interventions was channeled through a dedicated 'HYSAWA Fund' under the project.

Components of the Project

- Installation of 300 Community sanitation at districts in coastal belt areas;
- Introduction of 69 Environment Packages (per urban) in 3 north western districts;
- Installation of 6000 Deep Hand tube well (1000ft.Deep) at coastal belt;
- Installation of 15364 'Deep set pump tube well (250-300) ft. Deep) at NW districts;
- Installation of 87 pipe scheme at NW districts;
- Installation of 129 Rain water Harvesting System (community level) at coastal belt;

[1]IMED (2011) 'Indepth Monitoring Report HYSAWA Project',Ministry of Planning, Governement of Bangladesh.

- Installation of 60 pond sand filter at coastal belt; and
- Installation of 15 Iron/Arsenic removal unit at coastal belt.
- Installation of 13 and 100 other alternative water supply option at NGO and Coastal belt area.

Short Summary of the Project

The Hygiene, sanitation and water supply (HYSAWA) project was sponsored by ministry of Local Government, Rural Development and Co-operatives (MoLGRD&C) with the goal of reducing poverty through improved and sustainable public health and environment and reach the MDGs for water and sanitation. Besides this goal, the objectives of this project were to improve hygiene behavior or practices, promote community-led total sanitation and increase the coverage of safe water supply services. At the same time, strengthen the capacity of government, local government institutions and non-government stakeholders and promote greater devolution of administration and financial authority to local government institutions in regard to hygiene, sanitation and water supply.

HYSAWA project was implemented in 200 unions of 3 North Western districts namely Najshahi, Nawabgonj, Noagaon and 146 unions of 6 Coastal belt districts namely Noakhali, Feni, Laksmipur, Barisal, Pirojpur and Jhalokathi.

The original project was implemented during January 01, 2006 to December 31, 2010. Then it was revised and extended upto December 31, 2011. Hence the actual completion period of the project was January 01, 2006 to December 31, 2011 and was financed from GoB, PA and other sources. The total cost of the project was 31631.41 lakh taka of which 3707.28 lakh taka came from GoB and 18771.91 lakh taka from PA. The rest 9152.21 lakh taka was financed from other sources.

Under this project, more than 3.0 million people received practical training on hand washing, food and waste disposal, sanitation hygiene and water safety against the target of 1.7 million population coverage. More than 50,000 caretakers of tubewells received training on water safety including collection, preservation and consumption aspects of water safety plan. A total of 626 community sanitation schemes were approved by the project of which 620 were completed by November 2011. About 24000 additional water points was the target of HYSAWA project and another 3000 was aimed through incentive funds for Ups who demonstrated good governance. A total of 27,441 water points have been financed through Ups and completed by the end of the project. This additional water points created access to safe drinking water for about 1.8 million people within North-west and coastal district.

Objectives of the Project:

The goal of the project is to contribute to the government's policy to reduce poverty through improved and sustainable public health and environment and reach the MDGs for water and sanitation.The development objective of the project is: *To demonstrate sustainable hygienic, sanitation and water supply service delivery* through local government institutions in consultation with local people. The immediate objectives of the project are:

- To improve hygienic behavior/practices;
- To promote community-led total sanitation;
- To increase coverage of safe water supply services;
- To strengthen the capacity of Government, Local Government Institution (LGIs) and non-government stakeholders at all levels to play the roles required to achieve the above three immediate objectives; and
- To promote greater devolution of administrative and financial authority to local Government institutions in regard to hygienic, sanitation and water supply.

Coverage of project components/activities by geographic area is presented in the following Matrix.

Coverage of Project Components byArea

Components of the Project	Area	Probable outcomes/impacts
1. Community Sanitation	Coastal Belt Districts	Achieving awareness on sanitation and hygiene practices and total sanitation as well
2. Environment Packages in the peri Urban areas	North Western Districts	Achieving total sanitation in peri-urban areas
3. Deep Hand Tube well (1000ft.deep)	Coastal Belt Districts	- Increased access to safe, functional and adequate water supply - Increased access to and use of hygienic sanitation - Reduced water-borne diseases - Employment created,
4. Deep set Pump Tube well (250-300 ft. deep)	North Western Districts	
5. Mini Piped Scheme	Coastal Belt Districts	
6. Pipe Scheme	North Western	

	Districts	especially for the women - Women participation increased - Community management enhanced
7. Rain Water Harvesting System (community level)	Coastal Belt Districts	
8. Strengthening the capacity and devolution of power	All above	Capacities at all levels and devolution of power

1.3 Objectives and Scope of the Study

Given the above, it is important and timely to have as assessment of the HYSAWA project whether the project components have been implemented properly or not; and whether and to what extent the project have been able to make positive impact upon its beneficiaries. Keeping this in perspective, the objectives of the current assignment include the following:

- To investigate whether the components of project were fully implemented/achieved as per DPP and reasons for lapses and deviation.
- To review the present functional status of major inputs/activities at different areas and reasons for deviation and bottlenecks, if any.
- To examine whether the procurement process under this project was done following PPR'08.
- To assess the intended effects/outcome of project activities at different NW districts, Coastal Belt and NGO funded areas with respect to reducing:
    - Incidence of water borne common diseases;
    - Incidence of arsenic related diseases in the project and control areas;
    - Medical cost of women and children due to water borne diseases;
    - Loss of working days due to ill health;
    - Loss of school days for children; and
    - Time for fetching water from a longer distance.
- To assess the impact of project activities in increasing awareness of health practices, employment opportunity of women, self-employment, women's participation in development activities, impact on environment, sustainability of the project and

overall community management of water points as well as overall socio-economic betterment and poverty status of the rural community particularly women's involved in IGAs.

- To assess the extent of the institutional capacity of the Government, local government institutions and NGO as well as devolution of administrative and financial authority by local government institutions towards management of hygienic, sanitation and water supply. Capacity building of NGOs and the households will be given due priority in the assessment.
- To suggest recommendations for safer, easily accessible, affordable, sustainable management of water supplies and sanitation facilities to the rural community and identify the best practices which could be replicated in other needed areas of the country.
- To suggest how to replicate the project if it is found to be a good model with its accessible, affordable and sustainable features.

Scope of the Study

With the objectives outlined above, the study has three major sub-components: (i) assessment of impacts; (ii) review of the implementation of project components and activities; and (iii) review of the capacities of the communities and local government institutions. Components (ii) and (iii) have been addressed through reviewing various documents and reportsas well as carrying out interviews with the Project, LGIs and respective other officials. Component (i) has been addressed through carrying out a primary survey (both quantitative and qualitative). Objectives of the project and the study, broad indicators taken into consideration, sources of verification and probable respondents are presented in the following matrix.

1.4 Evaluation Challenges and Limitation of the Study

This study faces few challenges during the evaluation period, which impose a certain limitation over our study. The limitations of the study relates to the challenges during evaluation time that may impacted or influenced the interpretation of the results of the study.

- ✓ This face of the project completed almost four years ago.
- ✓ Project under evaluation doesn't exist anymore as it has already been completed.
- ✓ Overlapping with HYSAWA fund project in some of the sampled upazilas, i.e. Babuganj, Gaurnadi in Barisal district.

Table 1.1: Objectives, Verifiable Indicators, Means of Verification and the Respondents

Objectives	Indicators	Sources/Means of Verification	Respondent
1. To investigate whether the components of the project were implemented/ achieved as per DPP	Delivery of the inputs, timeliness, area coverage, reaching the beneficiaries	Project documents, KIIs	Representatives of respective agencies, Upazila WatSan Committee
2. Review the present functional status of major inputs/activities	Activities undertaken, progress, current status	Project documents, KIIs	Representatives of respective agencies
3. Examine whether the procurement process was done following PPR'08	Goods/services procured, time of procurement, processes of procurement	Procurement documents, KIIs	Project officials
4. Assess the intended effects/outcome of project activities among its beneficiaries to ensure increased coverage of safe water supply	Access to safe water supply, incidence of water borne diseases, of arsenic related diseases, medical cost of women and children due to water borne diseases, loss of working days due to ill health, etc.	Household survey and FGD	Sample households
5. Assess the impact of project activities in increasing awareness on health/hygiene practices, employment opportunity, women's participation in development activities, etc.	Hygiene practice, employment creation, women's employment, women's participation	Household survey and FGD	Sample households
6. Impact on environment, sustainability of the project and overall community-led total sanitation as well as overall socio-economic betterment and poverty status of the community	Access to and use of hygienic sanitation, community-based management of water points, community welfare, improvement in poverty status	KII, FGD, Household Survey	UpazilaWatSan Committee, PNGOs, Community Representatives, Sample household

Objectives	Indicators	Sources/Means of Verification	Respondent
7. Assess the extent of the institutional capacity of government, local government institutions, NGO, and the beneficiaries and devolution of administrative and financial authority	Training for local government institutions and NGO staff, and the community members and devolution of authority	KII and FGD	Project officials, UpazilaWatSan Committee, PNGOs, LGIs and Community Representatives
8. Suggest recommendations for safer, easier accessible affordable, sustainable management of water supplies and sanitation facilities	Recommendations and suggestions	Based on all above	Based on all above

CHAPTER TWO: ANALYTICAL FRAMEWORK AND METHODOLOGY

2.1 Research Questions

To assess the implementation and impact of the project under consideration, we need to seek answers of the following questions:

- What were the main as well as immediate objectives of the project?
- Which particular areas and groups of people were targeted and how would the project affect those groups?
- What are the differences within and between the groups of households which might lead them benefiting from the project in different ways and how could these be addressed?
- What types of impacts would the project activities have, in particular for the vulnerable groups identified?
- If the project activities have positive effect, how these positive effects are achieved and how they could be improved further?

2.2 Issues and Indicators

To address the above mentioned questions, the following issues and indicators will be taken into consideration in the present study:

Issues	**Indicators**
Access to safe water	• Adequate, safe and sustainable drinking water supply facility • Households having access to safe water • Time for fetching water from a longer distance
Total sanitation	• Access to hygienic sanitation • Use of hygienic sanitation • Practice of washing hands with soap/ash before handling food • Practice of washing hands with soap/ash after

	defecation • Knowledge, awareness and practices about hygiene
Improvements in health	• Sufferings of people and children from diarrhea, other water borne and related diseases • Extent of Arsenic related diseases in the selected areas • Expenditures on medical cost, especially for women and children due to water borne diseases • Loss of working days due to ill health • Loss of school days for children due to illness
Capacity building at all levels (government, LGIs, NGOs and community)	• Employment creation, especially for the women • Training provided • Training received • Devolution of power at the local levels
Sustainability and replication	• Financial sustainability • Management sustainability • How appropriate the facilities are • How successful the project activities are

2.3 Analytical Framework

Assessment of impacts of any intervention on the target beneficiaries requires both quantitative and qualitative information with emphasis on the former due to the techniques of measurement and other related indicators. The study, therefore, entails both statistical and econometric exercise using cross-sectional data. In the former, comparisons of achievements have been made between the experimental and the control groups. The summary indicators broadly correspond to hygiene practice, water supply and sanitation, along with household level indicators like education of the household members, health status, disease prevalence, employment, asset and income, etc. These indicators have been compared across groups of respondents by the nature of their background characteristics and whether participating in the

project (i.e., beneficiary) or not (i.e., control). In addition to this quantitative approach, qualitative methods have also been used to understand the processes.

The evaluation has been carried out keeping the initial goals and objectives in perspectives. It has been carried out in several steps. First, the inputs given into the process of implementation of the project has been taken into consideration. Second, outputs achieved against original plan that are quantifiable have been looked into. Third, the processes through which the project activities have been implemented have been critically reviewed. And, fourth, attempts have also been made to investigate the overall outcomes of the project at the beneficiary, community and macro level. The diagram below presents the framework of the proposed evaluation.

