

care

**Australian NGO
Cooperation
Programme (ANCP)**

**ANCP WASH
PROJECT ENDLINE
EVALUATION**

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

Chivi District, Zimbabwe

April 2022

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The project team gratefully acknowledges the support of the Australian Government through the Australian NGO Cooperation Program (ANCP) for financially supporting CARE International in Zimbabwe to implement the Water, Sanitation and Hygiene (WASH) project in Chivi District. The project is located in one of the most vulnerable districts in Zimbabwe. The consultant is honoured and recognises CARE International in Zimbabwe for choosing them among other consultants for the end of project evaluation. The team appreciates technical and logistical support provided by the CARE Zimbabwe WASH team, both during and after field work. Special thanks go to all enumerators who assisted in household data collection. The project team acknowledges the households and key stakeholders in Chivi District for agreeing to participate in the survey and providing the information that made possible to obtain the WASH end of project evaluation in the project intervention areas. This report was compiled by Andrew Chinyepe (Team Leader), Oswald Dengende and Christella Langton Chinyepe.

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ABBREVIATIONS & ACRONYMS

AdPlans	Annual Development Plan
ANCP	Australian NGO Cooperation Program
DDF	District Development Fund
DDC	District Development Coordinator
DEHO	District Environmental Health Officer
DFAT	Department of Foreign Affairs and Trade
DWSSC	District Water Supply and Sanitation Sub-Committee
ECD	Early Childhood Development
FGD	Focus Group Discussion
GWP	Global Water Partnership
IWRM	Integrated Water Resources Management
MEL	Monitoring Evaluation and Learning
MHM	Menstrual Hygiene Management
MOHCC	Ministry of Health and Child Care
MPSE	Ministry of Primary and Secondary Education
NAC	National Action Committee (WASH)
NGO	Non-Governmental Organization
ODF	Open Defecation Free
PHHE	Participatory Health and Hygiene Education
RUMPs	Reusable Menstrual Pads
SAG	Sanitation Action Group
SHC	School Health Coordinator
TOR	Terms of Reference
VHW	Village Health Worker
VPM	Village Pump Minder
VSLA	Village Savings and Loan Association
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WPC	Water Point Committee
WPM	Water Point Management
WSS	Water Supply and Sanitation
ZINWA	Zimbabwe National Water Authority

EXECUTIVE SUMMARY

CARE International in Zimbabwe, with funding from the Australian Government through the Australian NGO Cooperation Program (ANCP) implemented a five-year Rural WASH project in Chivi District, Masvingo, Zimbabwe. The project commenced in July 2017 and is ending in June 2022. It was implemented in 10 wards. The Chivi ANCP WASH Project was being implemented in collaboration with Government Ministries and Departments through the District Water Supply and Sanitation sub-Committee (DWSSC) with CARE playing a facilitatory role in implementing field activities. The project aimed to improve the water, sanitation and hygiene services in 10 Wards in Chivi South, and targeted 1700 households (65 391 people-13609 men, 16456 women, 18394 girls and 16 932 boys). The project was implemented in two main phases, each phase covering 5 wards. Within those two phases, the needs and areas of interventions were annually reviewed together with DWSSC and new targets and their supporting budgets developed. The three thematic areas of the project were: rehabilitation of WASH Infrastructure; construction of girl child friendly, disability and gender sensitive toilets and demand led sanitation and hygiene. At the end of the project, CARE commissioned an End of Project Evaluation whose purpose was to assess progress made in the implementation of planned activities and in achieving the objectives and expected results as described in the project documents. A consultant was engaged who used internationally and widely used standard evaluation criteria of relevance, coherence, effectiveness, efficiency, impact, and sustainability.

Material and methods- A mixed method approach was used, using quantitative and qualitative research methods, in this baseline study. Key WASH end of project evaluation questions were administered to 548 study participants from 5 sampled Wards (22, 23, 24, 26 and 27). The majority, 66% participants were women. the evaluation was carried out using desk study, Focus Group Discussions (FGDs), Key Informant Interviews (KIIs) and direct observations. 15 FGDs and 44 KIIs participants were purposefully selected and 350 households consulted using multi-stage cluster sampling. The multi stage cluster included the selection of project wards for evaluation inclusion. Five wards (22, 23, 24, 26 and 27) were selected. The second stage cluster selected villages from the five selected wards. Number of villages ranging from 2 to 5 were selected based on the number of villages and population in each sampled ward. The third stage cluster selected households from the village households. Twenty households in each sampled village were selected using random sampling. Different interview guides tailored to each category were used. Pre-testing of household questionnaires was carried out in Chihava Village, Ward 12, randomly selected among the Wards that were outside the sampling area. Collected data was analysed using excel. Quantitative data was analysed to extract the information from the sampled population. The analysis and presentation included descriptive statistics such as frequencies, percentages and averages. To determine the relationship between variables, regression analysis was performed. Quantitative information was validated and supported with qualitative data.

Socio –Demographic Survey

60% households were headed by males, 69% headed by married persons, 3% by singles, 25% by widows and 10% by divorced persons. 93% households reported that they are widows and 90% of the people who reported that they are divorced were women. This shows that most men remarried after being divorced or their wives died. There is high literacy rate in the project area; 92% household heads (36% primary and 56%secondary) completed at least primary education and could read and write. Approximately 8% of household heads had not attained any education.

Project effectiveness

Improved access to safe water facilities in communities and schools

- 77 boreholes were rehabilitated representing 77% of the revised target
- 30 VPMs were trained as targeted, 50% of them were women against a 70% target.
- Trained women VPMs said that working as VPMs was an area previously dominated by men before CARE ANCP project. Women were not initially confident in being trained as VPMs fearing that they were going to fail and also fearing that their communities were not going to accept them. To change from that perception was a challenge that the project overcame.
- 53 (100%) handwashing facilities were constructed in schools as was planned. Another notable achievement during the period under review, WPCs were able to mobilize resources and rehabilitate 9 boreholes. This shows the potential for sustainability of the project.
- There was a high participation (70%) of women in leadership. However, the project did not reach the planned target of 80% women in leadership positions.
- Water quality for all the rehabilitated boreholes was tested by the Ministry of Health and Child Care and all the water samples were found to be safe for drinking.
- 80% of the sampled households obtained their water from a safe source (70% borehole/handpump, 8.5% protected wells and 1.5% piped/tap water). There was an improvement of approximately 15% as compared to the baseline period which was 65%.
- 36% of households had their walking distances reduced because of the water points that were rehabilitated/repared. For example, two villagers in Ward 26 reported that before their nearest borehole was rehabilitated with support from CARE, they used to travel more than 4.5 km to the nearest water point.
- However, 56% households were still walking more than 500m to the nearest water point and are unable to meet the targeted 30minutes water collection time set by Zimbabwe government. During discussions with some VPMs and all the FGDs with men and women, a plea was made that of drilling new boreholes.

Gender responsibilities in accessing water and drinking water quality

- Adult women fetched more water at household level (63%) than men and children. The roles of men and women in accessing water for the household had not changed much from the baseline period. There was however a slight increase of 2% (from 19% at baseline to 21%) of men who are responsible for fetching water
- 89% reported that they consumed water with acceptable taste.

Water points management

- All consulted WPCs reported that they were functional and met at least once a month.
- 81% of HHs were satisfied to extremely satisfied with WPCs performances
- HHs contributed at least \$1 for water point maintenance. There was no statistically significant correlation between level of satisfaction and gender ($p=0.014$) and level of satisfaction and age ($p=0.027$).

Demand led community based total sanitation and hygiene - Communities achieve and maintain ODF status

The shared goal of sanitation and hygiene promotion approaches was to assist communities attain Open Defecation Free (ODF) villages. The project was implemented in line with government adopted strategy that is The Sanitation Focused Participatory Health and Hygiene Education (SafPHHE) which is a homegrown Zimbabwean strategy for the elimination of Open Defecation in Communities.

- Project met all its targets in terms of the 131 targeted villages, 60 latrine Builders trained, 55 of each of the Age Appropriate, Girl friendly and Disability friendly latrines, 53 multi-sprout hand washing facilities constructed in schools and functional, 106 School health coordinators trained and 53 school health clubs formed, trained and functional
- The project met 78% of its target on villages who attained the ODF status
- 40% of trained latrine builders were women against a target of 50%. Women were still reluctant to take up the challenge in the male dominated field.

People who access and safely use sanitation facilities with support from CARE and partners pursuant to relevant standards and defecation methods in the project area

- Approximately 53% of households had toilets during baseline period and 86% reported to have toilets during the end of project evaluation phase. This shows that the demand led sanitation was effective in inspiring the target communities to build for themselves after being educated on the importance of having toilets and what it takes to construct one.
- 89% of the participants defecated in toilets, 4% used cat method and 7% used the bush.
- Following the launch of demand led sanitation the project assisted in the formation of Sanitation Action Groups (SAGs), training of Village Health Workers and Latrine Builders.
- During FGDs it was established that in some villages VHWs and SAGs mobilised resources to build toilets for the most vulnerable like elderly people and people living with disabilities for example, Tizirai village in Ward 23, they built 3 toilets for the poor. Several innovative ideas were developed using local materials where households could not afford to buy all required materials. These initiatives among others resulted in increased ODF villages. Four consulted Village Health Workers in Ward 23 claimed that 15 out of 38 villages attained ODF status.
- However, harsh climate change related weather destroyed many toilets, especially the BVIP. The situation was worse in cases where households used local materials to construct sub structured latrines.

