ANCP CHIVI WASH ENDLINE SURVEY

FINAL REPORT

Australian NGO Cooperation Programme (ANCP)

Putting Women and Girls at the centre of improving Water, Sanitation and Hygiene (WASH) and Health Projects

Chivi District, Zimbabwe

May 2017

ACKNOWLEDGEMENTS

The consultants would like to sincerely thank the following groups of people for their support during data collection and report production:

- The DA
- Chivi RDC
- Chivi DWSSC members
- CARE Zimbabwe staff
- Care Australia staff
- WWSSC members for the wards visited
- Community members for the wards visited
- Staff members and SDC for schools visited
- Enumerators

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANCP	Australian Aid Non-Governmental Cooperative Partnership
BVIP	Blair Ventilated Improved Pipe latrine
CHCs	Community Health Clubs
DA	District Administrator
DAC	Development Assistance Committee
DDF	District Development Fund
DEHO	District Environmental Health Officer
DWSSC	District Water and Sanitation Sub-Committee
EHT	Environmental Health Technician
FGD	Focus Group Discussion
GoZ	Government of Zimbabwe
HBC	Home Base Care
HH	Household
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
ISAL	Internal Saving and Lending
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MoHCC	Ministry of Health and Child Care
NGO	Non- Governmental Organization
ODF	Open Defecation Free
PHHE	Participatory Health and Hygiene Education
PPP	Public Private Partnership
SAG	Sanitation Action Group
SaFPHHE	Sanitation Focused Health and Hygiene Education
SDC	School Development Committee
SPSS	Statistical Package for Social Sciences
RDC	Rural District Council
TOR	Terms of Reference
VHW	Village Health Worker
VPM	Village Pump Mechanics
WASH	Water Sanitation and Hygiene
WPC	Water Point Committee
WWSSC	Ward Water and Sanitation Sub-Committee
ZIM ASSET	Zimbabwe Agenda for Sustainable Socio-economic Transformation

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EXECUTIVE SUMMARY

The Chivi Water, Sanitation and Hygiene (WASH) project funded under the Australian NGO Corporation Program (ANCP) was implemented following the deteriorating WASH conditions in Zimbabwe's rural communities. Poor WASH infrastructure and services resulted in the 2008/9 cholera outbreak which affected both urban and rural populations. Despite significant improvements in the humanitarian conditions in the country, challenges continue to exist inhibiting the delivery of basic social services such as education, water, sanitation and health. The shortcomings have mainly been attributed to supply / subsidy based sanitation interventions. The Chivi WASH project aligns with the Ministry of Health and Child Care National Sanitation and Hygiene Strategy. The Strategy outlines key focus areas and strategic actions that ensure that Zimbabwe achieves zero open defecation through Demand –Creation. This is based on behaviour change and community managed approaches for sustained elimination of open defecation. The goal of the project is stated as: *Increased equitable and sustainable access to and use of safe water supply, improved sanitation and improved hygienic practices among the rural population of Chivi district*.

In February 2017, CARE International in Zimbabwe commissioned Vibes Consultancy Services to conduct an end-line evaluation of the project implemented during the period 2014 to 2017 in ten wards of Chivi District. The evaluation is expected to contribute to strengthening accountability of CARE International in Zimbabwe for its donors and key stakeholders (including beneficiaries), and to learn from this experience to inform future WASH projects. Key evaluation questions have been guided by Development Assistance Committee (DAC) criteria for development evaluations with special focus on project relevancy, efficiency, effectiveness, sustainability and impact of the project. This report therefore documents key findings of the evaluation as well as lessons learnt and recommendations useful in guiding the implementation of future projects in the sector.

In carrying out this evaluation, the consultants applied participatory, qualitative and quantitative methods to collect data relevant for addressing the evaluation questions. Specific methods include; review of secondary documents, 18 focus group discussions (FGDs), key informant interviews, administration of 396 household questionnaire interviews, field observation and inspection of water, sanitation and hygiene enabling infrastructure.

Key Findings

Context

The project commenced during a period of high food insecurity as a result of poor rainfall patterns. With the project promoting a demand-led approach to delivery of sanitation, which is a departure from the traditional supply driven approach, challenges in gaining community support were bound to arise. In times of hardships and humanitarian disasters, the rural communities had been used to receiving assistance from government and humanitarian organisations with minimal, if any, own contribution towards improvement of their livelihoods. In addition, while the project was implemented over a period of four years, the yearly funding of project activities meant that it was not possible to set performance targets covering the whole implementation period.. Consequently, only 5 wards were supported by the project since 2014 while implementation five additional wards commenced at the end of 2015. Hence, assessment of project performance needs to take into perspective these variations in project implementation between the targeted wards.

Relevance

The project was designed with recognition given to enabling national and district level policy frameworks governing the WASH sector. This relevance has been comprehensively articulated in the mid-term review project document. Through FGDs, communities confirmed that the project was quite relevant to their circumstances. Before the project, incidence of water borne diseases and related deaths were quite high, but the communities were not aware of the causes. Their surrounding bushes had become impassable, unsightly and unpleasant due to open defecation. The project strategy was also appropriate as communities realized the potential that existed within their communities to transform their circumstances.

Effectiveness

The collected data indicated that the project was effective in achieving its set objectives of ensuring that;

i) *Individuals, residing in school catchments, have sustained and secure access to water, sanitation services and sustained hygienic behaviours* - access to safe water was given to 50,377 people and 94% of the households reported using safe water sources. About 24,373 students in the 44 schools were also given access to safe water. Sanitation access was given to about 40,000 people and field data indicated that 98% of the households have improved access. Hygienic practices within homes were improved as evidenced by 97% and 100% having refuse pits and pot racks respectively. All 44 schools had functional hand washing tanks. The achievements were possible through making the communities responsible for their own development.

ii) *Community and local institutions in 10 wards in Chivi District are responsive to women's and girls' needs and priorities and accountable in upholding their rights* - participation of women and girls in WASH decision making structures is a critical milestone towards their empowerment. Both communities and schools ensured responsiveness and accountability through making women and girls the majority of the members in the committees that drove WASH issues. Women made up 70% of Sanitation Action Groups (SAGs) which were driving the implementation of sanitation and hygiene programmes in their villages whilst girls made up to 75% of the club members at schools. Women constitute 54% of School Development Committee (SDC) members tasked with running the school development programmes. These groups were trained to be sensitive to girls' needs in the planning and implementation of school developments resulting in construction and equipping of girl friendly latrines.

iii) *The Chivi District Water and Sanitation Sub-committee (DWSSC) has improved capacity to deliver effective and gender-inclusive WASH services* - DWSSC received training in gender mainstreaming and inclusiveness. The gender mainstreaming and sensitisation was cascaded to lower level structures, the ward and village structures through which the project was implemented.

Efficiency

The project had utilised 82% of its budget by the end of January 2017 and all the expected outputs were completed. CARE worked efficiently with a lean staff of 5 full time employees to deliver the outputs through use of the government staff members already employed to do WASH activities which CARE was facilitating. DWSSC and Ward Water and Sanitation Sub-committee (WWSSC) members implemented the project at district and ward level respectively. At village level community volunteers, through various committees led by the

village head, were responsible for implementation. Both the government workers and community workers performed tasks at no direct cost to the project. The project financed the provision of water supply hardware and supported trainings. The subsequent outputs (household latrines, pot racks, refuse pits) were from the community members' financing and use of local resources. All these factors were responsible for efficient utilisation of the project funds.

Impact

Comparison of baseline and end of project situations shows that the project had a big impact on the communities. In terms of water supply, there has been a notable increase of households accessing safe water sources from a baseline proportion of 69% of households to 94%of households having access to safe and protected sources of drinking water. The proportion is significantly higher in Old Wards (98%) compared to New Wards (90%). This is attributed to new boreholes being drilled and some broken down boreholes being rehabilitated. In terms of distance travelled to safe water sources, the change has been minimal when compared to baseline data. About a third of households interviewed were still travelling more than one kilometre to the nearest safe and protected water source.

In terms of water treatment, 13% of households in the Old Wards treated their water, but at end of project the proportion of households treating water decreased to 7%. In New Wards, there has been an increase in the proportion of households treating their water from 3% at baseline to 20% of households at the end-line. Water treatment is dependent on the source of water used by a household. For households accessing safe protected water sources there is no need for treatment. There has been a dramatic shift from using unsafe methods of water storage at baseline to using safe methods at end-line. At baseline only 7% of households in Old wards used safe methods (i.e. containers with lids) and at the end of the project, over 90% of households in both Old and New wards turned to using safe methods.

Sanitation: Human excreta disposal

The project was highly successful in improving sanitation conditions in targeted communities. Open defecation was completely eradicated in Old Wards while just 1% were still using the bush among households in New Wards. This is against a background of 45% and 37% of households in Old and New Wards respectively practising open defecation at baseline. While about 49% of households had their own toilets at the start of the project, there was a marked increase to 97% of households (in Old and New Wards) having their own toilets by the end of the project. For households that built their toilets before 2014, about 29% did some improvements to their toilets (25% Old Wards and 33% in New Wards) as a result of the knowledge learned on what is a safe toilet. These improvements included adding fly screens, toilet roofs and vent pipes.

A notable improvement was also recorded in hand washing practices at each of the five critical times (before eating, before preparing food, before feeding a baby, after using the toilet/ defecation, and after changing baby nappies) with most respondents (97%) washing their hands after defecation. However, the proportion of respondents washing their hands before feeding children and after changing baby nappies remained low at 10% or less before the project and at project end-line. Over 90% of respondents demonstrated correct methods of hand washing at the end of the project compared to 10% and 15% of households in Old and New Wards respectively at project baseline. A phenomenal increase in hygiene enabling facilities, that include pot racks and rubbish pits, was also recorded during the end-line evaluation for both Old and New Wards. With improved sanitation, diarrhoea cases reduced

from a baseline of 31% in Old Wards to 8% at project end-line evaluation, and from 22% of households in New Wards at baseline to 2% of households at the end of the project.

Sustainability

The project was implemented through the structures of government from district to the village level. This enhances sustainability of project benefits since these structures will still be there after the end of the project. The project's support of local leadership structures also contributes to continuity of project strategies even after the end of the project. All the government workers received training to enable them to carry on with the work. However, besides the presence of key personnel with improved skills and leadership support, the continuation of the projects impact also depends on sustaining the following systems that brought about the positive changes in the target areas:

1) Monitoring Systems
2) Supply of technical expertise
3) Supply of materials
4) Funding systems
5) Consideration of good hygiene practices as a social norm
6) Organised competition and recognition
7) Enforcement of local constitutions.

Insight into Project Processes

The project managed to achieve significant sanitation access using demand driven approaches largely due to the way awareness creation, implementation and monitoring was carried out. Information, Education and Communication (IEC) materials, which included shaming and motivating messages together with triggering strategies using live examples proved very effective in raising community awareness and consequently behaviour change.

Robust implementation processes enhanced community ownership and ensured effective implementation of project strategies. These included creation of group charts, decentralised trainings, use of village heads to lead SAGs, the utilisation of locally available resources, incorporation of WASH issues in village constitutions and attainment of open defecation free (ODF) villages as a community goal. Communities also made use of health and lending and saving clubs to raise money for their WASH needs. Community members participated in the identification of vulnerable households who benefited from project subsidies. Schools created WASH budgets and provided paid labour for parents/guardians with arrears in school fees.

An effective participatory monitoring system further contributed towards the achievement of project objectives. Communities participated in the development of monitoring tools. Monitoring took place at different levels from household, village, ward and district levels. Periodic performance reviews were useful in keeping the momentum high towards planned results.

Lessons Learnt

The project was one of the pilot programmes in putting women at the centre of the WASH agenda and as such provided many lessons for rural WASH programming. It is important to note that the project was successfully piloted during a period when rural communities in

Chivi were experiencing high food insecurity as a result of poor rainfall patterns. These following key lessons learnt should be seriously considered for all future programming.

a) *Active multi-stakeholder participation:* The active engagement and participation of stakeholders at national, provincial, district, ward and village levels, in all stages of the project cycle (including design, implementation and M&E) is critical for the success of development interventions.
b) *Action Oriented Knowledge Dissemination*: With focused training oriented towards behavior change and direct application of lessons learnt, communities are prepared to make investments leading to improved sanitation conditions (Open Defecation Free environments) with limited or no subsidy from external agencies.
c) *Participatory Project Monitoring, Accountability, Peer Review and Feedback Mechanism.* The project established and strengthened structures that enhanced participatory project monitoring at the different levels (from village to district levels). This also ensured accountability among different stakeholders and across different levels of project management.
d) *Clear articulation and understanding of communal and individual costs and benefits is crucial for community collaboration in development interventions:* For villagers to work together to improve their communities' sanitation and hygiene conditions, an understanding of both individual and communal costs and benefits is a pre-requisite. This has resulted in community members combining resources to assist some vulnerable households (elderly, widowed or disabled) within their villages to construct household latrines. This was also motivated by the need to attain ODF status.
e) Performance based rewards and recognition systems, such as ODF celebrations, enhance the achievement of desired targets:
f) Identification of key individuals to champion the cause of the project is useful in reaching out to critical groups in society for adoption and replication of project strategies. Traditional leadership should be involved from the onset as lead persons in all aspects including in look and learn visits so that they champion the WASH cause

Recommendations

The Rural WASH sector in Zimbabwe stands to draw a lot of lessons from the ANCP Chivi WASH Project, a pilot intervention for demand led provision of sanitation and hygiene services for rural communities. It is a key recommendation by the Consultant for CARE and partners to conduct a comprehensive documentation exercise for the project highlighting key structures, processes, challenges, successes and lessons learnt. This will be important in guiding future or on-going interventions in the sector.

In view of the annual funding arrangement, the Consultant recommends that CARE and partners develop a comprehensive proposal at the start of the project outlining the range of activities, outputs, coverage and associated costs for the achievement of set goals and objectives. This would enable implementing partners to prioritise activities and geographic areas to be covered upon receiving financial commitments from funding partners.

While the project achieved or exceeded targets in Old Wards that were better resourced and had a longer implementation period, there may be need to continue supporting New Wards, particularly in areas that are still lagging behind. The project needs to come up with a clear exit strategy (for both Old and New Wards) that ensures the gains recorded so far would not be eroded over time.

Based on information gained from the survey, specific recommendations for each of the four thematic areas are highlighted below:

i. Comparatively, more households in Old Wards than New Wards have better access to safe and protected sources of cooking and drinking water. With availability of funding, New Wards would need to be prioritized, particularly for the provision of safe and protected water points.

ii. In both Old and New Wards some support is still required on the community based management of water points. The water point committees (WPCs) are at different stages of development, with some committee members still doing most of the work on their own with limited support from other water users. Environmental management of the area around water points that includes fencing is an area requiring attention.

iii. It is without a shed of doubt that the project has made tremendous impact in eradicating open defecation among many villages in the targeted wards. However, there are still some villages, particularly in New Wards that are yet to achieve ODF status. It is important that a concerted effort be made through the established project structures at district and ward levels until all households in the targeted wards have built their own latrines.

iv. The thrust of the project was for every household to have a latrine whilst also making use of locally available resources. Consequently, quality of the structures was not a critical delivery aspect. With the cyclone that hit the province during the period of the survey, a number of structures have broken down. It is the view of the Consultant that some significant level of project support be provided to the most vulnerable households, most of whom are not able to construct more permanent structures. Without such support these vulnerable households may be forced to revert to open defecation.

v. The ANCP WASH project was very much welcome by both primary and secondary schools in the project area. However, the project was introduced well after the schools had prepared their annual budgets. This resulted in some SDC planned projects being suspended in favour of the WASH intervention. It is important for future programming to take note of the school calendar when designing projects that require financial commitments from schools.

vi. The school health clubs were running quite well in most primary schools as compared to health clubs in secondary schools. It was noted that in Secondary schools the main participants were students from Form 1 and 2 with Form 3 and 4s shunning the clubs. It is therefore recommended that the health clubs be mandatory for lower classes and optional for exam classes.

vii. The use of girl friendly toilets and facilities was quite low among older students particularly in secondary schools. To enhance use, it is recommended that toilets for senior girls be equipped with necessary facilities for improved menstrual hygiene. This will go a long way in reducing identification and stigma.

viii. Communities with difficulty accessing WASH materials need to be supported to organize themselves into groups and then make arrangements for traders' days/fairs to rural communities. This will also make it cost-effective for the trader.

ix. There is need to consider viable options for financing communally owned tools such as Village Pump Mechanic (VPM) tool kits. For instance, local private skilled force could be levied a small amount to finance the communally owned tools.

x. The established WASH structures at district and community levels should continue running and supporting communities in maintaining improved sanitation facilities. Periodic reports, that enhance accountability, should be provided at all levels. Demand for the same by higher level structures from village to provincial structures would ensure continuity of established processes and systems.

xi. Overall, there is need for projects to provide for ex-post evaluations well after project completion to enable assessment of sustainability of project results such as ODF status as well as the resiliency of established structures and processes.

1.0 INTRODUCTION

1.1 Background

Zimbabwe was signatory to the Millennium Development Goals (MDGs) which set out goals to be attained between 2000 and 2015. Goal 7 intended to reduce the number of people without access to both safe water and sanitation by half by the year 2015. (The MDGs have since been replaced by the Sustainable Development Goals and Zimbabwe has embraced them). Zimbabwe then set its own target for the MDGs at 100% access for both water and sanitation. Despite the government commitment to meeting the MGDs, access to WASH services deteriorated mainly due to the harsh economic environment. The regression in WASH services was evident in 2008/2009 period when about 4,300 people died countrywide due to the Cholera epidemic. The spread of the epidemic was related to poor WASH services. The high number of deaths signalled an urgent response to the WASH challenge to avert further loss of lives.

In response to the challenge CARE International in Zimbabwe, in partnership with Chivi Rural District Council (RDC) with funding from CARE Australia has been implementing a WASH project termed;"*Putting Women and Girls at the Center of WASH and Health in Chivi District"*. The funding which CARE Australia availed to CARE Zimbabwe was obtained from the Australian Aid Non-Governmental Cooperative Partnership (ANCP) and other private and charitable organisations including Thank you Group. The project is commonly referred to as the *ANCP Chivi WASH Project*. The overall goal of the project was to reach two categories of vulnerable women and children namely;

(i) Rural and vulnerable girls between the ages of 10-19 with limited choices and at high risk of early marriage, pregnancies and HIV and AIDS.

(ii) Poor rural women in female headed households unable to fully exercise their rights and residing in areas dependent on agricultural activities.

The intended outcomes were that:

- Individuals, residing in school catchments have sustained and secure access to water and sanitation services and sustained hygienic behaviours
- Community and local institutions in 10 wards in Chivi District are responsive to women's and girls' needs and priorities and are accountable to upholding their rights

The Chivi District Water and Sanitation Sub-committee has improved capacity to deliver effective and gender-inclusive WASH services.

These outcomes were to be achieved through four thematic areas as highlighted in Box 1.

Box 1: Thematic Areas for ANCP Chivi WASH Project

1) *Rehabilitation of WASH Infrastructure in 10 wards of Chivi District.*
2) *Demand Led Sanitation and Hygiene in 10 wards of Chivi District.*
3) *Public Private Partnership for Operation and Maintenance.*
4) *WASH Sector Monitoring, Gender and Governance.*

The project began in October 2013 although field activities started in January 2014. The project commenced with implementation in 5 wards (2, 4, 5, 6 and 7) but these were later increased to cover 5 more wards (1, 3, 8, 10 and 15) as more funding became available. The first 5 Wards are termed the Old Wards whilst the additional wards are referred to as New Wards. The thematic areas and scope across these two categories remained the same. In line with the project commitments in the 2017 plan an End of Line Survey was commissioned through Vibes Consultancy Services. The objectives of the End Line Survey as stated in the Terms of Reference (TORs) are:

- To assess the extent to which the project has contributed to broader development results at the sub-national level, and lessons learnt that will allow the replication and scaling up of the interventions.
- To draw on operational recommendations and lessons learned for further improvement and enhancement of relevant sector policies, plans, strategies through analysis of the factors contributing to the success or failure of the project.
- To provide strategic guidance to CARE International in Zimbabwe WASH sector in determining its focus areas of support to relevant ministries in WASH under the current country programme in addressing critical WASH issues
- To demonstrate achievements of the Rural WASH Project
- To provide credible data to ascertain the impact of the project
- Improve the institutional framework to sustain rural WASH in the long term;
- To demonstrate successful strategies

The survey focused on Relevance, Effectiveness, Efficiency, Impact and Sustainability as given in the TORs.

1.2 Methodology

The evaluation applied a mixed method approach to data collection and synthesis. This included the application of participatory, qualitative and quantitative approaches over a wide range of primary and secondary data sources. The survey was carried out through the guidance of CARE Zimbabwe and Chivi DWSSC who are the key stakeholders for the project. Whilst women and children constitute the main targeted project beneficiaries, the evaluation also assessed the structures that support these from the district, ward and village levels including the households and schools serving the targeted population groups. To establish project impact, a comparison is drawn between baseline, and end-line indicators. The main methods used in data collection include document review, key informant interviews, focus group discussions, personal observations and household questionnaire interviews.

Document Review

This involved collecting and reviewing documents such as project framework, annual plans, CARE gender policy documents, baseline report, mid-term evaluation report, progress/monthly reports and monthly progress tracker. In addition, a review of national level documents governing the sector such as the National Water Policy, Sanitation and Hygiene Strategy and ZIM ASSET document has been conducted.

Key Informant Interviews

The key informants included, CARE programme personnel, district level officials from Ministry of Education and Ministry of Health, Environmental Health Technicians (EHTs), School heads, Health Coordinators, Women builders and shop owners (Annex 1).

Focus Group Discussions

A total of 18 focus group discussions (FGDs) were conducted with stakeholders and beneficiaries at district and ward levels. These included DWSSC, Ward leadership (that included Village heads and WSSC members), Sanitation Action Groups (SAG), Water Point Committees (WPC) and artisans (Pump-minders and builders). At the school level, discussions were held with School Development Committees (SDCs) and members of school

health clubs. The venues of these FGDs and the numbers disaggregated by gender are indicated in Annex 1

Personal Observations

The evaluation team conducted some observations of the WASH infrastructure at ward, school and household levels. This included household and school toilets, water points, containers for cooking and drinking water, washing facilities, refuse pits and pot racks.The enumerators conducted spot checks and inspected the household latrines and availability of hygiene enabling facilities.