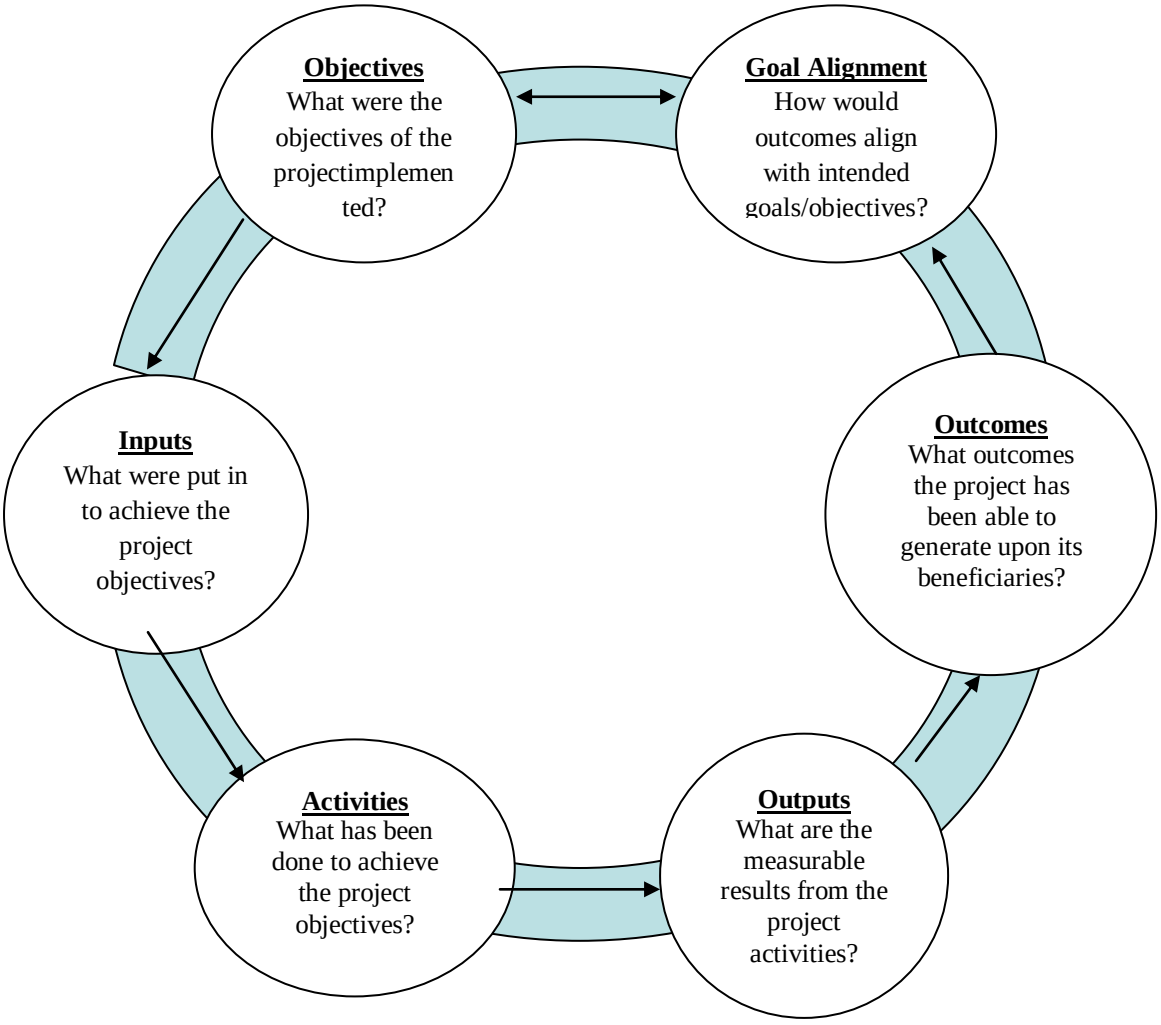


Figure 1: Framework of the Proposed Evaluation.

Measuring the Program Impact

A program's effect can be measured accurately only if one knows what would have happened without it. Because one obviously cannot observe the outcomes for the participants themselves had they not enrolled in the programme, a proxy group of non-participants must therefore be identified. Determining this hypothetical non-treatment (or counterfactual) state is the crux of designing an evaluation exercise. The study therefore collectedinformation for groups/households in both the treatment and the control areas. This has enabled us to measure the size of the impact by comparing post program outcome indicators with pre-program outcome indicators, and also match comparisons in which the post-program behavior of the participants is compared with the behavior of a group of individuals who were similar to the participants before they enrolled in the program. Hence, this compares the outcomes before and after HYSAWA interventions among a group benefited by the project (i.e., experimental group) to a group not benefited by the project (i.e., control group).

Interviewshave been carried out among the households of both groups through structured questionnaires. In addition, the researchers have visited the study areas, identified key informants and conducted in-depth open-ended interviews to gather data related to socio-economic characteristics of the project areas. Furthermore, Focus Group Discussions (FGDs) have also been carried with with the key stakeholders.

2.4 Sampling and Coverage

It goes without saying that the impact assessment survey coverage must be of adequate size, relative to the goals of the study. It must be large enough so that an effect of such magnitude is of statistical significance. It is just as important, however, that the coverage should not be too big, where an effect of little scientific importance is too statistically burdensome. Sample size is important for economic reasons as well. An under-sized study can be a waste of resources for not having the capability to produce useful and representative results, while an over-sized one uses more resources than are necessary.

Keeping this in consideration, and following the Terms of Reference, the study selected 20 percent of unions where HYAWA project has been implemented. Hence, a total of 70 unions were selected (out of 346 unions) which covers 10 upazilas of 7 districts (the whole of north-

western districts (3 districts) and 4 out of 6 coastal belt districts). In the first place, we have chosen 10 upazilas randomly from the project areas which span over 7 districts as mentioned earlier. In the second stage, almost all the unions of the selected upazilas were taken into consideration which gave us the total of 70 upazilas.

Sample size determination

There are several approaches to determining the sample size. However, probably the most suitable and widely used sample size determination process for household surveys considers a simple but efficient way. In this approach, one first specifies two critical considerations: (i) desired width of a confidence interval; and (ii) the level of certainty with which inference can be drawn about the population characteristics.

Based on the above, the sample size (n) can be determined using the following formula:

$$n = \frac{Z^2 * (p) * (1 - p)}{d^2} \qquad (1)$$

where,

Z = Z value (e.g. with a normal distribution the value is 1.96 for the 95% confidence interval)

p = target parameter (70% in this case).

d = precision level.

Now, given that the 95 percent confidence interval is most widely used and given that the 5% level of significance is recognized as fairly precise (we have however used here even less than 5%, i.e, 3% level of significance), we work with a sample of 1,075 households (considering design effect at 1.2 in this case) from both the project and control households from the selected unions. Detailed list of selected unions is presented in Annex-2.

Selection of Households

Form previously selected 70 unions, we have chosen 70 villages – one from each union – from which a total of 700 households have been chosen applying systematic random sampling technique. In addition, 35 control villages have also been chosen from the above 70 unions – one from every two unions – from which 375 households have been chosen applying the same technique. Control villages/communities are chosen from the same/neighbouring union parishad which possess the common socio-economic characteristics

to that of program villages/communities. Hence a total number of 1075 households are selected for this impact study. The number of sample districts and upazilas are shown in Table 2.1.

Table 2.1: Number of Sample Districts, Upazilas and Unions by Division

Division	Sample Districts	Sample Upazilas	Sample Unions	Sample Villages	No. of Respondents	
					Program	Control
Chittagong	2	4	25	37	10 x 25 = 250	11 x 12 = 132
Rajshahi	3	4	25	39	10 x 26 = 260	11 x 13 = 143
Barisal	2	3	20	29	10 x 19 = 190	10 x 10 = 100
All	**7**	**11**	**70**	**105**	**700**	**375**

Household Survey has done in the sampled upazila based on systematic random sampling technique. For applying the systematic random sampling, a list is prepared of all households in a village. Then a systematic random sampling technique[2] is applied to select the pre-determined sample from that list.

In addition, a total of 20 FGDs and 20 KIIs have also been carried out to collect information in addition to household survey.

Focused Group Discussions (FGDs) are carried out with the respondents from the associated villages/communities and beneficiaries of HYSAWA project. A total of 20 FGDs are carried out in selected upazila to collect information in addition to collecting data from household surveys. Focus group discussions are carried out with 10-12 participants in each.

Key Informants Interviews (KII)are also carried out with project officials, the representatives from the project Office, Chairman and memebers of Upazila and Union watsan committee. A total of 20 KIIs (excluding interviews with the project officials) are carried out to collect information.

Besides, review of all relevant documents of this project plays an important source of information behind this evaluation.

[2] In systematic random sampling, the researcher first randomly picks the first item or subject from the population. Then, the researcher will select each n'th subject from the list.

CHAPTER THREE: IMPLEMENTATION STATUS OF THE PROJECT

3.1 Implementation Status

The HYSAWA Project places Union Parishad (UP) in the driving seat with participation of the community to involve in planning and deciding on choice of service level. The Union Parishad plays the role of monitoring and facilitating initiative of HYSAWA activities. The capital grant is to stimulate community participation and ensure community ownership of water supply and sanitation administered by the UP.

Since the HYSAWA is a large scale investment project and direct funding to UPs, in order to manage and supervise the community based water supply and sanitation schemes the UPs management capacity shall be enhanced. Accordingly, the traditional attitude of the UPs in implementing development projects/ schemes needs to be changed so that the community can better play their expected roles through the process of community management. Hence the central approach follows the establishment and functioning of Community Development Forums (CDF). This forum takes the lead role for accessing and managing safe water supply with the help of partner NGOS (PNGOs). But it's the union WATSAN committee who monitors and supports the overall activities of the project. Moreover; the primary thinking is that the community people will take over the operation and maintenance functions including monitoring of the installation points.

For implementation of safe water access promotion, the union watsan committee is supposed to forms a water point management committee taking representatives from each poor households of the cluster where there is scarcity of safe water for want of tube well. As water point installation is highly subsidy backed and meant for the poor clusters, committee encourages the deserving households to select a common site for the installation and collect the participation cost as determined by the NGO for payment and get the delivery from the NGO selected supplier of the hardware. The water point management committee is also responsible for selection of one male and a female caretaker for each water point who will be trained on the technology so that the installation remains running round the year.

Study reveals that in most of the cases UP and Union WatSan Committee did not show active and functional interest to perform their assigned roles and responsibilities. Committee fails to show their recording of regular meeting, agendas and decisions that have been made. Even

this committee didn't take active action against the measurement flaw that has been revealed by upazila engineer during his random cross checking of actual depth of tubewells as reported by some of the chairman of upazila watsan committee. As they are not accountable to any one and there is no one to oversee their activities, this committee seems inactive in the whole process. But UP Chairmen and members are highly involved in the selection of beneficiary and placement of water sources. It is informed by the beneficiaries that siting of tubewells and water points favours the most influential rather than the neediest. Most of the cases the hard core poor are exempted from project benefit as they fails to deposit the cost sharing money. Even though in some of the unions they are able to contribution the money, they fail to get the access of water point due to lack of influential power.

Most of the water points are placed without following the project criteria. In some areas there are more than one tubewell placed in cluster without justifying the community demandand need where as in some remote places a large community is sharing a single tubewell. Peoplein remote areas are coming from far distance to collect the drinking water. Not only that they are maintaining a long serial and waiting for a long time to collect sufficient water according to their daily need.

Direct observation and conversation of the community reveals that in some cases there is no selection for placement of water point or tubewell. People those who are able to contribute the required money, get project tubewell. As individual deposits the money, he gets the water point in his corridor of house which is in many cases inaccessible for the community. In some of the places water points are surrounded by wall. So, only one household is benefited from project tubewells, which is against the norms of community development initiatives.

Continued and efficient operation and maintenance is an important issue for ensuring thelong-run sustainability of the benefits of HYSAWA activities.There is no budget in the project for capital replacement. However, two caretakers,one male and one female, are trained to maintain the installed water points. In addition, twomechanics from each UP are expected to receive training to create easy access to maintenance facility, which is assured to the beneficiaries during the installation of the water point. But in most of the unions the concept of providing mechanics is absent. Some of the tubewells turns to be inactive after 3 months of their installation. Hence, the water sources turn to be inactive after 3 months. Even there is no maintenance of the public toilets placed in market places and mosques under this project.

It is quite interesting that HYSAWA provides a tool kit box to all beneficiaries for necessary repair of tubewells. There are two ranges and onescrew driver, one plier driver in that kit box. Beneficiaries mention that those ranges do not even fit with the screws of the tubewells. Hence, the total tool kit box remains useless as reported by the beneficiaries. Beneficiaries also reported that although people share the cost of community tubewell, nobody wants to share the cost for its maintenance. Therefore, HYSAWA tubewell turns to be an overburden for the person by whose name the tubewell is issued in many instances.