School latrines and handwashing facilities

- 55 schools were reached out with girl friendly, age appropriate, and wheel chair friendly toilets and handwashing tank facilities. School health coordinators explained that the project donated building materials (such as cement, mesh wire, taps and GI pipes) and paid builders for all the construction works. Observations made were that wheel chair friendly toilets had enough toilet opening and inside to allow wheelchair use and grab bars for hand support.
- Hand washing facilities helped the schools even in fighting against COVID 19. However, in some schools the handwashing facility taps were vandalised and not working. Pupils were washing

their hands using the provided 20l handwashing buckets provided in response to COVID 19 pandemic.

School health Clubs

- The project was effective in supporting all the 38 schools that it proposed to do.
- Fifty-three (53) school health clubs were formed, trained and currently functional.
- During discussions with members of all school health clubs, it was discovered that menstrual health and hygiene was a topical issue that was never discussed at home and less in schools. A teacher from Shindi Primary school mentioned that menstrual health and hygiene was never taught as a practical subject because primary schools thought children were too young. He said that there is however an increased number of girls coming to school while menstruating after the CARE project helped them a lot.
- To increase a sense of responsibility, members of school health clubs were taught how to make reusable sanitary pads. Children were motivated by school competitions that were held on WASH related issues where knowledge and awareness were raised to the rest of the school through poems, dramas, music and dance.
- Children are key target group, they displayed potential to influence good health and hygiene practices not only in their schools but their homes and communities as well.

Handwashing practices

64% households washed hands using water only during baseline and 66% reported that they regularly use water, soap and ashes to wash their hands during evaluation phase.

- This can be attributed to increased knowledge on the importance of handwashing. FGDs with SAGs also revealed the COVID-19 pandemic caused handwashing campaigns to be intensified.
- Only 6% demonstrated correct handwashing methods before project implementation.
- Handwashing improved to 81%, demonstrating that trainings and community hygiene activities that were carried out by VHWs and/or SAGs were effective.
- Regression analysis was carried out to assess if there was any relationship between hand washing practice and distance to water point and education level. The results showed that there was a positive relationship between hand washing practices and walking distance to the water point ($p=0.025 < p=0.05$) and handwashing practices and education ($p=0.015$), both less than ($p=0.05$). It can be concluded that handwashing practices was significantly influenced by availability and value of water caused by distance to the water point and the knowledge of the importance of handwashing. Therefore, the knowledge gained through the project helped improve the level of handwashing in the project area.

Household waste management

Waste management is another indicator of good sanitation and hygiene behaviour at household level. 79% of households had pot rack, 93% had rubbish pits and 83% reported that they separated organic from inorganic waste. During baseline survey 60.8 % had pot racks and only 4 % reported solid waste separation. Therefore, the majority of the households significantly improved waste management and hygienic handling of kitchen utensils. A regression analysis was carried out to find out if household

waste management was dependent on the age of household head. Results of the analysis ($p= 0.15>$; $p=0.05$) show that there was no relationship between households with pot rake and age.

Women and girls have equal decision-making roles and responsibilities to men and boys in communities and schools to sustain WASH improved hygienic practices

By the time of project evaluation, it was reported that there were more than 50% women and in some cases 80% in leadership in the following committees and groups: Village Health workers, VPMs, Community Health Clubs, School Health Clubs and Sanitation Action Groups. Not only did the project support women to be in leadership structures, but also empowered them to occupy influential positions such as Chairpersons and Vice Chairpersons of committees.

Efficiency of the project

Collaboration

The project was efficient in collaboration. It was implemented in partnership with other key stakeholders and this enhanced sharing of some responsibilities and reduced some costs. Key to the project implementation were the government arms who were members of DWSSC, for example, whenever CARE visited schools, they were accompanied by an officer from the Ministry of Primary and Secondary Education and or from Ministry of Health. Local leadership and communities played a critical role in the execution of the project.

Resource utilization

The project operated under a tight budget as price of goods and services kept on changing, for example, it was reported that the project failed to rehabilitate all the target boreholes because the price of materials increased. In addition, some materials such as cement for toilets at one time were scarce. CARE Zimbabwe was also innovative in engaging N. Richards, a very big wholesaler to get cement at a fair price. Such interventions enhanced continuity of the project.

Capacitating relevant people close to area of need

Capacitating key resource persons who were local community members (VPMs, VHW, School Health Coordinators, SAGs, WPCs and SCH), was an effective but also an efficient strategy, as the approach was cheap, and easily accepted because these people were already integrated in the community, for example, school children as members of the school health club could easily communicate with their peers. In addition, during project implementation, trained persons needed not travel long distances as they were already in the community.

Adoption of demand led sanitation approach

By adopting demand led sanitation, the project aligned itself to the vision and development trajectory of the country and guaranteed project support from government. In addition, even though not easy, the strategy capacitated the local community not to rely on donations. The villages which attained ODF status bare testimony to the success of this approach.

Trainings

Most trainings were held within the communities and this was cheap and cost effective. If they were all going to be conducted outside the district it was going to be costly to the project. In addition, the trainings were very practical, for example during VPM trainings, participants had 3 days of theory training and 11 days of practical training, including actual rehabilitation or repairing of boreholes.

Reporting and monitoring

Annual reviews, interim reports and annual plans, helped the project to remain on track. As earlier communicated, Zimbabwe went through phases of an unstable economic environment, which saw project costs rising hence monitoring and review helped to strategies in consultation with key partners to achieve project goals.

Time management and working relations with stakeholders

Consulted stakeholders were asked if CARE was able to provide what they promised on time including times for meetings, supply of materials, and demand led sanitation awareness and training sessions. 97% of interviewed participants reported that CARE was punctual on the support they were providing and the following are mentioned examples;

- District Development Coordinator said that CARE always informed them on time of any program and they consulted them before doing anything in the district
- Schools reported that CARE supported them with materials for girl friendly and wheel chair friendly latrines on time
- VHW, WPCs and SAGS reported that CARE communicated about planned meetings in advance allowing them time for mobilisation. CARE staff punctually attended community meetings

Project relevance

- The project was very relevant to the needs of the target communities, focusing on areas of vulnerability as reported in the baseline report. The project also was relevant to the priorities of Chivi District and priority of the government of Zimbabwe. Some of the commitments made by Zimbabwe government are to reduce open defecation from 21.7 to 10% by 2025 and achieve 80% access to potable water by 2025
- Project was relevant to CARE International focus and principles. CARE International's focus says, 'We put women and girls in the center of our work because we know that we cannot overcome poverty until all people have equal rights and opportunities'. Some of the organisation's principles are; to promote empowerment, to work with partners, avoid discrimination and seek sustainable results. According to Section 73a and Section 77a of Constitution of Zimbabwe every person has a right to an environment that is not harmful to their health and wellbeing and right to safe, clean and portable water respectively. Project intervention was promoting targeted communities in Chivi District to realize these rights.
- The project was relevant to the current National Development Agenda for example National Development Strategy 1 under the infrastructure and utility pillar.
- The project was also relevant to national policies such as the Zimbabwe National Sanitation and Hygiene Policy. The policy promotes equity and inclusion. It reads, services will be designed,

operated and maintained to meet age, gender, poverty, disability, culture, religion and location specific needs¹

- At international level, the project contributed towards Sustainable Development Goal 6 which targets access to water and sanitation for all by 2030. UN General Assembly Resolution 64/292 of 2010 formally recognized access to clean water and sanitation as a human right. The project was relevant to Care International organization vision and focus of overcoming poverty while putting women and girls in the centre.

Satisfied by project implementation

The project can also be considered effective if it managed to satisfy its target beneficiaries. 80% of the households were satisfied by the implementation and results of the WASH project.

The project was also fair and appropriate in that it considered and deliberately gave attention to the most vulnerable people, such as people living with disabilities and youths, for example, disability and girl friendly toilets were constructed in all the targeted schools.

Choice of Chivi district was relevant as it was one of the most vulnerable districts with many villages that were yet to attain Open Defecation Free (ODF) status.

The project was also relevant to the target area needs as it was reported that designing and programming was informed by baseline study that was carried out before the project started.

Impacts of the project

- Two main ways that the project made an impact was in terms of changing lives of the local communities and capacity development and strengthening of local structures and related partner organizations.
- 80% of both men and women felt they had increased knowledge of sanitation and good hygiene as a result of the project. Some reported that the project also helped them to deal with the COVID 19 pandemic.
- Results at the end of the project showed a change in behaviour and practices, with 78% washing their hands before cooking, and over 58% after clearing children stool (poop) and before feeding children respectively.
- 81% of consulted household members were able to demonstrate correct handwashing.
- Project enhanced organizational ability for it became easier for schools to tackle WASH related subject topics in schools
- Boosted local community confidence and collaborations, for example, SAGs and VHWs were able to mobilize resources at local level to construct toilets for the most vulnerable people in their villages. One of the village health workers in Ward 23 and another in Ward 22, said that the project made them realise that in communities households need each other more than what they thought.
- They said the project made them realise that having neighbours practicing open defecation exposed them as well to the risks of eating and drinking contaminated food and water

¹ The Zimbabwe National Sanitation and Hygiene Policy. 2017

respectively. The risk of contamination was caused by flies that could carry exposed faeces from open defecation to any unprotected food or water in the nearby households. Risk is also high because in rural set up some domestic pets and fowls are raised as free range and end up eating faeces from open defecation and or spreads them to objects and surfaces.