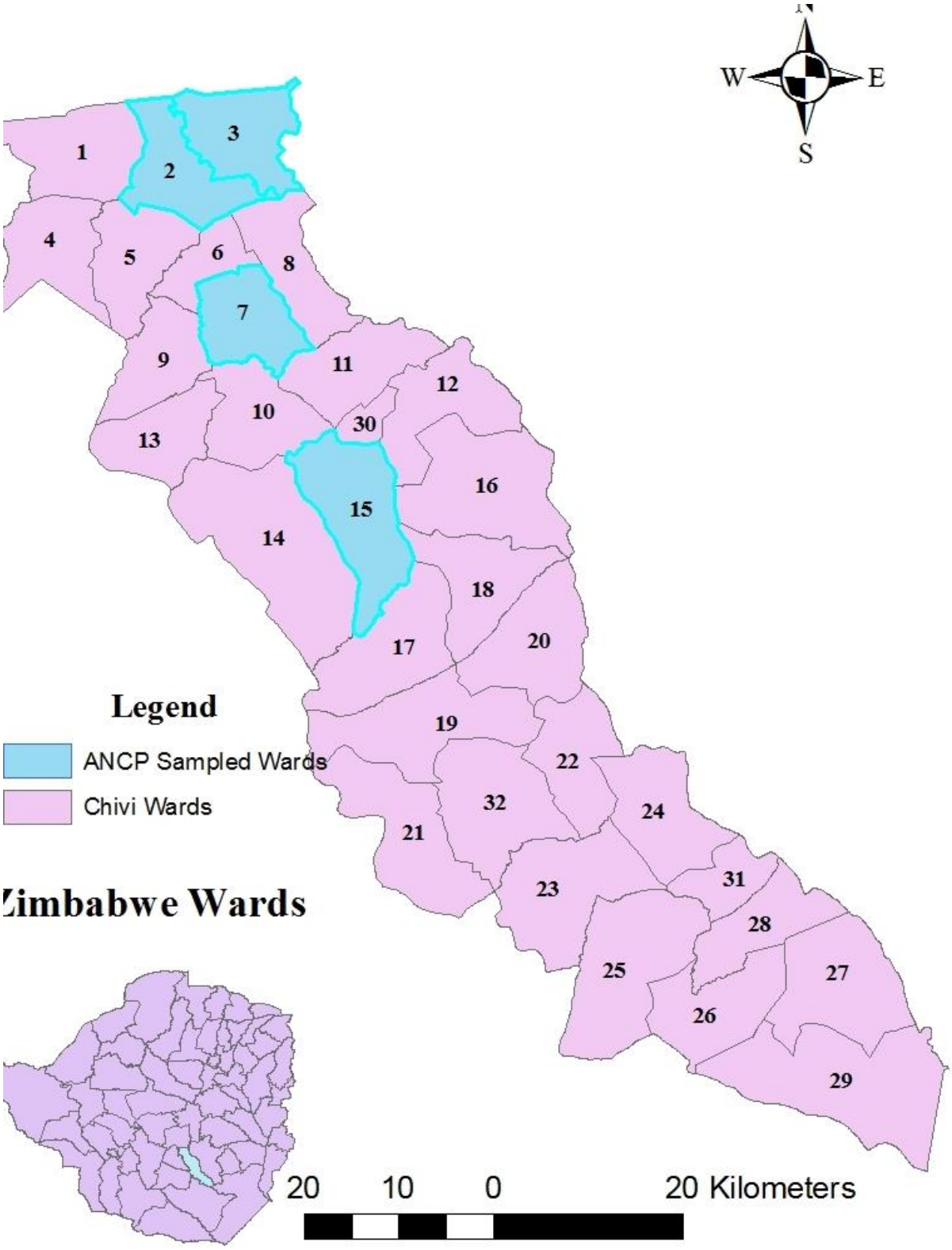
Household Questionnaire

A structured household questionnaire was administered in four wards (2, 3, 7 and 15which are highlighted in Figure 1 on the next page) by six (6) trained enumerators. To enhance comparison of the situation at baseline and at the end of project, the same questions used during baseline were also repeated at end-line survey. Two of the wards (2 and 7) are Old Wards where implementation started in 2014 while the other wards (3 and 15) are New Wards where implementation started in 2016.Table 1 shows the selected wards and the main reasons for selection.

Table 1: Survey wards and reasons for selection

Category	Ward Selected	Reason For Selection
Old Wards	2	Least percentage of ODF villages, high number of wheel chair friendly latrines and highest number of rehabilitated boreholes
	7	ODF ward, few targeted schools and low number of rehabilitated boreholes
New Wards	3	Least percentage of ODF villages, very few targeted schools, very few boreholes rehabilitated
	15	ODF free ward, high number of targeted schools and, wheel friendly toilets, high number of rehabilitated boreholes

Figure 1: Chivi District Map Showing Sampled Wards for End-line Evaluation



In each ward, six villages were randomly selected for the questionnaire survey (Table 2).

Table 2: Villages that participated in household survey and their ODF status

Ward 2		Ward 3		Ward 7		Ward 15	
Village	**ODF**	**Village**	**ODF**	**Village**	**ODF**	**Village**	**ODF**
Madamombe	Yes	Bhefura	Yes	Chitera	Yes	Rungano	Yes
Danha	Yes	Muzvidziwa	Yes	Gwauya	Yes	Magwenzi	Yes
Rera	Yes	Runesu	Yes	Mutangi	Yes	Mafuka	Yes
Makambe	No	Taruberekera	Yes	Chimwa	Yes	Mhare	Yes
Marecha	Yes	Penemene	Yes	Chidanhika	Yes	Chirongoma	Yes
Makohliso	Yes	Chaputika	Yes	Hware	Yes	Mupaike	Yes

In each ward, 96 questionnaire interviews were targeted with 384 questionnaires administered for the four wards. Table 3 below shows the number of respondents disaggregated by gender per ward. A total of 396 respondents (103% of target) were interviewed.

Table 3: Number of Respondents by Ward

Ward	Number of Respondents		
	Male	Female	Total
2	23 (24%)	72 (76%)	95
3	29 (29%)	72 (71%)	101
7	24 (24%)	77 (76%)	101
15	24 (24%)	75 (76%)	99
Total	**100 (25%)**	**296 (75%)**	**396**

75% of respondents were female. This was not by design but is a reflection of the key gender group that is commonly available within rural communities. This also underscores the relevance of project target; women and girls as being at the centre of rural WASH activities. Project baseline surveys used a ratio of 67% female and 33% male respondents.

Stakeholder consultations and feedback meetings

Project baseline and mid-term surveys were conducted entirely by CARE and stakeholders. This end-line survey has been led by an external consultant who applied a participatory approach to enhance learning among stakeholders. At the start of the survey, the consultant presented study objectives and methodology to CARE and Chivi DWSSC. The stakeholders participated in the pilot study and provided feedback to the consultant leading to the

finalisation of study tools. A district level stakeholders' feedback meeting was held to present and validate the findings.

1.3 Study Limitations

No critical challenges were encountered during the survey. Nevertheless, some few limitations are worth noting. Previous surveys driven by stakeholders had a 100% coverage of project wards as compared to the end-line survey that achieved 40% coverage. Although the end-line survey sample is adequate for assessing overall project performance as measured against key evaluation questions, some ward level differences could be missed. However, through the use of different methods of data collection representativeness of survey findings is enhanced.

While the participation of implementing partners/ stakeholders in evaluations has got a number of positive aspects, an element of stakeholder bias, particularly in selection of villages or institutions, cannot be ruled out. However, the consultant had the ultimate decision in most occasions.

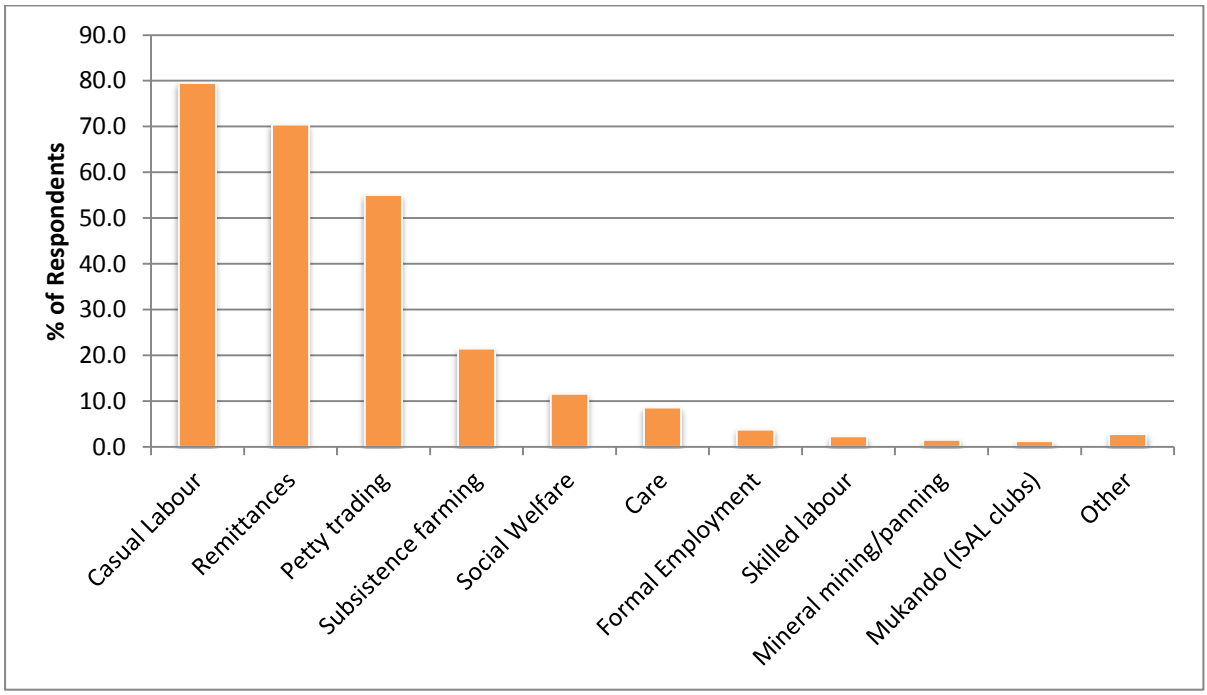
The survey was conducted during the rainy season and some sampled villages in one ward (ward 15) were not accessible. And these had to be replaced by other accessible villages in the same ward.

2.0 KEY FINDINGS

2.1 Context

The project commenced during a period of high food insecurity due to poor rainfall patterns. With the project advancing a demand-led approach to delivery of sanitation, a departure from the traditional supply driven approach, the project was bound to face challenges in gaining community support. Over the years, handouts from government and non-governmental organisations have played a critical role in alleviating food insecurity among rural households in Chivi district. Figure 2 shows key livelihood strategies for the households in the areas of study.

Figure 2: Livelihood Activities and Proportion of Respondents



Households are largely dependent on casual labour, remittances, petty trading and subsistence farming. About 12% and 9% of respondents regard social welfare and CARE respectively as some of their key sources of livelihoods.

The yearly funding of project activities meant that it was not possible to set performance targets in advance. Funding availed each year determined what activities could be carried out and project coverage. For instance, initial target of the project was 5 wards. With more

funding having been secured, the project expanded to additional five wards with almost similar activities but not necessarily at the same magnitude. One example being the drilling of boreholes; drilling was provided for in the old five wards but not the new wards. This was to do with availability of funding.

2.2 Relevance

The project has been designed with due recognition given to enabling national and district level policy frameworks governing the WASH sector. Project relevance to national and district level policies, plans and objectives has been well documented during the mid-line evaluation. Key policies and plans taken into consideration by the project include the National Water Policy (2013) and the Zimbabwe Agenda for Sustainable Socio-economic transformation (ZIM ASSET).Focus group discussions (FGDs) conducted at end-line further emphasised the significance of the project improving the living conditions of rural households. While at project start up some communities had been slow in embracing the demand led strategy having been used to hand outs, participants at FGDs confirmed that the project strategy was necessary as this opened their eyes on the ability they have to improve their living conditions without external material/financial support.

"When the project started, it looked as though it was not necessary. *But with the passage of time, there was great appreciation of project strategies from the community"*. Said one FGD participant in Ward 3.

Besides realising what they are able to do with local resources promoted by the project, issues of restoration of personal dignity were highlighted. This was not going to be possible with rampant OD. This practice, besides specifically polluting water bodies, had resulted in unsightly and unpleasant environments making it difficult for one to walk freely outdoors. All these factors meant that the project was addressing pertinent issues affecting the communities and households (women and girls in particular). At one FGD in ward 2, one elderly woman indicated the building of toilets also contributes to reduction in rape cases which could be exacerbated by open defecation (OD).

2.3 Effectiveness

The survey sought to establish the extent to which the project met its planned objectives as measured by the indicator defined in the monthly project tracker. The targets reported (data

obtained from project records) are a combination of what was done over the whole project period (up to January 2017) though the setting of targets was done annually. The setting of targets for the project has been on an incremental basis largely guided by available financial resources.

2.3.1 Objective 1: 41,889 individuals (53% women), residing in 44 school catchment areas have sustained and secure access to safe water and sanitation services and sustained hygienic behaviors.

This first objective was achieved through the rehabilitation of WASH infrastructure, demand led sanitation and hygiene as well as public private partnerships (PPPS). Thus the extent of its achievement is discussed through assessing progress made in improving access to water, sanitation and hygiene and private sector involvement.

Access to Safe Water

The project has made notable contribution towards improved access to safe water for cooking and drinking. Table 4 shows progress made as measured against outcome indicators. The drilling of new boreholes (21) and the rehabilitation/repair of water points (161) contributed significantly to improving access to safe water. Capacity testing was also carried out on new boreholes whilst water quality testing was done on both new and rehabilitated/repaired boreholes.

Table 4: Project Performance as measured against key indicators

Key Indicators	Performance Against Targets					
	Target		Number Achieved		% Achieved	
% of people accessing safe water source in target communities	100%				94%	
% of population travelling more than 1 km to fetch water	60%				35%	
Number of water points/boreholes repaired or rehabilitated.	69		161		233%	
Number of boreholes Drilled	21		21		100%	
Number of people provided with increased access to safe water	**Target**	**Achieved**	**Male**	**Female**	**Girls**	**Boys**
	17,250	50,377	7,978	10,668	16,693	15,038

Although field data showed that a 100% target of people accessing safe water in target communities was not met, commendable progress (94%) has been made. Table 5 shows key sources of water for cooking and drinking by proportion of respondents. The data shows that Old Wards (2 and 7) are comparatively better off than New Wards in terms of access to safe water for cooking and drinking. This is probably because of drillings, which were done in addition to the rehabilitations.

Table 5: Percentage of Respondents by Source of Water for Cooking and Drinking

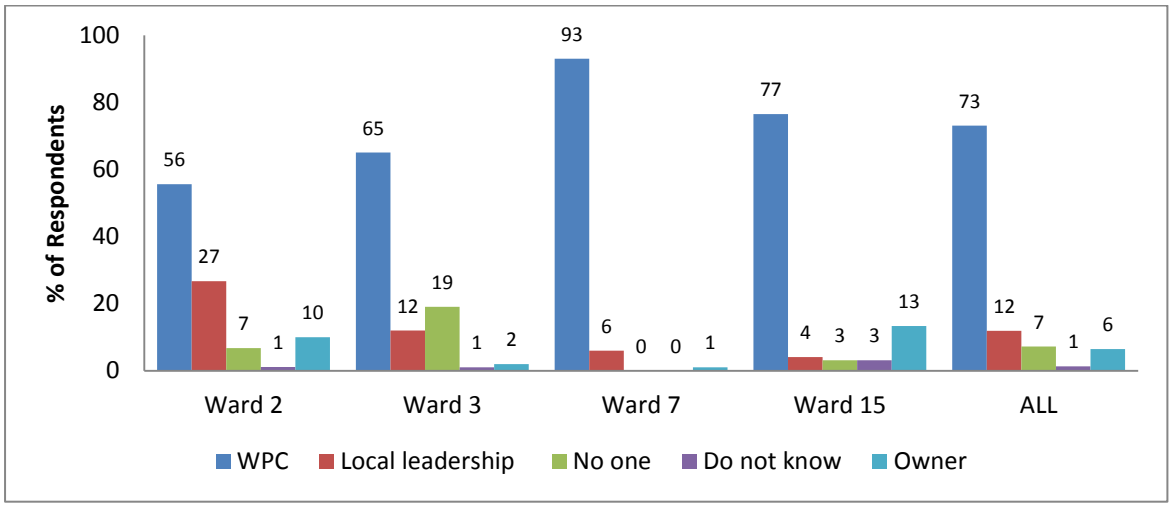
Source of Water	Ward 2	Ward 3	Ward 7	Ward 15	ALL
Borehole	84.20	78.20	98.00	63.60	81.10
Protected Well (Individual)	11.60	4.00	2.00	19.20	9.10
Protected Well (Community)	0.00	0.00	0.00	12.10	3.00
Tap /Piped water at household	1.10	1.00	0.00	0.00	0.50
Protected Spring	0.00	0.00	0.00	1.00	0.30
Total (%) Accessing Safe Water	***96.90***	***83.2***	***100.00***	***95.90***	***94.00***
Unprotected well, Irrigation Canal, Pond, Dam, River	1.10	13.90	0.00	3.00	4.50
Unprotected Spring	2.10	0.00	0.00	0.00	0.50
Sand Abstraction	0.00	3.00	0.00	0.00	0.80
Other, specify	0.00	0.00	0.00	1.00	0.30

(Source: End-line Survey Data)

Management of the Water Sources

Good water management is important for continued access to safe drinking water by households. The end-line survey noted that Water Point Committees (WPCs) is the main structure controlling access to water followed by the local leadership. Figure 3 shows the main leadership structures known by respondents that control access to water.

Figure 3: Who controls access to water by proportion of respondents

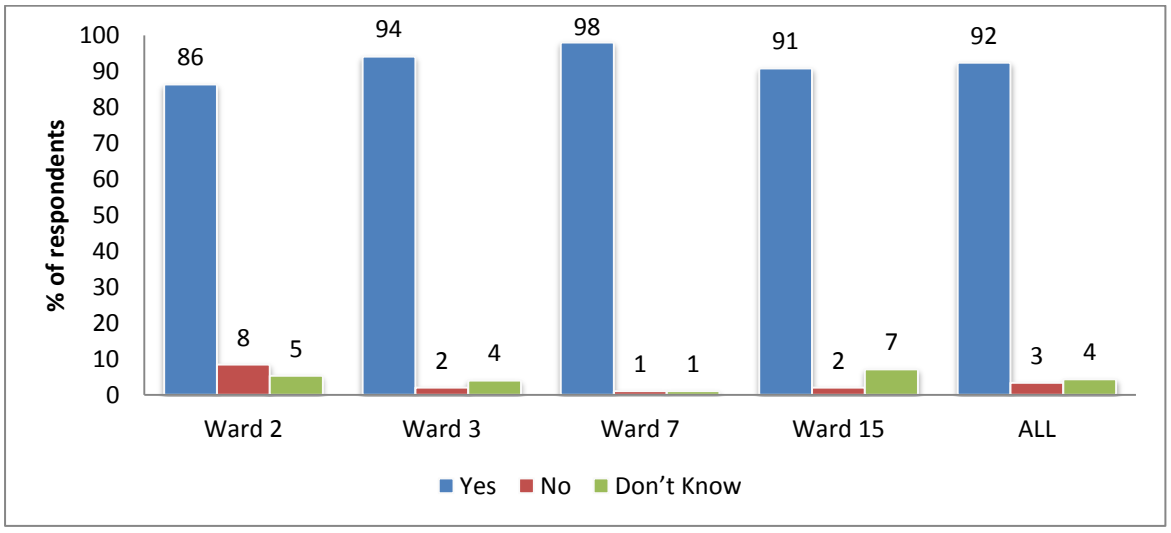


(Source: End-line Survey Data)

The majority of respondents (73%) across the four wards indicated that the WPC controls access to water. There is a marginal difference in knowledge between female and male respondents with 72% female and 75% male respondents aware of the WPC's role.

However, a significant proportion of respondents in Ward 3 (19%) and Ward 2 (7%) indicated that there was no one controlling access to water in their areas. In Ward 2 about 8% of respondents did not know that there was a WPC in their area (Figure 4). Though the proportions of respondents unaware of their water governance system was low, it still indicates the need to strengthen the WPC for sustainability.

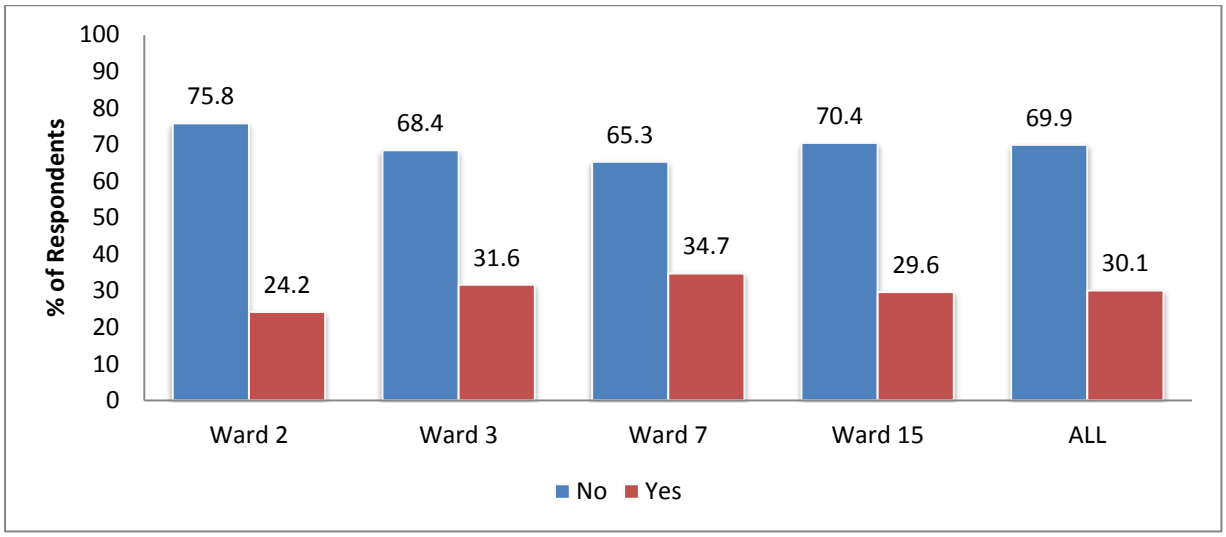
Figure 4: Knowledge about the availability of WPC by proportion of respondents



(Source: End-line Survey Data)

Effective control of access can only take place where there are enforceable rules and regulations. The respondents were asked if they knew any water collection regulations. Figure 5 shows that almost a third (30%) of all respondents (27% female and 38% male respondents) across the four wards indicated that there were regulations governing water collection.

