



OBJECTIVE ORIENTED OUTCOME EVALUATION OF COMMUNITY-LED TOTAL SANITATION AND HYGIENE PROGRAM IN MANNA WOREDA, JIMMA, OROMIA, SOUTH WESTERN ETHIOPIA, 2019.

AN EVALUATION REPORT SUBMITTED TO JIMMA UNIVERSITY, INSTITUTE OF HEALTH , FACULTY OF PUBLIC HEALTH, DEPARTMENT OF HEALTH ECONOMICS MANAGEMENT AND POLICY, MONITORING AND EVALUATION PROGRAM UNIT FOR THE PARTIAL FULFILMENT OF REQUIREMENT FOR DEGREE OF MASTERS SCIENCE IN HEALTH MONITORING AND EVALUATION.

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Objective Oriented Outcome Evaluation of Community-Led Total Sanitation and Hygiene program in Manna Woreda, Jimma Zone, Oromia, South western Ethiopia, 2019.

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ABSTRACT: -

Introduction: - Globally, 2.3 billion people still do not have basic sanitation facilities such as latrines. Inadequate sanitation is estimated to cause 280,000 diarrheal deaths annually. Poor utilization of latrine or open defecation is also a serious health risk practice. However, availability and level of latrine utilization and associated factors were not well known in the study area. Therefore, this study was employed to find evidences to show the current situation outcome level of Community Led Total Sanitation and Hygiene program and factor affecting latrine utilization in the study area.

Objectives: To assess the extent to which Community Led Total Sanitation and Hygiene program achieved its objectives in Manna Woreda, Oromia, Ethiopia, by 2019.

Methods: The Evaluation was conducted in Manna Woreda which contains 34292 Households. Community based cross- sectional study design used to evaluate the program. Both quantitative and qualitative data collection methods was deployed for this study by structured questionnaire, observational checklist tools and document review from March 15 /2019 to March 25/2019. For quantitative data multi stage sampling was used to get the required sample size (n=482) from 12 randomly selected kebeles by lottery method, and for qualitative KII (n=15) purposely selected from (Woreda health office, 4Health Centers, and 9 from selected kebele representative) and document reviewed at 20 health facilities. All evaluation processes were undertaken after ethical clearance was obtained from Jimma University and Oromia Regional Health Bureau. Collected data was entered in to epidata version 3.1 and exported to SPSS V.21. Both binary logistic analysis and multiple logistic analyses were used for analysis data.

Result: Four hundred eighty two households were included in the study making a response rate of 100%. Most of the study participants were female (328(68%) and participants mean age was 41.5 years (SD= 10.9). Out of total observed households (400 (83%)) of them had standardized latrine. Majority of these households' latrine (342(71%)) were traditional pit latrine with slab made of wood and earth. There was fresh foot path leading to latrine (382(79.3%)) among households' latrine observed during data collection. Presence of local community laws (AOR= 4.5) 95% CI (2.74, 7.41), P<0.0001) was significantly associated with utilization of latrines among family members. Among total observed soaps/substituent near hand washing facilities, 274(56.8%) were freshly used during data collection. Also about (207(50%)) of villages were certified for their success of ODF status. Average indicators for availability, utilization and compliance dimensions were 73%, 71% and 68.5% which was good, fair and very good according to criteria set by stake holders respectively. From in depth interview 4/7'th of these key informants revealed that households without hand washing facilities due to scarcity of water, households who did not graduated as model households, Households that were not participated during triggering were not always utilized latrines

Conclusion; From objective oriented outcome evaluation of CLTSH program over all judgment dimensions indicators value scores 71% that was good according to criteria set by stakeholders. But, it needs more improvement per national CLTSH objectives sated.

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ABBREVIATION AND ACRONYMS

CLTSH	Community Led Total Sanitation And Hygiene
EC	Ethiopian Calendar
EDHS	Ethiopian Demographic And Health Survey
E-SHIP	Ethiopian Sanitation and Hygiene Improvement Program
FMOH	Federal Ministry of Health
GSF	Global Sanitation Fund
HEW	Health Extension Worker
HC	Health Centers
HH	House Holds
HWF	Hand Washing Facility
IEC	Information, Education and Communications
ISH	Institutional Sanitization and Hygiene
KAPB	Knowledge, Attitude and Practice Based
KII	Key Informant Interview
MWE	Ministry Of Water and Energy
NGO	Non- Governmental Organization
NLs	Natural Leaders
OD	Open Defecation
ODF	Open Defecation Free
RESA	Region of East and Southern Africa
PRA	Participatory Rural Appraisal
UNCF	United Nations Children’s Fund
WHO	World Health Organization
WoHo	Woreda Health Office
WSSCC	Water Supply and Sanitation Collaborative Council

OPERATIONAL DEFINITION: -

Primary ODF:-Is where by the community is certified for ODF for the first time within one to three month after triggering.

Secondary ODF:- Is where by the community is re-verified after one year for progression, then re- certified after ODF for those step back to OD.

Sanitation facilities:- Availability of latrine, hand washing with water, soap and cover hole of the slab.

Latrine Utilization: - Existence of flies, fresh foot path leading to the latrine, latrine with flush of water on the hole or recently used soft in the latrine.

Hand Washing Facility Utilization: Existence of wet land around hand washing facility, fresh dumped land around hand washing facilities during data collection.

Cluster: Administrative unit that contain one health center with 15000 to 25000 populations.

Village: Administrative Unit Which Contains 30-40 Households.

Utilizing Soap/Ash after Utilization of Latrine:- Presence of fresh used soap/other substituent around the hand washing facilities.

Local Community laws: - Social norms that community sets to punish the offenders

Certified with green flag: 100 per cent latrines constructed by the community (of any design) are in use.

Certified with yellow flag:- At least 50 per cent of households have completed latrine construction of any type.

Certified with white flag: -100 per cent of latrines are in use, Hand washing facilities are on working order and have water and soap or a soap substitute after one year.

CHAPTER 1: INTRODUCTION

1.1. Back Ground

Globally 2.4 billion people do not use an improved sanitation facility (1), and an estimated of 946 million people is practiced open defecation in 2015, whom 90% of them lived in rural areas (2). Open defecation is a big problem in the developing World and adversely affects human health contributing to diarrheal diseases and childhood stunting. So, Creating proper waste management practices is an essential part for improved human health(3). For a decade, Governments and Non-Governmental organizations (NGOs) provided free or subsidized latrines to households, but practitioners widely believe that this approach was unable to guarantee regular latrine use. So, the new recognition led to a focus on hygiene and health education programs, often combined with latrine subsidies such as the Participatory Hygiene and Sanitation Transformation approach which led to the discovery of community-led total sanitation and hygiene(4).

Community Led Total Sanitation (CLTS) is a unique approach of addressing rural sanitation by mobilizing and sensitizing communities to discontinue open defecation. Its focus is also to trigger the community to generate sustained behavioral change leading to spontaneous and long term abandonment of open defecation practices and stimulating demand for sanitation and hygiene facilities without any external hardware support (4). The process of implementation of CLTSH program includes pre-triggering, triggering and post-triggering, and they involve the use of participatory tools such as transects walks (walk of shame) aimed at inducing feelings of shame and disgust among the community members ,feces mapping, and glass of water exercise. Community Led Total Sanitation also enables the communities to conduct their own sanitation profile through appraisal, observation, and analysis of their practice of open defecation and its effects(4).

Consequently, after CLTS was pioneered by Dr. Kamal Kar in India in 1999, Kar was proactive in the spread of CLTS first within Bangladesh, then to Asia more widely, and to African continent ,Latin America, the Middle East and the Pacific, but CLTSH is now used in over 40 countries (5).

In Africa continents CLTS was introduced in 2002, but the real story starts in 2007, when Kamal Kar facilitated two trainings in Tanzania and Ethiopia for Plan Region of East and Southern Africa (RESA)(4).

Moreover, Ethiopia adopted CLTSH program in 2011 and launched after two training events were organized and conducted in Arbaminch and Hawassa towns by Plan International Ethiopia. After launched in Ethiopia, implementation of the approach led to visible and striking results in the direction of improving the hygiene and sanitation condition in the country. In order to strengthen the efforts being made to address hygiene and sanitation concerns in the country and to maximize the effectiveness and efficiency of CLTS approach, the Federal Ministry of Health (F-MoH) organized National Hygiene Sanitation Task Force, and the CLTSH guideline is developed, and divides the implementation into 4 phases and 13 steps to elaborates the purposes, processes, methods, and expected outputs relevant to each step and identifies the parties responsible (2,5).

1.2. Problem statement

In Ethiopia up to 80% of disease burden related to poor sanitation and hygiene. About 3/4 health problems of under five children in Ethiopia were communicable diseases comes from the environment, specially water and sanitation(8). Basic sanitation and hygiene in Ethiopia is still low, around 20% of rural and 20% of urban households do not have access to toilets, and most of those do have only access to unimproved traditional pit latrines(9).

Basic and improved households Sanitation coverage in Ethiopia is estimated to be at 63% (10). The recent data of EDHS indicate that more than half 55% of households (56.7% in rural and 4.4% in urban areas of Ethiopia access to non-improved sanitation facility (pit latrine without slab or pit latrine). Overall, 35.5% of households (11.3% urban and 39.6% rural) live without toilet facility (12). The recent Health Sector Transformation Plan (HSTP) also indicates that diarrhea is the second biggest killer for less than five children next to acute respiratory infection(13).

But beyond administrative reports, assessment the outcome level of community led total sanitation and hygiene program were not undertaken in the study area.

1.3. Significance of the Evaluation

For policy maker

The evaluation may give evidence on factors contributing for the success and drawback in implementation of CLTSH program and changes for sustainability based on evaluation result.

For the researchers

The evaluation generates knowledge related to program implementation to show gaps for future studies on the study area.

For the users/ community

This evaluation contribute for the households to improve the availability, utilization of sanitation facility at households level that may have its own contribution in reduction of mortality and morbidity disease related to sanitation and hygiene.

For program implementers and funders

This evaluation also used for decision making and accountability for further improvement of the program in the study area.

Consequently, final result of this objective oriented outcome evaluation with its recommendations were provided to Manna Woreda health office, Jimma zone health department and different stakeholders according to their interest on the program.

CHAPTER 2: PROGRAM DESCRIPTION

There is a link between health, sanitation and water supply, although the role of clean water in diarrhea disease control is less important than that of sanitation and hygiene. Therefore, the health benefit that can be obtained from allocating more resources for water will be severely limited without paying adequate attention to sanitation promotion (15). Thus, educating community members about simple but important hygiene behaviors such as proper disposal of waste, hand washing, and latrine use has to get more focus.

So, Community-Led Total Sanitation and Hygiene (CLTSH) program was introduced which focusing on igniting a change in sanitation behavior rather than constructing toilets. CLTSH program concentrates on the whole community rather than an individual behaviors, and collective benefit from stopping open defecation (OD) that encourage a more cooperative approach. People decide together how they will create a clean and hygienic environment that benefits everyone(16).

Accordingly, Government of Ethiopia believes in the promotion of improved sanitation to ensure sustained change in sanitation and hygiene facilities to meet national and global commitments. For this effect, National Hygiene and Sanitation Task Force (NSHTF) established under the chairmanship of F-MoH in August 2009, and sanitation strategic plan adopted from(2011-2015) as approach. Consequently, introduction and institutionalization of CLTSH in Ethiopia has shown significant and encourage able progress in enabling communities to analyze, find collective solutions to the problems related to sanitation and hygiene(14).

2.1. Program stakeholders

During evaluability assessment stakeholders involved in the CLTSH program in Manna Woreda was identified and discussed about their role in the program and evaluation process and, the evaluation question they want to be answered was agreed. The stakeholders participating in CLTSH program in Manna Woreda were listed in stakeholder analysis matrix as follow;

Table 1:- CLTSH program stakeholder analysis matrix in Manna Woreda, Jimma, Oromia, 2019.

Stakeholder	Role in the program	Role in the Evaluation	Interest or perspective on evaluation	Communication strategies	Level (H,M &L)
Jimma zone health office	<ul style="list-style-type: none">) Coordinate relevant stakeholders) Monitor and evaluate the progress of CLTSH in zone regularly) Facilitate to prepare best experience sharing platforms with in and out of the zone 	<ul style="list-style-type: none">) Interpreting selected evaluation question and method) Disseminating information) Develop evaluation indicator 	<ul style="list-style-type: none">) Use evaluation finding for further improvement,) Use data for decision making 	<ul style="list-style-type: none"> Mobile phone Face to face 	H
Partners (Plan Ethiopia, Wash Project)	<ul style="list-style-type: none">) Support on supply and demand creation, mobilization of resources) Involve in advocacy, learning and coordination 	<ul style="list-style-type: none">) Select evaluation question and method) Developing evaluation indicator 	<ul style="list-style-type: none">) Use evaluation finding for resource allocation 	<ul style="list-style-type: none"> Email Mobile phone 	H
Manna Woreda education	<ul style="list-style-type: none">) Providing support on community mobilization,) Collaborators 	<ul style="list-style-type: none">) Serving as source of data 	<ul style="list-style-type: none">) Use source of data for information 	<ul style="list-style-type: none"> Face to face 	M

Sector			dissemination		
Manna woreda administrati ve unit	<ul style="list-style-type: none">) Coordinate all stakeholders and actors at woreda and community levels) Support supply 	<ul style="list-style-type: none">) Serve as source of data) Disseminating information 	<ul style="list-style-type: none">) Use evaluation result for decision making and resource allocation 	Face to face	M
Women, child and youth affairs office	<ul style="list-style-type: none">) Collaborators 	<ul style="list-style-type: none">) Serving as information disseminator 	<ul style="list-style-type: none">) Use the finding for information dissemination 	Face to face	L
Manna woreda health office	<ul style="list-style-type: none">) Coordinate all stakeholders) Provide technical assistance) Conduct follow up and supervision) Perform regular reporting and documentation activities 	<ul style="list-style-type: none">) Description of program history) Select evaluation question and method) Serving as sources of data) Interpreting the finding 	<ul style="list-style-type: none">) Use for accountability) For program improvement) Use for decision making 	Face to face	H
Health center	<ul style="list-style-type: none">) Link improved hygiene and sanitation to model households) Provide information to community about sanitation products) Register, document and report households having demand for improved 	<ul style="list-style-type: none">) Description of program history and activities) Developing evaluation indicator and criteria) Serving as sources of data 	<ul style="list-style-type: none">) Use for accountability) Use for program improvement,) Use for decision making 	Face to face Mobile phone	H

	sanitation and hygiene				
Health post/HEW	<ul style="list-style-type: none">) Ensure all HHs properly implement improved sanitation and hygiene) Register, document and report households sanitation and hygiene facilities 	<ul style="list-style-type: none">) Serving as sources of data) Interpreting and use the finding) Description of program history and activities 	<ul style="list-style-type: none">) Use for accountability) Use for program improvement 	Face to face Mobile	H
Religious, kebeles leader	<ul style="list-style-type: none">) Mobilization of communities) Play role model for the community 	<ul style="list-style-type: none">) Description of the program) Supply of resources 	<ul style="list-style-type: none">) Use for information dissemination 	Discussion	H
Program Communities	<ul style="list-style-type: none">) Construction, maintenance and utilization of standardized latrine 	<ul style="list-style-type: none">) Serving as sources of data 	<ul style="list-style-type: none">) Use for program improvement 	Discussion	H

level of importance;

High- Those participated in decision making in addition to facilitation and coordination of the program

Medium –Those who are not obligated to participated in decision making but important in the evaluation program

Low - Those which didn't involve in decision making but have role in the implementation of the program

2.2. Goal and objective of the programs

Goal of the program

- Reduction Of Morbidity And Mortality Disease Related To Sanitation And Hygiene.