- 53 schools were where assisted with wheelchair friendly toilets and a total of 178 (83 boys and 95 girls) with disability were reached. Previously learners with disabilities were not attending school due to unavailability of user-friendly toilets
- The project reduced the burden of travelling long distances to the nearest water point for villages who had their boreholes rehabilitated.
- The model of project implementation created a platform for sustainable community social support systems.
- However, area of need that was raised by stakeholders including villagers and schools was the distance to water points. Schools find it difficult to share water points with communities because of the high number of people that will congest at the water point, for example, at Nyahombe primary school there was one borehole serving more than 1700 children and a large community.

Sustainability of the project

- The demand led sanitation strategy allowed the local community to take a leading role in using their own resources in addressing WASH challenges, hence it created a platform for project sustainability.
- Collaboration of local structures such as SAGs, VHW and latrine builders indicated potential for sustainability of ODF in some villages.
- Capacity to rehabilitate/repair boreholes and build toilets - VPMs and latrine builders were provided with tools to use in the event of their needs. The strategy was sustainable in that these trained artisans had been capacitated to provide services in their communities even after project decommissioning.
- *Capacity to pay for Pump maintenance*
Approximately 51% households were able to contribute money for WP maintenance. Those who contributed reported that they contributed US\$1 or R10. However, in one interview with VPM in Ward 26, it was reported that communities can only raise money for minor repairs but cannot afford major repairs or rehabilitation.
- Upskilling school health coordinators was a good strategy that will ensure that even though members of the school health clubs may change as club members finish school, there will be training of new members. According to comments from the school health coordinators, the project was an eye opener especially on the need to support female students and children living with disabilities. A School Health Coordinator from Chongobwe Secondary school said the project was sustainable because it triggered and motivated schools through their School Development Committees and SDCs to do more for female students and children living with disabilities.

- During consultations in all participating schools, they appreciated the support of training school children to make Reusable Menstrual Pads (RUMPs). They said this was going to impact even homes where these children came from, as some of them were going to use their acquired skills at home. However, a concern was raised threatening the sustainability of RUMPs initiative. Schools reported that material for making RUMPs was not locally available and schools were likely to face challenges if CARE moved out.
- The project is likely to be sustainable because all structures including government officers will remain in the area after project decommissioning.
- Some women during FGDs said capacitating a woman is capacitating a village. Women were less mobile than men hence there is a high chance that trained VPMs, VHWs and Latrine Builders would be in their respective communities for a longer time offering their service to WASH infrastructural challenges.
- The project was in line with relevant government Ministry programs such as Ministry of Primary and Secondary Education, Ministry of Health and Child Care, Ministry of Gender and Ministry of Youth and as they will be implementing their programs in the district, they will contribute to sustainability of the intervention.
- However, consulted members of the DWSCC pointed out that for the project to be sustainable, handover should be done properly to ensure that project activities can be taken over and sustained by other institutions who were also championing the same cause.
- Concern was also raised by VHWs and one of the WPCs that the frequency of visits to provide support, which were being made by various government experts such as health experts, will be reduced when the project closed because of resource constraints and this may affect project sustainability.

Other cross cutting issues

Environmental Factors

The changing climate was a threat to ANCP WASH intervention in Chivi District in two ways. Recurrent droughts and extreme weather events like heavy rainfall storms and strong winds were and still a threat to WASH infrastructure, especially poorly constructed latrines and uBVIPs.

Financial Factors

In as much as the project had made huge impact by triggering demand for sanitation, there were households that were seriously incapacitated and had limited access to financial resources. This was a perennial challenge to the attainment of ODF. During discussions with SAGs it was found out that some households were keeping uBVIP structures as if they were permanent structures. This was caused by capacity challenges.

Disability inclusion

People with disabilities including children were mainstreamed in the programming of this project. They were considered in the designing and construction of wheelchair toilets in schools. At community level, they were given first priority in terms of support. This led to some villages through SAGs to construct toilets that suited the needs of the people living with disabilities in their villages.

Safeguarding

It can be reported that the project complied with DFAT's Child Protection and Prevention of Sexual Harassment Exploitation and Abuse policies. Discussions with CARE Zimbabwe revealed that all CARE employees were compelled to go through the PSHEA course on CARE Academy. The staff were also trained on child protection. CARE staff in turn mainstreamed sexual harassment and child protection issues in all district and ward-based trainings. During stakeholder consultation questions were asked if there were ever any incidences of child abuse or sexual exploitation during project implementation and the response was there was never any.

Conclusion

It can be concluded that the project made significant progress in contributing towards sustainable access to water, sanitation and hygiene in Chivi District. The project helped the target communities to improve their living conditions. Because of the harsh socio-economic environment, especially during 2017-2018 when the country was in transition of money currency, experiencing high inflation, increased costs of goods and services meant that some planned outcomes were revised, for example, the expected number of boreholes to be rehabilitated was revised down from 120 to 100. However, despite the socio-economic constraints and the logistical challenges that were caused by the COVID 19 pandemic, the project achieved its ultimate goal, that is, ***'Increased equitable and sustainable access to and use of safe water supply, improved sanitation and hygiene practices among the rural population of Chivi District.***

- The project managed to rehabilitate 78% of its revised targeted number of boreholes, girlfriendly and wheelchair friendly toilets.
- The project managed to capacitate (through training) all the key local services providers (VPMs, VHWs, Latrine Builders, School Health Coordinators, WPCs and SAGs. In addition, some were equipped with relevant tools such as latrine builders and VPM toolkits.
- The project achieved intended percentage representation of women decision-making structures such as VHW, and SAGs, but failed to achieve the same on trained VPMs and Latrine Builders and WPCs.
- In the consultant's opinion, the targeted percentage representation of women (80% in WPCs and 70% in VPMs) was too high and is not gender balanced. This was against the background that the project also wanted to increase the participation of men and boys in WASH activities; for example, efforts that were made through reflective gender dialogues. Therefore, according to the consultant's expert assessment, the project's achievement of 50% women VPMs and 70% women WPCs, was a realistic achievement.
- It can be concluded that the project made a huge impact through demand led sanitation, helping the 10 Wards of Chivi district to reach 78% ODF.
- WASH in schools was hugely successful through the girl friendly and wheelchair friendly toilets as well as health and hygiene education. However, the water supply side of intervention was limited just as in water supply for communities.

RECOMMENDATIONS

Based on the findings and discussions with stakeholders, the following recommendations were made:

- Future programmes should consider drilling of new boreholes to reduce walking distance to the water points
- Consider alternative water sources, for example feasibility study for abstracting water from Tugwi Mukosi, or other water abstraction technologies should be carried out considering that it's difficult to get productive boreholes in some parts of Chivi.
- To develop climate proof WASH response programming in future, that is WASH programming that is resilient to the impacts of climate change
- Strategies of capacitating local communities to upgrade the uBVIP after initial constructions with temporary superstructure should be developed. Members of DWSCC should critically review the successes and related challenges of uBVIP upgrading
- To keep on working on behaviour change towards demand led sanitation, there should be reinforcement of key messages that encourage the expected changes in behaviour. For example, the use of the word '*dhodhi muchimbuzi*', was a strong word in local language that shames those who practiced open defecation.
- DWSCC should plan for demand led sanitation refresher courses.
- Explore alternative ways of making materials for RUMPS available in the local areas.

6.0 LESSONS LEARNED

1. Construction of wheelchair friendly toilets was a noble idea, however only schools were able to construct them with assistance from CARE. Feedback from consulted health workers was that people living with disabilities need the same support at home, for example, children accessing wheelchair friendly toilets at school were experiencing difficulties when at home.
2. A lesson learnt from some villages that were triggered by demand led sanitation, and managed to attain ODF, was that using local materials like grass and poles to build toilets was good as a temporary or emergency measure but not sustainable in the long run. During consultations, the consultant established that most of the toilets that collapsed were the ones that were constructed using local materials.
3. Using UBVIP toilets is/was a good model in terms of easier uptake by the majority of households, especially those constrained by resources. However, households were facing challenges of upgrading, ranging from complacency and resource constraints. In terms of human behaviour, people have a tendency to relax, for example most of the toilets that collapsed were those that were constructed using local materials and meant for use in short period; but households ended up using them for a longer period and some treating them as permanent structures.
4. Demand led sanitation was a noble model of mainstreaming sanitation in villages, however it was influenced by local village governance, for example, most villages that attained ODF were those where local leadership made it mandatory for every HH to have toilet.

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1.0 INTRODUCTION

CARE International in Zimbabwe with funding from the Australian Government Department of Foreign Affairs and Trade (DFAT) through the Australian NGO Cooperation Program (ANCP), implemented a five-year rural WASH project in Chivi District, Masvingo Province, Zimbabwe. The project commenced in July 2017 ending in June 2022 and covered 10 wards. The Chivi ANCP WASH Project was being implemented in collaboration with Government Ministries and Departments through the District Water Supply and Sanitation sub-Committee (DWSSC) with CARE playing a facilitatory role in implementing field activities. The project aimed to improve the water, sanitation and hygiene services in 10 Wards in Chivi South, and targeted 1700 households (65,391 people-13609 men, 16456 women, 18394 girls and 16 932 boys)². Overall, the project intended to rehabilitate/repair 100 boreholes, assist 131 communities to build latrines and become open defecation free (ODF), and work with 55 schools to improve their water and sanitation facilities. The project was implemented in two main phases. The first phase covered 5 Wards (Ward 12, 24, 25, 26 and 31) and the second phase covered the remaining 5 Wards (Ward 21, 22, 23, 27 and 29). Within those two phases, the needs and areas of interventions were annually reviewed together with DWSSC and new targets and their supporting budgets developed. Funding was requested annually based on the planned scope of work for that particular year. As the project was coming to an end, CARE Zimbabwe engaged a consultant to carry out independent evaluation of the project. The purpose of the end of project evaluation was to provide a summative evaluation of outcomes which would assess the project's progress and impact from 2017 to 2022. Results would be used to measure project achievements against its design objectives and guide future WASH programming within CARE International in Zimbabwe (CIZ).