Figure 5: Availability of water collection regulations by proportion of respondents



(Source: End-line Survey Data)

Schools water Supply

The project managed to drill (6) and rehabilitate (33) water points which are used by schools resulting in 24,373 students having access to safe water. It is worthy noting that some schools were still underserved either because the budget for drilling new boreholes was not adequate or that there was not enough ground water to warrant drilling a borehole. Some school water points were managed by WPC with representatives from the school and community, especially where the water point was shared.

Picture 1: Dewe Primary School Water Point (Ward 15)

Access to Sanitation

This section focuses on progress made on sanitation and hygiene at community/household and school levels. Table 6 highlights project performance (source project reports) on key sanitation and hygiene indicators. The project met or exceeded its targets in over 75% of the sanitation and hygiene indicators. The only exception, where at least 80% of the targets have been met, is on indicators pertaining to establishment/strengthening of Community Health Clubs and the number of people provided with basic sanitation services through hygiene promotion activities.

Table 6: Performance against key sanitation and hygiene indicators

Key Indicators	Performance Against Targets						
	Target	Achieved	Male	Female	Girls	Boys	% achieved
Number of students provided with sanitation facilities	18,314	18,511	369	463	8,632	9,047	101
Number of villages triggered for ODF	230	230					100
Number of villages achieved ODF status	100	133					133
Number of SAGs formed and strengthened	230	230	483	1,127	0	0	100
Number of extension workers/facilitators trained at ward level on SaFPHHE	30	66	39	27	0	0	220
Number of Community Health Clubs (CHCs) supported	70	65	72	1,758	0	0	93*
Number of SDCs established/strengthened	44	44	138	189	0	0	100
Number of health teacher/master trained on PHHE/ODF-TOT etc.	88	88	44	44	0	0	100
Number of school clubs formed/strengthened	44	44	47	52	748	616	100
Number of people provided with basic sanitation services throughself-built latrines	42,613	37,710	-	-	-	-	88
Number of people provided with basic sanitation services through subsidised latrines	1,388	1,650					119%
Number provided with basic sanitation services through hygiene promotion activities.	53,111	46,227	8,783	9,708	14,330	13 406	87%
Number with increased knowledge of hygiene practices							
Number of people with hand washing facilities/soap/ ash/ other cleaning substances							

Household Sanitation and Hygiene

The project achieved improved access to sanitation for households within its target areas. The project managed to introduce demand led sanitation and hygiene through training 66 extension workers who, in turn, triggered all the 230 villages within the 10 wards. This resulted in the formation of SAGs, which facilitated both hygiene awareness and creation of community health clubs. The community health clubs, which were joined on voluntary basis, provided both a platform for learning more about WASH and for members to pool funds to assist each other in putting up sanitation infrastructure. As of January 2017, 133 villages had been certified as ODF and about 40,000 community members were given access to sanitary facilities, self-built and subsidised facilities. Discussions with both community members and extension workers indicated that more villages were now ODF but were still awaiting certification. Certification of the ODF status is carried out by WWSSC members. The certification process has been standardised at national level. This involves, among other things, checking that every household has a latrine and carrying transect walks checking for faeces.

About 42,613 people (representing 87% of target) from residents of the 10 wards were given access to hygiene knowledge through the village SAGs which moved through every household in the community spreading hygiene knowledge. Field observations showed that 98% of households were disposing their excreta into a toilet. Furthermore 97% and 100 % had pot racks and refuse pits respectively which are all evidence of improved hygiene.

The project managed to achieve these milestones because it placed the responsibility of latrine construction on the communities and encouraged innovation among them to produce desired results at a low cost. For example, communities were introduced to the one bag model upgradable Blair Ventilated Improved Pipe Latrine (uBVIP) which conformed to the expected below ground standards for safe toilets in Zimbabwe but allows incremental development and innovation for the superstructure. Some of the innovations for superstructure included use of empty beer plastic bottles as vent pipes and use of locally available materials like grass for the superstructure and roofing.

Sanitation access was also provided to 1,650 vulnerable members of society through cement and wire subsidies. The vulnerable members contributed the rest of the materials through their own resources and/or from assistance from other community members. Village heads facilitated the assistance from other community members. In the case of Gogo Chimbunde, a

77 year old grandmother in Ward 7, her own goat was sold to pay for the bricks. She went on to make a toilet seat using clay so that she could use the toilet with easy.

Picture 2: Well maintained toilet with tippy tape (Ward 2)

School Sanitation and Hygiene

Access to sanitation was also achieved within schools where a total of 299 squat holes were available for pupils and staff members. These consisted of 88 disability friendly toilets, 44 girl-friendly toilets and 167 standard squat holes. A girl friendly latrine is one that offers privacy required during menstrual periods and is also equipped with the necessary materials for one to freshen themselves up. The key components in a girl friendly latrine include a lockable door, a mirror, lotion, water, washing aid and pads and a toilet seat.

A latrine was also designed in consideration to disabled individuals. A disability friendly latrine has a wide door, a rail and toilet seat. The toilet is largely suited for those who use wheel chairs but are able to get off with the aid of rails if they need to relieve themselves. The girl friendly toilets gave access to 8,632 girls from the 44 schools. According to DWSSC all

the schools in the 10 wards have now achieved the squat to pupil ratios as recommended by the Ministry of Education. (The laid down standards of 1 squat hole: 25 boys and 1 squat hole: 20 girls). The current agreed standard in Chivi is one girl friendly toilet per school.

Picture 3: Materials inside a girl-friendly toilet

The project also brought improved hygiene through the formation of 44 school health clubs at both primary and secondary schools. The formation of the clubs was led by the 88 teachers who were trained by the project. In addition to the clubs the teachers facilitated good hygiene through leading the sewing of rumps for use by girls within the schools. Hygiene within schools was further enhanced by building a hand washing tank at each of the 44 schools, digging of refuse pits and installation of pot racks at the teachers' cottages. Separation of waste was encouraged within the schools by having three pits (decomposable, plastics and bottles/cans). However the visits made showed that the lining of pits was not consistently done by the schools. The club members perform poems, dramas within their clubs and are given opportunities to present these at either community events or at school assembly. These have been instrumental in creating awareness among school pupils and maintaining good hygienic environments at the school.

Observations made at each of the schools indicated that the tanks were being used to wash hands by the pupils after toilet use. However, there was no washing aid such as soap available at the washing place at three of the five schools visited.

Accessing Water, Sanitation and Hygiene Inputs and Services

The project intended to support access to inputs and services for water, sanitation and hygiene through PPPs. Under this thematic area, the project created expertise that would offer services such as private practitioners and linked traders with communities.

Capacity building of local artisans

Table 7 shows that the project achieved or surpassed the planned targets for VPMs and latrine builders trained. These then provided services to the communities as private players through negotiation with the communities and individuals. Of particular note is the promotion of women as private players in the provision of construction and maintenance services to their communities. For both builders and VPMs more women were trained.

Table 7: Performance Against Public Private Partnerships Key Indicators

Indicator	Performance Against Targets						
	Target	Achieved	Male	Female	Boys	Girls	
Number of VPM trained	28	29	13	16	0	0	104%
Number of latrine builders trained	80	80	33	47	0	0	100%

(Source: Project reports)

Promotion of Linkages with Traders

Though efforts to link communities to the traders were made, there was limited success in meeting this objective. The implications are that rural communities will continue to incur transportation costs to access materials thereby raising the financial resources required to provide the WASH services. In ward 2 Mr Mordern Machaka who has business outlets at both Chivi and Madamombe (Ward 2) increased the diversity of his stock at Madamombe in September 2016 to cover pipes, mesh wire, fly-screens and cement which are key inputs into construction of sanitary infrastructure. However, his actions were not driven by any direct engagement from the project but rather from increased demand of the same items by people from ward 2. Though the demand for the products at Madamombe outlet in ward 2 has been high, it is probably because of the triggered demand for sanitary facilities as it is unlikely that

it will be continued since sanitary facilities such as toilets can last more than 10 years. According to Mr Machaka access to loans and increased space for trading will motivate him to continue servicing the community with the WASH materials. However their low turn-around time outside peak demand periods may make servicing of the loan difficult.

Engagement with wholesalers was only successful in as far as keeping bulk cement stock for the project. The project team used to purchase as much as 70-150 bags a day from Pote for the rural households. Deliveries to the Chivi outlet were required every week. The demand has gone down to just a single truck every two weeks and only 12 bags of cement have been sold in the last 14 days. Whilst it is possible that the decline in demand was due to the rainy periods as it becomes risky to transport, mould bricks and even construct toilets, it is also possible that some of the decline may be because the triggered demand in the 10 wards had largely been met. Other WASH products stocked by these wholesalers include pipes, BVIP toilet seats, cement and fly screens. The stocking of WASH products at both Pote and N Richards could also be in response to the residents in the nearby suburbs such as Silver city who also use Blair toilets and therefore demand the same products required by rural households.

Though Chivi based wholesalers are diversifying their range of WASH products, the response is again due to expressed demand from their customers and not necessarily from deliberate efforts from the project team. Furthermore, these wholesalers have not been engaged by the project team to decentralise their supplies to reach those in remote areas. Even if efforts for wholesalers to avail materials to rural wards were made, success was unlikely because traders such as N Richards are, by policy, allowed to operate only from growth points and should not decentralise to outskirts. This is done to protect small businesses from unfair competition as these buy in bulk from the wholesalers. However "*If adequate engagements are made in time, it is possible for businesses to organise once off transportation of bulk quantities to community centres as part of their social responsibility"* remarked Mr Kuda Ndhlezani of N Richards.

Objective 2: Community and local institutions in 10 wards in Chivi District are responsive to women's and girls' needs and priorities and are accountable in upholding their rights.

The second objective was also achieved as both the communities and local institutions are now responsive to the needs of women and girls. Details on how this has been achieved are provided in the sections below.

Community level

The best strategy for being responsive to the needs of women and girls was to make them part of the structures in key decision-making processes for WASH. At a local level, women made up at least 50% of all the 475 WASH committees strengthened/established as indicated in Table 8.

Table 8: Women representation in WASH committees

Key Indicators	Performance Against Targets						
	Target	Achieved	Male	Female	Girls	Boys	% achieved
% of WASH committees in which women are equally represented.	475	475	998	2327	0	0	100%
Number of WASH committees supported with at least 50% women	475	475	998	2327	0	0	100%

(Source: Project Reports)

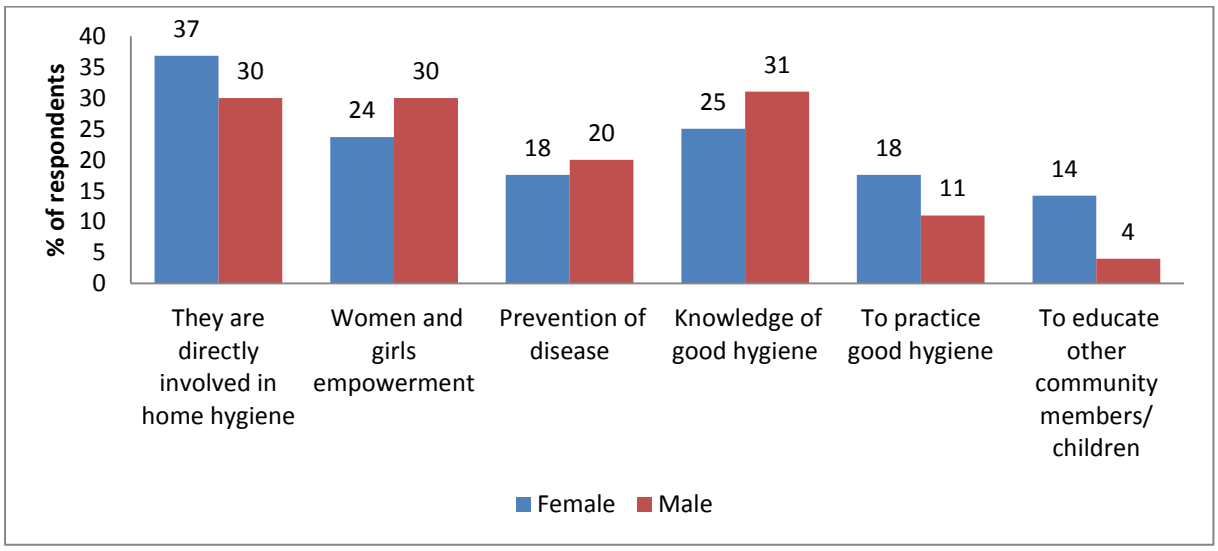
Women constituted 70% of the SAGs which were driving the Water, Sanitation and hygiene issues within villages. Furthermore, 96% of the Community Health Club members were women. Women also occupied key positions within Water Point committees responsible for water point maintenance. Table 9 shows number of women in the water point committees which were represented at the FGDs held in ward 15. Women made up at least 70% of the committee members. They also occupied positions of influence.

Table 9: Number of women in sampled WPC in Ward 15

Name of WP	Female	Male	Chairperson
i. **Matsveru**	5	2	Female
ii. **Mhare**	7	0	Female
iii. **Magwenzi**	6	1	Male
iv. **Ruzive**	5	2	Male
v. **Zimuto**	5	2	Female

Data collected in the field also showed that households support the placement of women in key roles for WASH for various reasons. Figure 6 shows the main reasons why women and girls should be at the centre of WASH activities. More women (37%) than men (30%) indicated that they are the ones mandated with ensuring good hygiene within the home. More men (30%) than women (24%) see it as an empowerment issue which is also a right for women.

Figure 6: Reasons why women and girls must be at the centre of WASH



Schools

SDCs are responsible for running all developmental issues for the schools. Women make up 54% of the SDC members who received training in WASH emphasizing the needs of girls. The SDC members consist of teachers and parents. The teachers who come into the SDC by

virtue of positions (head, deputy head, senior master and senior mistress) are permanent, whilst the parents are elected annually at an annual general meeting of all parents. The trainings served as a platform for the members to receive the awareness necessary for them to prioritise issues specific to girls. The SDC who constitute the highest decision making body within the schools had committed themselves to prioritizing girls' WASH needs and rights. Upholding of these rights was evident in the SDC leading the construction and equipping of girl friendly latrines with basic female sanitation needs (mirror, soap, lotion, pads and water). The equipping of the girl friendly latrines varied among the schools depending on available funds. At schools like Ruminya Secondary water was in movable buckets whilst fixed water containers with a sink were provided at other schools such as Jenya primary.

Within schools, health coordinators are responsible for overseeing the issues of water, sanitation and hygiene. The project trained a male and female from each school to ensure that girls' sanitation will be prioritised. The trained teachers are permanent within the schools but may move out due to transfers and/or death. The training included issues of menstrual hygiene management to ensure that both male and female teachers prioritized girl child issues. At Bwanya primary school the male health coordinator was active in sewing of Rumps. Discussions with health coordinators highlighted that pads supplied were being replenished in time when finished. Health clubs at schools lead the promotion of sanitation and hygiene issues. In most schools visited there was a higher proportion of girls than boys participating in the school health clubs. At some schools e.g. Tambudzayi Secondary, girls made up as much as 75% of the membership. The trained girls and boys move out from the schools after completing the highest level of primary or secondary education as offered by the school but new members are enrolled each year. New members to the schools health clubs are not disadvantaged because learning of the key concepts is continuous.

Objective 3: The Chivi District Water and Sanitation Sub-committee (DWSSC) have improved capacity to deliver effective and gender-inclusive WASH services.

The Chivi District Water and Sanitation Sub-Committee (DWSSC) played a critical role in driving the project towards the realization of set objectives. The Committee comprised of various government ministries at the district level and was actively involved from the start of the project. The ministries responsible for Health, Youth, Local Government, Education,

Agriculture as well as DDF were actively involved in DWSSC activities. At the Ward level, the Ward Water and Sanitation Sub-committee (WWSSC), also comprised government officers from various ministries, was responsible for community mobilisation and supervision of project processes. The ward committees received trainings at the start of the project. The trainings were later provided to project structures within the ward such as SAGs. The trainings provided at all levels incorporated gender mainstreaming and sensitisation aspects. The DWSSC committees worked closely with ward councilors and local traditional leadership, particularly village heads, and emphasized the importance of gender in WASH. Strategies that were used to promote the incorporation of gender included the use of respected members of society to talk about the importance of gender, use of both males and females to present the issues of gender, discussions with both men and women to understand their concerns in WASH and subsequently address them. For example training of builders initially required women to be away from home. However, upon reports that some women needed to be home in the evening to perform other responsibilities, changes were made and decentralized training was adopted allowing women to go back for the evening.

Periodic review meetings held at the district centre and attended by WWSSC members served as crucial platforms for performance monitoring as well as motivating key stakeholders to meet set targets including the inclusion and prioritisation of women in their committees.

2.4 Efficiency

The efficiency of the programme was examined by looking at how the project was managed, and the inputs used to produce the outputs. The project implementation, coordination and supervisory structure involving DWSSC, WWSSC and community based structures enabled the project to reach out to many households with minimal costs.

Table 10 presents a summary of the budget and expenditure patterns. At the time of project end-line evaluation total project expenditure was within the allocated budget at 82% of total budget.

Table 10: Summary of Project Budget and Expenditure

Budget Item	Total Budget		Expenditure	
	Actual (USD)	% of Total	Actual (USD)	% of Budget
Activity Personnel	625,469	36%	440,798	70%
Activity Travel	29,614	2%	6,574	22%
Material and Equipment	54,224	3%	47,724	88%
Component 1: Rehabilitation of WASH Infrastructure	272,389	16%	299,279	110%
Component 2: Demand-Led sanitation and hygiene	190,754	11%	183,288	96%
Component 3: Public Private Partnerships for operation and maintenance	15,939	1%	10,931	69%
Component 4: WASH sector monitoring, gender and governance	105,867	6%	30,713	29%
Performance monitoring evaluation and sharing	60,349	4%	35,640	59%
Other Costs (Visibility)	13,226	1%	13,869	105%
Total Activity Support Costs	207,980	12%	214,979	103%
CARE Australia ICR (10%)	142,534	8%	116,710	82%
TOTAL	**1,718,346**	100%	**1,400,505**	82%

Over expenditure was realised on Component 1 (Rehabilitation of WASH Infrastructure) and on Activity Support Costs (that included field office running costs). Over expenditure on Component 1 was largely a result of the drilling of new boreholes and provision of school sanitation BVIP latrines. Although the project more than doubled (233%) its original target of borehole rehabilitation and repairs, this did not exceed the budgeted amounts. The project provided cement for the construction of school toilets while SDCs provided bricks and labour for the construction.

At the household level, the project supported not more than 15 vulnerable households per ward with cement for construction of household latrines while other community members supported with labour and bricks. For the rest of the community members, households provided all the required materials and labour for construction with the supervision of WWSSC members. The celebrations held for a village that attained ODF status was an effective motivational strategy that instilled a competitive spirit among villages and households to meet their targets. Such cost-effective strategies ensured the project met its targets within the specified timeframe.

Management

The project was implemented by CARE through DWSSC and its substructures. CARE had a full time assistant project manager, a monitoring and evaluation officer and a field officer for each of the 5 wards. Though this staff compliment is quite lean compared to the number of villages (230) to be reached, success was high on working with the government officers who are mandated to carry out the task such that CARE officers were more of facilitators of project implementation. At District level DWSSC which is composed of all government ministries with a stake in WASH worked with both the project manager and field officers to bring the project to the wards and ultimately to the villages. "*The project was not a one person issue but it was all of us together*" remarked the members of Chivi DWSSC during an FGD meeting.

Within the wards, the government extension workers, together with the councillor, formed WWSSC, which propelled the project to the villages. Within the villages, Sanitation Action Groups made of volunteers, with the village head providing a supervisory and oversight role, resulted in the implementation within the communities. The support rendered from government extension officers in the project had challenges largely related to mobility. To improve mobility the project repaired bikes for the Ministry of Health and Child Care (MoHCC). Furthermore, fuel amounting to 20 litres per month was given to government extension workers to assist with their monitoring and supervision. However, mobility remained a challenge in those wards where the officers were not motorised, as the project did not have a budget to buy motor cycles for government workers.

The actual implementation of both the hardware and software was carried out through community members. The initial triggering of the villages was carried out by the WWSSC members but the subsequent awareness creation within the households was the responsibility of SAG members who either volunteered (eg in ward 2) or were nominated by community members (eg in ward 7). A Water Point Committee (WPC) made up of community members was responsible for facilitating borehole maintenance and repairs. During borehole repair, trained artisans called Village Pump Mechanics (VPMs) provided technical expertise whilst the community at large either provided labour and/or food. Rehabilitations and repair were done during the training of the VPMs and the water point users bore no additional finance costs. However, in cases where the borehole broke down, the communities through the WPC facilitated the repair process using the trained personnel. The costs for the VPMs averaged

$30.00 which was considered "*a token...since the VPM also benefited from the water and was trained on behalf of the community*" remarked community members during an FGD meeting in Ward 7. However, VPMs would at times do the work for less money or non-monetary contributions like maize or chicken from the community. The household toilets were built by the trained builders at a cost ranging from $50.00-$80.00 depending on the negotiations and when the builders were trained. The project trained builders charged less whilst the builders who were not directly trained by the project tended to have higher fees. In cases where the household only constructed the uBVIP, payment was only for the substructure whilst the household provided their own labour to put up the walls which were made of locally available materials bringing the labour costs down to about $30.00.

Quality of the work done

Borehole Rehabilitations and Repairs

The mechanical components for the repair were provided by the project and supervision was done by the District Development Fund (DDF). To increase the number of boreholes repaired for some boreholes only the faulty components were replaced. "*The work done was good since we obtained water from the boreholes which were no longer working*", remarked a community member. The number of strokes at the sampled boreholes averaged 4 which is indicative of good functionality. Cases where water could not come out was either due to a low water table or collapse of the drilled hole. However, the fencing of the borehole was left to the community members to complete. About 10% of the water points visited did not have fences erected or the fence had fallen down. Further, some of the fences, for example at a borehole in Ward 7, the entrance allowed larger animals to get close to the water points.

Picture 4: Borehole in Ward 2

Quality of Work at Hand Washing Tanks

The hand washing tanks within the schools were of good quality. However user friendliness depended on how much the schools were willing to invest. In some schools drainage channels from the hand washing place were constructed. These are useful in minimising splashes to the users making more attractive to the pupils. In some schools such as Ruminya, minimal investments had been done in making the tank more user friendly.

Household Toilets

Some households were putting up high quality toilets with others using locally available resources.. Table 11 below shows the presence of key quality factors such as darkness, fly screen and presence of the vent pipe across the wards sampled based on household observations made.