Community contribution for the setup of water points is a major cause of concern. The contribution money relates to total cost of water point and its setup arrangements. As reported the percentage varies from 10 to 20 percent depending on the economic condition of the beneficiary and the amount varies from min Tk. 2300 to Tk. 8400 where it is difficult to find any relation between the contributed amount and economic condition of the beneficiary. According to project monitoring officers of HYSAWA, community should contributeonly 10 percent of total cost which should be defined by the community development forum (CDF) based on willingness and ability to pay of selected beneficiaries. But there is no defined criteria of how much the poor and non-poor will contribute in a community to accumulate the contributing 10 percent money. In most of the cases the CDF is inactive and the union Watsan committee defines and collects the money according to their self-defined criteria. This is the one of the main areas of flaws in the project which promotessome irregular practices as well.

Some of the Community representatives share that it takes a lot of time to convince community people to take-up ownership of the tube-well by contribution of the money. But even once they are agreed, due to high price of contributing money most of the hard core poor are now reluctant to participate in the program. They report that they didn't find any justification behind determination of the contribution money. Even in some of the cases the Watsan Committee fails to give proper answer for the criteria of determining the money they are demanding in the name of community contribution. Some of the beneficiaries complain that they shared the contributing amount and accumulated it. Then the Watsan committee collects the money for providing tubewell. But so far they did not get the tubewell, they didn't get the money back either.

Another major cause of concern is the training provided for hygiene promotion. Survey reveals that hygiene promotion/hygiene interventionactivities being too few. It has been

hampered by the lack of information, education and communication tools and materials, and by a lack of a clearly defined strategy and framework for implementing hygiene promotion. PNGOs give on an average two days of training on hygiene practice but it only limits to the families who receive the project tubewell. Hence, the training is not a community based participation and promotional program. Some of the training recipient informs that they are already aware of the hygiene practice guideline provided in training from television and radio promotion. Hence, it does not add any value with their regular practice. Furthermore, Participants from various Focus Group Discussions reveal the truth of not having any PNGOs in some particular unions. In some of the unions PNGOs have lacked direction and experience. This is a significant weakness in the programme, especially the priority given to hygiene promotion under HYSAWA.

3.2 Procurement under the Project

The UPs are responsible for fund management at the field level and also for the procedures for planning, budgeting, monitoring and implementation at the field level. Procurementand purchase under this project relates to purchase of water and sanitation components only. According to UP chairman and project monitoring officer all procurements have done in compliance with the Public Procurement Rules (PPR) of GoB. Procurement has done on the basis of competitive bidding.

CHAPTER FOUR: SOCIO-ECONOMIC CHARACTERISTICS OF SAMPLED HOUSEHOLDS

This chapter represents a discussion of socio-economic conditions of the sampled households. We continue the discussion between program and control households using selected number of parameters.

Profile of survey households

We start our analysis with some basic characteristics of the survey households i.e. gender and educational status of household head, average income and expenditure per household to have some general idea about the socio-economic condition of these households. It has been seen from table 4.1 that the gender distribution of household is almost similar between program and control village considering gender of household head. Most of the household heads turn out to be males.In program households, 92 percent of the households are headed by male while only around 8 percent are headed by female. On the other hand, in control village around 95 percent of the households are headed by male while only 5 percent are headed by female.

4.1: Distribution of Households by Gender of Household's Head

Gender of Household's Head	Program		Control	
	Number	Percentage	Number	Percentage
Male	710	92.3	331	94.6
Female	59	7.7	19	5.4
Total	769	100	350	100

Distribution by occupational status of respondents is given in Table 4.2. About one-fourth of household head of program and control villages are farmer while slightly over one tenth of them are no agri-labour and engaged in small business. Besides,a sizeable proportion is working as agricultural labour both in program and control villages.

4.2: Distribution of Households by Main Occupation

List of Occupation	Program		Control	
	Number	Percentage	Number	Percentage
Farmer	199	25.9%	93	26.1%
Agri-Labour	70	9.1%	53	11.0%
Non Agri-Labour	78	10.1%	32	9.8%
Service	67	8.7%	18	7.6%
Petty Profession	34	4.4%	16	4.5%
Small Business	96	12.5%	46	12.7%
Medium/Big Business	69	9.0%	19	7.9%
Doctor/Lawyer/Teacher	9	1.2%	8	1.5%
Rickshaw/Van/Car Driver	32	4.2%	21	4.7%
Unemployed	42	5.5%	17	5.3%
Others	73	9.5%	27	8.9%
Total	769	100%	350	100%

If we look at Table-4.3, we see that about one third of household heads are illiterateand do not have any formal education both in program and control village. Illiteracy among beneficiaries is expected, but what issurprising is that about 50 percent of the household head in sampled villages have the education level upto class nine pass while only 3 percent have education level equivalent to honours and above (Table 4.3).

4.3: Distribution of Households by Level of Education of Household's Head

Level of Education	Program		Control	
	Number	Percentage	Number	Percentage
No Education	227	29.5%	102	29.1%
Class I to V	231	30.03%	122	34.85%
Class VI to IX	173	22.50%	69	19.71%
SSC	76	9.9%	39	11.1%
HSC	37	4.8%	9	2.65
Honors	18	2.3%	7	2.0%
Masters	7	0.9%	2	0.65%
Total	769	100%	350	100%

In case of income earnings, households derive their incomes from agriculture, wages and salaries received in exchange for labor and small business. Agriculture earnings come from sources like agricultural production, livestock and poultry rearing and fish cultivation and catching. Around 22 of household income come from this major source. 30 percent come from wages (agri and non-agri) and 11 percent from small business. For control households, about 20 percent of household income receives from sources relates to agriculture, 26 percent receive in the form of wages and 11 percent from small business (Table 4.4).

Table 4.4: Main Income Earning Source by Program participation

Income Sources	Program		Control	
	Number	Percentage	Number	Percentage
Agriculture	165	21.5%	69	19.7%
Rearing Livestock	2	0.3%	3	0.9%
Rearing Poultry	2	0.3%	0	0.0%
Agri-wage	79	10.3%	60	17.1%
Non agri-wage	82	10.7%	31	8.9%
Petty Profession	41	5.3%	21	6.0%
Rickshaw/Van Puller	38	4.9%	24	6.9%
Small Business	84	10.9%	46	13.1%
Medium/Big Business	75	9.8%	19	5.4%
Service	92	12.0%	24	6.9%
Foreign Remittance	69	9.0%	32	9.1%
Gift	8	1.0%	2	0.6%
Other	32	4.2%	19	5.4%
Total	769	100%	350	100%

Findings from Table 4.5 suggest that the average monthly income of program households (Tk. 10789.86) is slightly over 11 higher (11.42%) than that of control households (9556.86); while the average monthly expenditure is 9.26 percent higher for program compared to

control households. The mean difference[3] of the selected outcomes between program and control village shows that there is significant difference between income and expenditure of control and program households which confirms that beneficiaries are better off than non-beneficiary households. The detail table of income and expenditure are presented in Annex-1 as additional tables.

Table 4.5: Household's Monthly income and Expenditure

Monthly Income	Participants		Mean Difference
	Program	Control	
Average Income	10789.86	9556.86	1233 (0.02)**
Average Expenditure	8999.87	8166.11	833.76 (0.016)**

Note: *All values of mean comparison test are statistically significant at 5 % level.
*p values of mean comparison tests are given in the '()'.

The food security status of households shows that control households are suffered from always food deficit compared to program households. Besides, around 39 percent of program households have food surplus year round while only 35 percent of control household belong to this surplus category (Table 4.6).

Table 4.6: Food Sufficiency Status of Household

Security Status	Program		Control	
	Number	Percentage	Number	Percentage
Always Deficit	120	15.6	91	26.0
Sometimes Deficit	148	19.2	56	16.0
Neither deficit nor surplus	200	26.0	80	22.9
Surplus	301	39.1	123	35.1
Total	769	100	350	100

[3] Mean difference test is the t tests on the equality of two group's means to determine if the difference between the groups is statistically significant, that is, if the difference is due to something other than random chance.

CHAPTER FIVE: IMPACT OF HYSAWA ON ITS BENEFICIARIES

HYSAWA applies community level implementation strategies to build community capacity to plan, implement, operate and maintain the schemes. This strategytries to ensure equity-based representation of poor, women, disadvantages groups and general members of the community.

Water is life. Thus, acute water crisis have created a strong demand for deep tube-well water supply in NW and Costal belt region. Community people reported that from their past water crisis days, they are aware of the realistic needs assessment of the resources needed to keep the water system functioning. Considering the pitfalls of the project implementation mentioned in the previus section, the community people described how they have been benefited through the HYSAWA project.

5.1 Impact on income raising opportunities

The women describe how their income raising opportunities have been improving after program participation. They now have more time to take caring of children, managing household's activities easily, take care forpoultry, weaving baskets, and sewing more clothes. The men appreciate that they can workmore hours in the fields as there is no concern of collecting water for agricultural activities. This has enabled them to save their valuable time andinvest that time in additional activities to expand their income generating activities.

Improved accesses to adequate quantities of safe water have result in:

- Time savings (for women and young girls who carry water to the household)
- Greater production of home gardening
- Improved child care
- Strengthened economic activities (food preparation, cow/pig brewing, cultivation. handicrafts, working at the field)
- Girls and children are attending school more regularly.

5.1 Impact on Raising Health Benefits

The FGD findings reveal that the health status of the people of the communities has been improvedas a result of better access to clean and safe water. Women spoke of reduced incidence ofwater related diseases, such as diarrhoea, dysentery, and skin diseases, as well as, cold, typhoidand fever etc.

Access to clean water has also contributed to improving women's personal hygiene. Thereare also additional financial savings as a result of the decrease in moneys spent on medicines and *treatment.* Moreover, in some case it has seen that waste water of the tube-well is going to nearest home gardening. The overall improvement can be summarized as:

- Availability of safe water to drink
- More frequent bathing and hand washing
- More frequent laundering of clothes
- Improved domestic cleanliness and household sanitation practices
- Prevention of fecal contamination of household environment
- Reduces illnesses among under 5 children as well

In addition, household survey also reveal that better utilization of safe water, hygienic practices andhealthy sanitation facility improving people's health status through:

- ✓ Decreasing of water-borne diseases (diarrhoea, dysentery)
- ✓ Decreasing of water-washed diseases (skin infections related to lack of cleanliness)
- ✓ Decreasing of water-based disease vectors (Arsenic, malaria, dengue)

The result from household survey identifies the evidence of spillover of illnessontohousehold members′. Around 75 percent of households in program and control village suffered from different kinds of illness during the last 6 months (Table-5.1).

Table 5.1: Whether any member of household was ill during the last 6 months

Response	Program		Control	
	Number	Percentage	Number	Percentage
Ill during last 6 months	580	75.4	262	74.9
No one ill during last 6 months	189	24.6	88	25.1
Total	769	100%	350	100%

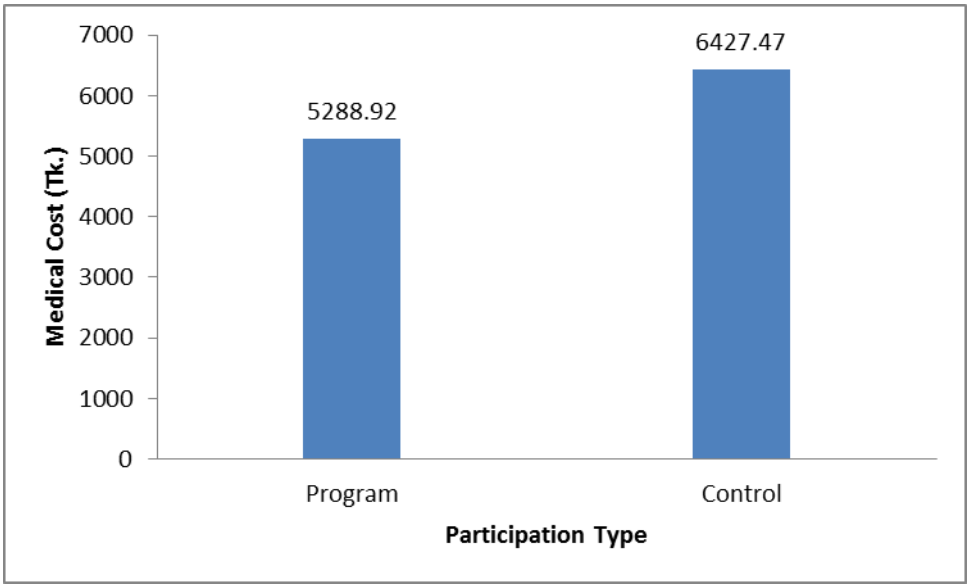
The study identifies that majority of the households in program and control village suffer from general fever and cuff. Besides, respondents report stomach pain and acute that assessed the economic costs of all illnessesaffecting households. 9 percent of the households report to suffer from diarrhoea both in program and control village.