The evaluation findings and processes would be used and shared by relevant stakeholders, including the Chivi DWSSC and CARE's Research and Business development Unit (RBDU), to influence programme sustainability and future WASH programming with CARE Zimbabwe and the WASH sector in general. Chivi DWSSC may use the report to influence WASH programming in the district focusing on key lessons learnt.

1.2 Structure and Content of the report

The report is structured as in the ToRs. Following is the outline of the report structure and details of each subheading is in Appendix.

Title and Opening pages (front matter)-should provide the following necessary information:

- i. Name of the project evaluated
- ii. Time frame of the evaluation and date of the report
- iii. Project location (districts and country)
- iv. CARE Zimbabwe logo
- v. Acknowledgements

Table of Contents-

² Terms of References

- List of acronyms and abbreviations
- Executive Summary
- Introduction
- Description of the Intervention
- Evaluation Scope and Objectives
- Evaluation Approach and Methods
- Findings and Conclusions
- Recommendations-
- Report Annexes

1.3 Brief profile of Chivi District-with map showing Wards of operation

The end of project evaluation was focused on the period July 2017 to June 2022, covering a total of 10 Wards (Figure 1). Chivi is a district in Masvingo Province and has a total number of 32 Wards with a total of 180 villages. The district is located 65 km South West of Masvingo, the Provincial Capital and has 3 510km² of area³. The district is situated in the drought prone region of the country, with semi-arid climate resulting in low average rainfall of 450mm per year. The infrastructure is not well developed. Dominant languages mostly spoken in the area is Shona, complimented by Ndebele and Tshivenda. The main land use in the district is communal farming which takes up 89.7% of the area. Other land uses are commercial farming 0.6% and resettlements 9.7%⁴.

³ Inter-Census Demographic Survey in Zim-Stat, 2017

⁴ Inter-Census Demographic Survey in Zim-Stat, 2017

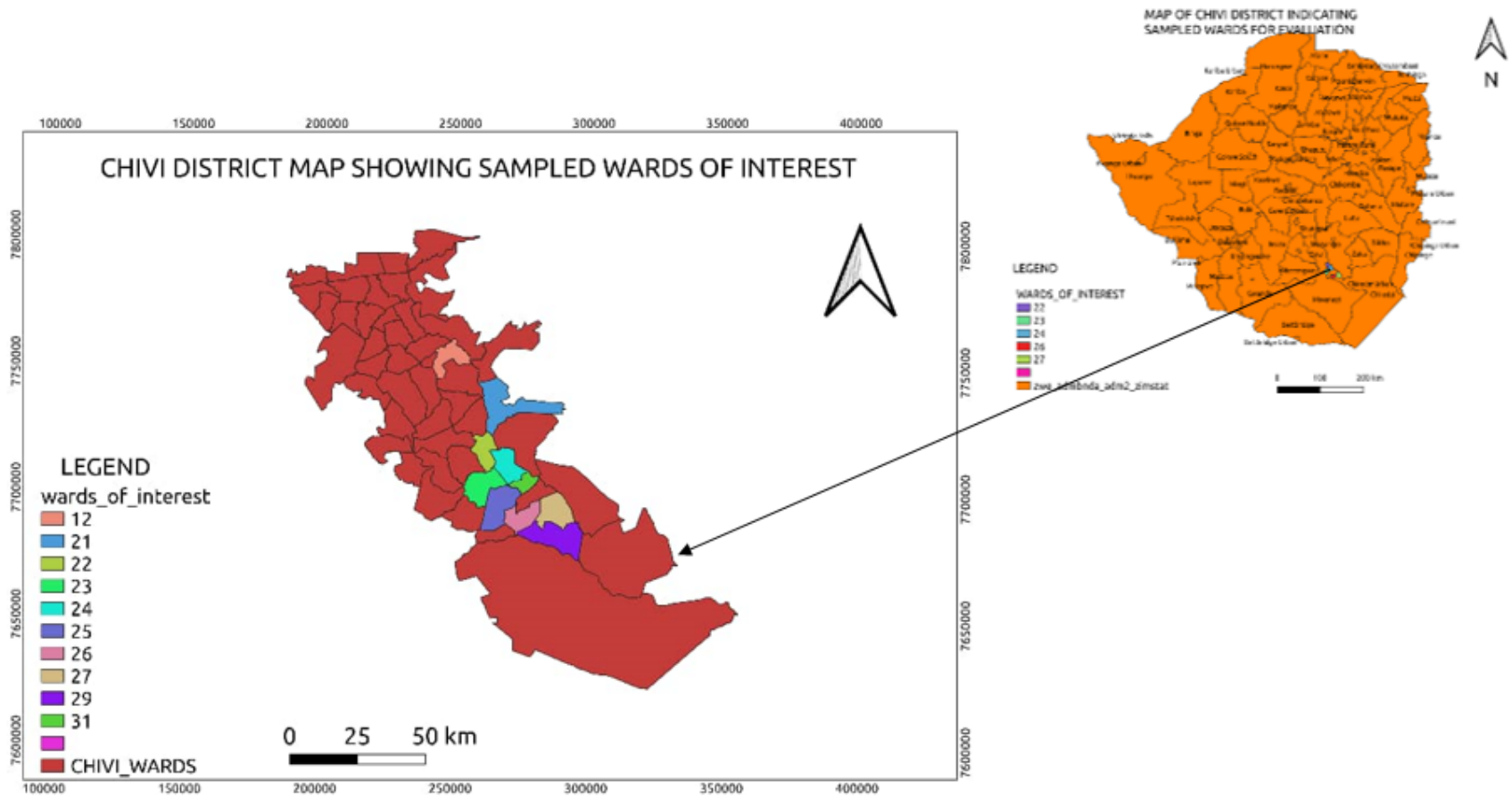


Figure 1: Map of the project area

2.0 EVALUATION SCOPE AND OBJECTIVES

2.1 Project goal and evaluation scope

As stated in the Terms of Reference (TOR) the overall goal of the project is: Increased equitable and sustainable access to and use of safe water supply, improved sanitation and hygiene practices among the rural population of Chivi District. To achieve the goal CARE Zimbabwe carried out the project addressing the following four thematic areas:

1. Rehabilitation of WASH Infrastructure in 10 wards of Chivi District
2. Construction of girl child friendly, disability and gender sensitive facilities.
3. Demand Led Sanitation and Hygiene in 10 wards of Chivi District.
4. WASH Sector Monitoring, Gender Equality and Governance.

2.2 Project Evaluation Objectives

According to the TOR, the endline evaluation has the following objectives:

- I. Verify that the project has achieved the stated outputs and outcomes among disaggregated stakeholder groups (including gender and disability). Data should be disaggregated by gender and disability.
- II. Evaluate the relevance of the intervention and appropriateness of implementation approaches used.
- III. Document promising practices, key lessons learned and recommendations, which will influence WASH Programming within CARE International in Zimbabwe and the WASH sector in general in Zimbabwe
- IV. Identify weaknesses in the project design, implementation or operating environment that constrained optimal project effectiveness
- V. For the villages that attained Open Defecation Free status, assess the degree of any slippage and recommend corrective measures
- VI. Assess the effectiveness of the Gender interventions implemented and make appropriate recommendations including the extent to which the project has progressed gender equality in the three domains of CARE's Gender Equality Framework (agency, relations, structure).
- VII. Assess how the needs of children, women and men with disabilities were addressed and effectively integrated in WASH in Schools and community level and any impact (positive or negative) this has had for people with disabilities

2.3 Evaluation Criteria

The consultant used the widely used and internationally accepted standard evaluation criteria of relevance, coherence, effectiveness, efficiency, impact, and sustainability.

- *Relevance*- is the intervention doing the right things?
- *Coherence*- how well does the intervention fit?
- *Effectiveness* is the intervention achieving its objectives?
- *Efficiency* how well are resources being used?
- *Impact* what difference does the intervention make?
- *Sustainability* will the benefits last?

The criteria were also used because it was recommended in the TOR.

2.4 Evaluation Questions

Several evaluation questions as guided by the TOR were used in this study. The evaluation questions were used to assess to what extent the project met its objectives in the context of the set evaluation criteria.