Table 11: Some Quality Parameters for Household Toilets

Parameter	Ward 2	Ward 3	Ward 7	Ward 15	ALL
Darkness inside toilet	98.3	89.2	98.1	94.6	94.8
Vent Pipe	100	89.2	98.1	94.6	95.1
Fly-screen	96.6	87.7	98.1	87.0	91.4

Picture 5: Household latrine (Ward 7)

School Toilets

All the school toilets visited were well done with darkness, vent pipes and fly screens. An exception was noted at Zvamapere secondary school where the girl friendly toilet was not roomy enough because the newly trained builders failed to read the toilet plan. The close monitoring of the builders reduced some of the errors during toilet construction. However, the finishing of the structures, such as plastering and painting the toilets, was dependent on whether the school has the required resources. In some areas, for example at Tambudzai secondary school, the toilets were tiled whilst in others the toilets were plastered and floored. The equipping of the girl friendly toilets was also dependent on the school. Some schools, for example Ruminya Secondary, placed movable water tanks within the toilet and soap whilst others such as Jenya primary placed fixed washing basins, soap, pads and lotion. The fixed facilities were easier to use.

Picture 6: Jenya Primary Girl Friendly Toilet

The Quality of Other Hygiene Enabling Facilities

The pot racks and tippy tapes were largely made of locally available materials particularly wood. Whilst the quality was good the longevity of these structures were short especially during the rainy season. Furthermore, the plastic tippy tape containers suffered from the sun's heat and thus had a short life span. The use of concrete pot racks

Picture 7: Pot rack at a homestead in Ward 15

was gaining prominence especially in schools such as Jenya Primary and secondary where all teachers' cottages had concrete ones. Discussions with households in all the 4 wards indicated that households also want to migrate to concrete pot racks to increase the life span. Use of materials with a short life span may reduce the gains and may not have been used long enough to make it a norm.

Discussions with both household representatives indicate that they acknowledged the importance of lining pits to enhance durability. However, very few households had lined pits.

Implementation of Mid Term Review Recommendations

The recommendations for speeding up progress were made under each of the four thematic areas and their extent of implementation is discussed in Table 12 below.

Table 12: Mid Term Review Recommendations and Action Taken

Thematic Area	Summary of Recommendation	Extent to Which the Recommendation was implemented
New WASH Infrastructure	Resuscitation of piped Water Schemes or Small schemes	Not implemented due to inadequate funding
	Drilling of Boreholes	Not implemented due to inadequate funds
Demand Led Sanitation	Acceleration with practical steps which allows early resolution of challenges and support	Implemented and coverage increased
	SAGs to increase visits to households	Done and produced the desired results
	Funding ODF Celebrations	Done and villages were given $350.00
	Re-spring bikes for EHT	Done
	Demonstration households	Done through household competitions
Public Private Partnerships	Engage private players to increase their participation	Limited implementation due to lack of national direction
WASH governance	Regular Reviews	Done
	Local leadership to encourage assistance to vulnerable households	Done
	Performance based incentives to SAGs and WSSC	Done

The recommendation for the Demand led and WASH governance were all implemented and outputs from these increased and surpassed targets. However the ones for new infrastructure could not be implemented due to unavailability of funds budgeted for that activity. In addition the PPP recommendations were also not implemented due to lack of a national framework to overcome the challenges currently faced by interested businesses.

2.5 Impact

The project brought significant positive changes to women and girls as well to the systems in the environments that support them. The changes are understood by comparing the status at the end of project with the baselines. These impacts relate to the access of safe water, sanitation and hygiene practices. Box 2 shows specific summarised changes on the lives of women and girls as a result of the project whilst the rest of the sections provide impacts to water supply, sanitation and hygiene.

Box 2: Summary of positive changes on women and girls

The ANCP project has positively affected the lives of women and girls in targeted wards of Chivi district. As at end-line evaluation, a typical woman/ girl in the district has restored dignity, self-esteem and safety as a result of improved access to a quality built toilet within the home environment. Her village is declared open-defecation free and with improved hand washing practices through the use of project introduced technologies such as the tippy taps and pot racks, cases of diarrhoea are now rare.

Not only did the woman get access to improved sanitation services, but the construction of toilets by women builders has also served as a key livelihood activity giving them between $30.00-80.00 per job. The woman has been economically empowered and is now involved in trades such as construction (latrine builders & village pump mechanics) that are traditionally viewed as a domain for men. Through the project, women have proved to be good builders and are even better trusted than men.

The new boreholes drilled or rehabilitated are effectively managed by water point committees in which women occupy the key positions for decision making. This has resulted in improved access to safe water although distance travelled is still quite high. Through gender sensitisation, other men in the household are sharing the responsibility of water collection thereby lessening the burden that was solely on women before the project.

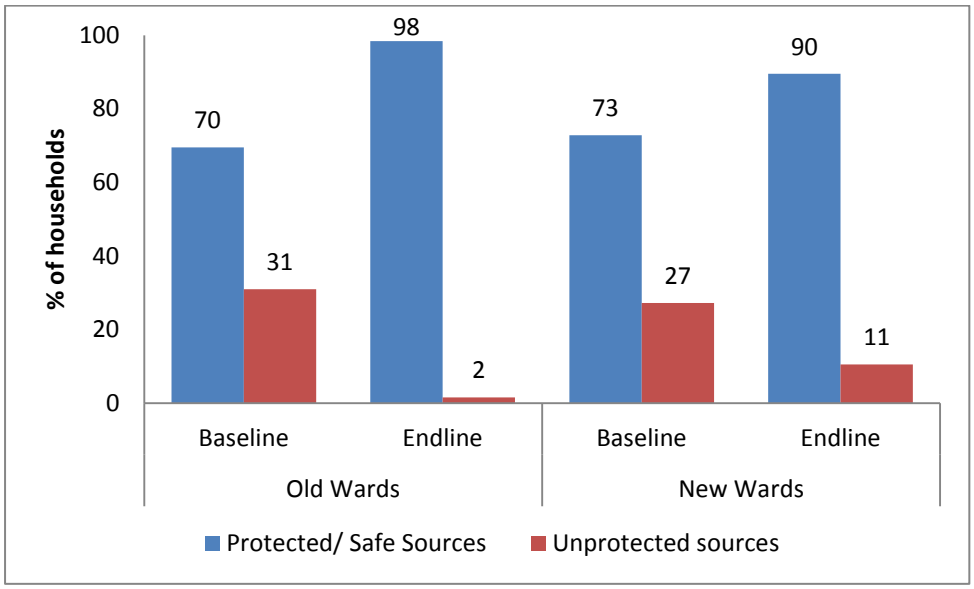
There is a marked improvement in school attendance and consequently performance by girls as a result of improved menstrual hygiene facilities within schools. Through school health clubs, in which both girls and boys equally participate, the future of girls is much brighter than before as boys also grow up aware and upholding the rights of girls.

a) Access to Safe Water

A comparison of baseline and end-line values shows improvement in access to safe water. Figure 7 shows a marked increase in the use of safe/ protected sources of water from 70% at baseline to 98% at end of project (Old wards) and from 73% to 90% in new wards. Findings from focus group discussions indicated that there was notable improvement in access to safe

water in the Old wards, particularly where new boreholes have been drilled and where broken down boreholes had been rehabilitated.

Figure 7: Percentage of households by source of water



As the project drilled boreholes in the Old wards compared to New Wards, this has contributed to more households having access to safe water in the Old Wards than the New Wards.

Distance to Source of Water for Cooking and Drinking

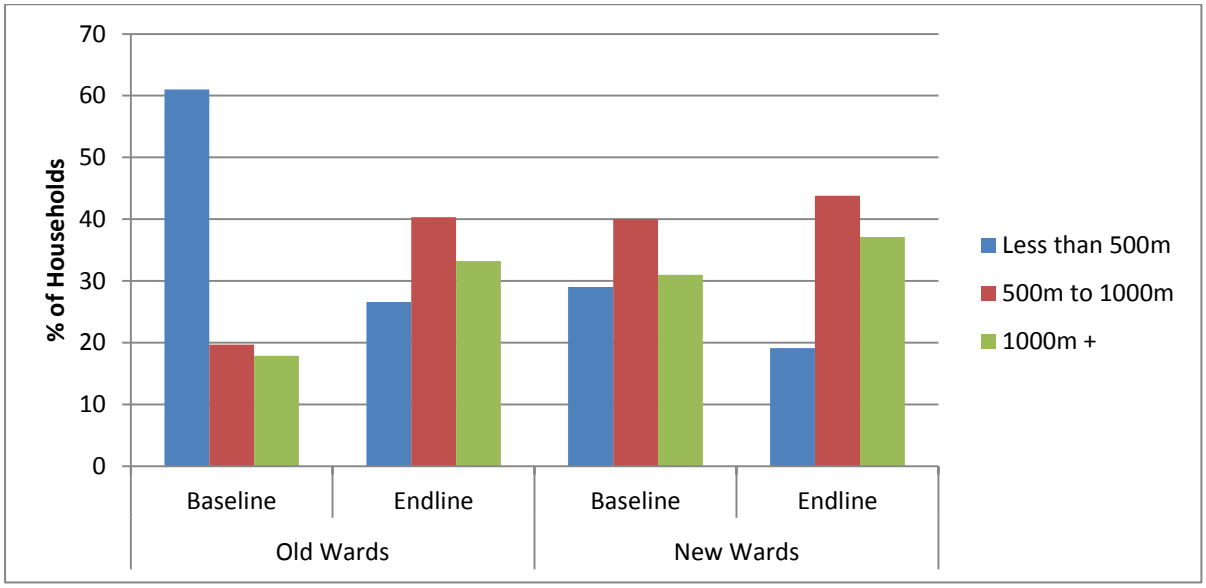
About 35% of respondents in the study areas travelled more than one kilometre to the nearest source of safe water for cooking and drinking (Table 13). This is more than the baseline value for both Old and New wards. A possible reason could be that communities are now more aware of the benefits of using safe water and thus travel the long journey required to access it.

Table 13: Distance travelled to source of water by percentage of respondents

Distance	Ward 2	Ward 3	Ward 7	Ward 15	Total
Less than 500m	28.40	20.00	24.80	18.20	22.80
500-1000m	38.90	38.00	41.60	49.50	42.00
% of households travelling less than 1 km	***67.30***	***58.00***	***66.40***	***67.70***	***64.80***
1000-2000m	18.90	34.00	27.70	19.20	25.10
2000-3000m	6.30	7.00	5.90	7.10	6.60
More than 3000m	7.40	1.00	0.00	6.10	3.50

Through FGDs it was pointed out that some communities (in both Old and New wards) were still under-serviced and households were travelling more than 1km to access safe drinking water while some relied on unprotected water sources. In the New Wards no new boreholes have been drilled while efforts made in rehabilitating some boreholes in Ward 3 did not yield the desired results. Figure 8 shows a comparison of distance travelled by households in the Old and New wards at baseline and end of project periods. The data shows that there has not been notable reduction in the distance travelled by households at baseline and at project end for both Old and New wards. The project intention was to repair the existing broken down boreholes and walking distance can only be reduced if new boreholes are drilled, thus making more boreholes available ultimately reducing the walking distance.

Figure 8: Distance travelled to source of water by percentage of households

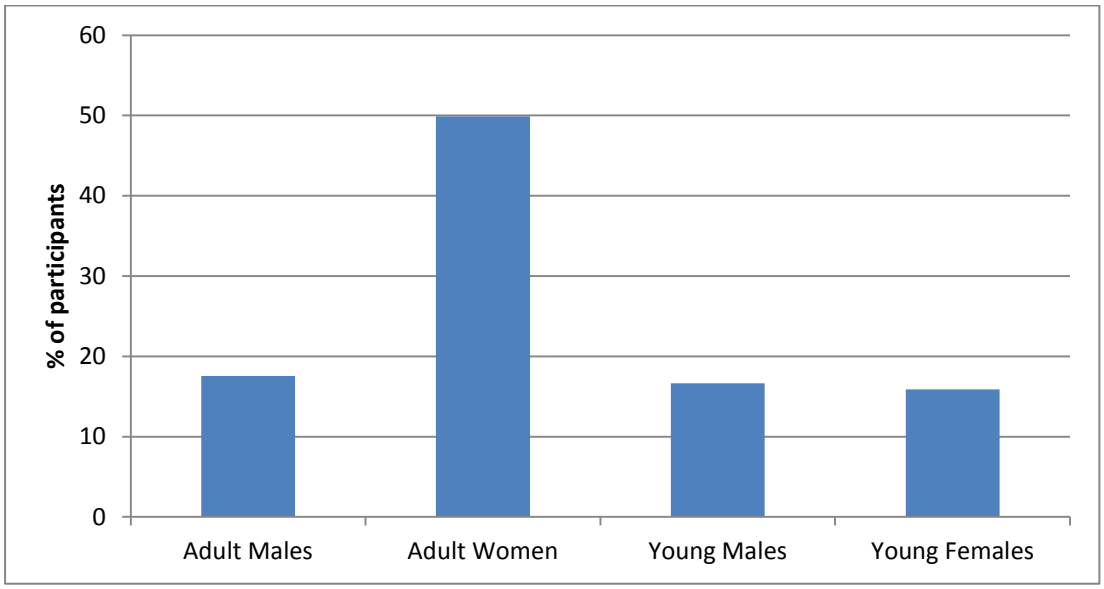


In order to reduce distances travelled, villagers of Dzviti and Chipamha sourced their own fuel and had two boreholes drilled with the assistance of the local Member of Parliament.

Who Fetches Water for Drinking

Adult women constitute the main participants in water collection (Figure 9). At the end of the project, about 50% of participants involved in water collection were women. At baseline 80% (Old Wards) and 72% (New Wards) of adult women were involved in water collection.

Figure 9: Main participants in fetching water by gender

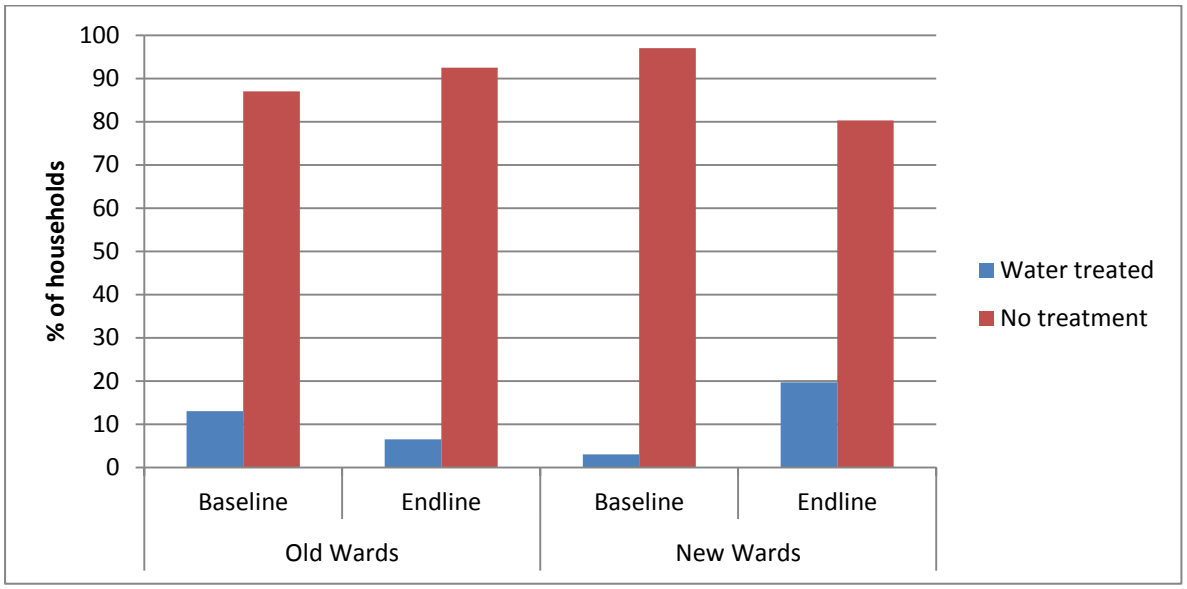


This data shows notable progress towards shared responsibility in water collection at the household level. At baseline 9% and 10% of adult men (Old and New Wards respectively) were involved in water collection. At the end of the project, 18% of adult men are involved in water collection. According to the discussions with the communities the project made males realise that WASH is not a woman only duty but that even males have a part to play. This increased awareness and behaviour change can be attributed to the trainings that were given to the communities. The trainings made the males realise that if they do not assist with the collection of safe water, the problem which befall the family as a result of unsafe water still comes back to the whole household including the males.

Water Treatment

Figure 10 shows measures taken by households to make water safe for drinking. At baseline, 13% of households in the Old Wards treated their water, but at end of project the proportion of households treating water has decreased to 7%. This may be due to the increase in availability of protected water sources rendering the need for treatment unnecessary. In New Wards, there has been an increase in the proportion of households treating their water from 3% at baseline to 20% of households at the end-line. One possible reason for the increase is the awareness for the need of safe water which was not matched by availability and thus communities treated the water to guarantee themselves access to safe water. The awareness was a result of the trainings conducted during the project either directly to committee members or indirectly via health clubs and SAGs.

Figure 10: Percentage of households treating drinking water

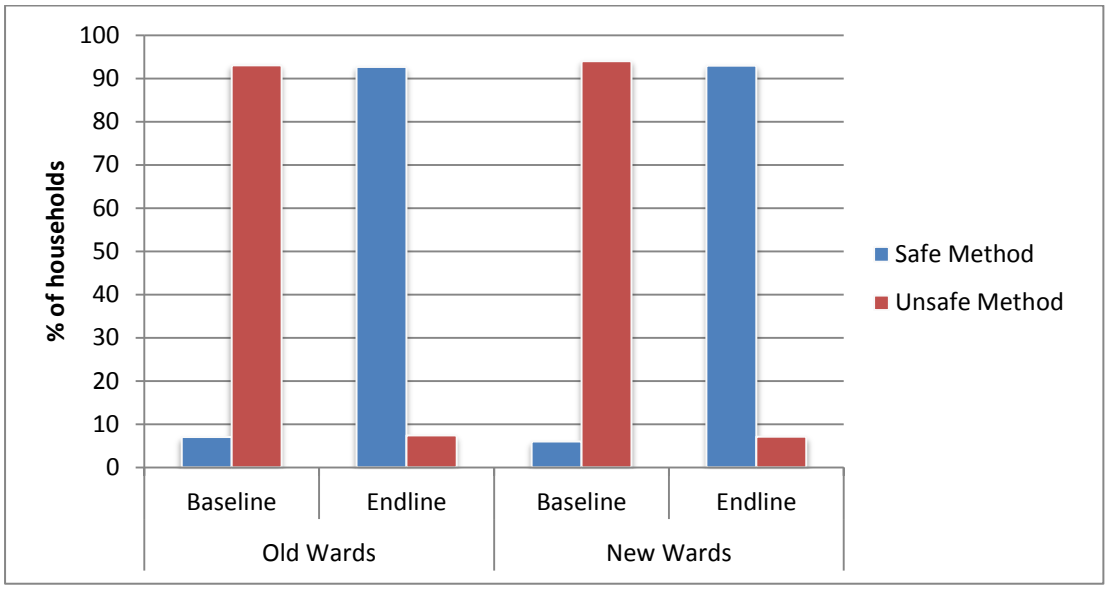


In New Wards there has been increased awareness of the need to treat drinking water. As there are relatively fewer protected water sources in New Wards, compared to Old Wards, water treatment in the former is critical.

Storage of Drinking Water

Households store their drinking water in metal or plastic containers with or without lids. Figure 11 shows the methods of water storage by proportion of households at baseline and end-line periods. There has been a drastic shift from using unsafe methods at baseline to using safe methods at end-line. At baseline only 7% of households in Old Wards used safe methods and at the end of the project, 93% of the households have turned to using safe methods. A similar trend has occurred in the New Wards. Discussions with community members highlighted that the awareness of the safe storage came about as a result of the knowledge given during trainings.

Figure 11: Methods used in Water Storage by Proportion of Households



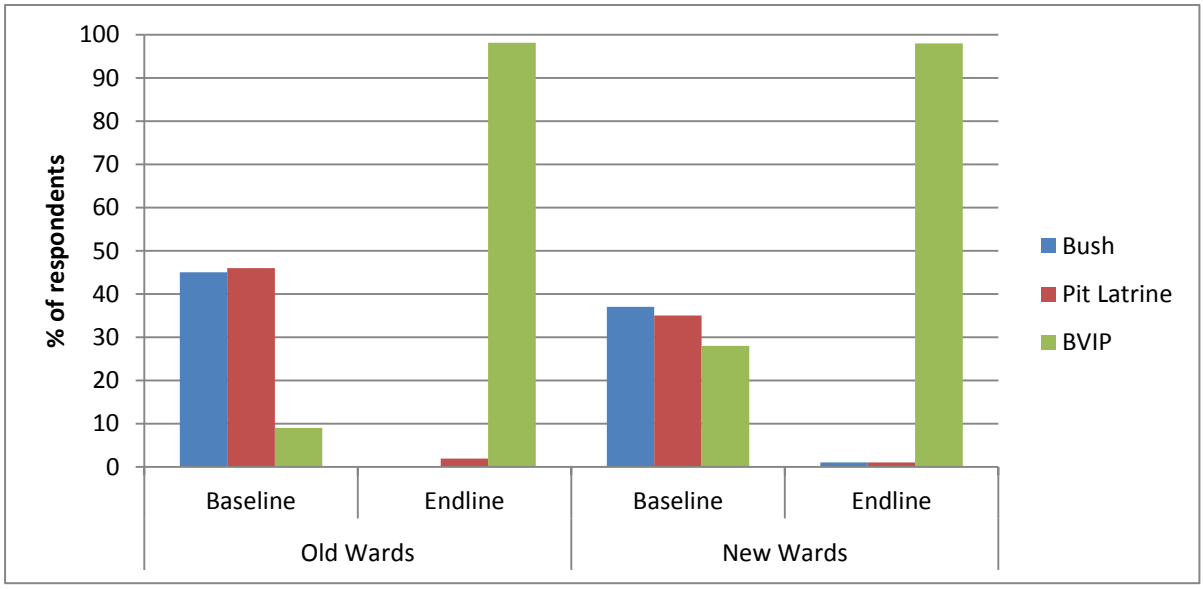
b) Access to Sanitation

Access to sanitation was improved at both households and schools.

Human Excreta Disposal within Households

The project has made notable contribution to improved sanitation through the construction of toilets at community and institution (school) levels. Figure 12 shows the methods used in excreta disposal by households at baseline and end of project periods.

Figure 12: Methods of excreta disposal by proportion of households



OD has been completely eradicated in the Old Wards. At baseline 45% of households in the Old Wards had been using the bush. For New Wards, 37% of the households were using the bush and by the end of the project just 1% of the households were using the bush.

The awareness created by the project resulted in communities constructing toilets at public gathering places such as their churches, boreholes and community meeting points. This change further demonstrates that communities now make safe disposal of their excreta a norm rather than an option.