Table 5.2: Type of Illness faced by member of household during the last 6 months

Type of Disease	Program	Control
General (fever/cuff)	47.23	42.47
Diarrhoea	9.73	9.14
Arsenic related	1.22	0.49
Typhoid	2.99	3.7
Jaundice	3.43	3.7
Stomach pain	10.84	13.83
Acute disease	10.18	15.56
Other	14.38	11.11
Total	100	100

To capture the cost of illness, we try to calculate both direct and indirect cost related to illness. Figure 5.1 summarizes the main variables relevant to the analysis of illness costs. The direct costs of illness refer to all household expenditures linked with seeking and obtaining treatment, including medical and non-medical expenses such as transport or special foods. We see that control households expend more for medical treatment due to illness compared to program households.

Figure 5.1: Expenditures on medical cost by Participation category



Indirect costs of illness are defined as the loss of productive labour time due to illness, for both patients and caregivers. The scope of indirect costs includes loss of working days and loss of school days for children due to illness. Table 5.3 shows that members of control households lose more working days and children lose more school days due to suffering of different illness.

Table 5.3: Loss due to ill health by Participation Category

Participation Type	Total No. of ill person	Totally lost working days	Total No. of ill Children	Totally lost school days
Program village	1.16	14.56	1.34	11.41
Control village	1.16	16.24	1.43	12.47
Total	1.16	15.64	1.37	11.79

5.3 Increased Access to Safe Water

Access to sate ware has increased significantly among the beneficiary households compared to that of the control households. While only about 60% of the control households have access to safe water sources, it is about 86% for the beneficiary households.

Table 5.4: Access to Safe Water

Main Source Of Drinking Water	Program		Control	
	Number	Percentage	Number	Percentage
Piped /Tap water into dwelling	13	1.7%	4	1.1%
Public tap(Community)	0	0.0%	2	0.6%
Tube well into dwelling	210	27.3%	128	36.6%
Community Tube well	437	56.8%	83	23.7%
Surface water (river, dam, lake, pond, stream)	3	0.4%	1	0.3%
Others	106	13.8%	132	37.7%
Total	769	100.0%	350	100%

There are also significant differences in the distances of water points from household between the beneficiary and control households. While the average distance of water points is about 100ft for the beneficiary households, it is about 200ft for the control households.

Table 5.5: Average Distance of water source from home

Participation Category	Meter
Program	34.38
Control	64.97
Total	43.95

Consequently, time requirement to fetch water is also significantly higher for the control households compared to that of the beneficiary households. In response to a question whether the water supply is adequate from the source or not, an overwhelming majority of the beneficiary (87.5%) reported that this as adequate as against of only 51.3% for the control households.

Table 5.6: Average time required to collect water from home

Participation Category	Minutes
Program	9.00
Control	12.49
Total	10.22

Table 5.7: Whether water supply is adequate from the source

Is it Sufficient	Program		Control	
	Number	Percentage	Number	Percentage
Sufficient	673	87.5	238	68.0
Insufficient	96	12.5	112	32.0
Total	769	100	350	100

5.4 Access to Sanitary Toilet

In respect of access to sanitary toilet, some differences have also been noticed (though not to the extent of the cases of access to safe water). While about 93% of the project beneficiaries have own toilet, the corresponding figure for the control households is 87%. Also, while access to pit/water sealed sanitary toilet is about 46% for the beneficiary households, it is only 31% for the control households. In respect of distance, not much difference is observed between them.

Table 5.8: No of Households having own latrine by Participation Category

Whether HH has own Latrine?	Program		Control	
	Number	Percentage	Number	Percentage
Has own latrine	711	92.46	305	87.14
Don't have own latrine	58	7.54	45	12.86
Total	769	100	350	100

Table 5.9: Types of Latrine used by Participation Category

Type of Latrine	Program		Control	
	Number	Percentage	Number	Percentage
Pit Latrine	95	13.36	43	14.10
Sanitary (water Sealed)	230	32.35	51	16.72
Sanitary (not water Sealed)	286	40.23	156	51.15
Unsealed/hanging latrines	97	13.64	55	18.03
Others	3	0.42	-	-

Table 5.10: Distance of Defecation palace by Participation Category

Distance	Program	Control	Mean Difference[4]
Avg Distance (Meter)	28.24	33.58	-5.37 (0.19)

* Note: p value of significance level is in the parenthesis and the value is statistically insignificant.

5.5 Hygiene Practice

While about 41% of the beneficiaries reported that they received training on hygiene practices, it is only about 13% for the control households. However, when we investigated about actual hygiene practice at the household level, we observed no significant differences in hygiene practice between the beneficiary and the control households. In respect of washing

[4] Mean difference test is the t tests on the equality of two group's means to determine if the difference between the groups is statistically significant, that is, if the difference is due to something other than random chance.

hands before meal and after defeacation, and also about materials used for washing, no signifant differences are observed. This means that the project has not been able to make significant impact on improving hygienic practices among its beneficiaries.

Table 5.11: Have you been participated in any training on hygiene?

Response	Program		Control		Chi-sqare Test[5]
	Number	Percentage	Number	Percentage	88.976
Participate in training	315	41.0%	44	12.6%	(0.000)**
Did not participate	454	59.0%	306	87.4%	
Total	769	100%	350	100%	

Note: * Test value is statistically significant at 5 % level.
*p values of Chi-sqare tests are given in the '()'.

Table 5.12: Does everybody in your household wash his/her hand before meal?

Response	Program		Control		Chi-sqare Test
	Number	Percentage	Number	Percentage	0.102
Yes, All	658	85.6%	302	86.3%	(0.749)
Yes, Some	29	3.8%	23	6.6%	
No one	82	10.7%	25	7.1%	
Total	769	100%	350	100%	

Note: * Test value is statistically insignificant at 5 % level.
* p values of Chi-sqare tests are given in the '()'.

Table 5.13: If yes, then what is used to wash hand?

Material	Program		Control	
	Number	Percentage	Number	Percentage
Soap	266	38.7%	84	34.6%
Detergent	2	0.3%	3	0.5%
Only water	419	61.0%	238	64.9%
Total	687	100%	325	100%

[5] The chi-square test is used to determine whether there is a significant difference between the expected frequencies and the observed frequencies in one or more categories.

Table 5.14: Respondents wash their hand after defecation

Response	Program		Control		Chi-sqare Test
	Number	Percentage	Number	Percentage	2.014
Wash Hands	694	90.2%	325	92.9%	(0.156)
Do not wash hands	75	9.8%	25	7.1%	
Total	769	100%	350	100%	

Note: * Test value is statistically insignificant at 5 % level.
*p values of Chi-sqare tests are given in the '()'.

Table 5.13: Types of Material used to wash hand after defecation

Material	Program		Control	
	Number	Percentage	Number	Percentage
Soap	542	78.1%	196	60.3%
Ash	78	11.2%	58	17.8%
Hand Wash	2	0.3%	0	0.0%
Soil	70	10.1%	68	20.9%
Other	2	0.3%	3	0.9%

CHAPTER SIX: MAJOR FINDINGS

The study identifies major findings of the project based on its strengths and weaknesses that come out from the analysis of primary data, review of secondary materials, discussion with beneficiaries, discussion with project officials, key informant interviews and focus group discussions. These findings of the project are very important to prepare and implement similar project in the near future.

Implementation Status:

- ✓ Project was implemented fully in terms of numbers but, not quite as per the rules and regulations of the project;
- ✓ Components were implemented without following the rules properly and taking the needs of the community into consideration in many places;
- ✓ Management and monitoring were also weak in most cases;
- ✓ Several agencies were involved in implementing the project and there were coordination problems as well.

Present Functional Status:

- ✓ Funcitonal Status of the project is mixed as some of them are fully functional, some are partially, and some are not at all;
- ✓ No current ongoing activities observed related to major inputs as the project is closed.

Procurement:

As the project completed four years ago and project office no longer exists, verification on procurement couldn't be made from the project office, however, the team tried to gather information from the filed level on this, and as it has been found, all procurements and purchases have been done following the Public Procurement Rules (PPR)'08.

Project Impacts:

- ✓ Access to safe water has increased significantly among the beneficiary households.
- ✓ Distance of water points from household is now much lower for the beneficiary households compared to their control counterparts.
- ✓ Time requirement to fetch water is also significantly lower them.

Impact in increasing awareness of hygiene practices:

Although about 41% of the beneficiaries received training on hygiene practices, no significant differences are observed in hygiene practices between the beneficiary and the control households.

Impact on Sanitation:

- ✓ Access to own toilet has increased for the program households.
- ✓ Access to safe sanitary toilet has also increased for the program households (46% for program against 31% for the control households).
- ✓ Not much difference is however observed in terms of distance to defecation place.

Institutional Capacity of the Institutions:

- ✓ Most of the cases UP and Union WatSan Committee did not show active and functional interest to perform project activities.
- ✓ No active action taken against the measurement flaw that has been revealed by upazila engineer.
- ✓ Many of the water points are placed without following the project criteria.
- ✓ In some of the unions PNGOs have lacked direction and experience for implementing hygiene promotion activities as well.

CHAPTER SEVEN: CONCLUSION AND RECOMMENDATIONS

Community management is an effective discipline for managing any social initiatives. The present initiative of community management in water supply is an innovative process that combined good outcomes with some challenges. Some of the key observations that study has been able to draw are summarized below:

- Community participation during water scheme development is encouragingwhich have developed some sense of ownership among the community, though slowly.
- The intervention has been able to make some positive impact upon its benbeficiaries.
- However, strong commitment and motivation of committee members towards managingcommunity needs and demands are absent.
- Lack of access to sufficient safe water andrelatively highwillingness to pay for safe water enables for charging relatively highcommunity contribution.
- Most of the water points are placed without following the project criteria and without justifying the community demand and need.
- Influentials individuals also also taking the benefit of project and are placing project tube-wells on their own premises.
- Efforts towards hygiene and behavior change motivation for households have not been effective.
- The study observes that, there is a prevalence of significant gaps between the desired and actual performances of the Upazila level actors. They did not play the facilitating roles towards enabling the watsan committees to assess, plan and implementproject activities properly.
- Union WatSan Committee also did not show active and functional interest to perform their assigned roles and responsibilities. The UP Chairperson and members, who are the major responsible actors at the local levels,have not been able to demonstrate their performance effectively on this that are needed for successful implementation of the project.

Therefore, the project has been an important intervention to facilitate access to safe water and sanitation and promote good hygiene practices. It has also contributed significantly towards achieving some of it.

But HYSAWA needs a long term strategic vision related to its function, organisation, and scale up. In order to extract the fuller benefit of it, a modified version of it may be implemented in some of the same and other areas. The modification may be made in the following areas:

Adapting an Inclusive Strategy: HYSAWA needs to review its pro-poor strategy to ensure that it is practical, relevant, and effective and meets the needs of both the poor and non-poor households. If the non-poor are interested in getting the benefit from the project, they have to contribute the full cost while the poor will get it at the subsidized rates. In fact, taking the ground reality into consideration, the project should target both poor and non-poor beneficiaries for providing the services but the non-poor with full cost contribution and the poor with subsidy. Otherwise, it would be difficult to implement it properly where the non-poor (many of them are influential as well) are also the aspirants of the services. Hence, taking the local socio-economic and political context (needs of the people of various spcoe-economic background, localpower structure, etc.) into consideration is also important for proper implementation of this kind of project.

Capacity Building of the Local Government Institutions (LGIs): Capacity building of the local government institutions and local bodies (e.g., watsan committee, etc.) are cruitial to implement this kind community based interventions in the country. Motivating the representatives of the LGIs as well as the local bodies and communities towards proper implementation of the project activities is also important. Capacity building training should be provided to UPs about how to effectively implement this kind of project involving the community peoole. They should also be provided training in procurement and financial management of such kind of big project with efficiency.

Ensuring Effective Monitoring: There should be a robust system for monitoring the activities of UPs in respect of implementation of the project as well as compliance to financial and procurement guidelines. A Strategic Monitoring Manager/Officer or Investment Manager should be made involved to HYSAWA staffing structure for long term strategic montoring of the project. The person recruited should take the responsibilities for all HYSAWA investments once made.