Objectives of the program

- By the end of 2019 Increased HHs who constructed standardized latrine 52% to 82%
- By the end 2019 Increased HHs utilizing latrine from 52% to 92%
- By the end of 2019 Increased ODF villages 42% to 66%.

2.3. Major strategies

- Community participation and ownership.
- Strengthening and encouraging community knowledge and skills.
- Strengthen inter-sectorial collaboration of all actors.
- System Strengthening, Integration, harmonization and alignment of stake holders.

2.4. Program resource, activities, output and out-come

Program resource:-

- The manpower,
- Finance,
- Guidelines,
- Recording tools,
- Reporting formats,
- Supervision checklist

Program Activities:-

- Training of manpower,
- Conducting Community advocacy on CLTSH,
- Conducting triggering villages/community,
- Constructing latrine at households level
- Verifying and celebrating ODF villages,
- Reporting quality information

Program output:-

- Trained manpower
- Triggered community
- Constructed standardized latrines by Households after triggering
- Increased Latrine with hand washing facilities and soaps/substituent
- Triggered village and reached ODF
- Certified villages for ODF status
- Quality of information reported

Program Outcome:

- Improved awareness of the community on the benefit of latrine and Hand washing facilities,
- Increased coverage and utilization of latrine
- Improved access to standardized latrine with hand washing facilities and soap/ash.
- Increased ODF villages.

Program impact:-

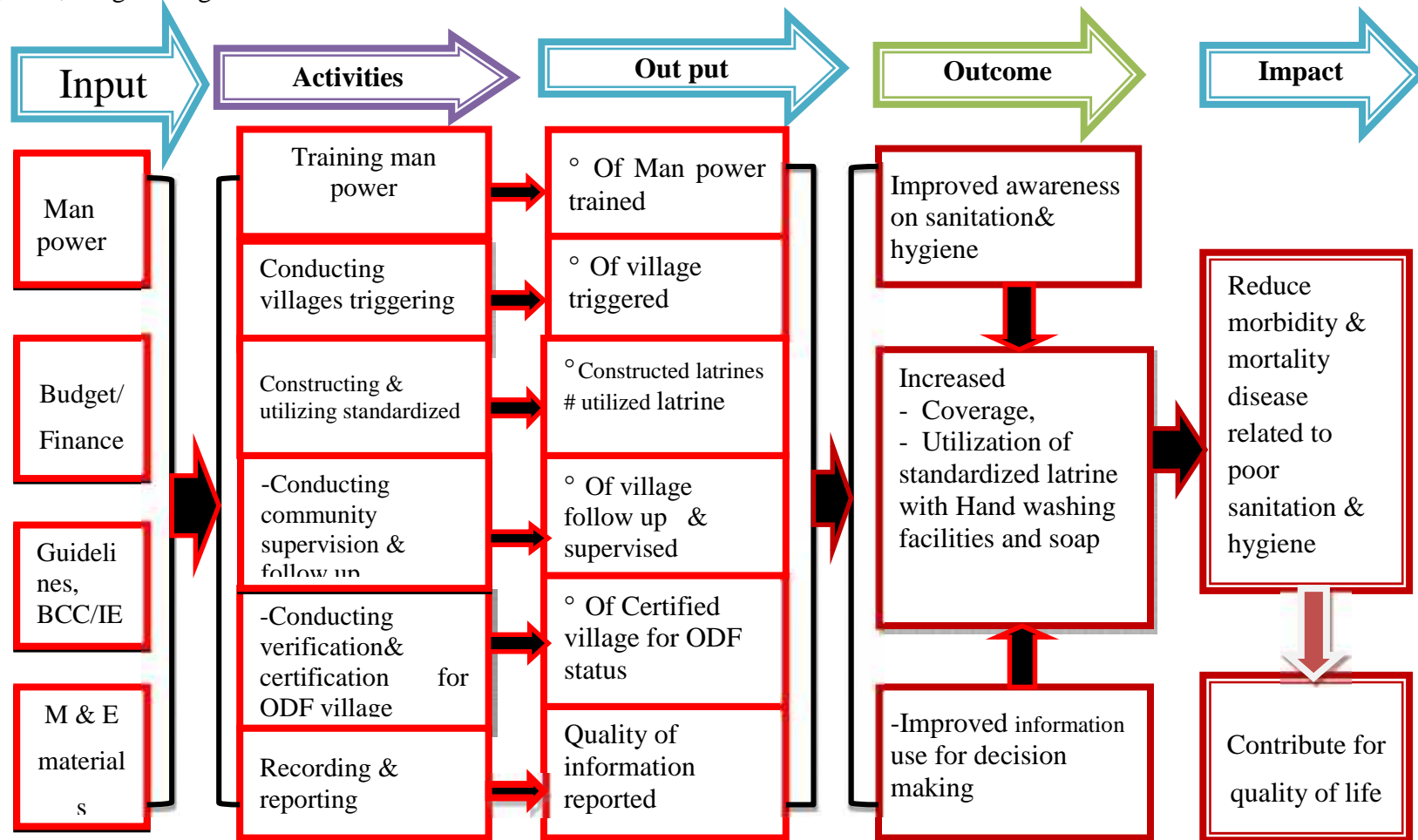
- Reduced mortality and morbidity related to poor sanitation and hygiene.
- Contribute for quality of life

2.5. Program Logic Model

Problem statement: In Ethiopia up to 80% of the disease burden related to poor sanitation and hygiene, and 3/4 of the health problems of under five children are communicable diseases comes from the environment, specially water and sanitation (8).

Goal: To reduce morbidity and mortality related to sanitation and hygiene in Manna Woreda, Jimma, Oromia, 2019.

Figure 1; Program logic model Manna Woreda health office.2019.



2.6. Stage of program development

In Ethiopia CLTSH training is conducted in Arba Minch in 2006 by Dr. Kemal Kars for the first time and proceeds to 40 Woredas of Amhara, Tigray, SNNPR and Oromia regions of the country that was built on global and national experiences gained in the pursuit of previously attempted community-driven approaches, including Community-Led Total Sanitation and Community-Led Total Behavioral Change in Hygiene and Sanitation (CLTBCHS)(18).

The Water Supply and Sanitation Collaborative Council (WSSCC) and Global Sanitation Fund (GSF) initiated a program termed as Ethiopia Sanitation and Hygiene Improvement Program (E-SHIP) in 2013. The program was implemented by the Ministry of Health through Health Extension Program (HEP) and financed by the Global Sanitation Fund(17).

The CLTSH approach combines the basic principles of Community-Led Total Sanitation with intensive interpersonal communication to foster improvements in hygiene practice through problem solving and collective action.

The CLTSH Program was introduced which made it compulsory for each household to have a latrine. As no subsidy was given for this and the idea behind the program was to achieve Open Defecation Free (ODF) status in all villages in the region(19).

CHAPTER 3:- LITERATURE REVIEW

Worldwide sanitation coverage rates have increased with 68% of the population using improved sanitation facilities in 2015 compared to 54% in 1990(23). The recent data Mini EDHS indicate that, in Ethiopia more than half 55% of households (56.7% in rural and 4.4% in urban areas) access to unimproved sanitation and Only 4.2% of households (10.1% in urban and 2.3% in rural areas) accessed improved toilet facilities that not shared with other households(1). A 2015-16 survey of CLTSH across 8 Regions of Ethiopia has also found that open defecation continues to reduce across the country, now estimated at 32% (20).

From research conducted in Kersa Woreda only 36.4% households had latrines in open defecation free kebeles (4). Availability of latrine facility was 81.2% in Oromia,71.4% in Amhara, and 89.7% in SNNP(24). A cross sectional survey of latrine availability in ODF kebele showed that (68%) in Laelay Maichew District North Ethiopia (25), 62.5% in Hintalo-Wajirat Tigray region (15), 58.4% in study conducted at Awabel district North Ethiopia (32).

Consequently, study conducted for availability of hand washing facilities near the latrine were 13.6% in Hetosa Woreda Arsi zone(1), 24.5% Hintalo-Wajirat Tigray region(15), 73.06% in Kersa(12). 4.2% Laila Maichew District, North Ethiopia(25). Regarding hand washing facilities with soaps study conducted in Arsi zone Hetosa Woreda shows that 18.3%(1), study conducted by UNICEF Ethiopia68% (17) and Awabel district North Ethiopia 26.8%(32). Result of latrine squat availability shows that 15.5% conducted in Hetosa Woreda Arsi zone(1), Laela Maichew District, North Ethiopia,38.6% (25).

Moreover, Global sanitation fund program outcome evaluation concludes that the CLTSH program improve all hygiene and sanitation situation of implementation area. As the outcome of 40 Woredas in the country after CLTSH implementation indicated coverage was improved in all Hygiene and sanitation program i.e. Household latrine coverage from 12% to 81.6%, access to improved water source 41.7% to 73.3%, safe water storage 8% to 93.5%, access to hand washing facility near latrine from 7% to 30.7%(1). As study conducted in Wando Genet district revealed that rate of latrine utilization among open defecation free kebeles in the rural community is about 83.1%(28), 88% in Hetosa Woreda in Arsi zone (1), 68% Unicef Ethiopia (17).

Regarding hand washing facilities utilization 49.5% Hetosa Woreda Arsi zone(1), 62.1% Laela Maichew District North Ethiopia(25), 73.6% at kersa Woreda(12) were on utilization during data collection. Study about soaps/substituent near hand washing facilities freshly used during data collection shows that 42.3% at Hetosa Woreda Arsi zone (1), 81% study at Kersa Woreda (12). From study conducted at Hetosa Woreda Arsi Zone 15.5% of latrine squat cover holes were on utilization during data collection(1) and 2% study conducted at Laela Maichew District, North Ethiopia(25). Additionally, all families members were only utilized latrine from study conducted in Tigray 40% (15) and Hetosa Woreda Arsi Zone, 83.2%(1).

Despite of the fact that, hierarchical pressure had a strong influence on behaviors of latrine utilization. Study conducted in Rural Zambia shows that being influential with traditional leaders often creating and enforcing binding local regulation (local community by laws) that require all households' members to construct and use of latrines(8).

Conceptual frame work

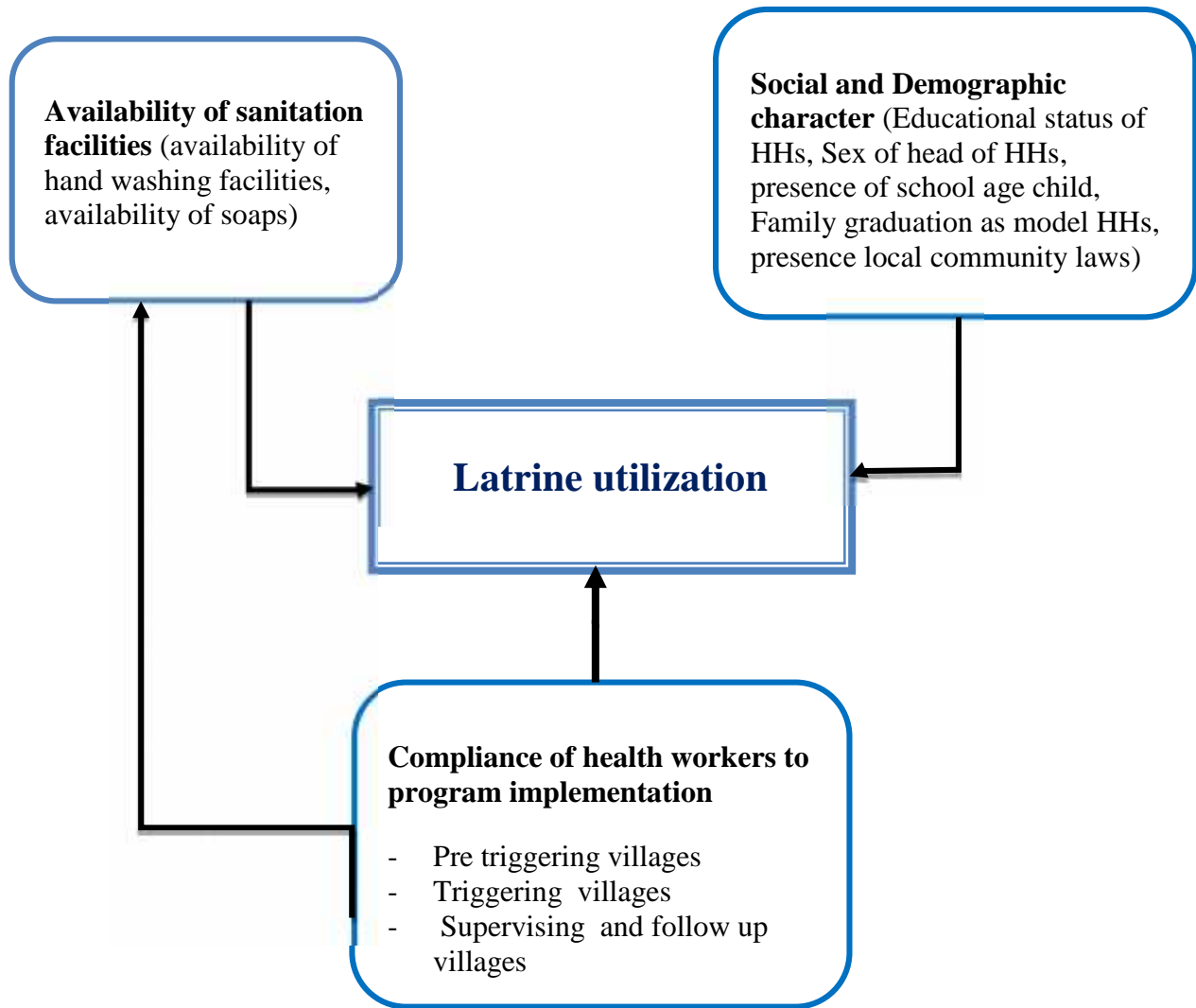


Figure 2:- Conceptual frame work of outcome evaluation of CLTSH program in Manna Woreda, Jimma, Oromia, 2019

CHAPTER 4:- EVALUATION QUESTIONS AND OBJECTIVE

4.1. Evaluation question

- To what extent the households have sanitation facilities? If not why?
- How do households utilize available sanitation facilities?
- Did the health workers complying with national guideline to achieve the intended outcome of CLTSH program? If not, why?