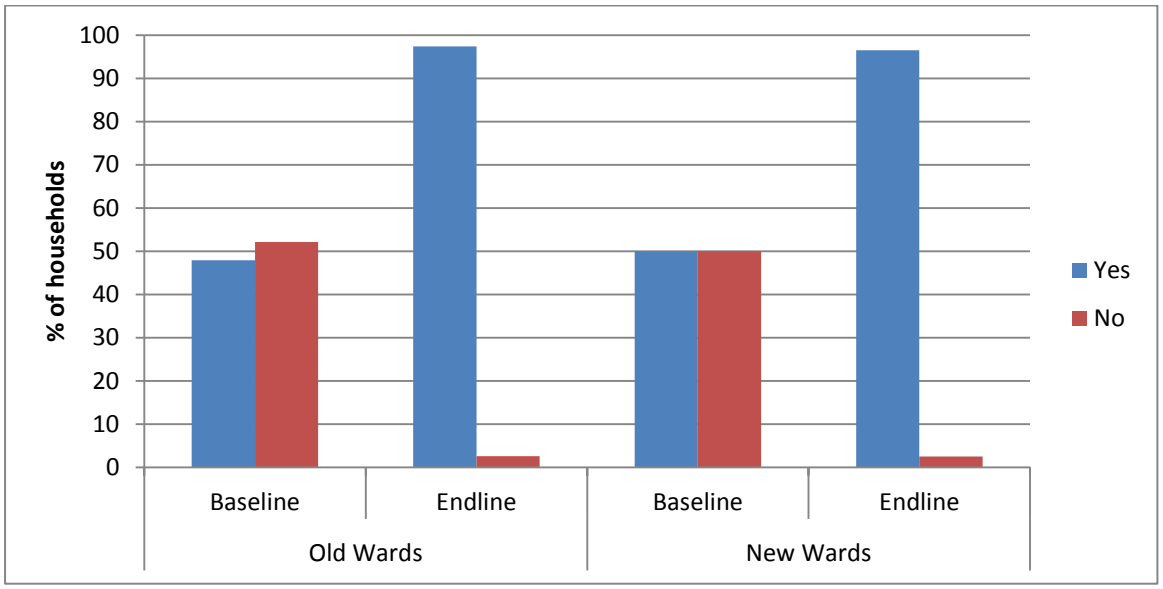
The improvements in excreta disposal were felt beyond the 10 operational wards. For example wards 23 and 14 have villages which have copied what was being done in the project wards. Two villages (Njodzi and Makarate) in ward 14 have also attained ODF status whilst in ward 23 Muza and Mudanikwa villages have made significant progress towards attaining ODF status (in Muza village 21/25 households have toilets, Mudanikwa village 25/30 households have toilets). According to the EHT for ward 23 such changes were encouraged by news flowing from project wards. It is also possible that these changes occurred through the efforts of the EHT for these wards who were called to witness ODF celebrations in project wards.

At the school level, discussions with SDCs and school health club members indicated a notable increase in the use of toilets and good hygiene practices by pupils. While the school health clubs and infrastructure developments played a significant role in changing pupil attitudes and behaviour, project activities at the community levels further enhanced appreciation of improved WASH infrastructure and services by students. Linking school health clubs to the community ones could further improve these positive impacts. Primary school authorities who visited, pointed out that young pupils are no longer afraid of using school toilets, as similar facilities are also available in their homes. This has resulted in clean school environments free from open defecation that was rampant before the project. Students interviewed also conceded that they have also put this into practice in their homes from what they learnt in the school health clubs. Some students indicated having assisted their parents/ guardians in the construction of pot racks and tippy tapes in their homes. At the school level, the health club members have become change agents for good hygienic practices amongst their peers.

Latrine Ownership and Sharing

At the end of the project, 10.7% of households in Old Wards were sharing toilets, while in New Wards, 10% of the households were sharing. Figure 13 shows the proportion of households with own latrines at the homestead at the start of the project and at end-line. About 48% of households in Old Wards and 50% of households in New Wards had own latrines at the project inception. By the end of the project there was a dramatic increase in latrine ownership with 97% of households in both Old and New Wards having their own latrines.

Figure 13: Percentage of households with own latrine on homestead



The end-line survey also noted that 60% of households in Old Wards built their toilets during the project period (2014-2017) while 50% of households in New Wards built their toilets during the same period (Table 14). For those that built their toilets before 2014, about 29% did some modifications to their toilets (25% Old Wards and 33% in New Wards).

Table 14: When Toilet was built by Percentage of Respondents

When Toilet was Built	Old Wards	New Wards	ALL
Before 2014 (2013 or earlier)	40%	50%	45%
2014 -2017	59%	50%	55%

Table 15 shows the main modifications done by percentage of respondents. The highest proportion of households (17%) added a fly screen to their toilets. This is followed by those adding toilet roof (9%) and then vent pipe (9%).

Table 15: Modifications done by percentage of respondents

Modification	Ward 2	Ward 3	Ward 7	Ward 15	ALL
Added toilet roof	9.5	11.9	6.9	8.1	9.1
Plastered the toilet	3.2	6.9	3.0	2.0	3.8
Added a vent pipe	5.3	8.9	5.0	15.2	8.6
Added fly screen	11.6	16.8	23.8	17.2	17.4
Added toilet seat	1.1	2.0	1.0	2.0	1.5
Other (Specify)	2.1	5.9	4.0	1.0	3.3

Discussions with communities highlighted that modifications to existing structures were generally made after communities became aware of what constituted a safe toilet. Thus the modifications done were to address the inadequacies which the existing sanitary structures had. The toilet seat modification was not related to safety but rather to cater for the needs of the sick and elderly who needed to be supported whilst relieving themselves.

Schools Sanitation and Menstrual and Hygiene Management

The menstrual hygiene awareness, availability of a girl-friendly toilet together with the accompanying pads has improved the girls' attendance at all schools visited especially for the Form 1 girls some of whom will be first timers. At Tambudzai secondary school about 10 girls per week used to go back home before the project period but as of February 2017 only 2 girls had gone back. The ones that go back are those who may have spoiled their dresses or are still too shy to discuss their situations. The use of the pads is not only limited to Form 1 for the signed register at that school indicated that 3, 3, 1, 2 girls from Forms 1, 2, 3 and 4 respectively had signed for the pads.

Whilst Rumps were being promoted in both primary and secondary schools their uptake was significantly lower than the disposable ones in all the schools visited. For example at Tambudzai 34 Rumps were in stock and the last uptake was 6 in 2016. However, it should be noted that the production of Rumps was meant to provide an option for the girls who could not afford to buy disposable pads from shops. The low uptake should not be viewed as a rejection by the girls. What is positive is that the project provided an alternative to the girls.

Another positive aspect is that the rumps raised the awareness of girls' menstrual needs among the SDC members who are now approving money to buy disposable pads. Furthermore, some parents through the FGDs acknowledged that they now appreciate the needs of girls and are therefore financially supporting some school authorities in to purchase disposable pads for the girls. Increased awareness and provision of disposable pads by parents/ guardians at the household level could also account for the low uptake of the rumps.

The introduction of menstrual hygiene management into schools has made boys to be more aware of the needs of girls. Boys were now participating in the sewing of rumps in several schools including Dewe. The awareness on girls' needs during menstruation has greatly reduced laughing by boys each time a girl spoiled their uniforms. Within homes the awareness of girls needs now make it easier for mothers to request for additional financing to cater for the purchase of pads for the girl child.

The use of disability friendly latrines has not been documented because no persons living with disability were reported as using the toilets. In the schools sampled the latrine was being used by either girls' or boys' prefects because the pupils with disabilities that require the special toilet were not available. However "*we need the toilet to cater for the eventuality that one day someone who needs it will be enrolled in the school or pass through it especially during sports days*" remarked the SDC chairperson for Bwanya primary school.

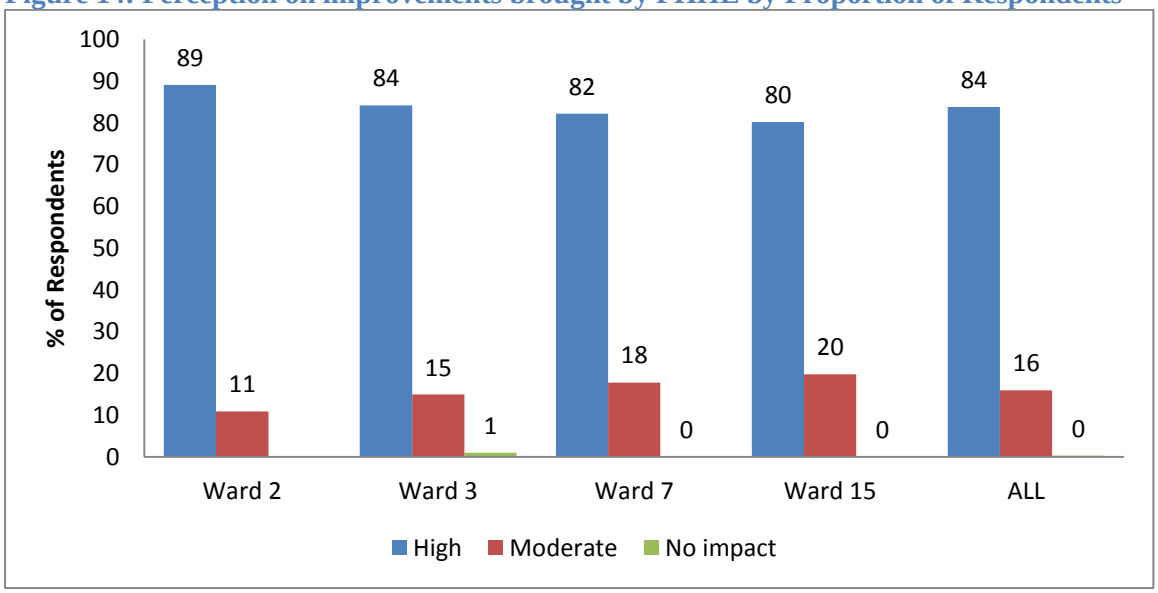
Self- financed Toilet

The project triggered schools to improve their sanitary facilities beyond what the project had brought to them. For example, Bwanya primary school went on to put up two additional toilets using their own funds. Furthermore, the knowledge gain resulted in improvements being made to already existing infrastructure to make them safer for school children.

c) Hygiene Practices

The hygienic improvements brought by the project were acknowledged throughout all the wards as indicated in figure 14 below. Because of the improved hygienic practices the environments within the household and the general community were cleaner. Discussions and transect walks highlighted the absence of faeces in the environment as was the norm before the project.

Figure 14: Perception on improvements brought by PHHE by Proportion of Respondents



About 84% of all respondents (86% female and 79% male) rated improvements brought about by the project as high. Positive changes are noticeable across all gender and age groups in the community. The quotes below highlight the perspectives of community members on key changes attributed to the project:

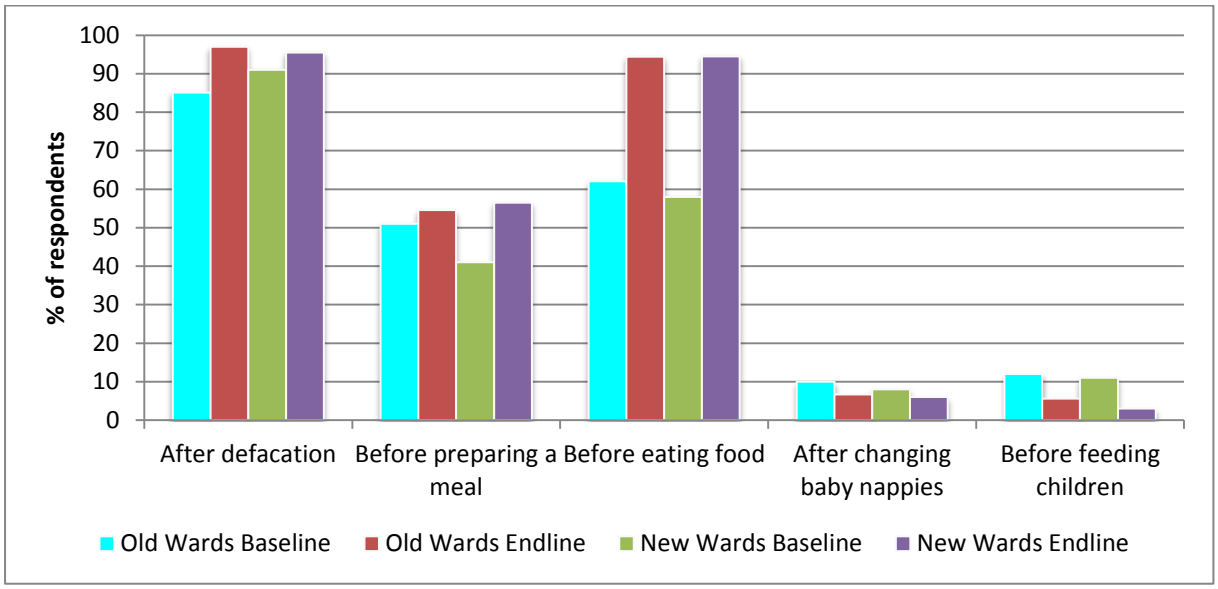
"Now the children like to use the toilet unlike before the project. Open defecation has been reduced. The community is now more health conscious". Bwanya Primary School Official

"Before 2016 we used to bury many people due to preventable WASH related diseases. In 2012, 9 people died of cholera in the ward. Before that we didn't even know what was causing the deaths. Since the project came on board, no WASH related deaths have been recorded in the ward'; Said one participant at an FGD in Ward 3.

Hand Washing

Hand washing is often practised after defecation by over 95% of respondents in the study wards. Figure 15 shows the critical times when hand washing is practiced at baseline and end of project. There has been an increase in hand washing after defecation in both Old and New Wards (from 85% at Baseline to 97% at end of Project in Old Wards, and from 91% at Baseline to 96% at end of Project in New Wards).

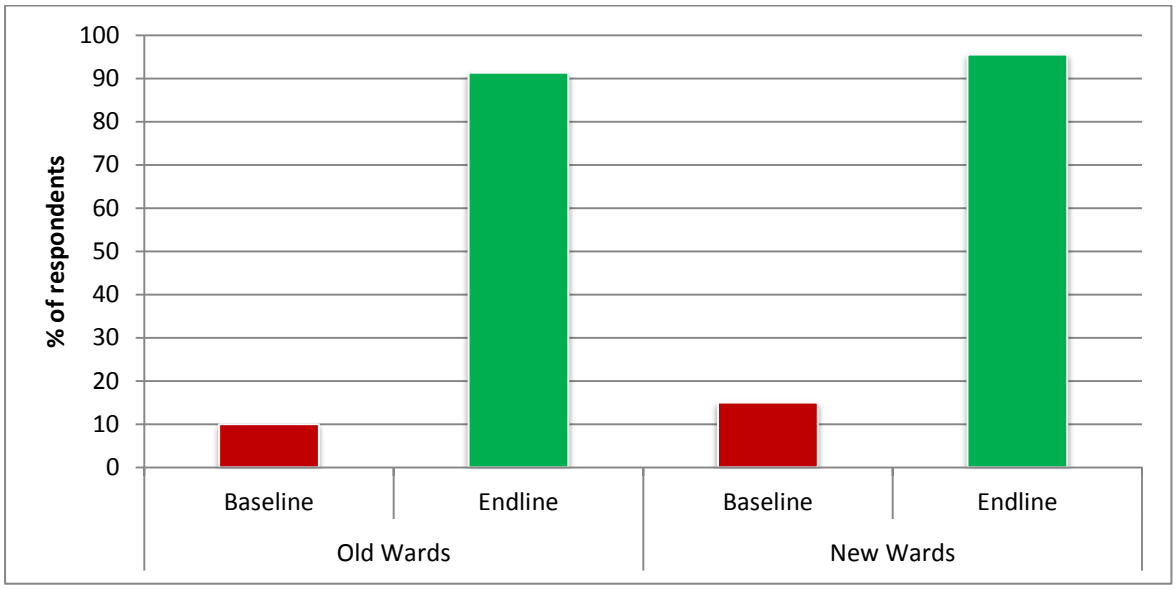
Figure 15: Critical times for hand-washing by period



Hand washing before preparing a meal is practiced by about 56% of participants at end-line evaluation compared to 46% before the project. About 94% of respondents wash their hands before eating food compared to 60% of respondents before the project. The proportion of households washing hands after changing baby nappies and before feeding children at the end of the project is well below 10%. Though discussions highlighted that the communities were taught about all the five critical times for hand washing the highest practise was only for after toilet use and before eating. A possible reason for the low hand washing practice after nappy change, before feeding a baby and before preparing food could be that water may not always be placed to where these chores are performed. Water for hand washing is always placed alongside food in the home and tippy tapes were also observed outside toilets within households thereby promoting the act of hand washing.

About 96% of respondents (97% female and 94% male) were aware of the drip to waste method of hand washing while the remainder were familiar with the communal dip method. Respondents were asked to demonstrate how they wash their hands. Figure 16 shows the proportion of respondents demonstrating correct methods of hand washing at baseline and end of project periods. At baseline only 10% and 15% of respondents in Old and New Wards respectively, demonstrated the correct methods of hand washing. At the end of the project 91% of respondents in Old Wards and 96% in New Wards demonstrated correct methods of hand washing. Almost an equal proportion of women and men (94% and 93% respectively) demonstrated correctly the recommended method in hand washing.

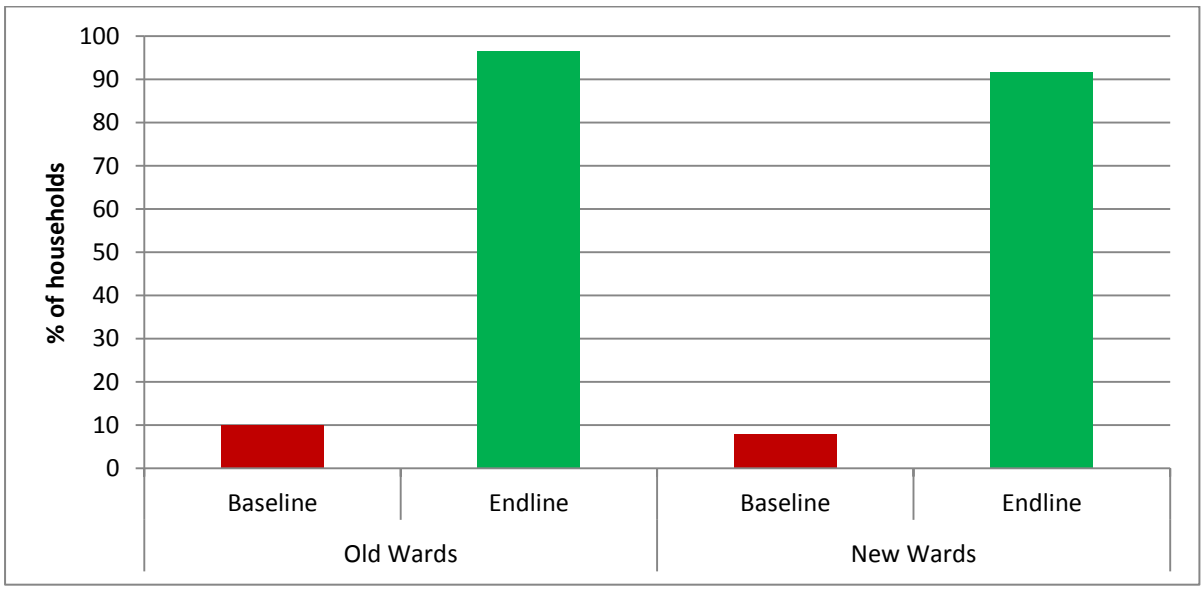
Figure 16: Percentage of respondents demonstrating correct method of hand-washing



Hand Washing Facilities

Figure 17 shows the proportion of households with appropriate hand washing facilities at baseline and end of project periods. A significant increase (from as low as 10% of households at baseline to over 90% at end of project) in hand washing facilities was recorded for both Old and New Wards.

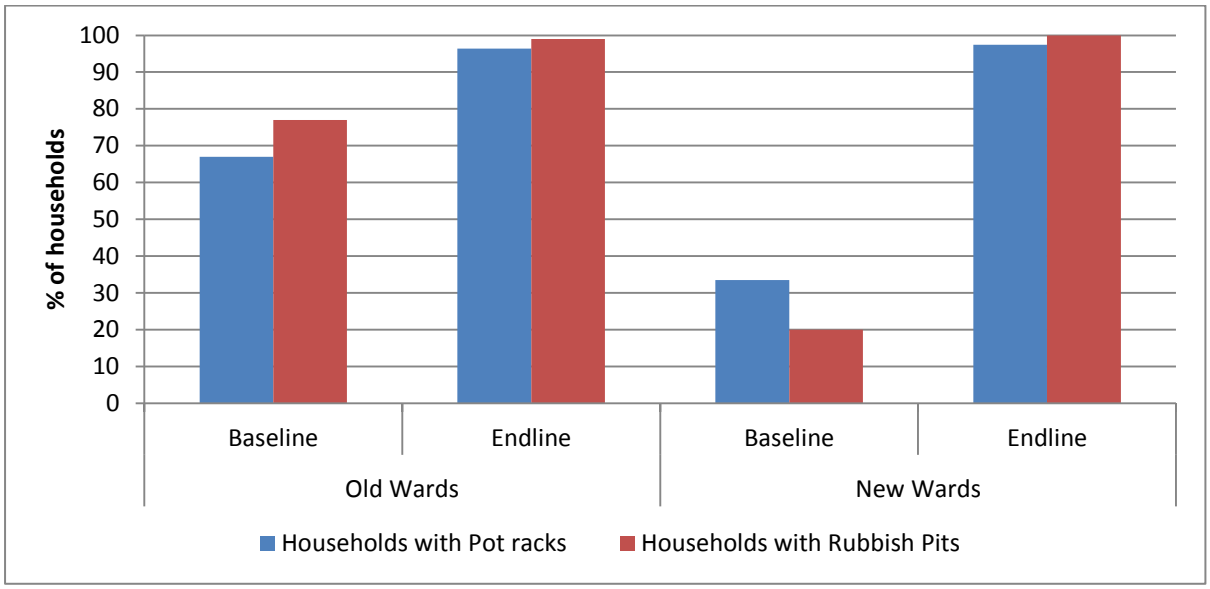
Figure 17: Proportion of households with hand-washing facility by period



Other Hygiene Enabling Facilities

The enumerators conducted spot checks and inspected availability of hygiene enabling facilities that include pot racks and rubbish pits. Figure 18 shows the proportion of households with pot racks and rubbish pits. In Old Wards the proportion of households with pot racks increased from 67% at baseline to 96% at end of project, while those with rubbish pits increased from 77% to 99%. In New Wards, there was a notable increase from 34% of households with pot racks at baseline to 97% at end of project. Households with rubbish pits in New Wards increased from 20% at baseline to 100% at end of project. Communities were motivated to put up pot racks with messages highlighting that dirty plates unattended on the ground are always washed by dogs and other animals before one does the dish washing. Community members were discouraged from sharing utensils with animals. Furthermore, pot racks made washing of plates easier for women as they could do the task whilst standing upright.