Encouraging Community Participation and Participatory Decision Making Throughout: In addition to ensuring involvement of UP as the core partner in the entire process, participation of the representatives of all the economic and social groups of the community should also be ensured (through forming a committee at the community level and having regular meetings) in the process of implementation and maintenance of the project. Participatory decision making process from start to end at all levels should also be ensured.

Quality Control: Ensuring the required qualification of manufactures, suppliers and contractors for the supply of project components is important and selection based on this shouls also be ensured for procurement and installation. Local participation and capacity building in recognition of quality, certification of installations and verification of location of installations should also beensured.

Ensuring Use Satisfaction: Utilisation of user satisfaction checklist should be introduced and filled out/completed and signed by the users of the project components during and after completion of the project. Capacity of Upazila watsan committee should be strengthened in this regard as wel and they should be held responsible for this.

Disclosure of Community Contribution: Formalising community contribution for the installations of project components and establishing and ensuring adherence to a system of Mandatory Disclosure of contributing information publicly are important. This will ensure transparency and accountability in receiving contribution form the community and utilizing them.

In addition, capacity development of caretakers and mechanics and mandatory monitoring of their activiites by watsan committee should also be ensured. Water quality testing before platform construction of water point should be ensured. Preparation of a defaulters list of contractors and their exclusion from further short-listing or participation in subsequent tendering procedures should be made. Finally, forwarding the cases of UP default to the HYSAWA Board, Ministry for their advice/action should be made on a timely manner for proper implementation and further expansion of this kind of project.

Annex

Annex-A: Results from the Households Survey

Table A1: Income Distribution by Participation Category

Monthly Income	Program		Control	
	Number	Percentage	Number	Percentage
Less than 5000	109	14.2%	72	20.6%
5000-10000	427	55.5%	188	53.7%
10000-20000	166	21.6%	68	19.4%
20000-30000	49	6.4%	14	4.0%
30000-40000	7	0.9%	6	1.7%
40000-50000	8	1.0%	2	0.6%
50000 and Above	3	0.4%	0	0.0%
Total	769	100%	350	100%

Table A2: Expenditure Distribution by Participation Category

Monthly Expenditure	Program		Control	
	Number	Percentage	Number	Percentage
Less than 5000	109	14.2%	72	20.6%
5000-10000	427	55.5%	188	52.2%
10000-20000	166	21.6%	68	19.4%
20000-30000	49	6.4%	14	4.0%
30000-40000	7	0.9%	6	1.7%
40000-50000	8	1.0%	2	0.6%
50000 and Above	3	0.4%	0	0.0%
Total	769	100%	350	100%

Table A3: Drinking waterby Participation Category

Main Source Of Drinking Water	Program		Control	
	Number	Percentage	Number	Percentage
Piped /Tap water into dwelling	13	1.7%	4	1.1%
Public tap(Community)	0	0.0%	2	0.6%
Tube well into dwelling	210	27.3%	128	36.6%
Community Tube well	437	56.8%	83	23.7%
Surface water (river, dam, lake, pond, stream)	3	0.4%	1	0.3%
Others	106	13.8%	132	37.7%
Total	769	100.0%	350	100%

Table A4: Was this Source installed under the Hysawa Project?

Status	Program	
	Number	Percentage
Yes	372	48.4%
No	397	51.6%
Total	769	100%

Table A5: Average Distance of water source from home

Under which Household	Meter
Program	34.38
Control	64.97
Total	43.95

Table A6: Average time required to collect water from home (get water and come back)

Under which Household	Minutes
Program	9.00
Control	12.49
Total	10.22

Table A7: Whether water supply is adequate from the source

Is it Sufficient	Program		Control	
	Number	Percentage	Number	Percentage
Yes	673	87.5%	238	68.0%
No	96	12.5%	112	32.0%
Total	769	100%	350	100%

Table A8: Satisfaction level regarding the quality of water

Satisfaction level	Program		Control	
	Number	Percentage	Number	Percentage
Very Satisfied	433	56.3%	141	51.3%
Satisfied	259	33.7%	137	35.4%
Unsatisfied	68	8.8%	67	12.1%
Very Unsatisfied	9	1.2%	5	1.3%
Total	769	100%	350	100%

Access to Sanitary Toilet

Table A9: No of Households having own latrine by Participation Category

Whether HH has own Latrine?	Program		Control	
	Number	Percentage	Number	Percentage
Yes	711	92.46	305	87.14
No	58	7.54	45	12.86
Total	769	100	350	100

Table A10: Type of Latrine use by Participation Category

Type of Latrine	Program		Control	
	Number	Percentage	Number	Percentage
Pit Latrine	95	13.36	43	14.10
Sanitary (water Sealed)	230	32.35	51	16.72
Sanitary (not water Sealed)	286	40.23	156	51.15
Unsealed/hanging latrines	97	13.64	55	18.03
Open Space	2	0.28	-	-
Others	1	0.14	-	-

Table A11: Place of Defecation(if Household have no latrine) by Participation Category

Place	Program		Control	
	Number	Percentage	Number	Percentage
Others Latrine	26	44.83	20	44.44
Community Latrine	1	1.72	5	11.11
Open fields/Jungles	13	22.41	11	24.44
Open field near house	17	29.31	9	20.00
Others	1	1.72	-	-

Table A11: Distance of Defecation palace by Participation Category

Distance	Program	Control	Mean Difference
Avg Distance (Meter)	28.24	33.58	-5.37 (0.19)

* Note: In bracket the p value of significance level and the value is statistically insignificant.

Hygiene practice

Table A12: Have you been participated in any training on hygiene?

Response	Program		Control	
	Number	Percentage	Number	Percentage
Yes	315	41.0%	44	12.6%
No	454	59.0%	306	87.4%
Total	769	100%	350	100%

Table A13: Was this training under Hysawa project?

Response	Program	
	Number	Percentage
Yes	270	85.7%
No	45	14.3%
Total	415	100%

Table A14: Does everybody in your household wash his/her hand before meal?

Response	Program		Control	
	Number	Percentage	Number	Percentage
Yes, All	658	85.6%	302	86.3%
Yes, Some	29	3.8%	23	6.6%
No	82	10.7%	25	7.1%
Total	769	100%	350	100%

Table A15: If yes, then which think is used to wash hand?

Material	Program		Control	
	Number	Percentage	Number	Percentage
Soap	266	38.7%	84	34.6%
Detergent	2	0.3%	3	0.5%
Only water	419	61.0%	238	64.9%
Total	687	100%	325	100%

Table A16: Number of respondent washes their hand after defecation

Response	Program		Control	
	Number	Percentage	Number	Percentage
Yes	694	90.2%	325	92.9%
No	75	9.8%	25	7.1%
Total	769	100%	350	100%

Table A17: Type of Material used to wash hand after defecation

Material	Program		Control	
	Number	Percentage	Number	Percentage
Soap	542	78.1%	196	60.3%
Ash	78	11.2%	58	17.8%
Hand Wash	2	0.3%	0	0.0%
Soil	70	10.1%	68	20.9%
Other	2	0.3%	3	0.9%
Total	694	100%	325	100%

Project related activities

Table A18: Whether any one worked under the project maintenance activities

Response	Program	
	Number	Percentage
Yes	75	9.8%
No	694	90.2%
Total	769	100%

Table A19: Average number of people worked only for program

Under which Household	If yes, then how many Male	If yes, then how many Female	How many days male were involved	How many days female were involved
Program village	1.25	1.08	23.02	20.73
Total	1.25	1.08	23.02	20.73

Table A20: Whether any female member worked under this project

Response	Program	
	Number	Percentage
Yes, Directly	48	4.3%
Yes Indirectly	13	1.2%
No	1058	94.5%
Total	1119	100%

Annex-B

Annex- B1: List of Sampling Districts, Upazilas, Unions and Villages

Division	District	Upazila	Union Parishad	Name of Village	Participation status
Chittagong	Noakhali	Chatkhil (8)	Sahapur	Rogunathpur	P
			Hatpukuria Ghatlabag	Gobindhopur	P
				Boktarpur	C
			Ramnarayanpur	Paschim Ramnarayanpur	P
			Parkote	Uttar Ramdebpur	P
				Poschim Sosalia	C
			Panchgaon	Nijvattar	P
			Nayakhola	Sarar Protsh	P
				Bishurampur	C
			Mohammadpur	Donnhopur	P
			Badalkut	Hoti Krishnopur	P
				Nischintopur	C
		Senbagh (7)	Chhatarpaia	Chhatarpaia	P
				Pachtopa	C
			Dumuria	Babupur Sripur	P
			Kabilpur	Purba Lalpur	P
				Azizpur	C
			Kadra	Hiazoli	P
			Kesharpar	Khajuria	P
			Nabipur	2 No. Gopalpur	P
				Debishinghopur	C
			Arjuntala	Uttor Manikpur	P
	Laksmipur	Ramganj (10)	Ichhapur	Ichhapur	P
			Noagaon	Saywaderkhil	P

Division	District	Upazila	Union Parishad	Name of Village	Participation status
Chittagong	Laksmipur	Ramganj (10)	Lamchar	Rochulpur	P
			Kanchanpur	Sainul	P
			Darbeshpur	Aya Nagar	P
			Chandipur	Harishchor	P
			Bholakot	Madhyapara	P
			Bhatra	Nandiapara	P
			Bhadur	Kethuri	P
			Karpara	Shyampur	P
		Raipur(4)	Bamni	Purba Sagordhi	C
			Kawruia	Lodua	C
				Enayetpur	C
			Sunapur	Sunapur	C
			Chormohona	Dakkhin Raipur	C
Rajshahi	Naogaon	Atrai (8)	Bhopara	Vhor Tetulia	P
				Kashin Bari	C
			Bisha	Bayiada Khali	P
				Raninagar	C
			Hatkalu Para	Mriddapara	P
			Kalikapur	Vatpara	P
				Jelepara	C
Rajshahi	Naogaon	Atrai (8)	Maniari	Maniari	P
			Panchupur	Mollapara	P
				Sahebganj	C
			Sahagola	Mirjapur	P
			Ahsanganj	Chowrobari	P
	Nawabgonj	Shibgonj (6)	Manakosa	Hangami	P

Division	District	Upazila	Union Parishad	Name of Village	Participation status
				Raninagar	C
			Naya Naobhanga	Birahimpur	P
			Chak Kitri	2 No. Chak Kitri	P
				Loholamari	C
			Binodpur	Ismail Bishwas Tola	P
			Satrujitpur	Rashikhagar	P
			Dhainagar	Pirgachi	P
				Moheshpur	C
		Nawabganj Sadar (6)	Alatuli	Kolimpur	P
			Ranihati	Krishno Gobindhopur	P
				DakkhinKrishno Gobindhopur	C
			Maharajpur	Purbo Shakpara	P
				Akundhupur	C
			Gobratla	Sorojon	P
				Munshappur	C
			Balidanga	Mohammad Khali Balogram	P
			Baragharia	Bishwaspara	P
	Rajshahi	Bhaga (6)	Bausa	Tawripara	P
			Pakuria	Alaipur	P
				Kishorpur	C
			Gargari	Shorerhat	P
				Chok Enayet	C
			Bajubagha	Chondipur	P
			Arani	Mina	P
			Manigram	Habashpur	P
				Parshawtta	C

Division	District	Upazila	Union Parishad	Name of Village	Participation status
Barisal	Barisal	Babuganj (5)	Agarpur	Chor Uttor Vooterdia	P
				Chor Hogal Patia	C
			Chandpasha	Doriabadh	P
			Dehergati	Rakudia	P
			Kedarpur	Poschim Vooterdia	P
			Rahmatpur	Purba Khanpura	P
		Gaurnadi (6)	Nalchira	Uttar Dingola Kati	P
				Boradia Gorangol	C
			Batajore	Batajore	P
			Chandshi	Dakkhin Chandshi	P
			Khanjapur	Mrdakul	P
				Salta	C
			Birthy	Bangila	C
			Sorikal	Adhuna	C
Barisal	Jhalokathi	Jhalokathi Sadar (10)	Gabha Ramchandrapur	Ramchandrapur	P
				Ramjankati	C
			Nathullabad	Nathullabad	P
				Hobirkati	C
			Sekherhat	Rajpasha	P
			Ponabalia	Rajapur	P
			Nabagram	Nabagram	P
				Betra	C
			Gabkhan Dhansiri	Baidharapur	P
			Binoykati	Sugandia	P
			Basanda	Badalkati	P