4.2. Objectives of the evaluation

General objectives;

- To assess the extent to which CLTSH program achieved its objectives in Manna Woreda by 2019.

Specific objective;

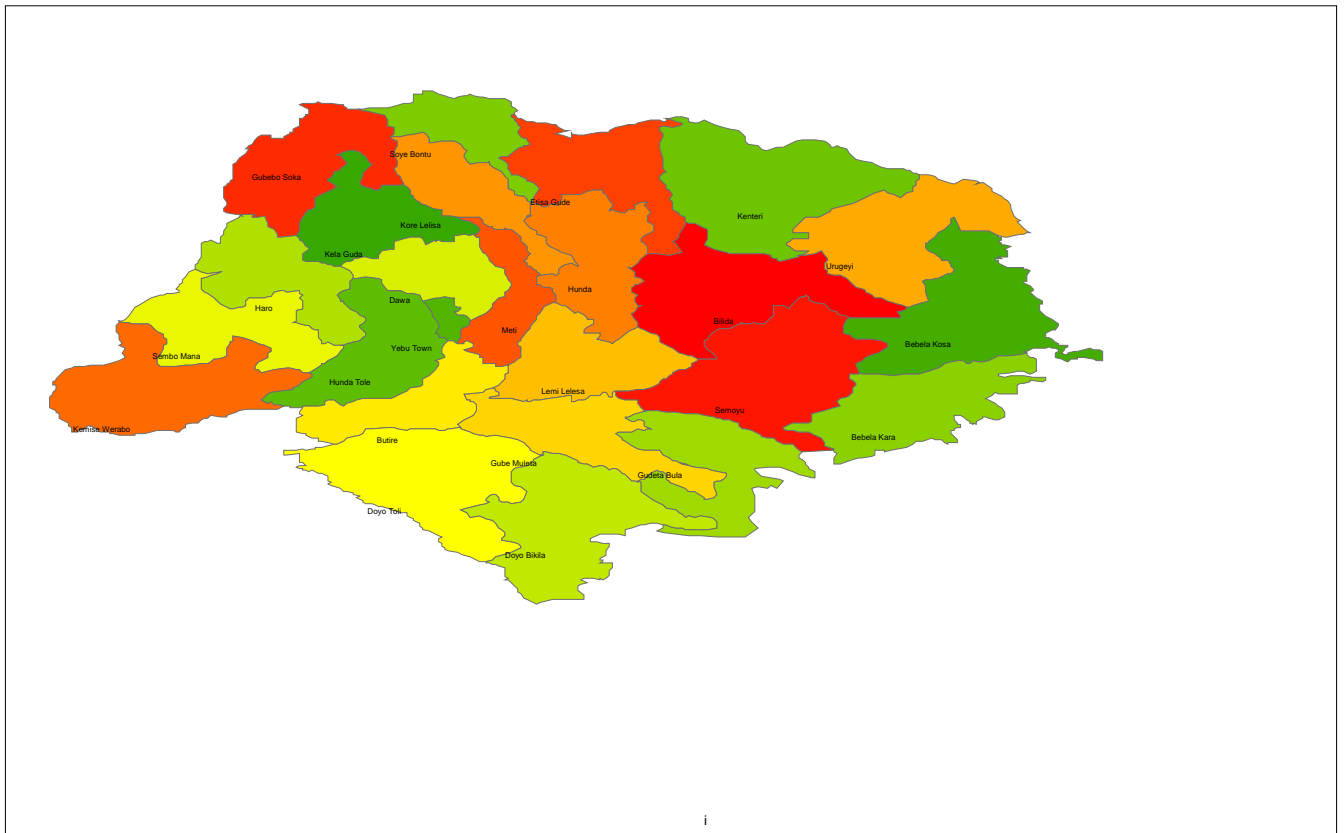
- To assess availability of standardized latrine among households in Manna Woreda, by 2019
- To determine level of utilization standardized latrine among households in Manna Woreda, by 2019.
- To determine factors affecting utilization of standardized latrine among households in Manna Woreda, by 2019.
- To assess health workers compliance to national guideline in realizing objectives of CLTSH program in Manna Woreda, by 2019.

CHAPTER 5: EVALUATION METHODS

5.1. Study Area

The study was conducted in Manna Woreda 22km far away from Jimma town and 370 km from Addis Ababa to south West direction. The Woreda has an area of 47,891KM²(47.891 hectare), and an elevation of 470-2610m above Sea level which contain total population of 1960153 and 34292 total Households. Geographically Manna Woreda is bounded by Seka Chokorsa in the South, Gomma Woreda in the West, Limmu Kossa in the North, and Kersa Woreda in the East direction. The administrative center of the Woreda is located in Yebu town containing. The Woreda has 26 kebeles (2 urban and 24 rural kebeles) which encompassed of seven cluster consists of 78 zones, 186 gare and 4336 one to five net-works (1-5 network). The Woreda has also has seven health centers and 26 health posts which consists of 183 health professionals and 67 health extension workers respectively.

Figure 3; Map administrative unit of Manna Woreda, Jimma, Oromia, 2019.



5.2. Evaluation period

The evaluation was conducted from March 15/2019 up to March 25/2019.

EA was conducted from February 1-10/2019.

5.3. Evaluation approach

Summative evaluation approach was used to identify extent to achievement of the program's objectives, and to determine how much the program objectives was successful achieved.

5.4. Evaluation design

Cross-sectional study design was used for evaluation of the program, because it has an advantage to understand programs information of outcome interest over a certain period of time. Also it helps for description of the extent and trend of risk factors, distribution of variables, and association among variables. Hence it can be adopted as both descriptive and analytic approaches. Therefore for descriptive type variables like coverage of intervention, utilization, and compliance of health workers to the program implementation and approach of program exposure and its effects (outcomes) on target beneficiaries was carried out(38). Information's related to program components was collected using qualitative and quantitative data collection methods.

5.5. Focus of Evaluation and Dimensions of Evaluation

5.5.1. Evaluation Focus

Programs were often established to meet one or more specific objectives which were described in the original program plans. So, out-come evaluation was used to conduct this evaluation, and study would be conducted to assess standardized latrine availability, latrine utilization and compliance of health workers with national guideline to the program in Manna Woreda.

5.5.2. Evaluation Dimension

The availability of standardized latrine, utilization of standardized latrine and compliance of health Workers to the program guidelines with the program was assessed in selected kebele of Manna Woreda.

5.6. Indicators/Variables

The following 16 indicators was selected with stakeholders of the program to identify inputs, activities, outputs and outcomes of the program interest based on selected dimensions.

Availability: -

- Proportion of households constructed standardized latrine facility
- Proportion of households with hand washing facility near the latrines
- Proportion of households availing soaps/substituent near hand washing facility.
- Proportion of households availing cover holes on the hole of slab latrine

Utilization: -

- Proportion of households with fresh foot path leading to the latrines.
- Proportion of households who functional hand washing facilities near the latrines.
- Proportion of households with fresh used soaps/substitute near hand washing facilities.
- Proportion of households latrine squats with cover hole on service.

Compliance:-

- Percent of health professional trained on CLTSH according to the standard.
- Proportion of villages pre-triggered according to CLTSH national guidelines.
- Proportion of villages triggered according to CLTSH national guidelines
- Proportion of villages/community follow up by health professional within one month of triggering
- Proportion of villages certified according CLTSH national guidelines
- Proportion of villages set local community laws to cause and to punish offenders during triggering
- Percentage of health facilities sends their complete report according to CLTSH national guidelines.

Variables:-**❖ Dependent variables:**

- Latrine utilization

❖ Independent variables:

- Educational status of households
- Sex of head of households
- Family graduated as Model households
- Presence of hand washing facilities near latrines
- Presence of hand washing facilities with soaps/substituent near latrines
- Presence of local community laws in the village

5.7. Populations and sampling

5.7.1. Target populations

All households in rural setting of Manna Woreda were considered as target populations.

5.7.2. Source of Population

All households in seven cluster of Manna Woreda.

5.7.3. Study population

All households from randomly selected kebeles

5.7.4. Study Units/unit of analysis

All randomly selected 482 households from selected kebeles, 15 individuals (9 from selected kebeles, 4 from health centers and 2 from Woreda health office), and document review at 20 health facilities (7 health centers and Woreda health office 12 health posts).

5.7.5. Sample size

Sample size for quantitative survey of households in the selected kebeles

$$n = (Z_{\alpha/2})^2 P(1-P)/d^2$$

Where: n = sample size used for data collection.

P = prevalence of latrine utilization in ODF 74.5% (source:- Assessment the magnitude of latrine utilization and associated factor in ODF rural Hetosa Woreda, Arsi, Ethiopia) which similar in population setting with Manna Woreda (39).

d = is precision of the estimate = 5%

Z = value at 95% level of significance () 1.96.

Accordingly, the calculated sample size will be as follows:

$$n = \frac{(1.96)^2 \cdot 0.7 \cdot (1-0.7)}{(0.05)^2} = 292$$

Design effect corresponding to Multistage sampling 1.5.

Then sample size is $292 \cdot 1.5 = 438$

Final sample size with Non-response rate 10% $= 438 + 44 = 482$

5.7.6. Sampling procedure/Technique

Both Quantitative and qualitative sampling technique was used to collect data. For quantitative cross-sectional survey, multi stage sampling technique was used to get required data from 12

randomly selected kebeles and for qualitative purposely selected KII from Manna Woreda health office and 4 head of health centers, 9 selected community leaders from best performers from selected kebeles and document reviewed at Woreda Health office, 7 Health Centers and 12 health posts from selected kebeles. Depending on proportional allocation of HH size at each cluster number of randomly selected kebeles was determined as follows, and a list of HH from selected kebeles were entered in to the computer and name of HHs contacted were drawn.

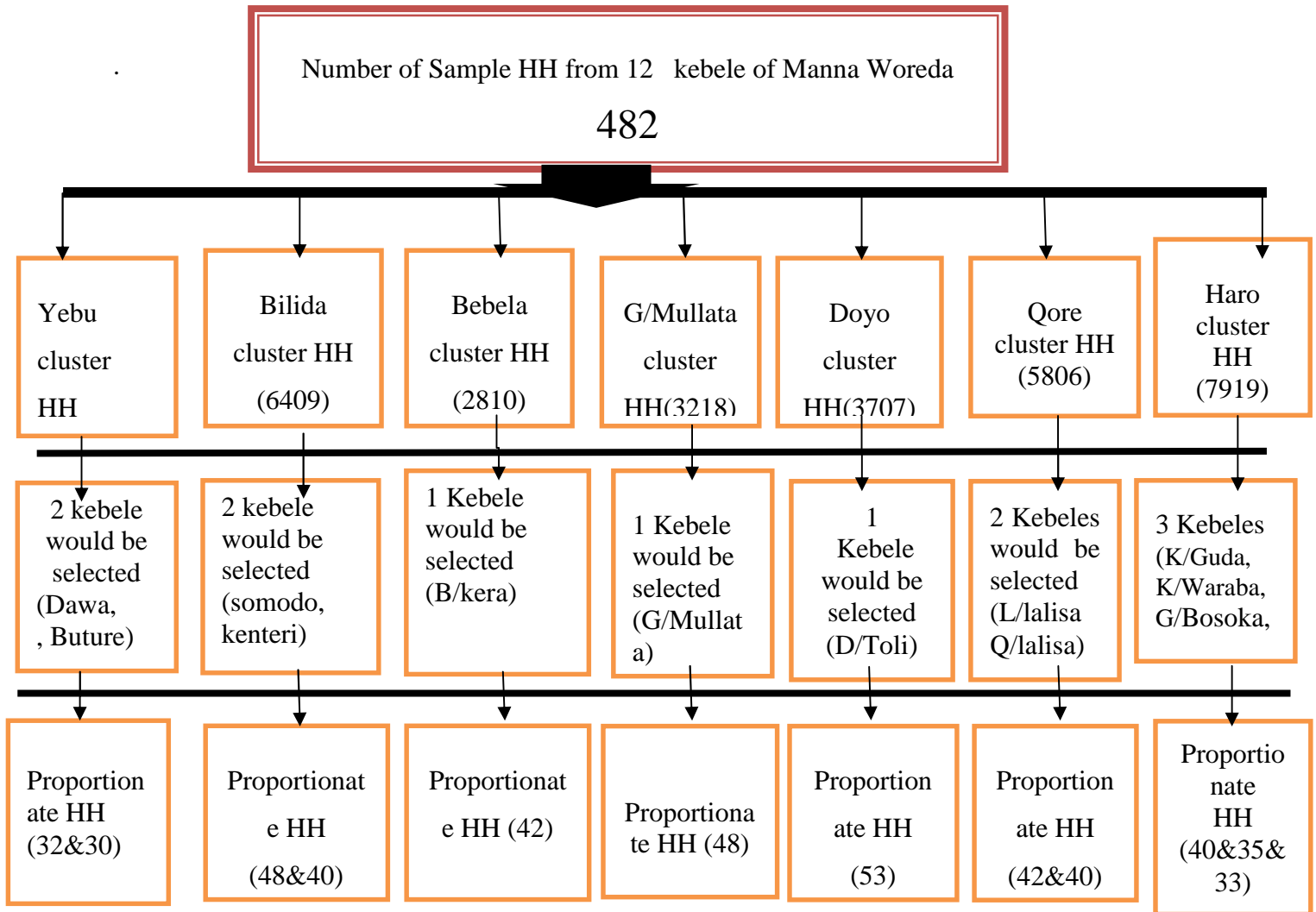


Figure 4:- Proportional allocation of households in Manna Woreda, Jimma Zone, Oromia, 2019

5.7.7. Inclusion and exclusion criteria

Inclusion

- All Households residing in selected kebeles in Manna Woreda.

Exclusion criteria

- Households residing in selected kebeles who cannot respond due to health problem.
- Children less than 18 year's age were not included in the study unit

5.8. Data Collection

Both quantitative and qualitative data collection method was used to get raw data from selected households and individuals by semi-structured questionnaires, observational checklist and document review.