Table 1: Evaluation questions

Evaluation Questions
<p><i>Relevance</i></p> <ul style="list-style-type: none"> - To what extent did the project design and implementation address perceived and evidenced community vulnerabilities and government priorities? - To what extent are community members satisfied with the implementation and results of the project? - How fair and appropriate was the implementation of the project? (e.g. considering gender, youth, culture, disability, displacement, etc.) - How were power and gender dynamics analysed and addressed in the project? -
<p><i>Effectiveness</i></p> <ul style="list-style-type: none"> - To what extent did the project achieve impact against the Monitoring, Evaluation and Learning framework (outputs, outcomes, goal and indicators)? - What are the achievements/degree of change against the set targets? Compare the endline results to the baseline. - Compare actual with planned outputs and how have outputs been translated into outcomes. - The evaluation will also establish the possible deviation from planned outputs and likely outcomes. - What was learned
<p><i>Efficiency</i></p> <ul style="list-style-type: none"> - Were the objectives of the project realistic relative to the funding provided? - How efficient were the project activities? Were all the project resources utilised optimally? - How could we have done things more cheaply and on time? - How could the efficiency of the project be improved without compromising outputs? - How adequate were the reporting and monitoring systems of the project? - To what degree did the outcomes justify the costs, and how does this compare with similar projects in terms of return on investment?
<p><i>Sustainability</i></p> <ul style="list-style-type: none"> - How sustainable are the systems and benefits established by the project? - How likely are the outcomes to be sustainable and enduring? - In what ways will it leave a legacy for its beneficiaries and the communities? - In what ways are women and men in communities (including men and women with disabilities), the local partners and government stakeholder's partners prepared to continue with the project outcome?
<p><i>Impact</i></p> <ul style="list-style-type: none"> - What positive and negative changes occurred as a result of the project, beyond what was initially planned by the project design focusing on schools, participants, households, village level and people with disabilities? - What were the most successful (or not) approaches/pathways to achieving impact for example system strengthening, advocacy, working with women's organisations, local

partners etc

-

3.0 EVALUATION APPROACH AND METHODS

A mixed method approach using quantitative and qualitative research methods, was used in this Endline study. Key WASH end of project evaluation questions were administered to the 548 study participants from 5 Wards (22, 23, 24, 26 and 27). The majority, 66% participants were women. More women were intentionally selected in terms of population, they are the majority and also the baseline report and other previous studies show that women are affected most by WASH related challenges. In addition, committees that were consulted (SAGs, WPC, and School Health Clubs) are dominated by women and girls respectively. The following mixed methods were applied to obtain relevant information.

- Desk Study and Literature Review
- Household Questionnaires
- Key Informant Interviews
- Focus Group Discussions (FGDs)
- Physical Inspection of Rehabilitated and Drilled Boreholes
- Direct Observation

3.1 Desk study/review of relevant documentation

A desk study was conducted to review relevant project documentation. This exercise was important as it helped the evaluation team to polish up its data collection instruments before embarking on field work.

The consultant reviewed the following documents;

- Interim Reports
- Annual Performance Reports
- Annual Development Plans (AdPlans)
- Training and Activity Reports
- ANCP Design 2017
- CWP Sustainability Study for Dissemination
- Chivi ANCP Baseline Report
- Theory of Change ANCP report
- ANCP Success stories
- Constitution of Zimbabwe
- National Development Strategy 1

The review provided detailed information on status of target beneficiaries before and after project implementation, number of beneficiaries, budgets, project activities, milestones, achievements and challenges.

3.2 Sampling and data collection

The target area has a population of 65,391 people. For purposes of the Endline, 5 wards were sampled out of the 10 wards. The consultant used multi stage cluster sampling of wards and villages. The multi stage cluster included the selection of project wards for evaluation inclusion. Five wards (22, 23, 24, 26 and 27) were selected. The second stage cluster selected villages from the five selected wards. Number of villages ranging from 2 to 5 were selected based on the number of villages and population in each sampled ward. The third stage cluster selected households from the village households. Twenty households in each sampled village were selected using random sampling. To establish sample size for household questionnaires, the Rao soft sample size calculator (<http://www.raosoft.com/>) was used at 95% confidence level and 5% margin of error.

3.3 Household Questionnaire

A total of 350 household questionnaires were administered to the sampled villages, 20 in each village. At household level women were given first preference for the interview. 66% of the household participants were women. The consultant trained and used enumerators to carry out household surveys. Household questionnaires were collected using tablets configured with KoBo toolkit. Table 2 and Table 3 show the number of sampled households per each village and village names respectively.

Table 2: Sampled households

	Ward 24	Ward 26	Ward 22	Ward 23	Ward 27	Total
# Villages	2	4	3	4	5	18
Number of HH	40	80	60	80	90	350

Table 3: Name of sampled villages

Wards	Ward 24	Ward 26	Ward 22	Ward 23	Ward 27
Villages	Gotoru Kutirai	Zangure Kufaune Buzura Mtikani	Mutoredzwana Zivuku Mukanga	Tamwa Mazuruse Chiduke Marufu	Maimbi Zivurani Bhodhera 5A Nyahombe

3.4 Observation and checklist

The consultant used data collection checklist to collect information on the condition of rehabilitated water point infrastructure and newly constructed toilets. The consultant assessed handling of wash infrastructure and capacity to maintain them (Plate 1). The checklist was developed using



the Global Water Initiative standard monitoring checklist for water points and latrines⁵. Photos were taken to support as visual evidence of the current status. In addition, household questionnaires had sections that allowed enumerators to capture information based on observation on toilets, pot racks and household waste management. Table 4 shows components of WASH infrastructure that were assessed in each ward. Two boreholes were assessed in each ward so as to spread out the sample and cater for geographical differences. Key stakeholders were purposefully selected for meetings and interviews. To enhance representation, wards that were included and those that were not included in the baseline survey were sampled.

3.5 Key informant interviews and meetings

A total of 44 key informant interviews were done to solicit their views regarding the ANCP project and these included members from the CARE Project Team, DWSSC, Village Pump Mechanics, Latrine Builders, School Health Coordinators, Village Head and Health Workers, in order to explore their engagement, the extent they participated and the potential for increased engagement and interventions. Key informants were purposefully selected based on their anticipated expert knowledge and experience in the different thematic areas. Consultations were also to solicit their view on the impact, effectiveness, efficiency and sustainability of the project interventions. Different interview guides tailored to each key informant category were used. Appendix 18 shows some of the stakeholders who were interviewed.

3.6 Focus group discussions

A total of 15 FGDs were conducted to encourage different categories of respondents to discuss access to water and demand led sanitation; access to services and infrastructure; social protection; gender roles; youth involvement; and other relevant water, sanitation, health and hygiene challenges and opportunities. Participants of FGDs were selected purposefully using one commonly cited guideline that says focus group research requires at least two groups for each defining demographic characteristic⁶. FGDs enable people who may otherwise be overlooked in larger community meetings to express their own point of view. FGDs were held with the following 6 groups of people; Women, Youths, Men, Water Point Committees (WPCs), Sanitation Action Groups (SAGs) and School Health Clubs. The different categories of FGDs were selected in such a way that the voice of women and youths were also heard, and views of different committees that are key for sustainable management of water points (critical for water supply) and behaviour change towards sustainable health and hygiene and sanitation are heard. FGDs were also held in village meeting points (familiar places for members of the community) and closer to their homes. Contributions from discussions were recorded and collected by both writing on note pads and recording using audio devices.

⁵ GWI Technical Series: Hardware Quality for Sustainable Water & Sanitation; Monitoring checklists: Water points and latrines.

<https://answers.practicalaction.org/our-resources/item/monitoring-checklists-water-points-and-latrines/>

⁶ Guest, G., Namely, E & McKenna, K. (2017). How many Focus groups are enough? Building an evidence base for nonprobability sample sizes. *Field Methods*. Vol 29. 3-22

Table 4: Observation and inspection

Water Points	Household Toilets	School Toilets	Handwashing facilities
10	10	10	10

3.7 Pre-testing of Data Collection Tools

Pre-testing was carried out in Ward 12 in Chihava Village, randomly selected among the Wards that were outside the sampling area. The pre-testing was carried out to check on the content of the questionnaire to ensure reliability and practicability of the instrument. The testing was also carried out to assess the time taken and the capability of the enumerator to administer the questionnaire.

3.8 Data analysis

The data collected was analysed using excel. Quantitative data was analysed to extract the information from the sampled population. The analysis and presentation include descriptive statistics such as frequencies, percentages and averages. To determine the relationship between variables, regression and chi-square test of independence (χ^2) were performed across the evaluation at 95% confidence interval. Quantitative information was validated and supported with qualitative data. Qualitative data was prepared and organised by proof reading rearranging the data. Data was reviewed several times to make sense of what participants were saying and coded along the identified themes under study. The themes were triangulated and integrated with quantitative information to produce results. Data was analysed to present results that will answer the effectiveness, efficiency, impact and sustainability questions of the project. Results show the extent to which outcomes were achieved.

3.9 Mobilization of the Communities for the Evaluation exercise

CARE Zimbabwe facilitated the induction of the consultant into the district through the District Development Coordinator`s office. They further assisted in the community mobilization in targeted areas. Community structures and project staff were effectively and proactively involved to support in the sensitization of targeted communities about the study.

4.0 FINDINGS AND CONCLUSIONS

4.1 Socio –Demographic Survey

Results from the survey in Table 5 show that approximately 60% of households are headed by males and 40% by women. Approximately 69% of the households are headed by married persons, 3% by singles, 25% by widows and 10% by divorced persons. Majority of widowed, single or divorced households are headed by women.

Table 5: Demography based on household samples

Variable		Number (350)	Frequency
Gender of household head	Male	210	60%
	Females	140	40%
Marital Status	Married	243	69%
	Single	9	3%
	Widowed	88 (82 females; 6men)	25%
	Divorced	10 (9 females; 1 men)	3%
Education Status of Household head	Primary	128	36%
	Secondary	181	52%
	Tertiary	13	4%
	No Schooling	28	8%
Households with Orphans & chronically ill persons	Households with orphans	119	34%
	Households with chronically ill persons	77	22%

In terms of education, 52% completed secondary education, 37% primary education only and 4% reached as far as tertiary education. A small number (8% of the household heads) did not go to school. This shows that the level of literacy in the sampled wards is high.

Approximately 34% of families in the target area live with an orphan. Approximately 22% of the target population live with a person with chronic disease. People with chronic conditions and Orphans and Vulnerable Children (OVCs) are more vulnerable to WASH challenges. For example, people who are asthmatic and those living with heart problems would find it difficult to carry water from long distances. OVCs have a higher risk of being abused if the water sources are far.