Division	District	Upazila	Union Parishad	Name of Village	Participation status
Barisal	Jhalokathi	Jhalokathi Sadar (10)		Damjori	C
			Kirtipasha	Gobindhodobal	P
				Adokati	C
			Keora	Pipolita	P
Total	**7**	**11**	**70**	**105**	

*****Note: 'P' denotes program and 'C' denotes control villages.

Annex-C: Matrix form of FGDs Response

Issues/Questionnaire	Response from FGDs	N	Percentage
১. এলাকায় পরিচালিত হাইজিন স্যানিটেশন এন্ড ওয়াটার সাপ্লাই (হাইসাওয়া) প্রকল্প সম্পর্কে ধারণা।	১.এলাকার অধিকাংশ মানুষের প্রকল্প সম্পর্কে ভালো ধারণা আছে।	**16**	80
	২. মোটামুটি ধারণা আছে।	**1**	5
	৩. কম ধারণা আছে।	**2**	10
	৪. ধারণা নেই।	**1**	5
২. প্রকল্পটির অধীনে লোকজনের সচেতনতা বৃদ্ধিতে উদ্যোগসমূহ ।	১. উঠান বৈঠকের মাধ্যমে প্রশিক্ষণের ব্যবস্থা করা হয়েছে।	**11**	55
	২. কর্মী নিয়োগ নিয়ে বাড়ি বাড়ি গিয়ে স্বাস্থ্য সচেতনতা সম্পর্কে শিখিয়েছে।	**7**	35
	৩. বায়োস্কোপের মাধ্যমে।	**2**	10
	৪. কার্ডের মাধ্যমে।	**2**	10
	৫. অভিনয়ের মাধ্যমে।	**1**	5
	৬. লিফলেট, ব্যানার, ফ্যাসটুন্স, সমাবেশের মাধ্যমে।	**1**	5
	৭. স্কুলের ছাত্র-ছাত্রীদের সচেতনতা বৃদ্ধির মাধ্যমে।	**1**	5
	৮. বিভিন্ন দিবসে অনুষ্ঠান আয়োজনের মাধ্যমে।	**1**	5
	৯. বিশুদ্দ পানি হিসাবে বৃষ্টির পানি সংরক্ষণ সম্পর্কে শিখিয়েছে।	**1**	5
	১০. সচেতনতা বৃদ্ধির জন্য কোন পদক্ষেপ নেয়া হয়নি	**4**	20
৩. প্রকল্পের অধীনে উপকার ভোগীদের জন্য বিশুদ্ধ পানির ব্যবস্থা কি করা হয়েছে ?	হ্যাঁ	**19**	95

	না	**1**	5
৪. হ্যাঁ হলে কিভাবে করা হয়েছে ?	১. গভীর নলকূপ স্থাপনের মাধ্যমে	**12**	60
	২. অগভীর নলকূপ স্থাপনের মাধ্যমে	**8**	40
৫. প্রকল্পের অধীনে কত শতাংশ লোক বিশুদ্ধ পানির সুবিধা পাচ্ছে ।	১. ০% লোক সুবিধা পাচ্ছে।	**2**	10
	২. ১% লোক সুবিধা পাচ্ছে।	**2**	10
	৩. ২% লোক সুবিধা পাচ্ছে।	**1**	5
	৪. ১০% লোক সুবিধা পাচ্ছে।	**2**	10
	৫. ১৩-১৪% লোক সুবিধা পাচ্ছে।	**1**	5
	৬. ১৫% লোক সুবিধা পাচ্ছে।	**1**	5
	৭. ২০% লোক সুবিধা পাচ্ছে।	**5**	25
	৮. ২৫% লোক সুবিধা পাচ্ছে।	**1**	5
	৯. ২০-৩০% লোক সুবিধা পাচ্ছে।	**1**	5
	১০. ৩০% লোক সুবিধা পাচ্ছে।	**1**	5
	১১. ৪০-৫০% লোক সুবিধা পাচ্ছে।	**1**	5
	১২. ৫০% লোক সুবিধা পাচ্ছে।	**1**	5
	১৩. ৬০% লোক সুবিধা পাচ্ছে।	**1**	5
৬. প্রকল্পটির অধীনে উপকার ভোগীদের জন্য উপযুক্ত স্যানিটেশনের ব্যবস্থা কি করা	১. হ্যাঁ	**6**	30

হয়েছে ?	২. না	**14**	70
৭. হ্যাঁ হলে কিভাবে করা হয়েছে ?	১. কমিউনিটি লেট্রিন স্থাপনের মাধ্যমে।	**6**	30
	২. ওয়াটার পয়েন্ট থেকে সুবিধা প্রাপ্ত খানাগুলিকে ওয়াটার সিল্ড রিং স্লাব লেট্রিন বসাতে বলার মাধ্যমে।	**2**	10
৮. প্রকল্পের অধীনে কত শতাংশ লোক উপযুক্ত স্যানিটেশনের সুবিধা পাচ্ছে ?	১. ০% লোক সুবিধা পাচ্ছে।	**14**	70
	২. ১% লোক সুবিধা পাচ্ছে।	**1**	5
	৩. ২% লোক সুবিধা পাচ্ছে।	**3**	15
	৪. ৫০% লোক সুবিধা পাচ্ছে।	**2**	10
৯. প্রকল্পটির অধীনে হাইজিন অথবা পরিষ্কার পরিচ্ছন্নতা সম্পর্কে ট্রেনিং অথবা উপকার ভোগীদের সচেতন বৃদ্ধির জন্য পদক্ষেপ নেয়া হয়েছিল কি ?	১. হ্যাঁ	**16**	80
	২. না	**4**	20
১০. হ্যাঁ হলে কি পদক্ষেপ নেয়া হয়েছিল ।	১. উঠান বৈঠকের মাধ্যমে সচেতনতা বৃদ্ধি।	**12**	60
	২. বাড়ি বাড়ি গিয়ে HYSAWA কর্মীর ফলোআপ করেছে।	**5**	25
	৩. NGO-এর মাধ্যমে বাড়িতে বাড়িতে গিয়ে সচেতন করেছে।	**3**	15
	৪. অভিনয়ের মাধ্যমে।	**1**	5
	৫. বায়োস্কপের মাধ্যমে	**1**	5
	৬. খানার বর্জ্য ব্যবস্থাপনার সম্পর্কে অবহিত করা।	**1**	5
	৭. ট্রেনিং প্রাপ্তরা প্রতিবেশীদের পরিস্কার পরিচ্ছন্নতার ধারণা দিত।	**1**	5
১১. এই সকল পদক্ষেপসমূহ কারা নিয়েছিল।	১. হাইসাওয়ার কর্তৃক নিয়োগ প্রাপ্ত NGO-কর্মীরা।	**12**	60

	২. হাইসাওয়ার প্রতিনিধিরা।	**5**	25
	৩. ইউনিয়নের চেয়ারম্যান।	**1**	5
	৪. মেম্বারগণ।	**1**	5
	৫. ট্রেনিং প্রাপ্ত প্রতিবেশীরা।	**3**	15
	৬. গ্রামের শিক্ষিত লোক।	**2**	10
	৭. বোর্ড পদক্ষেপ নেয়নি ।	**4**	20
১২. এতে উপকার ভোগীরা কি সচেতন হয়েছে?	১. হ্যাঁ	**16**	80
	২. না	**4**	20
১৩. হ্যাঁ হলে কিভাবে সচেতন হয়েছে ?	১. নিরাপদ পানির ব্যবহার।	**9**	45
	২. স্বাস্থ্য সম্মত ল্যাট্রিন ব্যবহার।	**8**	40
	৩. ব্যক্তিগতভাবে স্যানিটারী ল্যাট্রিন বসানো।	**1**	5
	৪. খাওয়ার আগে ও টয়লেট থেকে আসার পর সাবান দিয়ে হাত ধোয়া।	**8**	40
	৫. বাড়ির ময়লা আবর্জনা একটা নির্দিষ্ট গর্তে বা জায়গায় ফেলা।	**2**	10
	৬. শিশুর মলমূত্র পরিষ্কার করার পর সাবান দিয়ে হাত ধোয়া।	**4**	20
	৭. জুতা পড়ে ল্যাট্রিনে যাওয়া	**2**	10
	৮. খাবার ঢেকে রাখা	**1**	5
	৯. শাক-সবজি অল্প সিদ্ধ করে রান্না করা	**1**	5

১৪. না হলে কেন নয় ?	১. HYSAWA প্রকল্পের অধীনে পরিস্কার পরিচ্ছন্নতা কার্যক্রম ঠিকভাবে পরিচালিত হয়নি।	**3**	15
	২. মাঠকর্মী নিয়োজিত ছিল না।	**1**	5
১৫. প্রকল্পের কারনে উপকার ভোগীরা কি কি সুবিধা পেয়েছেন/ পাচ্ছেন ?	১. প্রকল্পের কারণে উপকার ভোগীরা নিরাপদ পানি পাচ্ছে।	**16**	80
	২. দৈনন্দিন জীবনে পরিস্কার পরিচ্ছন্নতার চর্চা বেড়েছে।	**14**	70
	৩. আগের তুলনায় রোগ ব্যধি কম হচ্ছে।	**2**	10
	৪. স্বাস্থ্য সম্মত পায়খানা ব্যবহার করছে।	**8**	40
	৫. স্থাপনাটি সরকারী ও খোলা জায়গায় হওয়াতে পানি সংগ্রহ করতে সমস্যা হয় না।	**3**	15
	৬. কোন সুবিধা পায়নি	**3**	15
	৭. অল্প খরছে পুষ্টিকর খাবার গ্রহণের উপায় জানা।	**1**	5
১৬. সুবিধা প্রাপ্তির প্রক্রিয়া কি ছিল ?	১. Cost Share-এর মাধ্যমে সুবিধা প্রাপ্তী।	**18**	90
	২. চেয়ারম্যান ও মেম্বার কর্তৃক ভোক্তা নির্বাচন।	**12**	60
	৩. চেয়ারম্যান ও মেম্বার কর্তৃক নলকূপ বসানোর স্থান নির্ধারণ	**10**	50
	৪. হতদরিদ্র ও দরিদ্রদের অগ্রাধিকার দেওয়া	**2**	10
১৭. প্রকল্পে কোন ধরনের অসুবিধা বা ত্রুটি বা অসঙ্গতি আছে কি ?	১. হ্যাঁ	**18**	90
	২. না	**2**	10
১৮. হ্যাঁ হলে কোন ধরনের অসুবিধা বা ত্রুটি বা অসঙ্গতি আছে ।	১. Cost Share-এর টাকা উত্তোলনে অসংগতি।	**4**	20
	২. Cost Share-এর টাকা নিয়ে নলকূপ সরবরাহ করে নাই।	**4**	20

	৩. চেয়ারম্যান, মেম্বার ও প্রভাবশালী লোকদের ক্ষমতার দাপট।	**7**	35
	৪. নলকূপ রক্ষণাবেক্ষণ কোন ব্যবস্থা নেই।	**8**	40
	৫. নলকূপগুলো একক ব্যাক্তি বা পরিবারভুক্ত।	**2**	10
	৬. নলকূপ মেরামতের ক্ষেত্রে কেউ ঈড়ংঃ ঝযধৎব করে না।	**6**	30
	৭. PNGO নিয়োগ না করা।	**4**	20
	৮. স্বাস্থ্য সম্মত পায়খানা প্রদান না করা।	**6**	30
	৯. প্রকল্প দক্ষ প্রকৌশলী না রাখা।	**4**	20
	১০. প্রকল্প সম্পর্কে সবাইকে সঠিকভাবে জানানো হয়নি।	**3**	15
	১১. কত ফুট পাইপ দেওয়া হবে তা জানানো হয় না।	**6**	30
	১২. নলকূপ সবানোর পর সঠিকভাবে পানি পরীক্ষা করা হয় না।	**2**	10
	১৩. টাকার পরিমাণ বেশী।	**4**	20
	১৪. প্রকল্পর মেয়াদ কম।	**1**	5
	১৫. নলকূপের যন্ত্রপাতি অনুন্নত।	**1**	5
	১৬. ল্যাট্রিনের ব্যবস্থা না করা।	**1**	5
	১৭. প্রশিক্ষণের জন্য শুধু নারীদের নেওয়া।	**1**	5
	১৮. দরিদ্র জনগোষ্ঠীর জন্য বিনামূল্য সুবিধা পাওয়ার ব্যবস্থা নেই।	**1**	5
	১৯. কন্ট্রাক্টর ইচ্ছামত কাজ করে। কোন জবাবদিহিতা নেই।	**1**	5