5.8.1: Development of data collection tools

A. Questionnaire: preliminary questions have been presented to recruited data collectors and supervisors, and further developed during the training and pre-test. However, the questions incorporated into a questionnaire of households survey were structured, and almost close ended composed of demographic, availability of standardized latrine and utilization of existed standardized latrine.

B. Check list: For observations that were carried out at the selected households, and check list of documents reviewed that states the required document at Woreda, Health centers and health posts level. Accordingly, necessary documents from selected health posts, Health centers and Woreda Health offices have been collected and reviewed.

5.8.2: Data collectors

The data collectors in this study were diploma graduate of health professional students with COC success and two supervisors which were found in the respective Woreda. Consequently, two BSC health professional and three data collectors was employed to participate in data collection who were hired from no-study areas to minimize bias.

5.8.3: Data collection field work

After training were given for both supervisors and data collectors for two days, process of data collection was carried out for 10 days and supervision conducted for each data collector every day. Daily performance, the way of the data collection process was assessed with the group members and appropriate correction for the next day in case when problem occurs.

5.8.4: Data quality assurance

Three data collectors and two supervisors were trained together three days prior to the starting of fieldwork. They have been trained for two days on how to approach households during the study, how to collect data, on how to control missing data, on how they put their observations in response to observational questions, and on how to communicate fieldworkers with supervisor.

Adapted questionnaire (39) and checklists was prepared in English, and translated to local language Afan Oromo by experienced health professional. Then the questioner was tested on 24 households (5% of the sample size) in Gembe kebele Gomma Woreda prior to the data collection. The response of the households were checked by supervisors and the principal investigator by administrating the questions/questionnaire at the end of the data collection to randomly selected 29 (6%) households of the households already visited by the fieldworkers. Furthermore, supervisors have checked everything recorded by a field worker in each questionnaire on daily basis having an objective of ensuring no data are missing, and data are precise and accurate.

5.9: Data management and analysis

5.9.1. Data entry

Data generated from the households' survey have been first cleaned and edited manually for consistence and completeness. Then it was entered into epidata version 3.1, and exported to SPSS version 21 data base for analysis.

5.9.2. Data cleaning

- **At field work:** - On daily basis field workers checked for internal consistency and recompleted for incomplete data. Also incomplete, inaccurate, inconsistent or invalid data obtained were detected and corrected or removed by discussing with evaluation team daily.
- **After data entry:** - After data cleaned, coded, entered into Epidata version 3.1 and exported to SPSS version 21 data for analysis. Then outliers was retained or justified, by calculating frequency missed data was identified and corrected.

5.9.3. Data analysis

After checked and coded, quantitative data was entered in to epidata version 3.1 and transported to SPSS version 21 for analysis. Descriptive statistics was used for quantitative data to determine frequencies and means, and analytical statistics by multiple logistic regression analysis was employed to identify predictor of outcome interest for the program, and statistically significant value was considered at cut-off point of $p < 0.05$.

Accordingly, percentages of various degrees of coverage and utilization of sanitation facilities by households were calculated and described to estimate the outcome level of the program at households' level and presents it using tables, charts and graphs.

On the other hand, the qualitative data were organized and analyzed in content analysis, and then results were presented in narrative form. Additionally; the results of the households' survey were supplemented by results of in-depth interviews.

Consequently; first, availability and utilization of latrine facilities of the study population was analyzed from the households' survey, and compliance of health workers to national guidelines was analyzed at health facilities level. The information from these in-depth interviews and document reviews were also be either analyzed to point out important findings or synthesized to produce sensible information. Then after, findings were compared to the previous study or with national guidelines.

5.11: Ethical Issue

The ethical approval and clearance letter was obtained from Jimma University Institutional Review Board Committee and Oromia Regional Health Bureau. In addition, official permission

and letter for health facilities was obtained from Manna Woreda health office. During data collection all respondents was asked their permission and informed consent was obtained privately and individually prior to the interview. Confidentiality of the respondent was kept and information they provide was not disclosed to any one and their name was not written on questionnaire.

5.12: Evaluation dissemination plan

Final draft of this outcome evaluation document was disseminated to the key stakeholders for their comments, after completion of the study before presenting the document to the responsible body. The comments were included without changing the original result. It was then presented to Jimma University Health Monitoring and Evaluation unit and comments was incorporated before dissemination of hard copy and soft copy of the final report to respective stakeholders.

CHAPTER 6: RESULTS

6.1. Socio-Demographic Characteristics

Four hundred eighty two households were included in the study making a response rate of 100%. Majority of these study participants were female 328(68%), and participants' age lies between 18years and 76 years with mean age value 41.5 years (SD= 10.96). Majority of households participated in the study were farmer 373(77.4%), and about 181(48.6) of these farmers were educated formal education. The mean value family size of studied households in selected kebeles were 4-(SD=1.405).

Table 2: - Socio demographic characteristic of households in selected kebeles Manna Woreda, Jimma, Oromia, 2019.

Variables	Category	frequency	%
Head of households	Male	154	32.0
	Female	328	68.0
Educational status of households	No education	209	43.4
	1-8grade	227	47.1
	9-12grade	31	6.4
	>12grade	15	3.1
Occupational status of husbands	Farmer	373	77.4
	Government employ	43	8.9
	Private	50	10.4
	Others	16	3.3
Under five year children in the family	Yes	240	49.8
	No	242	50.2
School age children in the families	Yes	341	70.7
	No	141	29.3
Ethnicity of the respondents	Oromo	373	77.4
	Amhara	35	7.3

	Dawaro	40	8.3
	Others	34	7.1
Religion of the respondents	Muslim	368	76.3
	Orthodox	53	11.0
	Protestant	36	7.5
	Others	25	5.2

6.2. Availability of resources for implementation of CLTSH program.

From document reviewed at twenty health facilities, CLTSH national guideline was availed only at one health facilities. Despite of the fact that the program was fully implemented in the study area for a long, it was not supported with budget and other logistic for program improvement.

6.2.1. Characteristics of available latrine

Out of total observed households latrine status, 400(83%) of them had standardized latrine. Majority of households' latrine, 342(71%) were traditional pit latrine with slab made of wood and earth while only, 19(3.9%) were ventilated improved latrine.

This study was also supported by qualitative findings. More than half of key informants interviewed in study area addressed that households who participated during triggering and exercised the process of triggering were constructed standard latrine in their compounds.

Another, 45 years age Man kebele leader, mentioned that: *“In our villages most of households participated during triggering stage were constructed latrines while Others who did not participated and did not exercise the process of triggering were late to construct and they simply used pit latrine. Also some others with educated and rich people were constructed ventilated improved latrine. But, some households like old age and under poverty were unwillingness to have their own latrines.”*

Similarly, another 37 years woman, HDA leader mentioned: *“In our village after we trained as 1-5 network we supervise each household latrine status in collaboration with HEW, religion leader and community leader to construct their own latrine so, majority of households in our village had standard latrine.”*

Majority of households' latrine 293(73%) were far greater than 20 meters from the main houses. Most of households 340(70.5%) were greater than two years since they own their own latrines. Among total observed households' latrines, 341(70.7%) were with hand washing facilities. Majority of observed total hand washing facilities 325(67.4%) had water in the container during data collection. Among conducted hand washing facilities, 316 (65.8%) were functional during data collection. Majority of conducted hand washing facilities, 274(56.8%) had soaps/substituent. Additionally, from observed latrine, 322 (67%) of latrine slab had squat cover hole. Majority 223(46.3%) slab of latrine squat was flat made of table simply covers the holes.

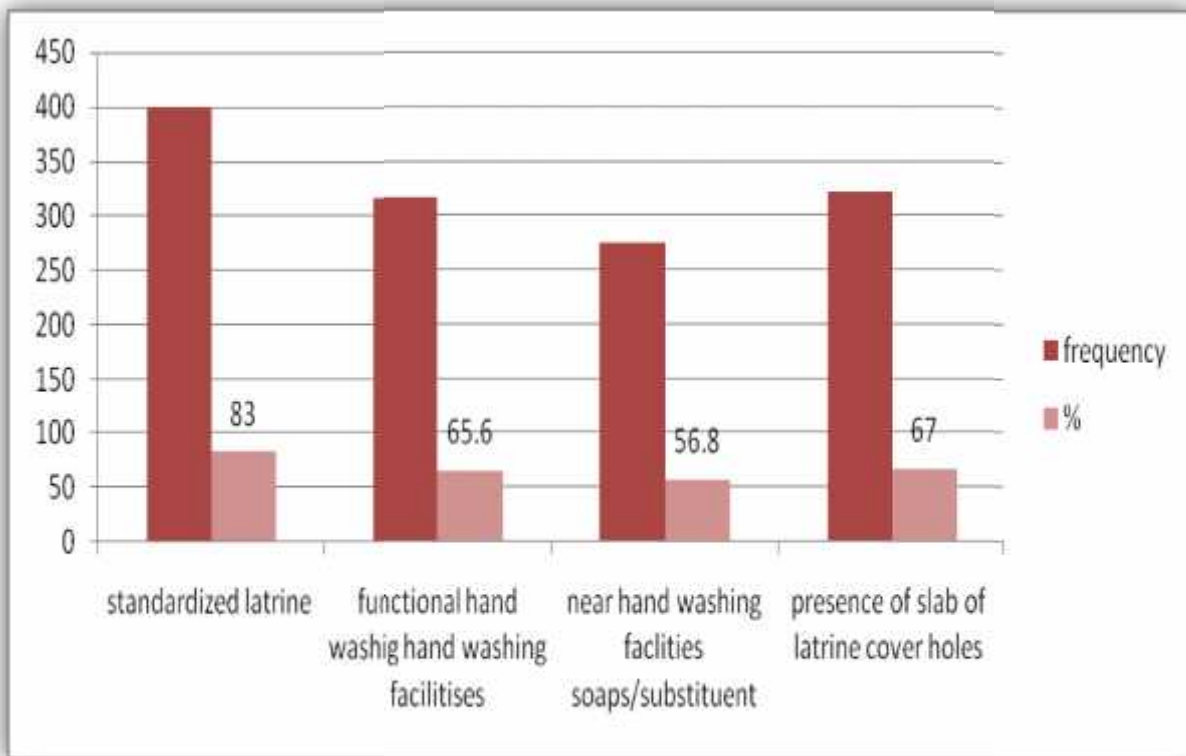


Figure 5: Types of sanitation facilities studied households in selected kebele of Manna woreda, Jimma zone, Oromia, 2019.

Regarding to avaiability of sanitation facilities an ideepth interview was conducted to reason out why some households did not had standardized latrines. Three fourth of key informants interview addressed that house holds who did not participated during triggering stage, old people who cannot afford , daily labours and households with rented house were deny to had latrines.

Another 38 years man, village leader mentioned that:-“ *In our village majority of people with out latrine were old age, daily labours and under poverty who cannot afford to construct their own latrine. Aditionally, some peoples did not know the advantage of having a latrine.*”

Similarly, 32 years health extension worker mentioned that; “ *even though I conducted supervision and follow up households latrine status, some of them with daily labours, old age, under poverty were refused to construct their own latrine. Also some households needs new face during follow up to enforce them construct their own latrine.*”

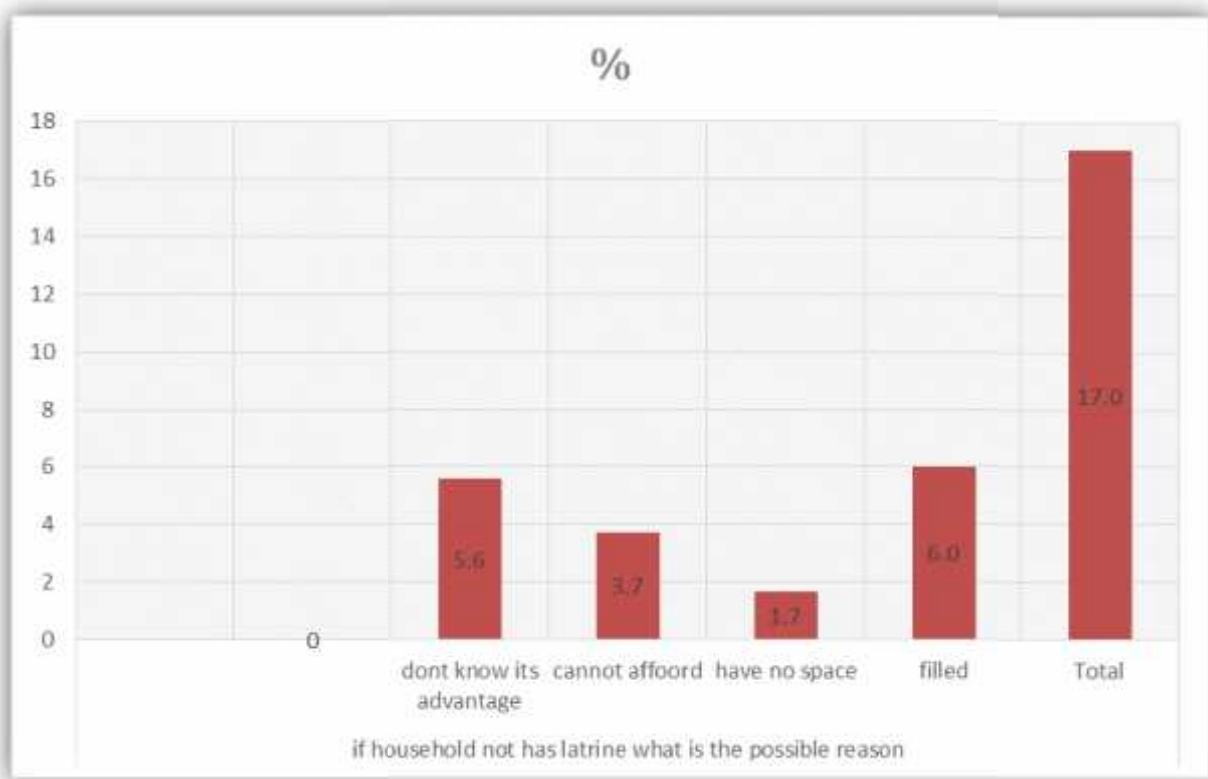


Figure 6: Reason of households that did not have latrine in selected kebele, Manna Woreda, Jimma, Oromia, 2019.

Table3:- Judgment matrix of availability indicators used for evaluation of CLTSH program in Manna Woreda, Jimma, Oromia, 2019.