Figure 18: Percentage of households with pot racks and rubbish pits



d) WASH Governance Systems

DWSSC and WSSC

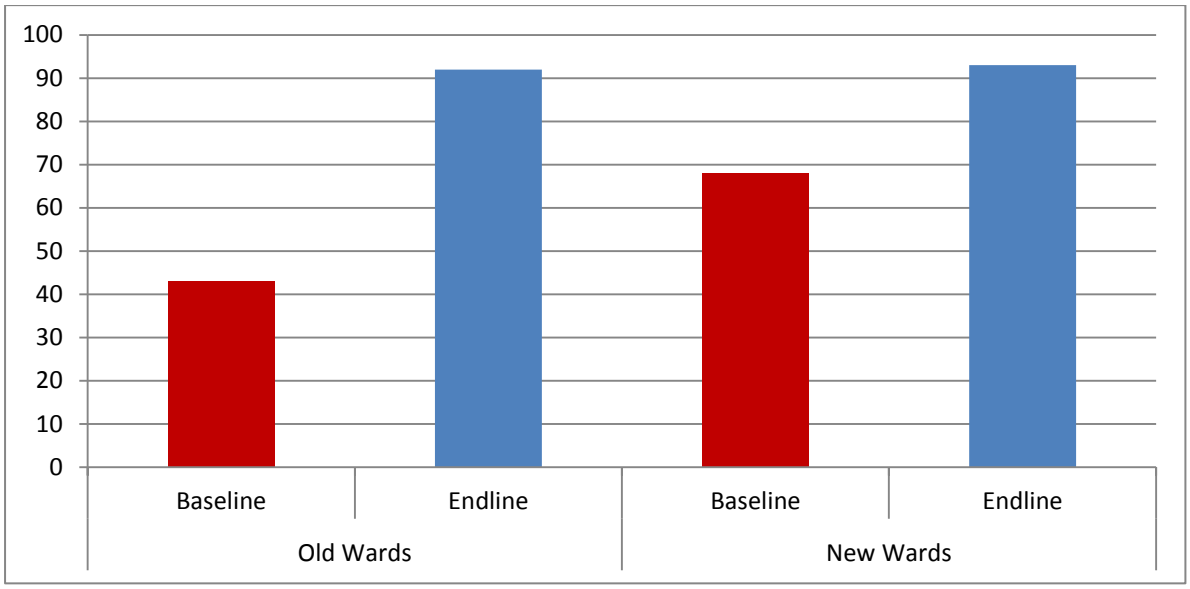
The project enhanced the functions of DWSSC through the facilitation of regular meetings. DWSSC meetings were now being held on monthly basis. In addition, the project assisted the

training of some new members who were not fully aware of their duties. The provision of water quality testing consumables has enabled more water quality samples to be analysed. WSSC members acknowledged that the project had also brought government extension workers in the various wards together as they worked to achieve objectives set by the ANCP project.

Water Point Committees

Figure 19 shows a comparison between baseline and end of project WPC awareness levels among participants. The data shows that there has been an increase in awareness in both Old and New Wards but the increase was more significant in the Old Wards. A possible reason could be that the water points in the New Wards were better functioning prior to project implementation and hence households knew who was responsible. The awareness of WPC is critical in that one cannot work with an entity that they are not knowledgeable about.

Figure 19: Knowledge about availability of WPC by proportion of respondents and period

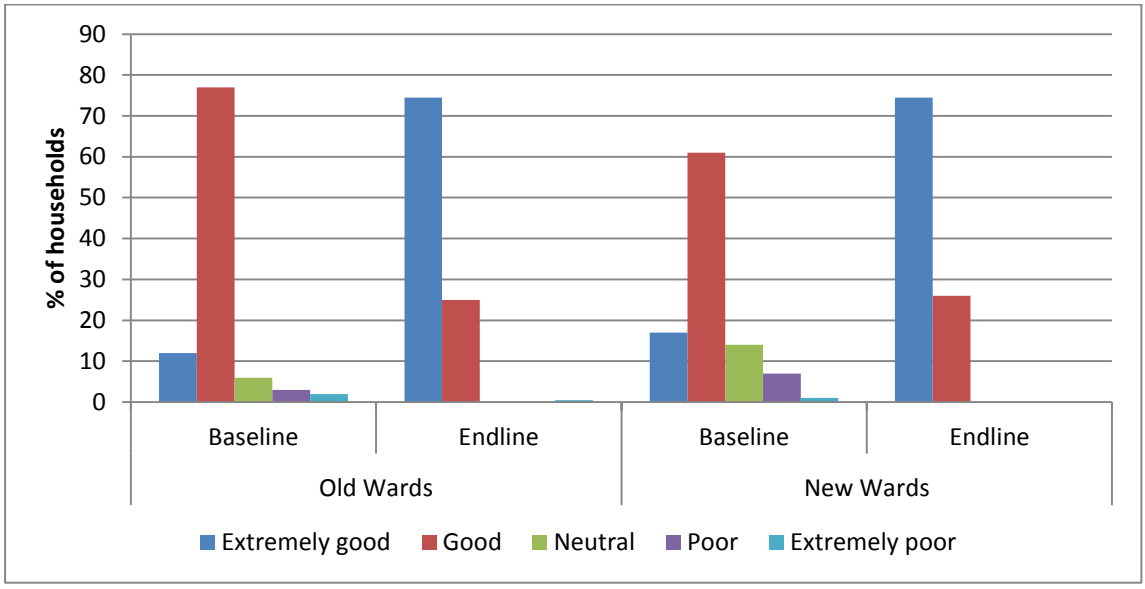


Participation of Girls and Women in WASH Activities

The participation of women and girls in WASH activities is generally higher than that of men. About 20% of all female respondents compared to 9% of male respondents were members of community health clubs.

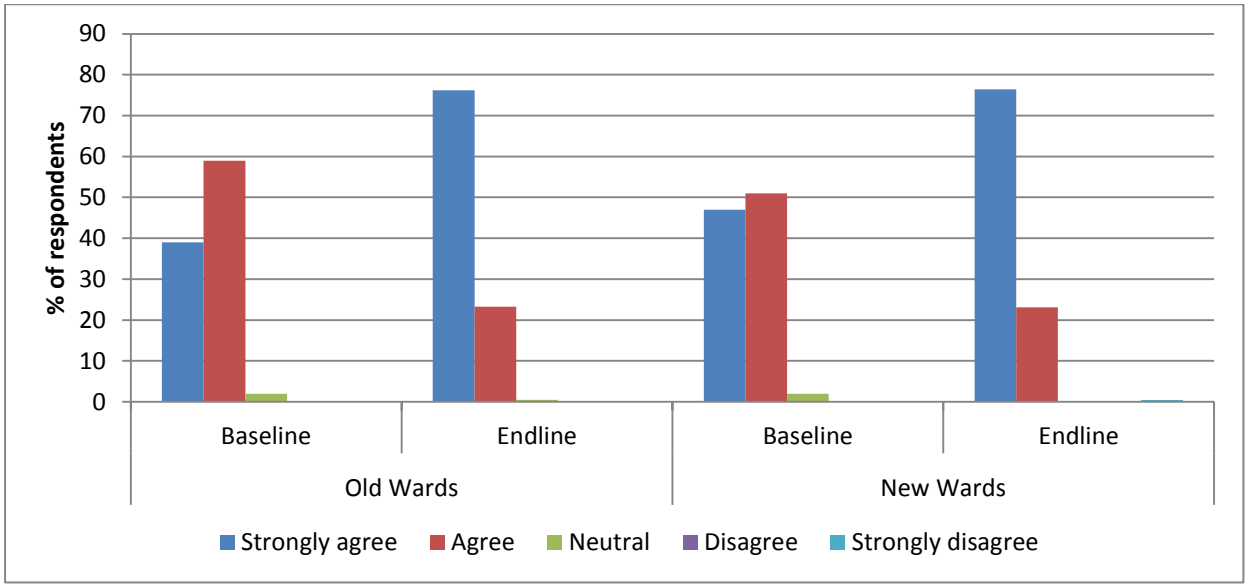
Respondents were also asked to rate the participation of women and girls in WASH Projects. A comparison of responses at baseline and end of project shows notable improvement in the participation of women and girls in WASH projects. Figure 20 shows how respondents rated the participation of women and girls in WASH Projects. There has been an upward movement with most respondents indicating that the participation is extremely good at the end of the project.

Figure 20: Rating of women and girls participation in WASH activities by period



Similarly, respondents positively agreed that women and girls need to be given more responsibility and occupy leadership positions in WASH projects (Figure 21). There has been a shift from baseline perceptions to more positive attitudes towards the empowerment of girls and women in WASH activities. According to the FGDs with community members and school children, the community acceptance of women and girls to be in leadership positions has helped males and boys to support the activities which they will be leading in both the community and schools.

Figure 21: Proportion of respondents who agree that women and girls should be empowered by period



Women were deliberately prioritised in trainings for builders and VPMs as a way of giving them more responsibility and empowerment in WASH issues. Women were purposefully targeted as these are often less mobile and commonly resident within the community. According to the information from the women who had been given these skills, the training had a positive impact on improving the livelihoods of women. For instance, the construction of toilets was a source of money for women builders such as the following from Ward 3: Fungai Ziwenga who built 24 toilets; Rasai Chifunda built 20 toilets and Rangai Mukozho built 15 toilets. The builders were being paid $30.00 per toilet constructed. It was however not possible to determine the extent of impact on female VPM since they had not had much exposure of providing the service. The case of Lorraine Munyati exemplifies the extent of the empowerment and the resultant livelihood changes.

Case Study : Putting Women at the Center of WASH Empowers Them

Lorraine Munyati is 32 years of age and comes from the Chimuti Village Ward 7 of Chivi district. She is single and is a mother to 2 boys aged 11 and 4. Both her parents are dead, which means Lorraine is the head of the family living with her children and siblings. She completed Form 4 in 2001 but with no technical training she did general jobs at Edgars and Powersales before going back to the village after her contract was not renewed. In the village she tried different activities to earn a living including *maricho* (casual labour) but life was a struggle as she failed to consistently pay fees for her children.

When the ANCP programme came to her ward in 2014 emphasising the need for women to be trained as builders she volunteered since she was tired of providing casual labour. The training was provided at Masunda to both women and male volunteers. The training, which included theory and practical approaches, was given free of charge over a ten day period. After her training she was given tools that include trowel, spirit level, fish liner, wooden float, brush and tape measure. Initially she worked with other experienced builders before she started working as the head builder training 3 other women builders to date.

Lorraine has so far built 31 toilets, 29 single BVIP and 2 Double BVIP with bath places. On average, she charges $45.00 per single squat hole but the amount varies depending on negotiations. She also accepts payment in kind. She has worked in her ward and also in the nearby ward 8. She also exported her labour to Shurugwi and Mhondoro-Ngezi districts. She has provided her labour for free to the vulnerable in her village as a way for facilitating it to attain ODF status. Her strategy for seeking employment is through introducing herself to the village heads of prospective work places as well as by word of mouth from those she will have served. Finding work has not been difficult for her because her products are of good quality.

Lorraine says that it is very important for women to be trained as builders because they are less mobile and the skills will be retained in the wards. She manages the conflicting roles of looking after the family and work with no problem. If she has a task close by she wakes up at 4 am to do her household chores and see her children off to school and is back by 4pm. She hires labour if necessary.

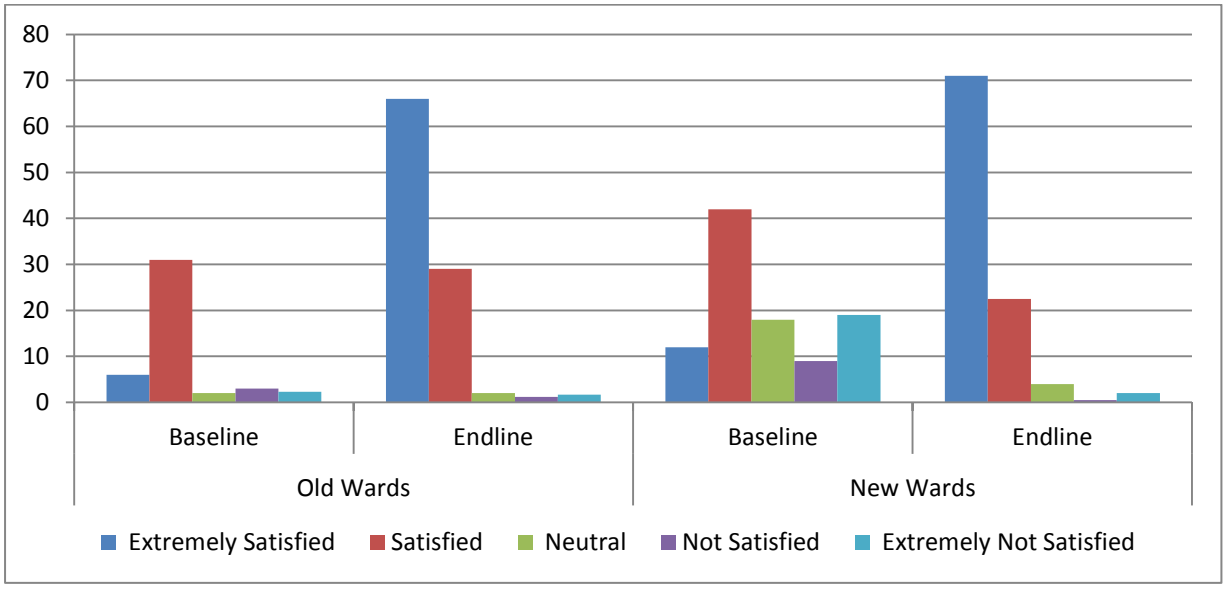
Her profession as a builder has improved her life. Thanks to the ANCP programme, which believed that women can do it. She is now able to pay schools fees for her children and siblings, buy all the food for the family and renew her hairstyle anytime. From the money earned through building toilets, she has bought chickens and 10 goats. Currently Lorraine is saving to buy cattle in the short to medium future. She plans to expand into building houses as well and intends to start by constructing her own house and add to the two huts that were left by her parents

Satisfaction with WPC

There has been an increase in the proportion of households that are satisfied with the WPCs as shown in Figure 22. The trends were similar for both Old and New Wards with only less than 10% expressing some degree of dissatisfaction.

A comparison between female and male respondent's shows that more women than men were satisfied with their WPCs as 72% of female respondents were extremely satisfied compared to 58% of male respondents.

Figure 22: Satisfaction with WPC by proportion of respondents by period



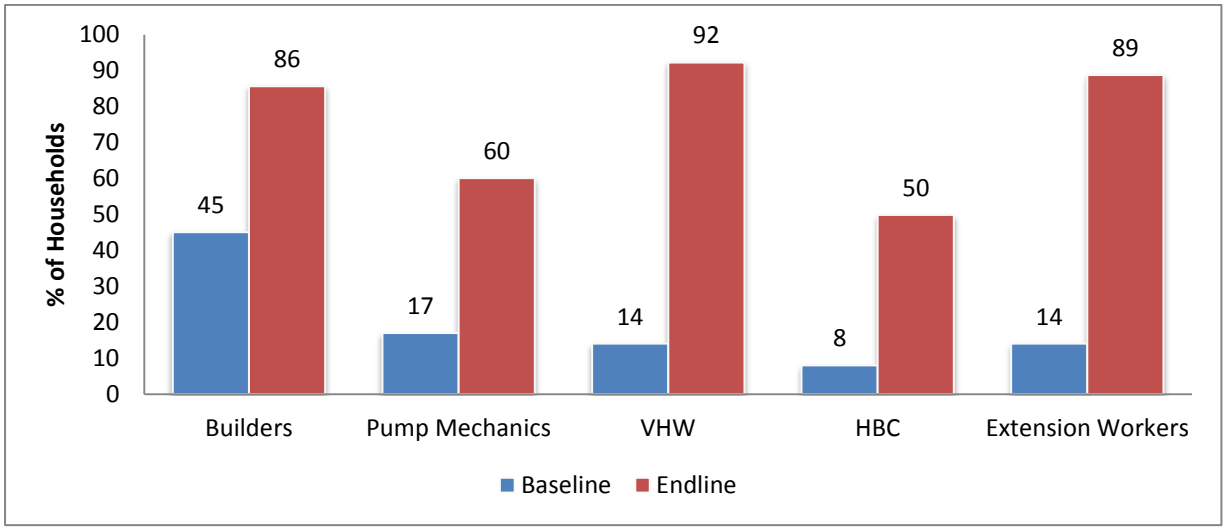
According to the FGDs with both community leaders and the WPC members the satisfaction was due to the trainings which the committee members had obtained from the project. It is also possible that the high satisfaction was due to the rehabilitations/repairs which were completed to the water sources and thus community members were satisfied because water was coming out of their water points. The involvement of women in these communities contributed to this satisfaction thus justifying the need to place women at the center of WASH projects.

Skills Present in Communities

The project has increased households' access to skills as provided by the various ward level government extension officers, private artisans and community based health promoters (Figure 23).The increased skills were important in giving communities the required technical expertise. According to the FGDs with community members, the high number of builders

enables the households to negotiate for better prizes. Women builders in particular were said to be willing to lower their prizes to help their peers. The project did not train extension workers but the involvement of these workers probably made the households to be more aware of these extension workers.

Figure 23: Proportion of households with access to WASH Skills (Old Wards)



Though the number of pump mechanics had increased more than three-fold, discussions with these artisans indicated that tools for use may become a limiting factor because only one tool box was purchased per ward. This implies that if two boreholes in the same ward break down at the same time VPMs will have to take turns to use the tool box thereby lengthening the breakdown period. Furthermore the builders who were trained on the job by those initially trained on the programme were not given tools and may therefore have to work as assistants until they raise enough money to buy their own tools.

e) Health Issues

WASH related Diseases

Reduction in incidences of WASH related diseases and deaths was acknowledged in all the FGDs held. Communities indicated that before the project WASH related deaths were quite high but at the end of the project no such deaths have been recorded. .The end-line survey noted a significant reduction in the proportion of households that experienced diarrhoea in the last seven days. Figure 24 shows that at baseline 31% and 22% of households in the Old and New Wards respectively experienced cases of diarrhoea among their household members.

However at the end of the project, only 8% of households in Old Wards and 2% in New Wards had diarrhoea cases.

Figure 24: Proportion of households that had diarrhoea cases in last 7 days

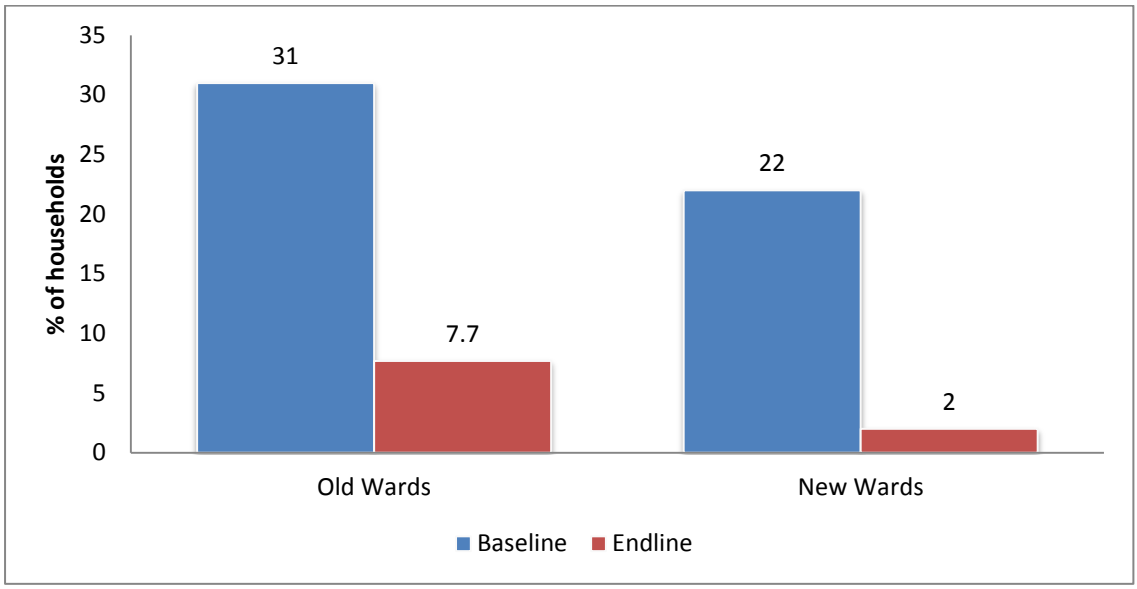
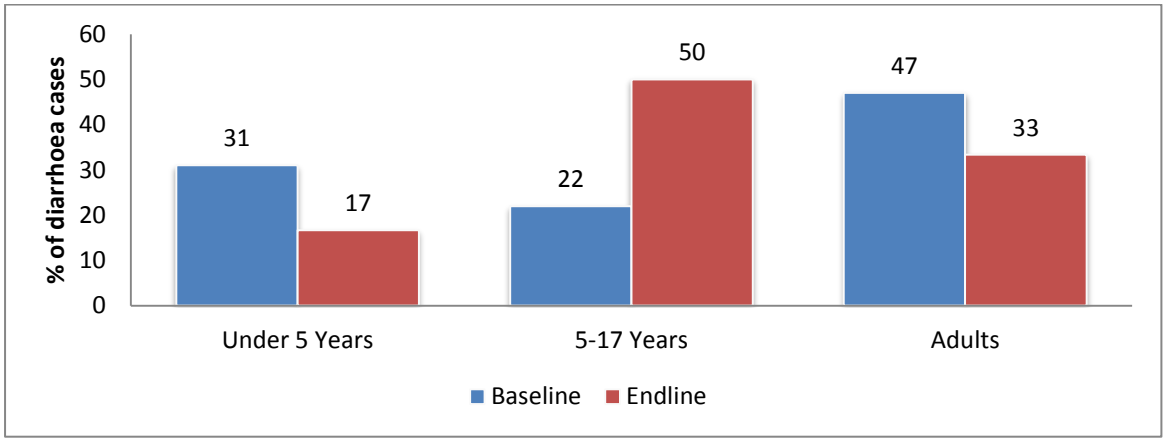


Figure 25 shows that there has been a reduction of diarrhoea cases among the under 5s from 31% at baseline to 17% at the end of the Project.