4.2 Project effectiveness

Effectiveness of the project was assessed based on the extent to which project outcomes and outputs were achieved. From the discussion with the CARE Zimbabwe team, the project was implemented in phases with annual review. Each year new targets were set in consultation with DWSSC. The project was meant to rehabilitate/repair 100 boreholes.

4.2.1. Improved access to safe water facilities in communities and schools

4.2.1.1 Rehabilitated boreholes, trained Village Pump Mechanics (VPMs) and Water point Committees (WPCs)

Results in Table 6 show interventions that were carried out to increase access to safe water facilities in communities and schools. To improve water access, the project rehabilitated and repaired existing water points. Results show the planned outcome versus what the project actually implemented over the entire project period. The results show that the project achieved 77% of its borehole rehabilitation targets. Information gathered in the annual reports revealed that during the first year of implementation, inflation was very high and prices of borehole components became higher than the budgeted funds, thus forcing the project to reduce its target. The project planned to train 30 VPMs and this target was achieved. However, 50% of the total number of VPMs trained were women, as opposed to the target of 70% women; representing 87.8% of the expected outcome on women representation. During FGDs, trained women VPM said that working as VPMs was an area previously dominated by men before CARE ANCP project. The repair of boreholes was best done by men. Women were not initially confident of being trained as a VPMs fearing that they were going to fail and also fearing that their communities were not going to accept them. To change from that perception was a challenge.

One woman said, "Takangokura tichiziva kuti basa rekugadzira zvibhorani nekuvaka nderana baba, nderavarume nevakomana"

Translated as "We grew up knowing that the job of repairing/rehabilitating boreholes and of building is responsibility of our husbands and job for men and boys".

In addition to community boreholes, Table 6 shows that the project managed to rehabilitate 7 boreholes and 55 handwashing facilities in schools as was planned. Another notable achievement during the period under review, WPCs were able to mobilize resources and rehabilitate 9 boreholes. This shows the potential for sustainability of the project.

There was high (80%) participation of women in leadership decision making. The project achieved its target.

Water quality testing for all the rehabilitated boreholes was done by the Ministry of Health and Child Care and all the water samples were found to be safe for drinking.

Table 6: Outputs of the project on improved water access

Variables	Target Number	Achieved Number	% Total Achievement	Gender (% of women target)
Number of functional Boreholes rehabilitated, repaired and drilled, tested	100	77	77%	
# WPC trained (# women; # men), how many chaired by women # of	169	169	100%	96%
WPCs hold regular meetings monthly	169	169	100%	96%
# VPM trained (#women; #men) that are functional	30 & 70% women	30	100 %	70%
% women occupying decision making WPCs	80%		70%	87.8%
# Functional Boreholes rehabilitated in schools (number of primary & secondary schools that had boreholes rehabilitated)	7	7	100%	
# functional Handwashing facilities out of those constructed in schools	53	53	100%	

Key

Target achieved	
Above 70%	

Overall there was high of (96%) women representation in WPCs. Trained female VPMs however reported that there has been an improvement and communities now trusted that women have capacity and they work very well with their male counterparts.

4.2.1.2 Water sources in target communities and their distance from the households

Figure 2a shows that 80% of the sampled households obtain their water from a safe source (70% borehole/ handpump, 8.5% protected wells and 1.5% piped/tap water). There is an improvement of approximately 12% as compared to the baseline period. The project did not drill new boreholes, but the scope of the work according to the project ADPlans and discussions held with CARE Zimbabwe, was focused on rehabilitating or repairing existing boreholes, particularly targeting perennial water points. As a result, approximately 36% had their walking distance reduced because of the water points that were rehabilitated/ repaired. For example, two villagers in Ward 26 reported that before their nearest borehole was rehabilitated with support from CARE, they used to travel more than 4.5 km to the nearest water point, a situation that used to force them to use water from unsafe sources, especially during the rainy season. One member of DWSSC during the interview, claimed that the average time taken fetching

water had been reduced from approximately 1.5 hours/ 2 hours to 45 minutes/ 1hour. However, 56% households walk more than 500m to the nearest water point and are unable to meet the targeted 30minutes water collection time set by Zimbabwe government⁷.

However, during discussions with some VPMs and all the FGDs with men and women, a plea was made that rehabilitation of boreholes was not enough to end the water challenge in the project area and recommended CARE or other development partners to assist them by drilling more new boreholes.

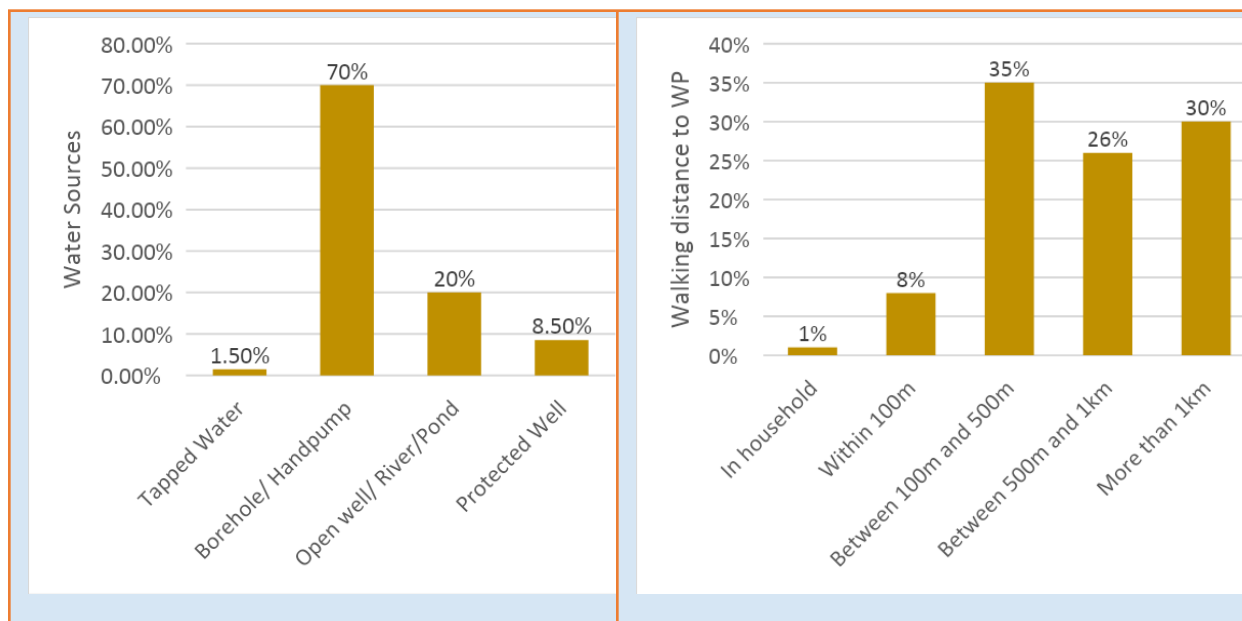


Figure 2: a) Map of the project area b) walking distance to water point

4.2.1.3 Gender responsibilities in accessing water and drinking water quality

Results from sampled households show that adult women fetch water more at household level (63%) than men and children. The roles of men and women in accessing water for the household had not changed much from the baseline period. According to Table 8, women constitutes 63 % and men 19% of people responsible for fetching water at household level. There was however a slight increase by 2% from baseline period of men who are responsible for fetching water. During FGDs with women in Ward 24 and Ward 27, they said it was the responsibility of everyone to access water for the household, but culturally it is women`s responsibility to ensure that there is water in the home. They however reported that more men and boys participate in fetching water when it is too far and, in some cases, require the use of ox drawn scotch carts. Men who participated in the FGDs confirmed that water for household use is mostly fetched by women. According to Table 7, 83% of households responded that there was no odour in their drinking water and 89% reported that they consume water with acceptable taste. Water

7

https://www.sanitationandwaterforall.org/sites/default/files/2020-12/2020%20Country%20Overview_Zimbabwe.pdf

with odour and unacceptable taste was mainly coming from open and unprotected water sources. It shows that a significant number of households shifted from unprotected and unsafe water sources when their boreholes were rehabilitated. The results are in line with water quality tests results that were carried out on rehabilitated boreholes by the Ministry of Health and Child Care.

Table 7: Responsibility and water fetching at household level

Who fetches water	Adult woman	Adult man	Female child (under 15)	Male child (under 15)	Drinking Water Quality	
					Baseline	End of Project
					No Taste	No Odour
Baseline	65%	19%	11%	5%	66.7%	66.7%
End of project	63%	21%	10%	6%	89%	83%

4.2.1.4 Water points management

Members of Water Point Committees who attended FGDs explained their roles in terms of monitoring functionality of water points, financial mobilisation and management, reporting if the borehole malfunctions, paying for spare parts, inspect the cleanliness of the water point area, work hand in hand with Village Health Workers (VHW) and implementing WP constitution. All consulted WPCs were functional and met at least once a month. They monitor and supervise duties assigned to members of the water point. Two of the consulted WPCs reported timely repair of WPs. WPCs indicated that they faced challenges such as inadequate finances and at times, unavailability of VPMs. They said some of the trained VPMs migrate because of economic challenges in the area, going to other places looking for jobs and other sources of livelihood.

To evaluate the effectiveness and performance of WPCs, one of the methods used was to ask the households about their existence and how they were satisfied by their operations. Figure 3 shows that the majority of households were aware of the existence of WPCs and worked with them. 81% were satisfied to extremely satisfied by the work that WPCs` work. Those with water points reported that they contributed at least \$1 for water point maintenance. There was no statistically significant correlation between level of satisfaction and gender ($p= 0.014$) and level of satisfaction and age ($p=0.027$). All the 10 VPMs who were interviewed confirmed that they were trained by DDF with support from CARE; 8 of them reported that they also received support in terms of tools to use in WP maintenance. However, 3 of the VPMs shared that sometimes WPCs fail to pay for their service.