Indicators	Weight given	observed value	Value achieved (%)	Agreed Criteria	Judgment criteria
Proportion of households constructed standardized latrine facility in their compounds	8	7	88	80 V.Good 68%-80%- Good 55%-67% - Fair <55% - poor	V. Good
Proportion of households with hand washing facility near the latrine	8	6	75		Good
Proportion of households availing soaps/substituent near hand washing facilities	7	4	57		Fair
Proportion of households with slab of latrine had cover holes	7	5	71		Good
Availability Dimension	30	22	73		Good

6.3. Magnitude of Latrine utilization

Majority of households' latrine observed 382(79.3%) were fresh foot path leading to latrine during data collection, and 28(5.8%) of households without latrine were also used public latrine during defecation (Table 5).

Table 4:- Magnitude of latrine utilization in selected kebele of Manna Woreda, Jimma Zone, Oromia, 2019.

variables	category	frequency	%
Fresh foot path leading to the latrine	Yes	382	79.3
	No	18	3.7
Place were families without latrine defecated	In the forest	15	3.1
	In public latrine	28	5.8
	In the garden	36	7.5
	Others	3	.6
Place where families with children defecate their feces	Popo	180	37.3
	Drain	46	9.5
	Garbage	14	2.9
During journey where did you defecate	Public latrine	416	86.3
	Open field	34	7.1
	Used abroad side	26	5.4
	Others	6	1.2

This finding was also supported by qualitative result, about two third of key informants interview addressed that majority of households in the study area who participated during triggering, follow up by HEW, who set local community laws to punish the offenders and got health education during community meeting were only utilized latrines during defecation.

Additionally, another 24 years kebele leader mentioned that; *“In our kebele we periodically organized all staff of kebele members to supervised and follow up the villages together with health extension workers, and we also gave health education on community meeting at different place to used only latrines.”*

Similarly, 30 years woman HADs, leader mentioned: *“In our village we have community meeting to assess health status of our villages, and have local community laws to punish the offenders. So, most of our households in the villages were only used latrine during defecation.”*

Out of study participants, 379(78.6%) of households' family members were only used latrines during defecation. About (255(64%)) of households revealed that all their families members were only used latrine during defecation due to fear of local community by laws in their villages to punish the offenders, and (244(61%)) of family graduated as model households revealed that their families members were only used latrine during defecation.

Consequently, Out of hand washing facilities containing water (316(65.6%)) were on utilization during data collection by proxy indicator like sweet land under the container. Likewise among total observed soaps/substituent near hand washing facilities, 274(56.8%) were freshly used during data collection. Majority of observed total households' latrines, 313(64.9%) were with squat cover holes during data collection.

This study was supported by qualitative findings. More than three fourth of key informant interviewed addressed that, households who participated during triggering stage, strong leadership at kebele and village levels, and highly committed HDAs to follow up each households were utilized hand washing facilities and soaps regularly.

Additionally, 36 years Man, Village leader mentioned that;

“ ..In my family we have standardized latrine that contain hand washing and soaps, and we always use after defecation. Even if there was no soap, we used ash, and majority of households in our village who graduated as model households were also always used hand washing facilities and soaps.”

Another 42 years, HEW mentioned that;

“I conducted supervision and follow up of the community on regular basis in my zones. Majorities of peoples in the zones were graduated as model households used hand washing facilities and soaps. But the others with hold age and poverty also used movable highland as hand washing facilities and also used ash.”

6.3.1 Reason not to Utilize latrine

Among respondent who were not utilized latrine were reason out that, slab is not save, squat hall is big and offensive odor. Likewise majority of households' families members not utilized their latrines were used in garden and public latrines (Table 6).

Most of observed households' (436(90.5%)) compounds during data collection were free of open field defecation. About 17(3.5%), 15(3.1%) and 18(3.7%) of families not always utilized latrine revealed that latrine is not comfortable to use, squat hole is big and slab of the latrine is not save respectively.

6.3.2. Factor affecting utilization of latrines

Binary logistic regression analysis was undertaken for each variable in relation to latrine utilization from all study population. The result of variables those made statistically significant association reviewed according to factors indicated on the conceptual framework, and variable with P-value<0.25 were mandated for further analysis (Table7).

Table 5:- Binary logistic regression analysis results of latrine utilization in selected kebele, Manna Woreda, Jimma, Oromia, 2019.

variables	category	Do all households' members only use latrines		p-value	COR	95% CI
		yes	No			
Family graduated as model household	Yes	336(70%)	43(9%)	0.009	0.471	(0.267, 0.832)
	No	81(17%)	22(5%)			
Is there school age children in the families	Yes	276(57%)	103(21%)	0.056	0.64	(0.403, 1.011)
	No	65(13%)	38(8%)			
Hand washing facilities near latrines	Yes	281(58%)	98(20%)	0.001	0.26	(0.165, 0.409)
	No	44(9%)	59(12%)			
Near hand washing facilities is there soaps/substituent	Yes	274(57%)	105(22%)	0.001	0.25	(0.161, 0.399)
	No	41(9%)	62(13%)			
presence of local	Yes	270(56%)	109(23%)	0.001	0.182	(0.113, 0.293)

community laws in the villages	No	32(7%)	71(15%)			
Sex of head of households	Male	121(25%)	258(53%)	0.983	1.005	(0.630, 1.603)
Educational level of households	no education	161(33%)	48(10%)	1	1	1
	1-8 grade	179(37%)	48(10%)	0.743	0.82	(0.250, 2.692)
	9-12 grade	28(6%)	3(0.6%)	0.615	0.737	(0.225, 2.419)
	>12 grades	11(2.3%)	4(0.8%)	0.267	0.259	(0.057,1.536)

Associated factors with latrine utilization were spotted using multiple logistic regression analysis. After backward stepwise analysis presence local community laws (AOR= 4.5) 95% CI (2.74, 7.41), $P < 0.0001$) was significantly associated with latrine utilization. The other variables were not associated with the outcome variables (Table 8).

Table 6:- Multiple logistic regression analysis for candidate variables associated with latrine utilization in selected kebele of Manna Woreda, Jimma zone, Oromia, 2019.

Variables	category	All households' members use only latrines		p-value	AOR	95% CI
		yes	No			
Family graduated as model household	Yes	336(70%)	43(9%)	0.360	1.346	(0.712, 2.543)
	No	81(17%)	22(5%)			
Presence of school age children in the families	Yes	276(57%)	103(21%)	0.703	1.106	(0.66, 1.856)
	No	65(13%)	38(8%)			
presence of hand washing facilities with water	Yes	281(58%)	98(20%)	0.187	1.635	(0.79, 3.393)
	No	44(9%)	59(12%)			
Presence of hand washing facilities with soaps	Yes	274(57%)	105(22%)	0.024	2.301	(1.117, 4.740)
	No	41(9%)	62(13%)			
presence of local community law in the village	Yes	270(56%)	109(23%)	0.0001	4.509	(2.74, 7.409)
	No	32(7%)	71(15%)			

An in depth interview was conducted for seven key informants interview to reason out why all family members did not always utilized latrine. Four of these key informants mentioned that; households without hand washing facilities due to scarcity of water, families who did not graduated as model households, families that were not participated during triggering were not used always latrines. While another key informants said “even if the community was triggered and pre triggered in the study area, in villages not setting local community laws peoples were not doubted to defecate at the open site.”

Another 34 years Woman, Community leader mentioned that; *“In our villages Health Extension Workers did not visited our latrines, even though our people needs continuous follow up and supervision. Additionally, in some village that did not set local community laws, and had not public latrine around road side were defecated at open field.”*

Table 7 :- Judgment matrix for utilization of standardized latrine in selected kebeles of Manna Woreda, Jimma, Oromia, 2019.

Indicators	Weight given	Observed Value	Value achieved (%)	Agreed Criteria	Judgment criteria
Proportion of households with fresh foot path leading to the latrines	6	5	83	85 V.Good 75%-84% Good 65%-74% Fair <65% poor	Good
Proportion of households with functional hand washing facilities near the latrines	7	5	71		Fair
Proportion of households’ family members only used latrine during defecation	8	6	75		Good
Proportion of households with cover hole of the squats of latrines during data collection	6	4	67		Fair
proportion of households with fresh used soaps/substitute near hand Washing facilities	8	5	66		Fair
Utilization Dimension	35	25	71		Fair

6.4: Compliance Dimension

Document was reviewed at twenty health facilities to identify status of village with CLTSH national guidelines. Among reviewed document of selected kebeles at health post level, 342(82%) were both pre triggered (identifying and greeting with the participants) and triggered (village mapping for OD, transect walk, glass of water exercise and calculating flow diagram). Majority village triggered (228(55%)) were supervised and follow up within one month of triggering. Additionally, among triggered villages (237(57%)) were set local community laws to punish the offenders. Likewise (207(50%)) villages were certified for their proceedings to ODF and 103(25%), 63(15%) and 41(10%) of them were certified with green, yellow, and white flag respectively. In addition to this, only one trained health professional was as focal person of CLTSH program in the study area.

From document reviewed for report completeness (registered all content of the reports and signed) and timeliness, all health facilities were sent complete data to Woreda health office with in time scheduled in last six month.

This finding is also supported qualitative result; five key informant interviews addressed that problem of trained man power, lack of budget, limitation of program guidelines, less commitment of the health workers to do on the program were the cause for low achievement of deliberate objectives.

Similarly, 24 years, Man Health Extension Supervisor, mentioned;

“In our health centers we have problem of man power for CLTSH program. I’m a nurse professional, but assigned as focal person for CLTSH without training and give supportive supervision and follow up for the village.”

In-depth interview was conducted for eight health workers to reason out why health workers did not comply with CLTSH guidelines, and more than two third of key informants interview reason out that limitation of trained man power, lack of liquidated budget, lack of training, negligence of health workers on the program in due of any incentives.

Likely, 40 years Woman, head of Woreda Health offices mentioned that;

“In our Woreda there was no enough man power for CLTSH program, and there was also no liquidated budget for the Program to recruit workers. In other case no health professional willing to do on the program due to limitation of budget and other logistics for supervision and follow up of the community.”

Table 8; Judgment matrix of compliance indicators used for evaluation of community led total sanitation and hygiene in Manna Woreda, Jimma zone, Oromia, 2019.

Indicators	Weight given	Observed Value	Value achieved (%)	Agreed Criteria	Judgment criteria
Proportion of kebeles/community pre-triggered according to CLTSH national guidelines	5	4	80	65 V.Good 57%-64% Good 52%-56% Fair <52 poor	V.Good
Proportion of kebeles triggered according to national CLTSH guidelines	6	5	83		V.Good
Number of health professional trained on CLTSH according to the standardized guidelines	4	2	50		poor
Number of health center who send their complete report according to CLTSH guideline	4	4	100		V.Good
Proportion of village set local community laws to punish the offenders	7	4	57		Good
Proportion of villages supervised and follow up by health professional within one month after triggering	5	3	60		Good
Proportion of villages certified according CLTSH national guidelines	4	2	50		poor
Compliance Dimension	35	24	68.5		V.Good

6.5. Over all judgment Matrix

As it was discussed before, based on three evaluation dimensions overall result of availability, utilization and compliance dimension of community led total sanitation and hygiene program in Manna Woreda indicated a total score of 71% which indicated good achievement based on the judgment criteria set by stakeholders as stated below;

Table 9:- Analysis and judgment matrix evaluating the availability, utilization coverage and compliance health workers towards community led total sanitation and hygiene in Manna Woreda, Jimma Zone, Oromia, 2019.

Dimension	Weight given	Observed value (score)	Percent achieved (%)	Agreed criteria	Judgment criteria
Over all availability of CLTSH sanitation facilities in CLTSH program	30	22	73	>80 V.Good	Good
				68%-80% Good	
				55%-67% Fair	
				<55% poor	
Over all utilization of sanitation facilities of CLTSH program	35	25	71	85V.Good	Fair
				75%-84% Good	
				65%-74% Fair	
				<65% poor	
Compliance of health workers to program standards	35	24	68.5	65 V.Good	V.Good
				57%-64% Good	
				52%-56% Fair	
				<52 poor	
Overall objective oriented outcome evaluation of CLTSH program	100	71	71	>80 V.Good	Good
				65%-80% Good	
				51%-64% Fair	
				<51% poor	

Table 10:-Change Occurred due to implementation of CLTSH program in Manna Woreda, Jimma, Oromia, South Western Ethiopia, 2019.

Program objectives	Actual performance	Status when compared with objective of program
Increased HHs who constructed standardized latrines 52% to 82%	83%	Achieved
Increased HHs utilizing standardized latrine from 52% to 92%	79.3%	Less by 12.7 %
Increased ODF villages according to the guidelines 42% to 66%	50%	Less by 16%

CHAPTER 7: DISCUSSION

This study was undertaken with intension to answer the level of latrine utilization and factor related in CLTSH implement of selected kebeles. Totally, 482 study respondents were participated in the study with 100% response rate.

Ethiopia reduced open defecation by more than 25% during MDG period the largest decrease (64%) in proportion of population practicing open defecation(from 92% 1990 to 29% in 2015) (40). Community led total sanitation and hygiene national guidelines recommend that all households should have their own latrine in ODF Villages. Based on observational checklist of study participants, 83% of households had standardized latrine, which was greater when compared with study conducted in Laelay Maichew District of North Ethiopia (68%) (26), Hintalo-Wajirat Tigray region 62.5%(15). Also result of this study was achieved the objective of the program intended due to an intermittent campaign to support the community constructing latrines in the study area. But difference of this result may be due to social characteristics of the population, and difference of study period between the study areas. In this study result of these findings implies that, alliance of Woreda administrative unit and other all stakeholders were played their role in encouraging people to construct their own latrine at individual and community level. Result of households' survey showed that, 70.7% of latrine were with hand washing facilities, which was greater than the study conducted Hetosa Woreda Arsi zone 13.6% (1)and less than study conducted in Kersa Woreda 73.06%(12). But, result of this study was less by 11.3% with the intended objective of the program. Low coverage of this finding was due to some of households in the study area used highlands during defecation. Also since some households were fetching water from distance they did not used hand washing facilities to save water. Additionally, health extension workers were spends most of their time on promotion of latrine than others.

About 56.8 % of hand washing facilities near the latrine had soaps/ substituent, which is; Greater than the study conducted at Hetosa Woreda Arsi zone 18.3%(1) and study conducted at Laela Maichew District, North Ethiopia, 26.8%(26). However, this result was less by 45.2% compared with objectives of the program in due of limited potential of households to afford soaps and unlikely use of substituent in the study area. But this verification from other study may be due to

the difference of socio economic status and study period between the study areas. About, 67% of the latrines squat hole had covers during data collection which was greater than the study conducted in Hetosa Woreda Arsi zone 15.5%(1), Laela Maichew District, North Ethiopia, 38.6%(26). But less by 15% when compared with objectives of the program. This verification may be due to difference level of supervision conducted by health workers between the study areas. Low coverage of this finding was due to low awareness and less concern of the beneficiaries were the cause and HEW was also not give more attention and concern on it rather than simply construction of the latrine promotion.