১৯. এই সকল অসুবিধা বা ত্রুটি বা অসঙ্গতিসমূহ দূরীকরনের উপায়সমূহ কি ?	১. প্রকল্প সম্পর্কে সবাইকে সঠিকভাবে জানানোর ব্যবস্থা করা।	**3**	15
	২. নলকূপ বসানোর সময় স্বচ্ছতা থাকতে হবে।	**2**	10
	৩. দক্ষ লোক দিয়ে নলক্কপের পানি নিয়মিত পরীক্ষা করাতে হবে।	**1**	5
	৪. দরিদ্র্য জনগোষ্ঠীর জন্য প্রাথমিকভাবে জমাকৃত টাকার পরিমাণ কমানো প্রয়োজন।	**3**	15
	৫. উঠান বৈঠকের পরিমাণ বাড়ানো	**1**	5
	৬. চেয়ারম্যান মেম্বারদের সর্বাধিক ক্ষমতা প্রদান না করা।	**2**	10
	৭. সঠিকভাবে Cost Share-এর টাকা উত্তোলন করা।	**3**	15
	৮. নলকূপ রক্ষণাবেক্ষণের জন্য আলাদা ফান্ড ব্যবস্থা করা।	**3**	15
	৯. ভোক্তা নির্বাচন ও এলাকা নির্বাচন-এ নিরপেক্ষ ব্যক্তি বা সংগঠন নিযুক্ত করা।	**6**	30
	১০. দক্ষ PNGO-নিয়োগ করা।	**2**	10
	১১. সঠিক মনিটরিং এর ব্যবস্থা করা।	**4**	20
	১২. একুইফার লেবেল জরিপের মাধ্যমে নলকূপ স্থাপন করা।	**6**	30
	১৩. স্বচ্ছ জবাবদিহিতার জন্য বিভিন্ন ধরনের কমিটি গঠন করতে হবে।	**1**	5
	১৪. একই ব্যক্তি একাধিক কমিটিতে থাকতে পারবে না।	**1**	5
	১৫. প্রকল্পের মেয়াদ বাড়ানো।	**1**	5
	১৬. Device স্থাপনের জন্য সঠিক স্থান নির্ধারণের সময় কমিউনিটির মতামতকে গুরুত্ব দেওয়া।	**1**	5

২০. এলাকার জনগণের স্বাস্থ্যগত অবস্থার উন্নয়নে প্রকল্পটি কি ভূমিকা রেখেছে ?	১. বিশুদ্ধ পানি ব্যবহারের ফলে অধিকাংশ লোক পানিবাহিত রোগ থেকে মুক্ত হতে পারছে।	**14**	70
	২. হাইজিন সম্পর্কে ভাল ধারণা লাভ করেছে। ফলে রোগ ব্যধি কমে গেছে।	**6**	30
	৩. আর্সেনিক মুক্ত প্রকল্প হয়েছে।	**6**	30
	৪. স্বাস্থ্য সচেতন হয়েছে।	**7**	35
	৫. স্বাস্থ্য সম্মত পায়খানা ব্যবহারের ফলে পরিবেশ দূষিত হয় না। তাই মানুষের রোগ ব্যধি কম হয়।	**4**	20
	৬. চিকিৎসা খরচ কম হচ্ছে।	**1**	5
	৭. স্বাস্থ্যগত উন্নয়নে প্রকল্পটি কোন ভূমিকা রাখেনি।	**4**	20
২১. হাইসাওয়া মডেলটি বাংলাদেশের অন্যান্য এলাকায় অনুসরণ করা যায় কি ?	১. হ্যাঁ	**17**	85
	২. না	**2**	10
২২. হ্যাঁ হলে কেন ।	১. এ প্রকল্পের মাধ্যমে মানুষের নিরাপদ বা বিশুদ্ধ পানির ব্যবস্থা করা হয়েছে।	**14**	70
	২. পরিস্কার পরিচ্ছন্নতা সম্পর্কে সচেতন করা হয়েছে।	**6**	30
	৩. পরিবেশ সুন্দর রাখতে মানুষকে উদ্বুদ্ধ করেছে।	**1**	5
	৪. স্বাস্থ্যগত দিক বিবেচনা করলে খুবই ভালো মডেল তাই অনুসরণ করা যায়।	**9**	45
	৫. দরিদ্র ও হতদরিদ্র কম মূল্যে নলকূপ পাবে।	**2**	10
২৩. না হলে কেন নয়।	১. Cost Share-এর টাকা উত্তোলনে দূর্নীতি।	**2**	10
	২. চেয়ারম্যান স্বোরগণ কর্তৃক দূর্নীতি ও স্বজনপ্রীতি।	**4**	20

	৩. নলকূপ বাড়ির ভিতরে স্থাপন করা।	**4**	20
	৪. হ্যান্ড টিউবওয়েলে বেশী পরিবার সুবিধা লাভ করে না।	**2**	10

*Note: All responses are the outcome of successive probing by the respective field officers.

Annex- D: Survey Questionnaire

Evaluation of the Hygiene, Sanitation and Water Supply (HYSAWA) Project

খানা জরিপের প্রশ্নমালা

(এই জরিপের মাধ্যমে সংগ্রহীত সকল তথ্য গোপন রাখা হবে এবং কোন ব্যক্তির নাম বা ঠিকানা রিপোর্টে প্রকাশ করা হবে না। সংগৃহীত তথ্য শুধুমাত্র গবেষণার কাজে ব্যবহৃত হবে। উক্ত জরিপ কার্যক্রমে আপনার সার্বিক সাহায্য ও সহযোগিতা একান্তভাবে কাম্য।)

এপ্রিল ২০১৪

বাংলাদেশ উন্নয়ন গবেষণা প্রতিষ্ঠান (BIDS)
ই-১৭, আগারগাঁও, ঢাকা-১২০৭

১. খানা প্রধানের নামঃ খানা কোডঃ | |

২. পিতার নামঃ

৩. গ্রাম/মহল্লাঃ ইউনিয়ন/ওয়ার্ডকোডঃ | |

উপজেলাকোডঃ | | জেলাকোডঃ | |

৪. এই খানাটি কার অধীনেঃ |

[১. Program village২.Control village]

৫. উত্তরদাতার সর্ম্পকিত তথ্যাবলী

ক্রমিক নং	**প্রশ্নমালা**	**কোড বসান/সঠিক উত্তরে √ চিহ্ন দিন**
৫.১	উত্তরদাতারনামঃ	
৫.২	উত্তরদাতারলিঙ্গ	১. পুরুষ২. মহিলা
৫.৩	খানা প্রধানের লিঙ্গ?	১. পুরুষ২. মহিলা
৫.৪	খানা প্রধানেরপ্রধান পেশা? [কোডঃ ১=কৃষক, ২=কৃষি শ্রমিক, ৩= অকৃষিশ্রমিক, ৪=চাকুরী, ৫= ক্ষুদ্র পেশাজীবী (কামার/কুমার/তাঁতী/জেলে ইত্যাদি), ৬= ক্ষুদ্র ব্যবসা, ৭= মাঝারী/বড় ব্যবসা, ৮=চিকিৎসক/আইনজীবী/শিক্ষক, ৯= রিক্সা/ভ্যান/গাড়ি চালক, ১০=বেকার/কিছু করে না, ১১=অন্যান্য উল্লেখ করুনঃ_____]	
৫.৫	খানা প্রধানের শিক্ষাগত যোগ্যতা? [Completed years of schooling]	
৫.৬	খানার সদস্য সংখ্যা কতজন?	পুরুষ _____ জন মহিলা_____ জন

৬. আর্থ-সামাজিক তথ্যাবলী

ক্রমিক নং	প্রশ্নমালা	কোড বসান/সঠিক উত্তরে √ চিহ্ন দিন
৬.১	খানার নিজস্ব মালিকানাধীন কৃষি জমির পরিমানঃ	_____ শতাংশ
৬.২	খানার মালিকানাধীন বাড়ির প্রকৃতিঃ [কোডঃ ১=নিজস্ব, ২= ভাড়া, ৩=অন্যের বাড়িতে, ৪=অন্যান্য উল্লেখ করুনঃ_____]	
৬.৩	বাড়িতে কি কি সম্পদ আছে? (উত্তর একাধিক হতে পারে) [কোডঃ ১=মোটরসাইকেল, ২= সাইকেল, ৩=টেলিভিশন, ৪=রেডিও, ৫=মোবাইল ফোন, ৬=গরু/মহিষ, ৭=ছাগল/ভেড়া, ৮=হাঁস/মুরগী, ৯=ট্রাক্টর, ১০= সেলাই মেশিন, ১১= নৌকা, ১২. খাট/চৌকী, ১৩= চেয়ার ও টেবিল, ১৪=আলমারী, ১৫=অন্যান্য উল্লেখ করুনঃ _____]	
৬.৪	আপনার খানার আয়ের প্রধান উৎস কি? [কোডঃ ১=কৃষি, ২=গরু/ছাগল লালন পালন, ৩=হাঁস/মুরগী লালন পালন, ৪=মাছ ধরা/বিক্রয়, ৫=কৃষি মজুরী, ৬= অকৃষি মজুরী, ৭= ক্ষুদ্র পেশা (কামার/কুমার/তাঁতী/জেলে ইত্যাদি), ৮=রিক্সা/ভ্যান/গাড়ি চালনা, ৯= ক্ষুদ্র ব্যবসা, ১০= মাঝারী/বড় ব্যবসা, ১১= চাকুরী/বেতন, ১২= রেমিটেন্স (বিদেশ থেকে), ১৩=উপহার/দান, ১৪=অন্যান্য উল্লেখ করুনঃ_____]	
৬.৫	গত **১২ মাসে** খানার গড় মাসিক আয় কত ছিল?	টাকা _____
৬.৬	গত **১২ মাসে** খানার গড় মাসিক ব্যয় কত ছিল?	টাকা _____
৬.৭	সারা বছরের খাদ্য গ্রহন বিবেচনায় আপনি আপনার খানাকে নিম্নোক্ত কোন শ্রেনীভূক্ত করবেন? [কোডঃ ১= সারা বছর ঘাটতি, ২= কখনও কখনও ঘাটতি, ৩=ঘাটতিও না উদ্বৃত্ত না, ৪= উদ্বৃত্ত]	

৭. খাবার পানির উৎস

ক্রমিক নং	প্রশ্নমালা	কোড বসান/সঠিক উত্তরে √ চিহ্ন দিন
৭.১	খানার খাবার পানির প্রধান উৎস কি? [কোডঃ ১=পাইপ/টেপের পানি (নিজ বাড়িতে), ২=সরকারি টেপের পানি (কমিউনিটি), ৩= নিজস্ব টিউবওয়েল, ৪=কমিউনিটি টিউবওয়েল, ৫=কুয়া (সংরক্ষিত), ৬=কুয়া (অসংরক্ষিত), ৭=বৃষ্টির পানি, ৮=বোতলের/ মিনারেলের পানি, ৯=নদী/লেক/পুকুর/খাল, ১০=অন্যান্য উল্লেখ করুনঃ_____]	
৭.২	এই উৎস কি হাইসওয়া প্রকল্পের আওতায় স্থাপিত হয়েছিল? [কোডঃ ১. হ্যাঁ, ২. না (না হলে প্রশ্ন ৭.৪-এ যান)]	
৭.৩	যদি হ্যাঁ হয়, তবে কত সালে?	
৭.৪	পানির প্রধান উৎস বাড়ি থেকে কত দূরে?	মিটার _____
৭.৫	প্রধান উৎস থেকে পানি সংগ্রহ করতে কত সময় লাগে? (আসা-যাওয়া এবং অপেক্ষা)	মিনিট_____
৭.৬	আপনি যে পরিমান পানি উৎস থেকে পান তা কি পর্যাপ্ত?	১. হ্যাঁ২. না
৭.৭	খাবার পানি গুনগতমান নিয়ে আপনি কি সন্তুষ্ট? [কোডঃ ১= খুবই সন্তুষ্ট, ২= মোটামুটি সন্তুষ্ট, ৩=অসন্তুষ্ট, ৪= খুবই অসন্তুষ্ট]	
৭.৮	যদি সন্তুষ্ট না হন/অসন্তুষ্ট তবে কেন?? (উত্তর একাধিক হতে পারে) [কোডঃ ১= ময়লা পানি, ২= দুর্গন্ধযুক্ত পানি, ৩= জীবানুযুক্ত: ভাইরাস ও ব্যাকটেরিয়া / নিরাপদ নয়, ৪= পশু-পাখি এ পানি ব্যবহার করে, ৫=পানিতে পোকা মাকড় ভাসে, ৬= অন্যান্য উল্লেখ করুনঃ_____]	
৭.৯	বিশুদ্ধ পানি পান করা ছাড়া আর কি কাজে ব্যবহার করেন?? (উত্তর একাধিক হতে পারে) [কোডঃ ১=রান্না-বান্না, ২=বাচ্চার খাবার তৈরিতে, ৩=ধোঁয়া মোছা (কাপড়),	