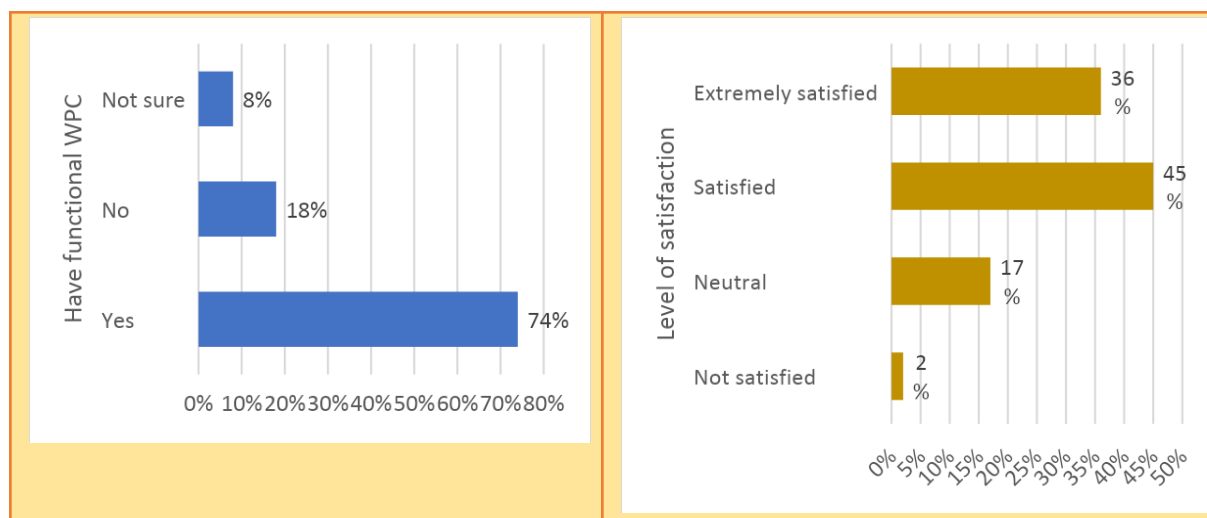


Figure 3: Availability of WPC and level of satisfaction

4.2.2 Demand led community based total sanitation and hygiene -Communities achieve and maintain ODF status

The shared goal of sanitation and hygiene promotion approaches was to assist communities to attain Open Defecation Free (ODF) status. The project was implemented in line with government adopted strategy that is The Sanitation Focused Participatory Health and Hygiene Education (SafPHHE) which is a homegrown Zimbabwean strategy for the elimination of Open Defecation in Communities. Therefore, instead of the usual donor/ NGO supply driven intervention, the project triggered the communities to demand for sanitation facilities. To achieve this, CARE implemented several interventions including helping to establish and train Sanitation Action Groups (SAGs), Village Health Workers (VHWs) and latrine builders. Gender was mainstreamed in all the trainings, to ensure shared responsibility and aims to speed up the attainment of ODF communities. Table 8 compares the planned outputs against what was achieved. The table also shows the support that was provided by the project in schools including:

- Construction of wheelchair friendly latrines
- Construction of girl friendly latrines.
- Construction of school handwashing facilities
- Training of school health clubs
- Training of school health coordinators

Table 8: Targeted and achieved sanitation and hygiene related outputs

TOTAL Number	Target number	Number achieved	% Achievement	Gender (% women)
Number of triggered villages	131	131	100%	
Number VHW Trained (Number men; women)	61	61	100%	89%
Latrine Builders trained (#men; women) and available	60	60	100%	40%

Villages attained ODF status	131	102	78%	
SAGs trained (#men; women) and functional	131	131	100%	
Number of primary and secondary schools reached with functional newly constructed sanitation facilities	55	55	100%	
Age-appropriate Girl and Disability friendly latrines constructed in Schools	55	55	100%	
multi-sprout hand washing facilities constructed in schools and functional	53	55	100%	
# School health coordinators trained	106	106	100%	
# Number of school health clubs formed, trained and functional	55	55	100%	

4.2.2.2 People who access and safely use sanitation facilities with support from CARE and partners pursuant to relevant standards

Figure 4 a) and b) show the percentage of households who had toilets during the two phases of assessment. Approximately 53% of households had toilets during baseline period and 86% reported to have toilets during the end of project evaluation phase. This shows that the demand led sanitation was effective in inspiring the target communities to build for themselves after being educated of the importance of having toilets and what it takes to construct one.

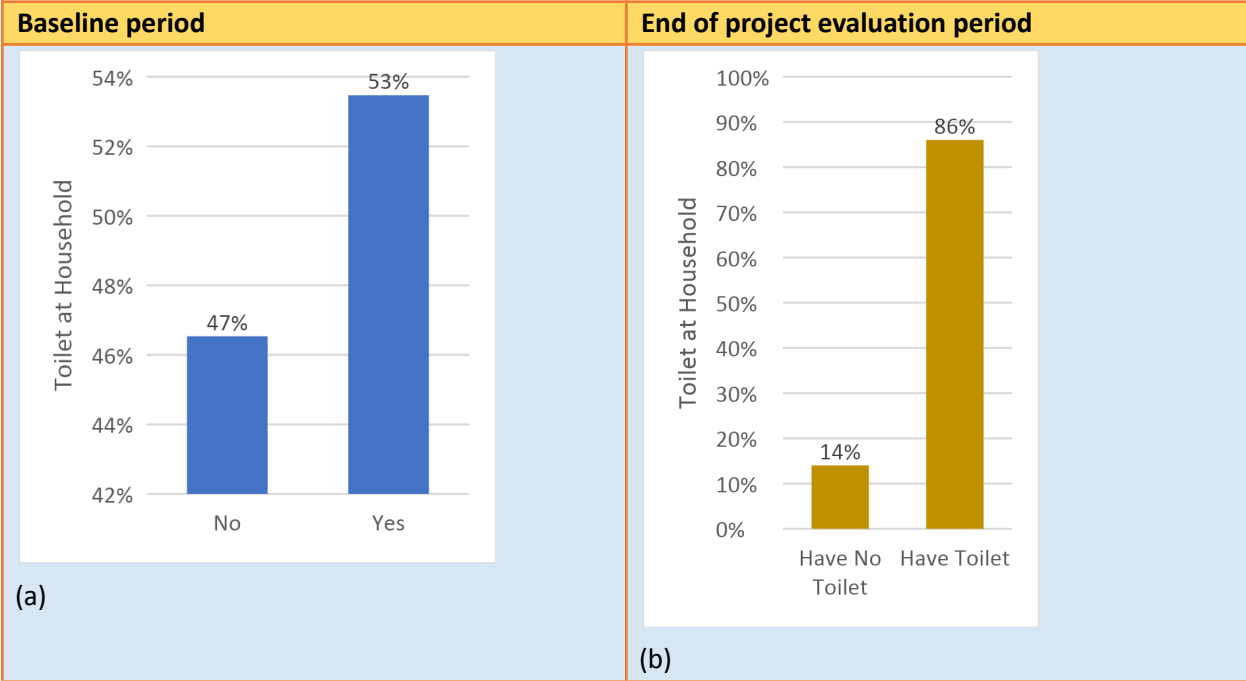


Figure 4: Toilet availability at household before and after the project intervention

During consultative interviews with DEHO, it was shared that some wards had achieved the ODF status because of the project and gave examples of Ward 7 and 31. DEHO explained that the majority of

villagers now know the importance of having toilets and confirmed that the demand led sanitation model was a sustainable model of capacitating villagers to take responsibility for their own sanitation at household level.

4.2.2.3 Defecation methods in the project area

Figure 5 a) and b) show that 89% of the participants defecate in toilets, 4% use cat method and 7% in the bush. There were a huge improvement and results attests that the majority of households had attained ODF status in the project area.