In communities where the usage of latrine is low the prevalence of water borne diseases especially diarrhea is found to be very high (21). In this finding majority of respondents, 79.3% were utilized latrines, which was slightly similar with study conducted in rural community of Won do Genet district 83.1%(28), and greater than study conducted in Hintalo Wajirat of Tigray region 71.9%(15), UNICEF Ethiopia 2017(68%) (17), Laelay Maichew District of North Ethiopia 47.4%(26), but less than Hetosa Woreda in Arsi zone 88%(1). However, result of this study was less by 12.5% to achieve the intended objective of the program due to concern of health workers were on construction of latrine than utilization in sanitation promotion and low awareness of households on vital utilization of the latrines. Additionally, most of the time health workers, health extension workers and other collaborators were reactive in utilization of latrine promotion at different place. But the cause for verification of this finding from other can be due to quality of ODF verification, declaration, certification and follows up after ODF declaration by Woreda and kebele ODF teams.

Likewise hand washing facilities result of this study showed that, 65.8% latrine had functional hand washing facilities with sweet land under the container and drop of water in the container, which was greater than study conducted by Arsi zone Hetosa Woreda 49.5 % (1), Hintalo-Wajirat district of Tigray region 24.5%(15), but less than in Kersa Woreda 73% (12). Result of this finding also less by 26.2% with the intended outcome of the program, as an alternative most of households were took water by highlands. Low use of hand washing facilities in the study area can be explained that some households were got water from a distance and they were used for other purpose than for hand washing facilities. Though, health extension workers were also less active in teaching proper hand washing utilization after defecation.

In this study among accessed households, 78.6% of households' family members were only used latrine during defecation which was slightly similar with study conducted in Hetosa Woreda Arsi zone 83.2 %(1), and greater than the study conducted in Tigray region 40%(34). This may due to difference awareness of community in the study area about CLTSH between rural and urban population. In this study low coverage may be due to less active in health education, supports and follows up of the community by health professional and other stakeholders. Most of households in the study area were farmer who spent most of the time in work place on cultivation. So, they cannot come back to their residence and simply used the surrounds. Additionally, health education and promotion at different place like school, village level was not given to enhance all the community utilized only latrines every occasion. There were also less inter-sect oral collaboration of health extension workers and school community to change the behaviors of school age children who can support to change communities behaviors on utilization of latrines.

In Ethiopia the use of hand washing with soap reduces the risk of diarrhea by 48%(46). Similarly, findings from this study shows that, presence of soaps/substituent near hand washing facilities showed that 56.8% were on utilization during data collection by observing bubbles of soaps/substituent or fresh used soaps/substituent near hand washing facilities which was less than the study conducted in Kersa 81%(12) and less than Hetosa Woreda Arsi Zone(79%)(1). But result of this finding was less by 35.2% with objective the program due to low awareness and limited capacity to afford due to economic status in the study area. In the study area most of households were deny buying soaps and unlikely use of substituent due to low awareness on the effect of utilization of soap/substituent. However, verification of this finding from other may be due to difference of health extension workers commitment to supervise and follow up of the community and difference in socio economic characteristics between the study areas. Based on observational checklist, about 64.9% of households latrine slab had cover holes during data collection, which was greater than the study conducted in Hetosa Woreda Arsi zone 18.3%(1). But result of this finding was also less by 28% incase low commitment and negligence of family members to covers the holes were the cause for under achievement compared to the intended objectives. However, verification for this result may be due to difference of supportive supervision, follow up and social characteristics of population between the study areas. From

result of in-depth interview most of key informants interviewed agreed that households without hand washing facilities due to scarcity of water, families who did not graduated as model households, households who did not participated during triggering were not used always latrines.

This study also looked at health workers compliance with CLTSH national guidelines, 82% of villages were both pre-triggered and triggered, which had performed above the intended objective of the program due strong leader and inter -sect oral collaboration of all actors at a time. However, this finding shows only about 55% of villages were supervised and follow up within one month of triggering in the study area, which was also not aligned with CLTSH national guidelines that showed all villages must supervised and follow up within one month of triggering and less by 11% when compared with intended objective of the program due to limitation of supportive resources to conduct supervision and follow up. Result of this finding implies that, limitation of budget, other logistics and man power were critical problem that in turn influence expected outcome result in the study area. From this finding, only one trained health professional was as focal person of CLTSH program in the study area, which was incompatible with the guidelines due to limitation of budget to recruit additional health worker and to train other worker.

Result of document reviewed at twenty health facilities showed that all facilities were send their complete (filled all content of the program reports and sign) reports on time with in intended scheduled interval in the last six months, which was compatible with national CLTSH guidelines. In the study area strong reporting system and commitment of focal person to enforce lower health workers contributes for the best performance.

Hierarchical pressure had a strong influence on behaviors of latrine utilization. In this study area traditional leaders, including chief and villages headmen have an important cultural in the community and play a major role in changing sanitation behaviors. Study conducted in Rural Zambia shows that being influential with traditional leaders often creating and enforcing binding local regulation (local community by laws) that require all households' members to construct and use of latrines(8). In this finding 57% of villages were set local community laws which were not aligned with national CLTSH guidelines that suggest the entire village in ODF status set local community laws to punish offenders. Consequently, results from multiple logistic regression

analysis shows that existence of local community laws was significantly associated with latrine utilization among families' members. As a result, family members of households' with villages set local community laws for the offenders were greater 4.5 likely to utilize only the latrine than households' family members in villages without local community laws. This finding implies that, in study area community leadership, including traditional chiefs and villages' headmen is a powerful tool for encouraging communities to embrace the CLTSH program and mobilize to construct and use of latrine by setting local community laws to stop the offenders. From in-depth interview most of key informant's interviewed agreed that limitation of trained man power, lack of budget, limitation of training, negligence of health workers on the program in due of any incentives were the cause to achieve celebrated objective of the program.

7.1. Limitations of Evaluation

- Since some of the information based on secondary data, there were quality issues during registration of those data due to careless reporting and recording system by health workers. But using different method the evaluator was tried to minimize those effects on result.
- The evaluation were not determine the effect of the program since it was difficult to get the comparison group as study design which was beyond the scope of this evaluation, but it determined outcome level of the program at study area.

7.2. Strength of the Evaluation

- Observational checklist was used to identify proper utilization of latrine by sign of latrine use

CHAPTER 8: CONCLUSION AND RECOMMENDATION

8.1 Conclusions

Overall aspect of this evaluation lead to reach on the following conclusion based on the sated judgment criteria which were developed with involvement of different stakeholders.

The availability of standardized latrine among studied population was good when compared with other studies. But availability and utilization of hand washing facilities with soaps needs more consideration on the study area that needs health education and promotion. Utilization of latrine among assessed households also needs more concentration for program improvement in the study area. Average indicators of latrine availability were 73% which was good according to agreed criteria set by stake holders.

There was also poor inter sect oral collaboration of all actors on promotion of hand washing facilities utilization with soaps/substituent. Utilization of only latrine among households was highly associated with presence of local community laws in the villages. Family with local community laws was 4.5 times greater only to utilize latrine than family without local community laws during defecation. The average latrine utilization indicators were 71% which was fair in agreed criteria set by stakeholders that need more improvement. Level of supportive supervision and follow up of households conducted by health workers were low.

Regarding to compliance the man power and guidelines used for implementation of the program was not enough to achieve the intended objectives. Also the problem of budget in the study area was a critical problem at all health facilities. However, process of triggering villages was good as Ethiopian CLTSH implementation guidelines. But supportive supervision and follow up of triggered villages were not adequate due to limitation of trained health professional on the program and, absence of budget for supportive supervision and follows up. There was also limitation of training for health professional to conduct supervision and follow up. The average compliance indicators in the study area were 68.5 % that was very good according to the agreed criteria set by concerned stakeholders.

8.2. Recommendations

Based on major findings of this evaluation the following recommendations were forward to Jimma Zone Health Department, Manna Woreda health office, Health Centers and health posts in Manna Woreda.

❖ Recommendation to Jimma Zone health offices and partners

- Give training for health workers on the program.
- Support with other logistics and materials for program accomplishment

❖ Recommendation to Manna Woreda Health offices

- Recruit additional health workers to support the community
- Strengthening inter sectorial collaboration of all actors and concerned bodies on latrine utilization promotion and hand washing facilities utilization.
- Closely support the health extension workers to make supervision and follow up of the community.
- Provide supportive guidelines for the health centers on the program
- Make Clarification and certification of the community that succeeded in ODF.

❖ Recommendation to health centers and health posts workers

- Continuous follow up of the community after triggering.
- Promote health education on utilization of latrines with hand washing facilities and soaps
- Give health education on vital use of latrines squats cover holes
- Empower community leader, religious leader and other famous people in the kebeles to set community laws to stop OD for all.
- Increase awareness of the community on utilization of substituent if cannot soaps
- Give awareness for the community in participation during triggering for real exercise of the program elements
- Give health education on behavioral change of the community to stop open defecation and only use of the latrines at different place

CHAPTER 9: META-EVALUATION

Meta evaluation is an evaluation that occurs throughout evaluation process to assess evaluation study of Manna Woreda CLTSH intervention. It was used to check the adequacy of study designs in answering evaluation questions. This requires standards that provide guidelines used to follow when need arises to decide among evaluation options. Furthermore, the standards could be applied and result of his Meta evaluation assessed was Very Good with value 82.5%.

9.1: Utility

Key stakeholders were involved and communicated during Evaluability assessment and during the whole process of evaluation. In addition, the findings were communicated with stakeholders. So that, there was a high chance of addressing the information needs of stakeholders which ensures utilization of evaluation findings.

9.2: Propriety

Ethical clearance obtained from Jimma University ethical clearance committee and letters was provided to legal ground on each level of data collection. Evaluation was conducted with the regard for the right and interests of those involved and affected by evaluation on CLTSH program. It was accomplished by requesting informed consent from study participants prior to data collection.

9.3: Feasibility

Evaluation study of CLTSH program in Manna Woreda was practical and realistic. Time allocated for data collection was adequate to assure data quality.

9.4: Accuracy

Representativeness of study participants (sampled households) were assured by applying scientific method of sample size determination, sampling technique. Data was collected, triangulated to different data collection methods to ensure good quality information to be generate

REFERANCE

1. For R, Masters The, Of D, Health P. Assessment Of Magnitude Of Latrine Utilization And Associated Factor In Rural Setting Of Hetosa Woreda , Arsi , Oromia , Ethiopia 2017 ; (June).
2. Crocker J, Saywell D, Bartram J. International Journal Of Hygiene And Sustainability Of Community-Led Total Sanitation Outcomes : Evidence From Ethiopia And Ghana. *Int J Hyg Environ Health* [Internet]. 2017;220(3):551–7. Available From: [Http://Dx. Doi.Org /10.1016 /J.Ijheh.2017.02.011](http://dx.doi.org/10.1016/j.ijheh.2017.02.011)
3. Town Ad, Region A, West N. Investigations Of Latrine Coverage And Associated Factors. 2016;5(2):137–41.
4. Kar KaP, K. Subsidy or self-respect? Community led total sanitation an update on recent developments. Working Paper. 2005; 257, Brighton: IDS.
5. Milligan A, Ashley H. Tales Of Shit: Community- Led Total Sanitation In Africa – An Overview 1. :27–50.
6. Sciences H. Policy Brief Number 10. 2009;(10).
7. Garn J V, Sclar Gd, Freeman Mc, Penakalapati G, Alexander Kt, Brooks P, Et Al, 2010. International Journal Of Hygiene And The Impact Of Sanitation Interventions On Latrine Coverage And Latrine Use : A Systematic Review And Meta-Analysis & . *Int J Hyg Environ Health* [Internet]. 2017;220(2):329–40. Available From: [Http://Dx. Doi.Org /10.1016 /J.Ijheh.2016.10.001](http://dx.doi.org/10.1016/j.ijheh.2016.10.001)
8. Lawrence Jj, Yeboah-Antwi K, Biemba G, Ram Pk, Osbert N, Sabin Ll, Et Al. Beliefs, Behaviors, And Perceptions Of Community-Led Total Sanitation And Their Relation To Improved Sanitation In Rural Zambia. *Am J Trop Med Hyg*. 2016;94(3):553–62.
9. Democratic F, Of R, Wash One, Program N. Final 14. 2018;(March):1–101.
10. Jones O, Birhane G, Pearce-Oroz G, Victor J. Monitoring Sanitation And Hygiene In Rural Ethiopia : A Diagnostic Analysis Of Systems , Tools And Capacity. 2015;(June).
11. Sector H, Plan T. Health Sector Transformation Plan, 2015-2020.
12. Disease D, Eshete N, Beyene A, Terefe G. Implementation Of Community-Led Total Sanitation And Hygiene Approach Implementation Of Community-Led Total Sanitation And Hygiene Approach On The Prevention Of Diarrheal Disease In Kersa District , Jimma Zone Ethiopia. 2015;(August).
13. Godana W, Mengistie B. Imedpub Journals Exploring Barriers Related To The Use Of Latrine And Health Impacts In Rural Kebeles Of Dirashe District Southern Ethiopia : Implications For Community Lead Total Sanitations Study Area And Setting. 2017;1–5.
14. Federal Democratic Republic Of Ethiopia Ministry Of Health Rural And Peri-Urban Sanitation Marketing Guideline. 2012;(April).
15. Ghebremedhin G. Evidence Based , Objective Oriented Outcome Evaluation : Hintalo-Wajirat , Tigray , Ethiopia Evidence Based , Objective Oriented Outcome Evaluation,2008 :
16. African E, Journal M. Assessment Of Community Led Total Sanitation Uptake In Rural Kenya. 2016;2016(10):39–42.
17. Report F. Outcome Evaluation Of Cltsh Program In Ethiopia From 2012-2015 1. 2015;
18. Republic Fd. Federal Democratic Republic Of Ethiopia Ministry Of Health Implementation Programming Guideline For Cltsh January 2012. 2012;(January).