Figure 25: Proportion of diarrhoea cases by age category (New Wards)



NB: No numbers for Old Wards baseline

An increase was recorded among the 5-17 age group as 22% was recorded at baseline with the proportion increasing to 50% at the end of the project. Among the adult members, the proportion decreased from 47% at baseline to 33% at end of the project. Table 16 shows the actual numbers of people that had diarrhoea over the last week of the end-line survey.

Table 16: Number of individuals with diarrhoea over the last week

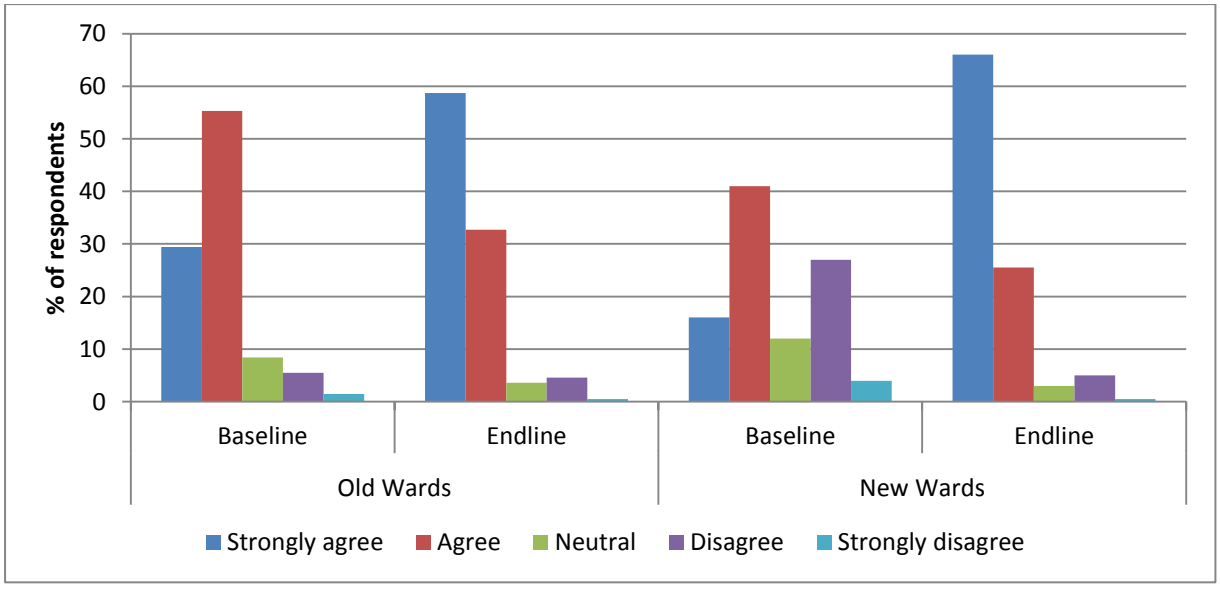
Ward	Under 5 Years	5-17 Years	Adults (Above 18 Years)	Total
Ward 2	4	15	11	**30**
Ward 7	0	0	2	**2**
Total Old Wards	**4**	**15**	**13**	**32**
Ward 3	0	3	1	**4**
Ward 15	1	0	1	**2**
Total New Wards	**1**	**3**	**2**	**6**
Grand Total	**5**	**18**	**15**	**38**

The age group 5-17 had the highest incidences of diarrhoea possibly because this group spends most of their time away from the home environment thereby exposing themselves to unsafe water sources and unhygienic practices.

HIV and AIDS

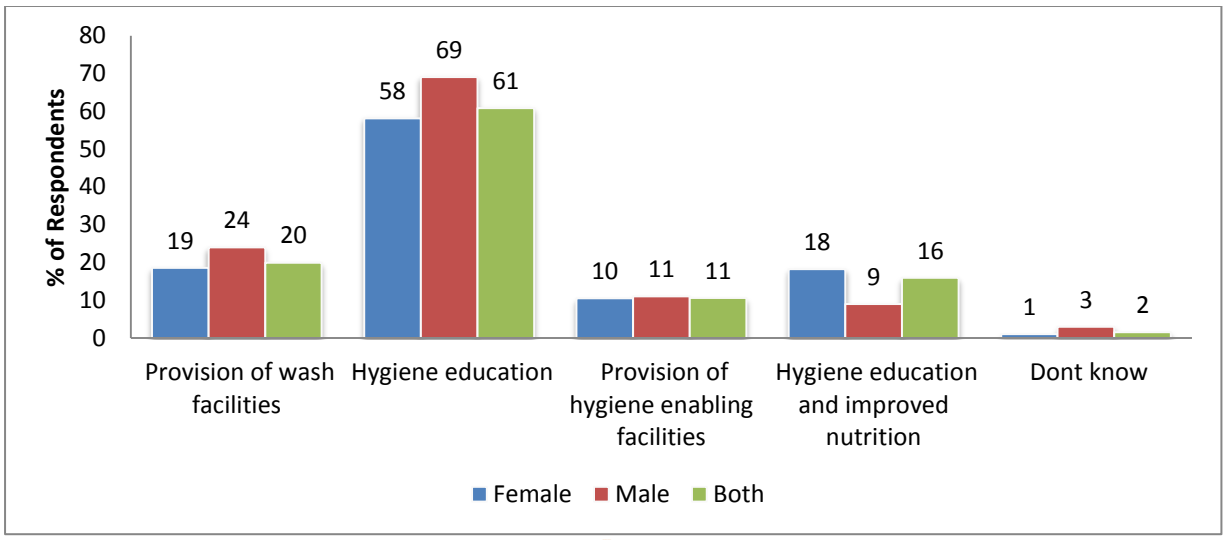
HIV and AIDs is a cross cutting issue in the project. Respondents were asked their perceptions on the role played by WASH in HIV and AIDS prevention and mitigation. Figure 26 shows that more respondents at end of project than at baseline agreed that WASH has an important role to play in prevention and mitigation of HIV and AIDS.

Figure 26: Proportion of respondents who agree that WASH has a role to play in prevention and mitigation of HIV & AIDS by period



A gender analysis shows no marked difference between the views of men and women on the role of WASH in HIV and AIDS prevention and mitigation. About 92% of female respondents and 90% of male respondents agree/ strongly agree that WASH has a role to play in the prevention and mitigation of HIV and AIDS. Figure 27 shows the perceptions of men and women.

Figure 27: Roles of WASH in prevention and mitigation of HIV and AIDS by proportion of respondents



2.6 Sustainability

The project brought significant changes to the lives of women and girls in Chivi district. The project was implemented through the structures of government from district to the village level. As government structures will still be there after the end of the project, this will enhance continuation of project processes and benefits. The project's support of local leadership structures contribute to continuity of project strategies even after the end of the project. All the government workers had the capacity of skills necessary to carry on with the work. However, besides the presence of skilled key personnel and leadership support, the sustainability of these benefits also depends on sustaining the following systems that brought about the impacts already discussed:

Monitoring Systems

Physical monitoring of communities by DWSSC through WSSC has been influential in the achievement of the results. However, the monitoring was largely done through the project vehicle as well as fuel allocation, which was provided by the ANCP project. These benefits will no longer be available and the monitoring from DWSSC and WSSC may weaken in time

leaving the households to depend on their SAGs and mobile extension officers to carry out the physical visits. The DA is already making the village accountable for WASH in his or her village. The regular contacts between the village head and the DA are guaranteed through monthly meetings when they come to collect their pay-outs. Since accountability has already been established, strengthening it is likely to sustain the WASH benefits within households. The schools' status is likely to continue because the schools inspector are already motorised to carry out their function and the schools are likely to keep the momentum. However the formal recognition and standardization of fully equipped girl and disable friendly toilets, lined refuse pits and improved hand washing tanks within schools, will be critical in ensuring school authorities allocate financial resources for their establishment and maintenance.

The community health clubs and the school health clubs are key to the continued awareness of WASH within homes and schools. However, discussions with all school coordinators and club highlighted the need for monitoring for their continued existence. Monitoring these clubs have added to the ward based EHT duties but the current shortage of staff and lack of motorisation may compromise delivery.

Supply of Technical Expertise

The builders and VPMs have been trained to provide the expertise required for either households or schools infrastructure. The financial returns which ranges from $30.00 to $80.00 are attractive enough for one to remain in the trade given the fact those trained are largely women who have settled in these communities. It is often the practice that the builders work with an assistant builder who in time will also learn the expertise. These defacto arrangements ensure that the skills remain resident in the communities for a long time to come. However, the skills given to the newly trained VPMs have not been tested since there are very limited boreholes that need repair. The effective utilisation of these skills by new VPMs may depend on the length of continued partnerships with the experienced VPMs.

Supply of Materials

While some households were sourcing their own cement, others got assistance with transportation from either government or project vehicles going their direction resulting in savings of up to $3.00 per bag. Whilst efforts were made by the project to decentralise the supply of cement and other WASH products, there was very limited success. These materials

are slow moving and not suitable for rural small businesses with limited capital. For water supply the low turnover of spare parts is unlikely to result in businesses stocking them. Hence, centralised storage at council or sub-council offices could be the way forward. Furthermore, households may need subsidy for those parts, which require users to pay more than $1.00 per household. Specialised tools e.g. the VPM tool kits are key to the repair of boreholes but the procured parts will wear out in time. Levying the VPMs for usage maybe an option. The presence of a WASH fund within schools will ensure continued supply of inputs.

Funding Systems

The funding systems that were used by schools are well established and therefore likely to continue. Through internal saving and lending schemes, (ISAL), households were able to mould bricks and buy cement to build/maintain their own toilets. These have been turned into health clubs which help members acquire household assets and are likely to continue because of the benefits members get from them.

Good Hygiene as a Continued Norm

The current ODF status will largely depend on these facilities being regarded as the norms of any household and community. According to community members ODF status will be maintained because "*it is not the project that built toilets for us…we will continue to maintain good sanitation and hygiene standards because it's part of us, it's in us";* FGD Participant in Ward 15.

*"Kudhota hakufi kwakapera, naizvozvo chirongwa hachiperi asi kana tasoniwa zasi (As people will continue to defecate, construction of toilets will never end unless we stop defecating)".*FGD participant in Ward 3.

The realisation of these sentiments will continue as long as these facilities are regarded as norms in society.

Organised Competitions and Recognition

Competition between wards/villages/ schools have also been responsible for schools and households going the extra mile. However, the source of funding of the competition needs to be localised for sustainability. Some club members contribute prize money and that could possibly work but it leaves out non-club members who may eventually lose interest in keeping the momentum. The criteria for assessing winning schools needs to be continued possibly through the Ministry of Education so that the infrastructure would be sustained. Alongside competitions, recognition of the drivers of WASH need continued visible recognition thorough IEC materials such as t-shirts. Furthermore, the education curriculum needs to recognise the health clubs so that within schools it is given the prominence and will not be sidelined during certain periods of the year.

Enforcement of Local Constitution

Constitutions for water points and WASH village constitutions have been put in place and are being enforced. However, reports of members not doing their allocated duties at water points indicate that enforcement needs to be strengthened for sustainability. Support of these local committees from the District Administrator's office and continued mentioning of their importance during gatherings even from all centres of power will ensure continued functionality

3.0 INSIGHTS INTO PROJECT PROCESSES

The project was unique in that it achieved considerable impact for the WASH sector using approaches that placed emphasis on women coupled with minimal hardware support for the communities. This section summarises what worked during the awareness creation and project implementation and monitoring highlighting where appropriate changes made as the project progressed.

Awareness Creation

Awareness creation was the key driver for the project because it relied on individuals empowered with knowledge to allocate time and resources towards putting up WASH

infrastructure and changing their practices. The following aspects worked well to create the necessary awareness:

1. *Triggering of communities using live examples* - WSSC members used fresh faeces which they collected from each village surroundings in the presence of the villagers. The flies that naturally follow these faeces and later on migrate to exposed food and household utensils left an imprint in the minds of the communities such that they were convinced on the need to take action.
2. *Making the village head the lead person in SAGs*- It was realised that SAG members without the village were facing resistance from those communities who were not yet convinced of the need to take action. Corrective action taken was to make the village head the leader of SAGs and households know that by virtue of being the village head him/her he had a right to approach their households with information deemed important for the village. Once information on the involvement of the village head filtered to everyone resistance to SAG members was reduced to negligible levels.
3. *Peer education*-. In family with both parents, the father is the head of the household and having males bring information to other males worked to illustrate that WASH was not a woman only thing. The involvement of males particularly in SAGs was important in influencing the action taken by males. The same strategy was implored in schools where a male health coordinator was also appointed in order to appeal not only to male teachers but male students as well. Health coordinators after training also educated other teachers in the form of a report back session. The health clubs in both schools and communities created a critical mass of peers with the knowledge on WASH and these then spread the message to their peer. Even among councilors, a champion was identified to spear head the education of other councilors. The SDC members also cascaded learnt knowledge to other parents.
4. *Using Shaming and Motivating messages*- The project used a mixture of shaming and motivating messages to create awareness among both the communities and in schools. The message encouraged individuals to take corrective action. For example, some of the messages were '*Usadhotera pose pose*/ Do not defecate everywhere, *Dhoti muchimbuzi*/Faeces into the toilet, *Geza maoko nguva dzose*/Wash your hands all the time.

5. *Use of IEC Material*- Materials such as t-shirts and posters helped to create awareness among target members. SAG members and SDC members were given t-shirts printed with messages to either encourage good hygiene behaviours or discourage bad practices.

Implementation

Once the target group was aware of the need to improve their WASH the following worked to improve the roll out processes:

1. *Creation of Group Chats*- The Whatsapp chats created for sharing of information among like groups (e.g. school health coordinators, WSSC members, DWSSC) helped in not only sharing the progress made but also became learning platforms and a means to put pressure on the less performing members.
2. *Decentralised trainings*-At first the trainings for builders were done at a central place but with the involvement of women who needed to perform chores at home, decentralisation to levels that allowed women to spend more time at home was adopted.
3. *Use of Locally available resources*- Toilets were initially viewed by communities as something expensive requiring significant financial inputs. The project's emphasis on use of locally available resources encouraged communities to embark on putting up infrastructure for toilets and hand washing using what they could afford first with progressive upgrading as resources become more available. This worked well to create a practice of using the toilet which will drive the communities to replace or renew them. Examples of local resources used included grass, old plastic containers, old scud/plastic beer bottles.

Picture 8: Household toilet constructed using local resources

4. *Village constitutions specifying Toilet first* – Village heads insisted that all new homesteads should not be occupied without a toilet and made it difficult to host funerals at households with no toilet.
5. *Making ODF a community goal*- the ODF status was made a goal for everyone in the village as the village was not certified until everyone had a toilet. This created a need for

community members to help each other through providing labour. Trained builders either lowered or offered their labour for free to people in their villages. The celebrations in which the whole village participated marked the height of ODF status as a community achievement

6. *Use of Community Health Clubs*- The communities helped each other through the ISALS where they were contributing $1.00 - $2.00 and then using the money to buy cement and other requirements for their WASH infrastructure. Those members who had completed putting up the toilets were planning to assist each other in constructing concrete pot racks.
7. *Provision of pads at the school* – The provision of pads at schools gave the girls assurance of assistance in the event of unplanned need. However making the girls sign for the pads did not always work well since some girls were shy of writing their names down on collection. Furthermore, making the Rumps compete with the disposable pads did not work well for the girls preferred the disposable pads to Rumps.
8. *WASH budgets* –Provision of a WASH budget worked well in ensuring that the requirements to maintain hygienic standards with the schools were maintained. Strategies for the WASH funds varied from school to school. At some schools for example Mudadisi Primary in Ward 5 WASH levies were introduced with each child paying $1.00 per term for tissues whilst at Bwanya primary in ward 3 each child paid $0.10 for purchase of tissue papers. At other schools e.g. Tambudzayi the SDC sets aside a WASH budget and as of January 2017 this was set at $285.00.
9. *Allowing the community to select the vulnerable* – The communities collectively selected the vulnerable households to benefit from the assistance. This worked well and removed any bias.
10. *Giving priority for any paid work to parents who owed the school fees*- Construction of toilets at the schools required input of locally available materials such as bricks and sand. Parents who owed the school were given priority to supply these materials and their payment was used to reduce what they owed the school in terms of school fees.
11. *Exchange Visits for SAGs and DWSSC* – Look and Learn visits worked to motivate both the DWSSC and SAGs members to achieve what they thought was impossible. Chivi DWSSC members went to Masvingo to learn about use of local resources and it encouraged them to advocate for their use in their own district. Similarly SAG members were encouraged through visits to other villages.

Monitoring

1. *Multi level monitoring*- Monitoring of progress through all levels- DWSSC, WWSSC and SAGs worked very well to keep the project momentum in check. The monitoring was done in teams whereby members drawn from the various committees would visit villages to check on progress. The multi-stakeholder team often visited problem sites and households.
2. *Preparation of Monitoring Tools*- The assessment of school performance was carried out through an agreed standard tool thereby encouraging participants to be at their best to achieve the standard they had actively participated in setting.
3. *Performance Reviews*-Participatory performance reviews were held at ward level to review targets that each one will have set. Corrective strategies were discussed at these platforms and they obtained high buy-in since communities will have suggested and or agreed to them.
4. *Use of ward hygiene facilitators*- Though not part of the normal NAC structures the use of ward based hygiene facilitators assisted in monitoring the activities, which were being done by the communities.

4.0 LESSONS LEARNT

The project was one of the pilot programmes in putting women at the centre of WASH agenda and as such provided many lessons for rural WASH programming. It is important to note that the project was successfully piloted during a period when rural communities in Chivi were experiencing high food insecurity as a result of poor rainfall patterns. In addition, communities had been accustomed to supply driven provision of sanitation infrastructure and services as well as social assistance (for household food security) from government and development partners. Hence, the project's demand driven provision of sanitation at community and school levels was never going to be an easy task. Below are some key lessons that can be drawn from the project's experience for future programming. These lessons learnt should be seriously considered for all future programming since the project made remarkable achievements:

1. *Active multi-stakeholder participation*: The active engagement and participation of stakeholders at national, provincial, district, ward and village levels, in all stages of

the project cycle (including design, implementation and M&E) is critical for the success of development interventions. Following the approval of the project concept at national and provincial levels, the participation of stakeholders at district level, as represented by DWSSC, and ward level institutions (represented by WWSSC), was paramount in fostering oneness as well as ownership of the project. At the ward and village levels, the local leaders (chiefs, councilors and village heads) and school authorities (SDCs, headmasters and teachers) were engaged throughout all the phases. The project capitalized on the provisions of the Traditional Leadership Act to emphasise and support the role of chiefs and village heads in community. It was through the increased participation of village heads that many villages were able to achieve ODF status. It is also through the continued enforcement of related village constitutions by village heads that the ODF status will be maintained.

2. *Action Oriented Knowledge Dissemination*: With focused training oriented towards behavior change and direct application of lessons learnt, communities are prepared to make investments leading to improved sanitation conditions (ODF environments) with limited or no subsidy from external agencies. The trainings provided at the start of the project triggered community action towards improved household and institutional level sanitation conditions. With the project emphasizing the use of locally available resources in the construction of household latrines, it was possible for villages to obtain ODF status as no individual would cite the shortage of resources as the main obstacle in household latrine construction. What is important is for a household practicing OD to construct a toilet using available resources. With the passage of time and resources permitting, the structures would then be upgraded. A number of households have been noted modifying toilets built before the project in order to meet standards recommended by the project. It is therefore important to note that within any given community, households have different capabilities; some well-resourced and early adopters of new learning while others are seriously under-resourced and slow adopters. Hence, project interventions need to take into consideration the different circumstances of rural households.

3. *Participatory Project Monitoring, Accountability, Peer Review and Feedback Mechanism.* The project established/ strengthened structures that enhanced participatory project monitoring at the different levels (from village to district levels).

This also ensured accountability among different stakeholders and across different levels of project management. The multi-stakeholder periodic planning and review meetings at ward and district levels served as important platforms for peer review and challenging each other towards high performance.

4. *Clear articulation and understanding of communal and individual costs and benefits is crucial for community collaboration in development interventions*: For villagers to work together to improve their communities' sanitation and hygiene conditions, an understanding of both individual and communal costs and benefits is a pre-requisite. This has resulted in community members combining resources to assist some vulnerable households (elderly, widowed or disabled) within their villages to construct household latrines.

5. *Performance based rewards and recognition systems enhance the achievement of desired targets:* The project instituted a performance based rewarding and recognition system amongst the wards and villages within the project area. This includes tokens of appreciation for best performing wards (meeting or exceeding planned targets) or schools (excelling in WASH competitions) as well as celebrations for villages attaining ODF status. This instilled a sense of competition among villagers and schools leading to high performance levels as measured against set targets.

6. *Empowerment of girls and women critical for the establishment and maintenance of WASH structures.* For the project communities, the participation of women in traditionally male dominated sectors such as the construction industry was a key lesson learnt. The communities conceded that women builders and pump mechanics are able to perform as well as their male counterparts given appropriate resources and support. Such female empowerment was considered appropriate as women are at the centre of WASH activities within their homes and communities. Furthermore, women builders have an added advantage of being less mobile than males and therefore often available when needed. In addition, women builders feel safer especially in households with young girls and or single females.

7. *Identification of key individuals to champion the cause of the project is useful in reaching out to critical groups in society for adoption and replication of project strategies.* At the inception of the ANCP project, a ward councilor was identified to

reach out to fellow councilors. This proved effective as the project was able to gain full support of councilors in participating wards.

8. *Traditional leadership should be given lead roles from the onset and be involved in look and learn visits.* Initial SAG members operated without the heavy involvement of village heads but this arrangement did not produce change among difficult villagers. However once the village heads were involved acceptance of the project improved.

5.0 RECOMMENDATIONS

The Rural WASH sector in Zimbabwe stands to draw a lot of lessons from the ANCP Chivi WASH Project, a pilot intervention for demand led provision of sanitation and hygiene services for rural communities. It is a key recommendation by the consultant for CARE and partners to conduct a comprehensive documentation exercise for the project highlighting key structures, processes, challenges, successes and lessons learnt. This will be important in guiding future or ongoing interventions in the sector.

The consultant also takes note of the annual funding arrangement of the project that made it impossible to come up with clear performance targets (at project inception) for the whole four year project implementation period. This has challenges in assessing project performance and particularly, efficiency in resource utilisation as the range of project activities and coverage was only determined annually upon the project receiving financial commitment from the funding partners. In order to avoid such challenges in future programming and under similar funding arrangements, the consultant recommends that CARE and partners develop comprehensive proposal at the start of the project outlining the range of activities, coverage and associated costs for the achievement of set goals and objectives. Upon receiving financial commitment from funding partners, it will be easy to prioritise activities and areas to be covered in line with available funds. One area to be prioritised should be repair of motor bikes for all extension workers in order to improve mobility.