	৪=ধোঁয়া মোছা (থালাবাসন), ৫=হাতধুঁতে, ৬=গোসল, ৭=অন্যান্য উল্লেখ করুনঃ_____]	
৭.১০	আপনি কি পানির উৎস পরিস্কার/রক্ষনাবেক্ষণে টাকা ব্যয় করেন?	১. হ্যাঁ২. না
৭.১১	হ্যাঁ হলে, মাসিক গড়ে কত টাকা ব্যয় করেন?	
৭.১২	যদি না হয় তবে কেন নয়? [কোডঃ ১= খরচ বেশি, ২= দরকার নেই, ৩= অন্যান্য উল্লেখ করুনঃ _____]	
৭.১৩	আপনার এলাকায় পানি সরবরাহে কি ধরনের সমস্যা হয়/আছে? (উত্তর একাধিক হতে পারে) [কোডঃ ১= কোন সমস্যা নাই, ২= পানির স্বল্পতা, ৩= পানির উৎস দূরে, ৪= পানি বহনে খরচ বেশি, ৫= পানি অপরিস্কার/ময়লাযুক্ত, ৬= অন্যান্য উল্লেখ করুনঃ_____]	

৮. সেনিটেশন এবং পরিষ্কার পরিচ্ছন্নতা

ক্রমিক নং	প্রশ্নমালা	কোড বসান/সঠিক উত্তরে √ চিহ্ন দিন
৮.১	আপনি কি পরিষ্কার পরিচ্ছন্নতা সর্ম্পকিত কোন ট্রেনিংয়ে অংশ নিয়েছেন?	১. হ্যাঁ ২. না
৮.২	হ্যাঁ হলে এই ট্রেনিংকি হাইসওয়া প্রকল্পের আওতাধীন ছিল?	১. হ্যাঁ ২. না
৮.৩	আপনি পরিষ্কার পরিচ্ছন্ন সম্পর্কিত কি ধরনের উপদেশ শুনছেন/ পেয়েছেন? (উত্তর একাধিক হতে পারে) [কোডঃ ১=কোন কিছু শুনিনি, ২=সেনেটারি লেট্রিন ব্যবহার, ৩=বিশুদ্ধ পানি ব্যবহার, ৪=হাত ধোয়া, ৫=সাবান দিয়ে হাত ধোয়া, ৬=অপরিষ্কার পানি/বদ্ধ পানি পরিষ্কার অথবা সংস্কার, ৭=বাচ্চার ময়লা/আবর্জনা নিরাপদ স্থানে ফেলা, ৮=অন্যান্য উল্লেখ করুনঃ_____]	
৮.৪	কোথা থেকে আপনি এ তথ্য শুনছেন/পেয়েছেন?? (উত্তর একাধিক হতে পারে)	

	[কোডঃ ১= কমিউনিটিমিটিং, ২= গ্রামের প্রধান, ৩= প্রতিবেশী, ৪= আত্নীয়-স্বজন, ৫= রেডিও, ৬= ছবি/পোস্টার, ৭= বিলবোর্ডের বিজ্ঞাপন, ৮= টেলিভিশনের বিজ্ঞাপন, ৯= এনজিও কর্মী, ১০= সরকারি প্রতিনিধি, ১১= স্বাস্থ্য কেন্দ্র, ১২=স্বাস্থ্য কর্মী, ১৩=স্কুল/শিক্ষক, ১৪=ধর্মীয় নেতা, ১৫=জানি না, ১৬=অন্যান্য উল্লেখ করুনঃ_____]	
৮.৫	আপনার বাড়িতে নিজস্ব লেট্রিন/শৌচাগার আছে কি?	১. হ্যাঁ২. না
৮.৬	যদি হ্যাঁ হয় তবে কি ধরনের লেট্রিন/শৌচাগার আছে? [কোডঃ ১=পাকা ল্যাট্রিন, ২=স্যানিটারী (water sealed), ৩= স্যানিটারী (not water sealed), ৪=কাঁচা পায়খানা/ঝুলন্ত পায়খানা, ৫= খোলা জায়গা, ৬= অন্যান্য উল্লেখ করুনঃ_____]	
৮.৭	যদি না হয়, তবে বাড়ির সদস্যরা সাধারনত কোথায় মলমূত্র ত্যাগ করে? [কোডঃ ১=অন্যের শৌচাগারে, ২=কমিউনিটি শৌচাগারে, ৩=খোলা মাঠে/জঙ্গলে (দূরে), ৪=খোলামাঠে (বাড়ি কাছে), ৫=অন্যান্য উল্লেখ করুনঃ_____]	
৮.৮	বাড়ি থেকে সেই স্থানের দূরত্ব কত মিটার?	মিটারঃ

৯. Hygiene Practice

ক্রমিক নং	প্রশ্নমালা	কোড বসান/সঠিক উত্তরে √ চিহ্ন দিন
৯.১	খাদ্য গ্রহনের পূর্বে বাড়ির সবাই কি হাত ধোয়? [কোডঃ ১= হ্যাঁ, সবাই, ২= হ্যাঁ, কেউ কেউ, ৩=না]	
৯.২	যদি হ্যাঁ হয় তবে কি দিয়ে হাত ধোয়া হয়? [কোডঃ ১=সাবান, ২=ডিটার্জেন্ট, ৩=হ্যান্ড ওয়াশ, ৪=অন্যান্য উল্লেখ করুনঃ_____]	
৯.৩	লেট্রিন ব্যবহারের পর আপনি/অন্যান্যরা কিহাত পরিষ্কার করেন?	১. হ্যাঁ২. না
৯.৪	যদি হ্যাঁ হয় তবে কি দিয়ে হাত পরিষ্কার করা হয়? [কোডঃ ১=সাবান, ২=ছাই, ৩=হ্যান্ড ওয়াশ, ৪= মাটি, ৫=অন্যান্য উল্লেখ করুনঃ_____]	
৯.৫	বাচ্চার মলমূত্র পরিষ্কারের পর আপনি/অন্যান্যরা কি হাত পরিষ্কার করে?	১. হ্যাঁ২. না
৯.৬	যদি হ্যাঁ হয় তবে কি দিয়ে হাত পরিষ্কার করা হয়? [কোডঃ ১=সাবান, ২=ছাই, ৩=হ্যান্ড ওয়াশ, ৪= মাটি, ৫=অন্যান্য উল্লেখ করুনঃ_____]	

১০. স্বাস্থ্য সংক্রান্ত তথ্যঃ

ক্রমিক নং	প্রশ্নমালা	কোড বসান/সঠিক উত্তরে √ চিহ্ন দিন
১০.১	গত ছয় মাসে আপনার পরিবারের কোন সদস্য কি অসুস্থ ছিলেন? (না হলে প্রশ্ন ১০.৫-এ যান)	১. হ্যাঁ২. না
১০.২	যদি হ্যাঁ হয়, তবে কি ধরনের অসুস্থতা? [কোডঃ ১= সাধারণ (জর/কাশি), ২=ডায়রিয়া, ৩=আর্সেনিক সংক্রান্ত, ৪=টাইফয়েড, ৫= জন্ডিস, ৬=পেটের পীড়া, ৭= জটিল রোগ, ৮= অন্যান্য উল্লেখ করুনঃ_____]	
১০.৩	এই জন্য কি তাকে কোন ধরনের চিকিৎসা সেবা নিতে হয়েছিল?	১. হ্যাঁ২. না

১০.৪	যদি হ্যাঁ হয়, তবে এ বাবদ কত খরচ হয়েছিল?	টাকা_____
১০.৫	সাধারনত পরিবারে বাচ্চাদের যাতে ডায়রিয়া না হয় সেজন্য আপনি কি কোন ধরনের সতর্কতামূলক ব্যবস্থা নিয়েথাকেন?	১. হ্যাঁ২. না
১০.৬	যদি হ্যাঁ হয়, তবে কি ধরনের সতর্কতামূলক ব্যবস্থা নিয়েথাকেন? [কোডঃ ১=খাবার ভালোভাবে রান্না করা, ২= কোন ধরনের খাবার খাওয়া হচ্ছে যে সম্পর্কে সজাগ থাকা, ৩=পানি সেদ্ধ কর খাওয়া, ৪=শাক-সবজিও ফলমূল পরিষ্কার পানি দিয়ে ধোয়া, ৫=টয়লেট ব্যবহারের পর হাত সাবান দিয়ে ধোয়া, ৬=রান্নার পূর্বে হাত সাবান দিয়ে ধোয়া, ৭=বাচ্চার মলমূত্র পরিষ্কারের পর হাত সাবান দিয়ে ধোয়া , ৮=খাবার ঢেকে রাখা, ৯=রান্নাঘর ও বাসন কোসন পরিস্কার রাখা, ১০=বাচ্চাদের সবসময় পরিস্কার পরিচ্ছন্ন রাখা, ১১= বাচ্চাদের সবসময় পরিস্কার পরিচ্ছন্ন পোশাক পরিধান করানো, ১২=স্রস্টার কাছে প্রার্থনা, ১৩= অন্যান্য উল্লেখ করুনঃ_____]	
১০.৭	যদি না হয়, তবে কেন নয়? [কোডঃ ১= জানি না কি করতে হবে, ২= অসুস্থ হলে ব্যবস্থা নেব, ৩= অন্যান্য উল্লেখ করুনঃ_____]	
১০.৮	বাচ্চাদের ডায়রিয়ার হলে সাধারনত কি ধরনের ব্যবস্থা নেয়া হয়? [কোডঃ ১= অসুস্থ বাচ্চাকে ক্লিনিক/হাসপাতালে নেয়া , ২= অসুস্থ্য বাচ্চাকে সাধারণ/সনাতনী পদ্ধতিতে চিকিৎসা দেয়া/কবিরাজ দেখানো, ৩= হাতে তেরী স্যালাইন খাওয়ানো, ৪=ওরস্যালাইন দেয়া, ৫= কিছু না করে অপেক্ষা করা ৬=অন্যান্য উল্লেখ করুনঃ_____]	
১০.৯	অসুস্থতার জন্য গত ছয় মাসে কত দিন পরিবারের উপার্জনক্ষম সদস্য/ সদস্যরা কাজে যেতে পারেন নি?	কত জনঃ মোট কত দিনঃ
১০.১০	অসুস্থতার জন্য গত ছয় মাসে কত দিন আপনার ছেলে-মেয়ে স্কুলে যেতে পারে নি?	কত জনঃ মোট কত দিনঃ

১১. নিয়োগ সংক্রান্ত ও অন্যান্য

ক্রমিক নং	প্রশ্নমালা	কোড বসান/সঠিক উত্তরে √ চিহ্ন দিন
১০.১	প্রকল্প বাস্তবায়ন বা রক্ষনাবেক্ষন কাজে আপনার পরিবারের কোন সদস্য কি নিয়োজিত ছিলেন?	১. হ্যাঁ২. না
১০.২	যদি হ্যাঁ হয়, তবে কত জন?	পুরুষঃ মহিলাঃ
১০.৩	তারা কতদিন একাজে নিয়োজিত ছিলেন?	পুরুষঃ দিন মহিলাঃ দিন
১০.৪	আপনার পরিবারের মহিলারা কি কোনভাবে প্রকল্পের কাজের সাথে যুক্ত ছিলেন? [কোডঃ ১= হ্যাঁ, প্রত্যক্ষভাবে, ২= হ্যাঁ, প্ররোক্ষভাবে, ৩= না]	