19. Mehta L. Community-Led Total Sanitation (Clts) Across The Seas. 2009.
20. Progress On Cltsh - Findings From A National Review Of Rural Sanitation In Ethiopia. 2016.
21. Country-Specific Agreed Definitions For Odf and For Improved / Unimproved Sanitation, facilities , 2013.
22. Colopmentsultants Dd, Maze T. An Evaluation Of The Community Led Total (Clts) Programme In Sierra. 2011;
23. Thomas J. A Review Of Sanitation And Hygiene In Tanzania. 2013;(April).
24. Commission E. Vulnerability Of Older People In Ethiopia, 2009.
25. Alula Sb, Dejene Em, Terefe Ml, Abinet As, Bazie M. Knowledge, Attitude And Practice On Hand Washing And Associated Factors Among Public Primary Schools Children In Hosanna Town, Southern Ethiopia. *J Public Heal Epidemiol.* 2018;10(6):205–14.
26. Assessment Of Community Led Total Sanitation And Hygiene Approach On Improvement Of Latrine Utilization In Laelay Maichew District, North Ethiopia. A Comparative Cross-Sectional 2017;
27. National School Water , Sanitation And Hygiene (Swash) Strategy And Implementation Action Plan. 2017;
28. Lopera Ma, Laval U, Osbert N. Final Report : Impact Evaluation Of Community-Led Total Sanitation (Clts) In Rural Mali. 2015;1–29.
29. Matthew Pt, Ross B. Odf Sustainability Study. 2013;(December).
30. Tsegaye Z, Wandera J. Snv Ethiopia Experiences Including The Outsider. 2007;(C).
31. District A, Gedefaw M, Amsalu Y, Tarekegn M, Awoke W. Opportunities , And Challenges Of Latrine Utilization Among Rural Communities Of. 2015;(May):98–106.
32. Opportunities, And Challenges Of Latrine Utilization Among Rural Communities Of Awabel District, Northwest Ethiopia, 2014
33. Submitted At, Partial In, Of F, For R, Award The, The Of, Et Al. Latrine Use And Associated Factors Among Rural Community Members In Samburu East.2015;(February).
34. Gebremariam B, Hagos G, Abay M. Assessment Of Community Led Total Sanitation And Hygiene Approach On Improvement Of Latrine Utilization In Laelay Maichew District , North Ethiopia . A Comparative Cross-Sectional Study. 2018;1–11. Available From: [Http://Dx.Doi.Org/10.1371/Journal.Pone.0203458](http://dx.doi.org/10.1371/journal.pone.0203458)
35. Alemu Ka, Chercos Dh. Latrine Utilization And Associated Factors Among People Living In Rural Areas Of Denbia District, Northwest Ethiopia, 2013, A Cross-Sectional Study. 2014;(August).
36. Leshargie Ct, Alebel A, Negesse A, Mengistu G, Wondemagegn At, Mulugeta H, Et Al. Household Latrine Utilization And Its Association With Educational Status Of Household Heads In Ethiopia : A Systematic Review And Meta-Analysis. 2018;1–12.
37. Mengistie B, Baraki N. Community Based Assessment On Household Management Of Waste And Hygiene Practices In Kersa Woreda , Eastern.
38. Thisted Ra. The Cross-Sectional Study : Investigating Prevalence And Association. 2006;
40. Sallami Za. Assessment Of Hand Hygiene Attitude , Knowledge And Practice Among Health Science Students In Aden University. 2016;25–32.
41. Literature G, Dc W. Testing Clts Approaches For Scalability Systematic Literature Review. 2012.
42. Note Wf. Progress On Cltsh In Ethiopia : Findings From A National Review. 2015;1–6.
44. The Handwashing Handbook A Guide For Developing A Hygiene Promotion Program To Increase Handwashing With Soap,2015. .

45. Periodic Overview of Hand Washing Literature, 2013.
46. Awoke W, Muche S. A Cross Sectional Study : Latrine Coverage And Associated Factors Among Rural Communities In The District Of Bahir Dar Zuria , Ethiopia. 2013;2-7.
47. Lemma T, Abera K, Sintayehu Bh, Hailu Fd, Mesfin Ts. Latrine Utilization And Associated Factors Among Kebeles Implementing And Non Implementing Urban Community Led Total Sanitation And Hygiene In Hawassa Town, Ethiopia. African J Environ Sci Technol. 2017;11(3):151-62.

ANNEX: - QUESTIONNAIRE AND CHECKLIST

Annex I; Household Survey questionnaire.

Instruction:

Hello, my name is_____ I am one of the data collectors for the evaluation that will carried out on CLTSH programs with the purpose of program improvement in this area. Your participation in this evaluation is voluntary and your responses will remain confidential as your name will not be written on questionnaire. If you feel uneasy during interview, you can stop at any time in between. We hope you will agree to participate as your views on the questions of this research are important. The interview might last about 30:00-45:00 minute.

Thank you!!

Do you have any questions about this Evaluation?

Have you agreed to participate? If yes continue, if refused stop.

Identification	Date of the interview D/M/Y_____/_____/_____
Name of kebele _____	
Name of Village_____	
Code of Respondent_____	

Part I. Socio-Demography Characteristics

S.N	Variable	Possible answer	Skip	Code
Q001	Name of Kebele	_____		
Q002	ODF status of Kebele	1. Primary 2. Secondary		
Q003	How far since kebele triggered	1. <1 2. 1-2 3. 2-3 4. >3		
Q004	Name of Village/Gare	_____		
Q005	Code of the respondent	_____		
Q006	Sex of the respondents	1. Male 2. Female		
Q007	Age of respondent	_____		
Q008	Sex of the Head of the household	1. Male 2. Female		
Q009	Marital status of the head of household?	1. Single 2. Married 3. Divorced 4. Widowed 5. Others_____		
Q010	What is Educational status of husband?	1. Illiterate 2. Grade 1-8 3. Grade 9-12 4. >12 grade		
Q011	What is the occupation of husband?	1. Farmer 2. Governmental employ 3. Private 4. Others		
Q012	Total number of family member (those living In one house)?	_____		
Q013	Is there <5 Year child among house hold Member?	1. Yes 2. No		
Q014	Is there any seriously sick person in this	1. Yes		

	house?	2. No		
Q015	Are the school age children of any age Attending formal education in this house?	1. Yes 2. No →	To Q117	
Q016	If answer for Q015 yes what is the level of their education?	1. Primary 2. Secondary 3. Higher education (>12)		
Q017	What is the ethnicity of the respondent?	1. Oromo 2. Amhara 3. Tigre 4. Dawaro 5. Gurage 6. Others (specify		
Q018	What is the religious of the respondent?	1. Muslim 2. Orthodox 3. Protestant 4. Catholic 5. Others (specify		
Part II. Practice of sanitation				
Q019	Is there standardized latrine available in the house?	1. Yes 2. No →	024	
Q020	What type of latrine available for your house hold? (<i>observe the storage, tick only one</i>)	1. Ventilated improved pit latrine 2. Traditional pit latrine with cemented slab or stone slab 3. Traditional pit latrine with wood log and earth cover 4. Others (specify)_____		
Q021	If yes to Q019 How far since you own your latrine?	1. <1year 2. 1-2 years 3. 2-3 years 4. >3 years		
Q022	If yes to Q019 is there fresh foot path leading to the latrine now?	1. Yes 2. No		
Q023	If yes to Q019, Do all household members always use the latrine?	1. Yes all are Always use latrine 2. No all are not Always 3. Others _____	→ Q026	

Q024	If No to Q019 what is the possible reason?	1. Don't know its advantage 2. can't afford 3. Have no space 4. Filled 5. Others _____		
Q025	If answer No to Q019 where did the families used to defecate?	1. In the forest 2. Public latrine 3. In the garden 4. Others _____		
Q026	If No to Q023 what are the Possible reasons? [multiple choice possible]	1. Offensive odor 2. Squatting hall is big. 3. Not comfortable to use 4. The slab is not safe to use 5. other reason_____		
Q027	Is there hand washing facility near the latrine now?(Hint: observe)	1. Yes 2. No		
Q028	If yes to Q027 is it contain water now?	1. Yes 2. No		
Q029	If yes to Q027 do you use it after latrine utilization? (Hint; See if wet land below it)	1. Yes 2. No		
Q030	Near the hand washing facility, is there soap/substitute now? (observe)	1. Yes 2. No		
Q031	If yes to Q030 is there fresh used soap/substitute near hand Washing facilities?	1. Yes 2. No		
Q032	Does the latrine squat hole have cover hole? (observe)	1. Yes 2. No		
Q033	If yes to Q032 what types of cover holes the squat has?(observe)	1. Flat table 2. Flat table with handling >1m long 3. Flat table hanged with tap 4. Others -----		
Q034	If you have under five children how baby's feces are disposed of? (Circle only one which is very often)	1. Put into latrine using Popo 2. Put into drain/ditch 3. Thrown in garbage Buried. 4. Left open 5. others_____		

Q035	During journey on the road, when you want to defecate what action do you take?	1. I will use public latrine beside the road 2. Defecate on the field 3. Use latrines of house hold found on the road side. 4. Other action -----		
Q036	Is there a local community bylaws regarding latrine utilization in your community? (hint: probe)	1. Yes 2. No		
Q037	Have you ever this house hold was graduated as model House hold(Hint: observe graduation paper)	1. Yes 2. No		
Q041	Is there open field defecation near the house (observe cleanness of the compound)	1. Yes 2. No		
PART III	Compliance dimension questions of health worker	At health facilities level		
Q042	Did the village/community pre-triggered according to guidelines?(Hint: observe document for evidence)	1. Yes 2. No		
Q043	Did the village triggered according to CLTSH national guidelines (Hint: observe document for evidence)	1. Yes 2. No		
Q044	If yes to Q042 is there list of /number of participants that properly documented with each kebeles?	1. Yes 2. No		
Q045	Is there CLTSH trained person in the facilities (Hint: observe evidence)	1. Yes 2. No		
Q046	If No to Q045 what is the possible reason?	1. Limit of budget 2. Absence of structure for it 3. Others_____		
Q047	Is there on time report sent from health centres within one month of triggering	1. Yes 2. No		
Q048	If yes to Q045 is focal person supervised and followed up the community within one month after triggering(Hint ; Observe feedback)	1. Yes 2. No		
Q049	If no to Q048 what is the reason behind?	1. No liquidated budget for CLTSH program 2. Lack of transportation like motorcycle for		

		<p>CLTSH</p> <p>3. Limit of focal person to conduct supervision</p> <p>4. Burden of work on focal person</p> <p>5. Others_____</p>		
Q050	Is there certified village with green flag (hint; observe Evidence)	<p>1. Yes</p> <p>2. No</p>		
Q051	If yes to Q050 how many of villages certified with green flag?	_____		
Q-052	Is there certified kebele with white flag?(hint; observe Evidence)	<p>1. Yes</p> <p>2. No</p>		
Q053	If yes to Q052 how many of villages certified with white flag?	_____		
Q054	Is there certified kebele with yellow flag?(hint; observe Evidence)	<p>1. Yes</p> <p>2. No</p>		
Q055	If yes to Q054 how many of villages certified with yellow flag?	_____		

Annex: II

Jimma University, Institute of Health and medical science, Department of Health Planning and Health Services Management, Monitoring and Evaluation Unit;

Evaluation to be conducted on CLTSH program from **March 15/2019 to March 25/2019**

Annex II: interview guide for Woreda CLTSH program focal person/ health office/ health center head/ health extension supervisors, 2019.

Instruction:

Hello, my name is _____. I am the primary investigator of the evaluation that has been carried out on CLTSH program with the purpose of program improvement in this area. Your participation in this evaluation is voluntary and your responses will remain confidential. If you feel uneasy during interview, you can stop at any time in between. We hope you will agree to participate. The interview might last about 1:00 to 1:30 Hours.

Thank you!!

Do you have any questions about this Evaluation?

Have you agreed to participate? If yes continue, if refused stop

Respondent: CLTSH focal person of the Woreda/ Woreda health office head/ Head of health center and community representative. .

Responsibility / position of respondent _____

Age _____ sex _____ service year _____

1. Would you tell me the major health problems and causative factor in your catchment area?

2. What is/are the prevention and control interventions have been implemented to alleviate? Could you describe the adequacy of CLTSH to the community? Probe for the achievement they want to attain? _____
3. Could you describe the adequacy of resources used for CLTSH intervention? (Probe for: trained human power, IEC/BCC materials and its type, source for resources, shortage and measure to tackle) _____
4. How could you perceive the process of community triggering to achieve the objectives of CLSH? _____

Annex III

In-depth interview

In-depth interview for kebeles leader/representatives

Name of interview _____ sign _____ Date of interview _____

What is the major health problem in your area?

What is the causative factor for the problem?

If there is intervention given in the area what did the contribution of the program in health of the community?

How you perceive about CLTSH program in your kebeles?(probe)

How about the triggering status of community on CLTSH program in your kebele?(probe)

How you perceive availability and utilization of latrine in your area?

How you perceive the level of supervision conducted by health professional in your area?

ANNEX IV. BARGAAFII AFAAN OROMOO

Qo'annoo adeemsifamu ilaalchisee fuula hirmaatonni odeeffanoo irra itti kennamuu fi feedhiin isaanii itti gaafatamuu.

Seensaa: Akkam jirtu ani maqaan koo _____jedhama. Sababni asitti argameef odeeffaannoowwaan barbaachisoo qo'annoo digirii lammaaffaa yuunivarsiitii Jimmaatti barachaa jiru xumuruu guutachuuf. Qo'annichaa ilaalchisee yaada hubannoo gabaabaa akka argatuuf odeeffanoo siifan keennaa, irraatti hirmachuuf ta'e hirmaachuu baachuu mirga qabda.

Mata duree qo'annichaa:- Sadarkaa itti fayyadamuu mana fincaanii fi dhimmoota danqaa ta'anii fi Haala mijataa jiru gandoota ODF ta'e addaa baasuuf.

Fayidaan isaa maali; - namoon gaafii fi deebii qo'annoo kanaa irraatti hirmaatan kallaatiin wanti fayyadamuu hin jiru. Garuu odeeffanoo hirmaatota irraa argamu sadarkaa itti fayyaadama mana fincaanii jiruu dhimmoota rakkoo ta'an adda baasuuf Kan gargaarudha. Odeeffanoo fi namoota biro hirmaatan irraa argamu dhimmaa kana waliin walqabatee haalaa ganda fi aanaa keessaan keessaa jiruu ibsuuf gargaara. Kanaafuu qaamoni biro foyyaa'insaa iitti faayadama mana fincaanii irraatti hojjetan itti fayyaadamuu danda'u.

Miidhaan nama hirmaatu irraa gahuu ilaalchisee;- Qo'annichi namoota yaada kennuu irraatti hirmaatan waan miidhu hin qabu. Sa'aa muraasa qofa waan fudhatuuf sa'atii muraasaa jalaa qisaasuu danda'a.