While the project achieved or exceeded targets in Old Wards that were better resourced and had a longer implementation period, there may be need to continue supporting New Wards in areas that are still lagging behind highlighting the need for DWSSC to be capacitated enough to continue all aspects they were involved in. However, the consultant takes note of the phenomenal progress made in New Wards in all components of the project over a short period of project implementation. The project needs to come up with a clear exit strategy (for both Old and New Wards) that ensures the gains recorded so far would not be eroded over time.

Below are specific recommendations organised by thematic area;

A. Rehabilitation of WASH Infrastructure

i. The Project drilled boreholes in Old Wards and conducted rehabilitation of water points in both Old and New Wards. Comparatively, more households in Old Wards than New Wards have better access to safe and protected sources of cooking and drinking water. With availability of funding, New Wards would need to be prioritised, particularly for the provision of safe and protected water points.

ii. In both Old and New Wards some support is still required on the community based management of water points. The WPCs are at different stages of development, with some committee members still doing most of the work on their own with limited support from other water users. Environmental management of the area around water points that includes fencing is an area requiring attention.

iii. With well drilled and rehabilitated boreholes, the project implementation period does not provide ample time for establishing response rate for various community based structures (such as WPCs and VPMs) to incidence of borehole breakdown. Most of the boreholes visited during the evaluation had never broken down since being drilled or rehabilitated. Hence, this can be well catered for in ex-post evaluations.

B. Demand Led Sanitation and Hygiene

iv. It is without a shed of doubt that the project has made tremendous impact in eradicating OD among many villages in the targeted wards. However, there are still some villages, particularly in New Wards, that are yet to achieve ODF status. It is important that a concerted effort be made through the established project structures at district and ward levels until all households in the targeted wards have built their own latrines. Ways to expedite this process should be articulated in the exit strategy. Furthermore ODF celebrations should continue to be held for all the villages that will have attained ODF status to further encourage communities to work towards a recognized end.

v. The thrust of the project was for every household to have a latrine whilst also making use of locally available resources. Consequently, quality of the structures was not a

critical delivery aspect. With the cyclone that hit the province during the period of the survey, it is most likely that a number of poorly constructed structures may have broken down. It is the view of the Consultant that some significant level of project support be provided to the most vulnerable households, most of whom are not able to construct more permanent structures. The fact that some vulnerable households have committed their meager resources to construct the weak structures shows they appreciate the need for the latrines and would need external support to construct more permanent structures. Without such support these vulnerable households forced to revert to OD. However subsidies for the vulnerable should be provided towards the end of the program to give a chance to the vulnerable households to put up their own toilet structures with own resources thereby minimizing dependency.

vi. The WASH project was very much welcome by both primary and secondary schools in the project area. However, the project was introduced well after the schools had prepared their annual budgets. This resulted in some SDC planned projects being suspended in favour of the WASH intervention. It is important for future programming to take note of the school calendar when designing projects that require financial commitments from schools.

vii. The school health clubs were running quite well in most primary schools as compared to health clubs in secondary schools. It was noted that in Secondary schools the main participants were students from Form 1 and 2 with Form 3 and 4s shunning the Clubs. It is therefore recommended that the health clubs be mandatory for lower classes and optional for exam classes. Furthermore more emphasis should be put on linking the school health clubs to health clubs within the communities.

viii. Utilisation of girl friendly toilets and facilities was quite low among older students particularly in secondary schools. To enhance use, it is recommended that toilets for senior girls be equipped with necessary facilities for improved menstrual hygiene. This will go a long way in reducing identification and stigmatization. Furthermore Rumps should largely be used to create awareness of girls needs and thus should only be allocated a minimum budget for use in project start up.

ix. Use of three pits (decomposable, plastics and bottle) was common in schools and nearly non-existent in households. Whilst this tri separation of waste would be ideal in

areas directly linked to recycling companies it probably will not bring any much value in the current set up. Use of two pits (decomposable and non decomposable) may probably suffice and less resources will be required for lining of the pits

C. Public Private Partnership for Operation and Maintenance.

x. Communities with difficulties in accessing WASH materials need to be supported to organize themselves into groups and then make arrangements for traders' days/fairs to rural communities. This can be an option worth considering so that communities have one or two days in a month where they are given opportunities to buy materials which are difficult to transport. This will also make it cost-effective for the trader.

xi. There is need to consider viable options for financing communally owned tools such as VPM tool kits. For instance, local private skilled force could be levied a small amount to finance the communally owned tools.

D. WASH Sector Monitoring, Gender and Governance.

xii. The established/strengthened WASH structures at district and community levels should continue running and supporting communities in establishing and maintaining improved sanitation facilities. Periodic reports, that enhance accountability, should be provided at all levels. Demand for the same by higher level structures from village to provincial structures would ensure continuity of established processes and systems. Monitoring of the communities WASH activities should be made a key deliverable for village heads, government extension workers and school authorities if sustainability of the project gains is to be realised.

Overall, there is need for projects to provide for ex-post evaluations well after project completion to enable assessment of sustainability of project results such as ODF status as well as the resiliency of established structures and processes. The end-line evaluation only serves to assess what the project has done to ensure sustainability.

Annex 1: FGDs and KII Participants

1. **FGDs**

Ward	Venue	Audience	No. Males	No. Females	Total
2	Ruminya Secondary School	SDC	4	1	6
2	"	School Health Club	6	4	10
2	MadamombeBussinessCenter	WSSC and Village Heads	8	3	11
2	"	WPC, SAG, Builders and VPM	10	15	25
3	Bwanya Primary School	SDC	2	3	5
3	Bwanya Primary School	School Health Club	10	10	20
3	Ward center	WSSC and Village Heads	7	7	14
3	Ward Center	WPC, SAG, Builders and VPMs	8	8	16
7	Jenya Primary school	SDC	3	2	5
7	"	School Health Club	5	5	10
7	Utsinda Primary School	WSSC and Village Heads	11	6	17
7	"	WPC, SAG, Builders and VPMs			
15	Dewe Primary School	WSSC and Village heads	10	20	30
15	Dewe Primary School	WPC, Builders, Pump minders, SAGs	6	26	32
15	Dewe Primary School	SDC	3	4	7
15	Dewe Primary School	Health Club	7	5	12
8	Tambudzayi Secondary School	SDC	2	2	4
8	"	Health Club	5	15	20

2. Key Informants

Organisation	Name	Position	Gender
Care	Mr Mujuru	Programme Manager	Male
Care	Mr Chowoita	Assistant Programme Manager	Male
Care	Mr Tofa	Field Officer	Male
Care	Mrs Zireva	Field Officer	Female
Ministry of Primary and Secondary Education	Mr Teererai	DSI	Male
MoPSE	Mr Gwamuri	Inspector	Male
Pote Whole sale	Mr L. Marambire	Sales Man	Male
"	Ms S Moyo	Sales Lady	Female
N Richards	Mr K. Ndhlezani	Manager	Male
Ruminya Sec School	Mr J. Makuudze	Health Coordinator	Males
"	Mrs E. Dube	"	Female
Bwanya Primary School	Mr M Mawere	"	Male
"	Mrs Munyaradzi	"	Female
Jenya Primary School	Mr Vuranda	"	Male
Jenya Primary School	Mrs Gwindingwi	"	Female
Chimuti Village (ward 7)	Lorraine Munyati	Builder	Female
Gwauya Village	GogoChimbunde	Vulnerable (Advanced Age)	Female
Nhapata Village	Mr Nhapata	Headman	Male
Ward 15	Mr Gonda	Builder	Male
"	Mr Madhaku	VPM	Male
Dewe Primary School	Mrs Shayawabaya	Health Coordinator	Female
"	Mr Maumbeyi	"	Male
Zvamapere Secondary School	Mr Masarira	Health Coordinator	Male
"	Ms Chishaka	Health Coordinator	Female
Tambudzai Secondary school	Mrs Tamuka	Health Coordinator	Female
Ward 2	Mr MordernMachaka	Shop Owner	Male
Ward 2	Mr Ruwizhi	EHT	Male
District/Ward 23	Mr Chiruka	EHT	Male

Annex II: Evaluation Tools

1. Household Questionnaire

QUESTIONNAIRE CODE NUMBER				

1.Ward	2.Village	3. Date	4. Interviewer

Demographics & Education						
5.Sex of respondent	Female = 1	Male = 2	**6.** Age of Respondent			
7.Household Type ***(Is the household headed by a man, woman or child)***	FHH = 1 MHH = 2 CHH = 3	**8. What is the marital status of the HH head?**	Married living together = 1	Married living apart = 2,	Divorced/Separated = 3,	
			Widow/Widower = 4,	Never Married = 5	Other	
9. What is the number of years spent at school by HH head?	Illiterate = 0	Up to and including 7 years *(primary)* = 1	Up to and including 13 years (sec. form 6) = 3	Tertiary = 4		

10. How many household members are in each group below	**a.** Male	**b**. Female	**c.** Total
11. Infants & young children (0 – 59 Months)			
12. Children (5 – 17 years)			
13. Adults (18 – 64 years)			
14. Elderly (equal or greater than 65 years)			
Total			
15. Chronically ill adult members			
16. People Living with disability			
17. Orphaned and vulnerable children			

Livelihoods Strategies

18. What are the 3 main sources of livelihood for this household? ***Circle and rank the 3(1 being the most popular and 3 the least popular)***	**1=** Casual Labour…… **2**= Formal Employment**/**Wage labour…… [ ] **3=** Petty trading……[ ] **4**=Subsistence farming (crop or animal rearing)…… [ ] **5**=Commercial farming (crop or animal rearing) … [ ] **6**=Domestic work …… [ ] **7**=Skilled labour (Carpentry, plumbing, electrician, bricklaying, and building)… [ ] **8=** Artisans…… [ ] **9**=Unemployed; no source of income …[ ] **10=** No source of income, bartering or selling of assets…. [ ] **11**=No source of income, borrowing…… [ ] **12**= Regular national or international remittances…… [ ] **13**= No direct source of income: rely on assistance from friends …… [ ] **14**=Mineral mining/panning and sales

	15= Other _____ … [ ]**16**=Sell Macimbi **{ }**

Water Supply

19	**What is the main source of safe water for your cooking and drinking?**	1=Borehole 2= Protected Well (Individual); 3=Protected Well (Community) 4=Unprotected well, Irrigation Canal, Pond, Dam, River/Riverbed 5=Tap /Piped water at household 6=Unprotected Spring 7= Protected Spring 8=Sand Abstraction 9=Other, specify.....	
20	**Who usually fetches water for cooking and drinking from this source? Circle all that apply**		1= Adult Males 2=Adult Women 3=Young Male 4=Young Females 5=Other Specify -
21	**What distance do you travel to your normal source of drinking and cooking water?**		1=less than 500m 2=500-1000m 3=1000-2000m 4=2000-3000m 5=more than 3000m
22	**What do you do to make your water safer to drink ? Circle all that apply**		1=Nothing 2=Boiling 3=Add Water Guard 4=Filtration 5= Add Jik/Bleach 6=Pill 7=Other Specify
23	**How much water (litres) do you collect from your normal source? How many buckets? BUCKETS HERE**		**PUT LITRES HERE**
24	**Are there any regulations regarding quantities of water collected from your regular water source?**		1= No 2=Yes
25	**Who controls access to water at your source?**		1=WPC 2=Local leadership 3=Council/RDC officials 4=No one 5=Do not know 6=Owner 7=Others (specify)

Sanitation and Household Hygiene

26	**What do you currently use for human excreta disposal?**	1= Own toilet 2= Neighbour's toilet 3=Bush 4=Cat sanitation 5=Other
27	**When did you build the Toilet (If built 2014 to 2017 complete the toilet inspection form)**	1=Before 2014 (2013 or earlier) 2=2014 -2017 3=No Toilet
28	**If not, did you do any modifications to your toilet (built before 2014)**	1= Yes 2=No
29	**If yes, which modifications did you do? (Circle all that apply)**	1= Added toilet roof 2=Plastered the toilet 3=Added a vent pipe 4=Added fly screen 5=Added toilet seat 6=Other (Specify)
30	**Is the Toilet you are using shared with other households?**	1=Yes 2=No

31	**Are you a member of the Community Health club?**	1=Yes 2=No 3=Inapplicable
32	**Which times are critical for one to wash their hands? (Circle all that apply)**	1=After using toilet/bush(after defecation) 2=Before preparing a meal 3= Before eating food 4=After changing baby nappies 5=Before feeding children
33	**How do you usually wash your hands?**	1=Communal dip (put water in a dish and wash) 2=Drip to waste (running water from a container) 3=Running water from a tap 4=Other (specify)
34	**What would you say about the improvements brought by PHHE sessions on your level of hygiene?**	1= High 2=Moderate 3=Low 4=No impact

PARTICIPATION IN WASH ACTIVITIES			
35	How would you rate participation of women and girls in wash programes?	**1**= Extremely Good **2**= Quiet Good **3**= Slightly Good **4**= Neutral **5**= Slightly Poor **6**= Quiet Poor **7**= Extremely Poor	
36	Indicate your level of agreement on the following statement "Women and girls should be given equal opportunities and play a leading role in wash projects for example as chairpersons of WPC"	**1**= Strongly Agree **2**= Agree **3**= Neutral**4**= Disagree **5**= Strongly Disagree	
37	Why should women and girls be at the center of wash and health projects ? **(Circle all that apply)**	**1**= It is the role of women to do so **2**= Women and girls are directly involved in home hygiene **3**= Women and girls empowerment **4**= Prevention of disease **5**= Knowledge of good hygiene **6**= To enable them to practice good hygiene **7**= To enable them to educate other community members/ children **8**= Other (specify)	
HIV/ AIDS			
38	Do you agree that "WASH has role to play in the prevention and mitigation of HIV/AIDS"	**1**= Strongly Agree **2**= Agree **3**= Neutral **4**= Disagree **5**= Strongly Disagree	
39	What are roles of WASH in the prevention and mitigation of HIV and AIDS	**1**= Provision of wash facilities **2**= Hygiene education **3**= Provision of hygiene enabling facilities **4**= Hygiene education and improved nutrition **5**= Don't know **6**= Other (specify) _____	

HOUSEHOLD HEALTH									
40	Has anyone in the household had diarrhoea in the last week?					**1**= Yes **2**= No			
41	How many individuals in the indicated categories have had diarrhoea in the past 7 days?	**Under 5yrs**		**5-17yrs**		**Above 18yrs**		**Total**	
		Male	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**

WASH GOVERNANCE						
42	Does your village have a Water Point Committee (WPC) ?	**1**= Yes ; **2**= No; 3=Dont Know				
43	How would you rate your satisfaction with existing WPC?	**1**= Extremely Satisfied **2**= Quiet Satisfied **3**= Slightly Satisfied **4**= Neutral **5**= Slightly Not Satisfied **6**= Quiet Not Satisfied **7**= Extremely Not Satisfied 8= Not applicable				
44	How many of these Skilled community members are present in your community (village)	**Builders**	**Pump Mechanic**	**Village Health Workers**	**Home Based Care-giver**	**Extension Workers**
45	**GENERAL REMARKS** **What are your overall comments regarding the WASH Programme?**					

OBSERVATION & DEMONSTRATION

46	**Can you demonstrate how you wash your hands**	1=Correct Way demonstrated 2= Wrong Way
47	**Show me containers where you store your drinking & cooking water? Circle all that apply**	1=Metal water container without a lid 2=Metal water container with a lid 3=Plastic container without a lid 4=Plastic container with a lid 5=Clay pot without a lid 6=Clay pot with a lid 7= Other, specify
48	**Show Me Your Pot Rack**	1=Pot Rack Seen 2=Pot Rack Missing
49	**Observe the Material used for the Pot Rack**	1=wood 2=wood and wire 3=wood and zinc 4=Cement/Concrete 5=Other
50	**Show me where youdispose of your rubbish/solid waste from your household?**	1=Put into a refuse/rubbish pits 2=throw into backyard/field 3=Burn 4=Bury 5=Other (specify)
51	**Show me a place designated for hand washing within your household (Observe and Record)**	1=Tippy Tape 2=Sink 3=Bucket 4=None 4=Other Specify
52	**Is it Functional?**	1=Yes 2=No
53	**Is there a Washing Aid at the designated Place**	1=Soap 2=Ash 3=None 4=Other

Thank You/Tatenda/Siyabonga!

3. Key Informants Interviews -Guiding Questions

Care Officers/DWSSC meeting

Aspect	Questions
Relevance	**1.** Was the relevance identified at the start of the project still applicable at the end of the ANCP WASH project?
Efficiency	1. What was the role of Care /DWSSC in the ANCP WASH project? 2. What did the project achieve in terms of both software and hardware? 3. What internal monitoring systems did you have for the WASH project? 4. Was the information obtained from monitoring used to modify implementation? If so how? 5. What is your comment on the performance of CARE project team? (DWSSC only) 6. Was the project managed with reasonable regard for optimal use of resources? **7.** How does the planned schedule compare with what has actual transpired in terms of project activities? 8. To want extent did the project meet the donor's obligations on reporting requirements? (Care only)
Effectiveness	1. To what extent were the project objectives achieved? 2. What are the reasons for the achievement/non achievement of the objectives?/ 3. Has the programme contributed to the reduction in WASH related diseases? (Attribution…….) 4. Has the programme contributed to reduction in women and girls'/WASH related workload? 5. Did the programme ensured representation and active participation of women and disable members of the community and households?
Impact	1. What changes (negative and positive) has happened as a result of the ANCP project? a. Changes to the way DWSSC and its substructures operate b. Changes in the way council prioritises WASH in its budget c. Changes in schools- SDC operations, Girls attendance, Hygiene behaviour d. Changes in community behaviour/culture/norms e. Changes in management of water points, attitudes towards subsidy and construction of toilets 2. What initiatives have been made to influence policy in terms of planning and delivery of WASH services in local authorities and government? Is there evidence of this influence?
Sustainability	1. To what extent will the positive impacts or changes in schools, communities explained under impact continue to be maintained beyond the project? 2. What should be done to ensure that the changes will continue to be maintained? 3. What modalities have been put in place to increase synergies between the RWIMS and community based operations and maintenance? 4. Do you think the structures and systems established under the project (WPCs and SAGs etc.) to sustain and maintain the WASH structures (e.g. Boreholes etc.) and outcomes (ODF status of the villages) will continue to operate after the end of project. If not; what steps should have been taken to ensure that they continue to operate?

Aspect	Questions
Other Cross Cutting Issues	1. How did the project mainstream the cross cutting themes of gender, disability, environment, disaster risk management, poverty HIV and AIDS? 2. Were the conclusions and lessons concerning these issues fed back into implementation as the project progressed?
Lessons Learnt	1. What lessons have you learnt from the project? 2. How have disseminated the information/lessons from project to other wards and to other local authorities? Can the project be replicated elsewhere?
Recommendations/Anything else	

4. FGDs

Community Artizans/ Technical Helpers – EHTs, Builders/VPM/School Health Coordinators/Shop Owners

Aspect	Questions
Relevance	1. What was the relevance of the ANCP WASH project to your daily activities?
Efficiency	1. What was your role in the WASH project? 2. Did you get any training for the role you played in the ANCP WASH project? If so how long was the training and what materials/support were you given for use in your role? 3. How were your activities monitored? By who? 4. How was the feedback you gave to the project team used to modify the project design and implementation? 5. How much work have you done since your involvement with the ANCP WASH project? 6. How much do your charge for your work?
Effectiveness	1. Do you think that you are achieving what you were supposed to do? 2. Why do you think you are achieving it/Not achieving it? ……can
Impact	1. What changes have your participation in the ANCP WASH project brought to your life/school/business or daily activities? 2. What could have been done to increase the extent of change? 3. What has been the impact of girl friendily and disable friendily latrines to the attendance of the targeted groups? (School Coordinators only)
Sustainability	1. Do you think that the benefits you obtained from the ANCP WASH project will continue after funding has ceased? Why? 2. What is needed to ensure that you continue to offer the services/activities?
Other Cross Cutting Issues	1. How did the project mainstream the cross cutting themes of gender, disability, environment, poverty, HIV and AIDS?
Lessons Learnt	What lessons have you learnt from the project
Recommendations/Anything else	

Community Leadership/SAG Members/WPC

Aspect	Questions
Relevance	2. What are the objectives of the ANCP WASH project? Were the project objectives relevant to your daily lives? Why?
Efficiency	1. What role did you play in the ANCP project? How were you selected? 2. Did you receive any training to enable you to do your role? How long was the training 3. How much have you managed to do? 4. How was the selection of project beneficiaries for subsidies done? 5. Who monitored what you were doing?
Effectiveness	1. Did you think that the project achieved its objectives? Why do you say? 2. Did you manage to do what you were trained for? 3. Has the programme contributed to the reduction in WASH related diseases, women's/WASH related workload and gender equality? Why do you say so?
Impact	1. What changes (water supply, sanitation, hygiene, role of women and girls in WASH) have happened in your area as result of the project?
Sustainability	1. Do you think the positive changes eg ODF status, hygiene behaviour will continue after the project ceases? Why? 2. What do you think should be done for the positive things/gains to be continued?
Other Cross Cutting Issues	How did the project mainstream the cross cutting themes of gender, disability environment, poverty HIV and AIDS?
Lessons Learnt	What lessons have you learnt from the project?
Recommendations/Anything else	

School Health Clubs – Schools

Aspect	Questions
Relevance	1. What WASH challenges do people in your school/village face? **2.** Why did you join the Health Club?
Efficiency	1. How many members- male and female in your club? 2. What is the leadership structure for your group like? 3. What activities do you do in your club? 4. How are your club activities financed? 5. When do you meet- How often and what times? 6. What is the usually percentage attendance? 7. How is the planning for your activities done?
Effectiveness	1. Is your club achieving its objectives? 2. What are the reasons for the achievement/non achievement of the objectives? 3. What could have been done to make your club more effective?
Impact	1. What real difference has your club brought to your school/community? Discuss changes to hygiene behaviour
Sustainability	1. How long do you think your club will survive? Why? 2.
Gender	1. How were the gender related factors considered in planning and implementation of your club activities?
Lessons Learnt	2. What lessons have you learnt from the project?
Recommendations/Anything else	

4. Hardware Inspection

INSPECTION FORM VIP LATRINE

Ward_____ **Village**_____

Name of Assessor_____ **Date**_____

Location of Latrine (HH, Clinic, School or Meeting Center)_____

Type of Toilet_____

Aspect to be observed	Yes	No
Toilet complete		
Darkness in Toilet		
Vent Pipe fitted		
Fly Trap/Screen Fitted		
Functional Hand washing facility nearby If Yes state type		
Washing aid (soap/ash etc) nearby		
Toilet Clean		
Rump fitted/Wide door		
Toilet Seat		
Fitted Door		
Window		