Mirga hirmaatotaa ilaalchisee;- gaafii deebii kana irraatti akka hirmaattu kan ta'uu fedhii keetin. Gaafilee isiniif dhihaatan keessaa deebii itti kennuu kan hin barbaadne irra darbuu ni dandeessu yookin yeroo barbaade addaan kuttee deemuu ni dandeeessaa.

Icciti eeguu ilaalchisee: - Unki gaaffii fi deebiin irraatti taasifame kun nama qo'annoo adeemsisuu fi isa hordofuuf malee qaama kamiifuu dabarfamee hin keennaamu. Deebiin ati naaf kennitu kamiyyuu maqaa keessaan waliin tokkoyyuu walitti dhufeenyaa hin qabu, kanaafuu iccitiin isaa akka sirritti argamu abdiin guddaa qabaadhaa. Qo'annoo adeemsifamu ilaalchisee gaaffii ifa hin tanee osoo qo'anniichi hin adeemsifamin, osoo adeemsifamaa jiruu fi erga adeemsifamee booda yoo qabataan, mirga gafaachuu guutuu qabdu.

Ani _____ qo'annoo adeemsifamu kana irratti hirmachuuf feedhinii qabu ibseen jira.

Lakkoofsa Addaa Waraqaa Gaaffii fi Deebii _____ guyyaa gaaffii fi Deebii _____				
	Maqaa garee _____		Dabarsa	
Q01	Odeeffannoo ODF ilaalchisee	1. Marsaa tokkooffaf 2. Marsaa lammaffaaf		
Q02	Erga ODF ta'e hamman ta'a?	1. Waggaa tokkoo gadi 2. Waggaa 1-2 3. Waggaa 2-3 4. Waggaa >3		
Q03	Saala abbaa Warraa	1. Dhiira 2. Dubara		
Q04	Umurii hirmaataa	_____		
Q05	Ittigafatamaan/wamamaan abbaa waarraa eenyu?	1. Abbaa warraa 2. Haadha warraa		
Q06	Haala fuudha fi heerumaa ittigaafatamaa abbaa warraa	1. Gonkumaa hin heerumne/fuune 2. Yeroo ammaa fudee/heerumeeti Kan jiru. 3. Kan hike ykn addaan bahan 4. Kan jala du'e'duute		
Q97	Sadarkaa barumsaaf abbaa waarraa/yoo hin heerumne abban mana gaggeessu meeqa?	1. Gonkumaa hin baranee 2. 1-8 3. 9-12 4. >12		
Q08	Akaakuu hojii maatii	1. Q/Bulaa 2. Dhunfaaa. 3. Kan biroo		
Q09	Baayyina maatii	_____		
Q10	Waggaatti galii hanga meeqa argatu?	_____		

Q11	Daa'imtti umriin Ishii waggaa 5 gadii ni jirtii?	1. Eeyyee 2. Lakki		
Q12	Ijoolleen mana barumsaaf geese jirtii?	1. Eeyyee 2. lakki		
Q14	Ijoolleen mana barumsaaf geese jirtii?	1. Eeyyee 2. Lakki		
Q15	Amantaan ati ittin waaqeffaattu maali?	1. Ortodoksii 2. Protestaantii 3. Musiliim 4. Waaqeffannaa 5. .Kan biro		

Kutaa Lama. Waa'ee Qulqullin Ilaalchisee Gaaffiiwwaan Dhihaatan.

Q16	Abbaan Warraa/Maatiin Kun mana fincaanii ni qabaa?	1. Eeyyee 2. Lakki	22	
Q17	Deebiin G16 eeyyen yoo ta'e, Mana fincaanii gosa akkamittu jira?	3. Ventilated improved pit latrine 4. Traditional pit latrine with wood log and earth cover 5. Traditional pit latrine with stone slab 6. Others (specify) _____		
Q18	Deebii gaaffii 16 eeyyee yoo ta'e erga mana fincaanii ijaarratte hammam	1. Waggaa 1 gadi 2. Waggaa 1-2 3. Waggaa2-3 4. Waggaa >3		
Q19	Deebiin gaaffii G016 eeyyee yoo ta'e mana jireenyaa irraa hangam fagaata?	1. 1-10 metres 2. 10-20 meters 3. >3 yrs		
Q20	Deebiin gaaffii 016eeyyee yoo ta'e Karan mana fincaanii geessu jiraa?	1. Eeyyee 2. Lakki		

Q21	Deebiin gaaffii 16 ffaa eeyee yoo ta'e maatiin hundi ni fayyadamuu?	1. Eeyyee 2. Lakki		
Q22	Deebii gaaffii 016 lakki yoo ta'e sababni isaa maalo?	1. Faayidaa isaa hin beeku 2. Ijaarracuu hin danda'u 3. Bakka itti ijaaran hin qabu 4. Ni guute 5. Kanbiroo _____		
Q23	Deebiin gaaffii 016 lakki yoo ta'e maatiin eessatti bobba'u?	1. Caakkaa 2. Mana fincaanii uummataa 3. Borootti 4. ksnbiraa _____		
Q24	Deebiin gaaffii 22 yoo lakki ta'e sababni isaa maali?	1. Ni ajaa'a 2. Huraan boollaa ballaadha 3. Mijataa miti 4. Slab isaa mijataa miti		
Q25	Harki dhiqannaa jiraa amma?	1. Eeyyee 2. Lakki		
Q26	Harki dhiqannaa bishaan qabaa?	1. Eeyyee 2. Lakki		
Q27	Harki dhiqannaa jalli isaa jiidhina qabaa?	1. Eeyyee 2. Lakki		
Q28	Harka dhiqannaa bira saamunaa ykn daaraan jiraa?	1. Eeyyee 2. Lakki		
	Q29 Yeroo ammaa saamunaa ykn daaraan itti fayyadamame jiraa?	1. Eeyyee 2. Lakki		

Annex V:

Meta Evaluation Checklist For Evaluation Of Design And Reports

Title Of The Evaluation: - Objective Oriented Outcome Evaluation Of Community Led Total Sanitation And Hygiene In Manna Woreda, Jimma, Oromia, 2019.

By: Oli Refera

1. Utility standard	Criteria met			Elaborati on
	Yes	No	N A	
Standard: Stakeholder Identification				
Specific Criteria:				
Are the audiences for the evaluation identified?				
Have the needs of the audiences been identified?	1			
Are the objectives of the evaluation consistent with the needs of the audience?	1			
Does the information to be provided allow necessary decisions about the program to be made?	1			
Standard: Evaluator credibility				
Specific criteria				
a. Does the person conducting evaluation was competent?	1			
b. Are the evaluation findings achieve maximum credibility?	1			
c. Are the evaluation finding achieve maximum acceptance?		1		
Standard: information scope and selection				
Specific criteria				
a) Are the collected information address pertinent questions about the program?	1			
b) Are the information responsive to the needs and interest of clients and other stakeholders?	1			
Standard: values identification				
a) Does the perspectives use to interpret the findings are carefully described?	1			
b) Are the procedures used to interpret the findings carefully described?	1			
c) Does the rationale used to interpret the findings are described?	1			
Standard: Report clarity				
Specific criteria				

a) Does the evaluation report clearly describe the program being evaluated?	1			
b) Does the evaluation report provide essential information?	1			
c) Are the evaluation report clearly understood?	1			
Standard: report timeliness and dissemination				
Specific Criteria				
a) Are the interim findings and evaluation reports distributed to intended users?		1		
b) Do the intended users utilize the report in a timely fashion?		1		
Standard: Evaluation impact				
Specific criteria:				
a) Does the evaluation planned in ways that encourage follow-through by stakeholders?	1			
b) Does the evaluation conducted and reported in ways that encourage follow-through by stakeholders	1			
c) Does the evaluation reported in ways that encourage follow-through by stakeholders	1	1		
Total score /20	16(80%)	4(20%)		Good
2. Accuracy standards				
Standard: Reliable Information				
Specific criteria:				
Are information collection procedures described well?	1			
Will care be taken to ensure minimal error?	1			
Are scoring or coding procedures influenced by the evaluators own perspectives?		1		
Is information generated using evaluation instrument verifiable?	1			
Standard: valid information				
Specific criteria				
a) Does the information gathering procedure developed?	1			
b) Does the information gathering procedures implemented?	1			
c) Are the interpretations of the evaluation valid for the intended users?	1			
Standard: systematic information				
Specific criteria				
a) Are the information collection procedures systematically reviewed?	1			
b) Are the errors corrected?	1			

Standard: analysis of quantitative information				
Specific criteria				
a) Are quantitative information's analyzed appropriately and systematically	1			
b) Are evaluation questions answered effectively?	1			
Standard: analysis of qualitative information				
Specific criteria				
a) Are qualitative information's analyzed appropriately and systematically	1			
b) Are evaluation questions answered effectively?	1			
Standard: justified conclusions				
Specific criteria				
a) Does the conclusion explicitly justified the evaluation?	1			
b) Are the stakeholders assessing them?	1			
Standard: impartial reporting				
Specific criteria				
a) Does the reporting procedures should guard against distortion caused by personal feelings and biases of any party to the evaluation?		1		
b) Are the evaluation reports fairly reflecting the evaluation findings?	1			
Standard: meta-evaluation				
Specific criteria				
a) Does the evaluation itself should be formatively and Summative evaluated against this and other pertinent standards?	1			
b) Do stakeholders on completion closely examine its strengths and weaknesses?	1			
Total score/19	17(89%)	2(11%)	0	V.Good
3. Feasibility standards				
Standard: Practical Procedure				
Specific criteria:				
Are the evaluation resources (time, money, and personnel)		1		1
Are management plans specified for conducting the evaluation?	1			
Has adequate planning being done to support the feasibility of conducting complex activities?	1			
Standard: political viability				
Specific criteria				

a) Does the evaluation planned with anticipation of different position of various interest groups?	1			
b) Does the evaluation conducted with the anticipation of various interest groups?	1			
c) Does the evaluation obtain the cooperation of various interest groups?	1			
Standard: cost effectiveness				
Specific criteria				
a) Does the evaluation produce information with sufficient value?	1			
b) Does the resources expended for the evaluation justified?	1			
Total score/8	7(87.5%)	1(12.5%)		V.Good
4. Propriety standards				
Standard: service orientation				
a) Does the evaluation designed to assist organizations?	1			
b) Does the evaluation address the needs of targeted participants?	1			
c) Does the evaluation effectively serve the needs of the full ranges of targeted participants?		1		
Standard: formal agreement				
Specific criteria				
a) Does the obligations of the formal parties to an evaluation was agreed?	1			
b) Does all the formal parties adhere to all conditions of the agreement?		1		
Standard: rights of human subjects				
Specific criteria				
a) Does the evaluation design to respect and protect the rights and welfares of human subjects?	1			
Standard: human interaction				
Specific criteria				
a) Are the evaluators respect human dignity and worth in their interaction with other persons associated with an evaluation?	1			
b) Does the participants are not threatened or harmed?		1		
Standard: complete and fair assessment				
Specific criteria				
a) Does the evaluation complete and fair in its examination and recording?	1			

b) Are the strengths and weakness of the program being evaluated was described fairly?	1			
c) Are the evaluation strengths built up on and problem areas addressed?		1		
Standard: Disclosure of findings				
Specific criteria				
a) Does the full set of evaluation findings along with pertinent limitations are made accessible to the persons affected by the evaluations?	1			
Standard: conflict of interest				
Specific criteria				
a) Does conflict of interest deal openly and honestly?	1			
b) Are conflict of interests compromise the evaluation process and results?	1			
Standard: fiscal responsibility				
Specific criteria				
a) Are the evaluators' allocations and expenditures of resources reflect sound accountable procedures?	1			
b) Are the expenditures accounted and appropriate for the evaluation?	1			
Total score/16	12(75%)	4(25%)		Good
Overall score /63	52(82.5%)	11(17.5%)		V.Good

Judgment parameter: if:-

> 80% Very Good

60-80% Good

51- 60 Satisfactory

<50%-Unsatisfactory

Annex VI: Indicator definition of objective oriented outcome evaluation of community led total sanitation and hygiene program in Manna Woreda,2019.

Proportion of households constructed standardized latrine facility in their compounds	No of households who have standardized latrine *100
	Total no of households latrine observed in selected kebeles
Proportion of households with hand washing facility near the latrine	No of households who have hand washing facilities near latrine *100
	Total no of households latrine observed in selected kebeles
Proportion of households availing soaps/substituent near hand washing facility.	No of households availing soaps/substituent *100
	Total no of households latrine observed in selected kebeles
Proportion of households availing cover hole on the hole of slab latrine	No of households who have availed cover holes on latrines *100
	Total no of households latrine observed in selected kebeles
Proportion of households with fresh foot path leading to the latrines	No of households latrine with fresh foot path leading to latrine *100
	Total no of households latrine observed in selected kebeles
Proportion of households used hand washing facilities near the latrines	No of households who utilized hand washing facilities near latrine *100
	Total number of households observed in selected kebeles
proportion of households with fresh used soaps/substitute near hand Washing facilities	No of households with fresh used soaps*100
	Total no of households latrine observed in selected kebeles
Proportion of households latrine squats with cover	No of latrine squat with cove holes on utilization during data collection *100

hole on service	Total no of latrine squats observed in selected kebele
Proportion of villages pre-triggered according to CLTSH national guidelines	$\frac{\text{No of villages pre-triggered}}{\text{Total no of villages expected in selected kebeles}} * 100$
	Total no of villages expected in selected kebeles
Proportion of villages triggered according to CLTSH national guidelines	$\frac{\text{No of villages triggered in selected kebele}}{\text{Total no of villages expected to triggered in selected kebeles}} * 100$
	Total no of villages expected to triggered in selected kebeles
Proportion of villages/community followed up by health professional within one month of triggering	$\frac{\text{No of villages got follow up with in one month of triggering}}{\text{Total no of villages expected to follow up within one month after triggering in selected kebeles}} * 100$
	Total no of villages expected to follow up within one month after triggering in selected kebeles
Proportion of villages certified according CLTSH to national guidelines	$\frac{\text{No of villages certified for their ODF}}{\text{Total no of villages expected to be ODF in selected kebeles}} * 100$
	Total no of villages expected to be ODF in selected kebeles
Proportion of villages set local community laws to show solidarity to the cause and to punish offenders during triggering	$\frac{\text{No of villages expected to triggered}}{\text{Total no of villages expected in selected kebeles}} * 100$
	Total no of villages expected in selected kebeles
Proportion of health facilities sends their complete report according to CLTSH national guidelines	$\frac{\text{No of health facilities send their CLTSH report to concerned body with in scheduled time frame}}{\text{Total numbers of health facilities expected to send CLTSH program report within expected time frame}} * 100$
	Total numbers of health facilities expected to send CLTSH program report within expected time frame