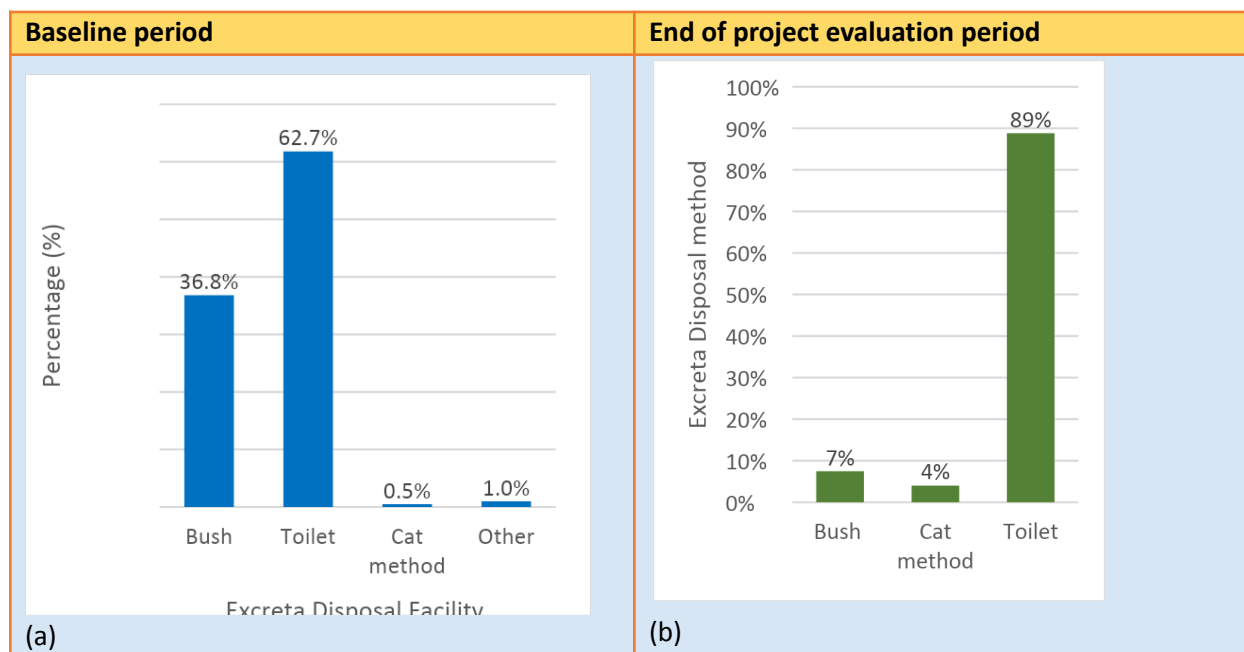


Figure 5: Excreta disposal method

SAGs and Villages health workers worked hand in hand and were encouraged to be innovative for villages to attain ODF status. To motivate local communities, celebrations were held for villages who attained ODF and CARE and the community jointly contributed towards the celebrations. During FGDs it was established that in some villages, VHWs and SAGs mobilised resources to build toilets for the more vulnerable, like the elderly and people living with disabilities. For example, in Tizirai village in Ward 23, they built 3 toilets for the poor. Several innovative ideas were developed using local materials for where households could not afford to buy all required materials. These initiatives among others resulted in increased ODF villages. Four consulted Village Health Workers in Ward 23 claimed that 15 villages attained ODF out of 38 Villages. However, it was confirmed by Ministry of Health and Child Care that overly 78% of the villages in the target areas attained ODF status.



Plate 2: Innovative latrine with connecting rope for people with visual impairment and elderly persons



Plate 3: a) An improvised vent pipe from locally available materials b) Latrine constructed from local material destroyed by extreme weather event

However, not all toilets constructed using local materials survived. During FGDs and interviews with village health workers, it was established that some villages attained ODF but climate related risks such as heavy storms with strong winds destroyed some of the toilet structures (see Plate 3b above for damage caused by 2021 heavy rains). It was established during FGDs that there were some households who did not use cement in the construction of super structure for the uBVIP. Such kinds of structures were not only weak and prone to collapse but also pose health risks caused by recurrent climate related extreme weather events like cyclones and heavy rains. Some were also affected by high temperatures. Some of the grass which was used for thatching were eaten by cattle making it difficult for upholding the ODF status. Some treated temporary toilet structures as permanent, and they eventually collapsed. During FGDs with both men and women, it was revealed that Chivi is experiencing recurrent droughts

and extreme weather events as a result of climate change and this has affected the source of livelihood for the majority of people. As a result, acquiring building materials such as cement was still a challenge for some poor households, especially the elderly and those living with disabilities.

4.2.2.4 School latrines and handwashing facilities

Plate 4 shows the number of girl friendly and wheelchair friendly facilities. School health coordinators explained that the project donated building materials (such as cement, mesh wire, taps and GI pipes) and paid builders for all the construction works. Observations made were that wheelchair friendly toilets were designed to accommodate free movement of a wheelchair and there are rails to support movement. All the visited girl friendly and wheelchair friendly toilets were clean. Discussions with school health coordinators revealed that the toilets were very useful for the target beneficiaries. One school reported that one of their former students living with a disability still used the school toilet because he lived close to the school. This was caused by a gap that was created of not having such toilets at household level. However, such practise exposed these children to risk of being abused especially after school hours. Hand washing facilities helped the schools even in fighting against COVID-19. However, in some schools, the handwashing facilities taps were abused and not working. Pupils were washing their hands using the provided 20l handwashing buckets provided in response to COVID-19 pandemic.





Plate 4: Girl and wheelchair friendly toilet and handwashing facility

4.2.2.5 School health Clubs

The project was effective in supporting all the 55 schools that it proposed to do. 53 school health clubs were formed, trained and currently functional. During discussions with sampled health clubs, they reported support that they gained from the project and activities carried out to date including: promoting peer learning on WASH; promoting outreach programmes on WASH; and developing reusable sanitary pads. In some schools, boys who were members of the club were taught how to sew face masks and sanitary pads for girls. Some clubs had a mix of teachers and learners, including those with disabilities.

Health clubs were trained on:

- COVID-19 mitigation
- Disinfection of toilets and classrooms
- Menstrual health and hygiene
- Child abuse
- General hygiene practices
- Waste management including separating organics from inorganics
- Drug abuse
- Child marriage

Vimbai, a Form 3 girl and member of school health club from Chongobwe Secondary school said, "I used to be absent from school during my periods because I had no proper sanitary pads. No one had properly taught me on menstrual health and hygiene. It was also difficult to know exactly my period days. This affected my confidence when it happened at school because some girls laughed at me. But I learned a lot through our school health club and the RUMP that we sew at school helped me and a lot of girls at school. I am now involved in teaching my friends and school mates"

During discussions with members of all school health clubs, it was discovered that menstrual health and hygiene was a topical issue that was never discussed at home and less in schools. A teacher from Shindi

Primary school mentioned that menstrual health and hygiene was never taught as a practical subject area because primary schools thought children were too young. He said that there is however an increased number of girls who go for periods while still at primary level and CARE's project helped them a lot. To increase the sense of responsibility, members of the school health club were taught how to sew reusable sanitary pads. This helped a lot of girls to have access to sanitary pads. However, sewing of sanitary pads was affected by COVID 19 when schools were closed. During end of project evaluation some schools were yet to resume sewing of sanitary pads program. Children were motivated by school competitions that were held on WASH related issues. In these school competitions, more awareness on sanitation and health were raised through citing of poems, dramas, music and dance by school children. Children demonstrated the knowledge gained from their school health clubs.



Plate 5: Reusable sanitary pads produced by the school

4.2.2.6 School attendance

Figure 6a shows that 14% of school going age children were not attending school in the target area. The number of children not going to school increased as compared to the baseline period (Figure 6b) that had 11%. In addition, among those children currently not going to school 64% are males. Before project implementation, the majority of children not going school were females (58%). The COVID-19 pandemic was cited as the major contributor of school dropouts. Even though the consultant could not get statistics of dropouts in Chivi districts, other sources indicated that more than 20,000 school children dropped out of school between 2020 and 2021 and the major causes were getting into early marriages and pregnancies⁸. During the baseline period, menstrual hygiene was mentioned as one of the causes of

⁸ <https://zimfact.org/zimbabwes-school-dropout-crisis-how-many-children-have-left-school-under-covid-19/>

reduced school attendance by girl children. However, there were no reports of children failing to attend school because of menstrual hygiene issues by the end of the project. This can be attributed to menstrual hygiene education and support with RUMP and girl friendly latrines constructed in schools. The impact of the support was also confirmed by school health coordinators.

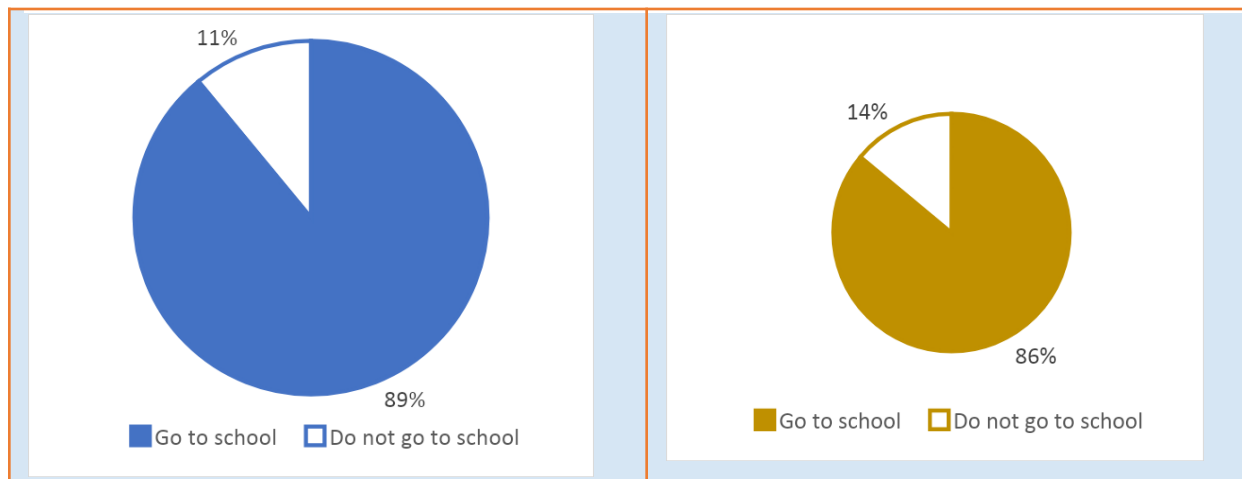


Figure 6: a) School attendance during baseline b) School attendance during end of the project evaluation

4.2.2.7 Handwashing practices

During the baseline, the majority of households washed their hands using only water, with 64% using water only to wash their hands. At the end of the project evaluation stage, 66% reported that they regularly use water, soap and ashes to wash their hands (Figure 7). This can be attributed to increased knowledge of the importance of handwashing. FGDs with SAGs also revealed the COVID-19 pandemic caused handwashing campaigns to be intensified, leading to more people regularly washing their hands. When entering some places like local shops, one had to sanitise their hands.

Baseline phase	End of project evaluation phase
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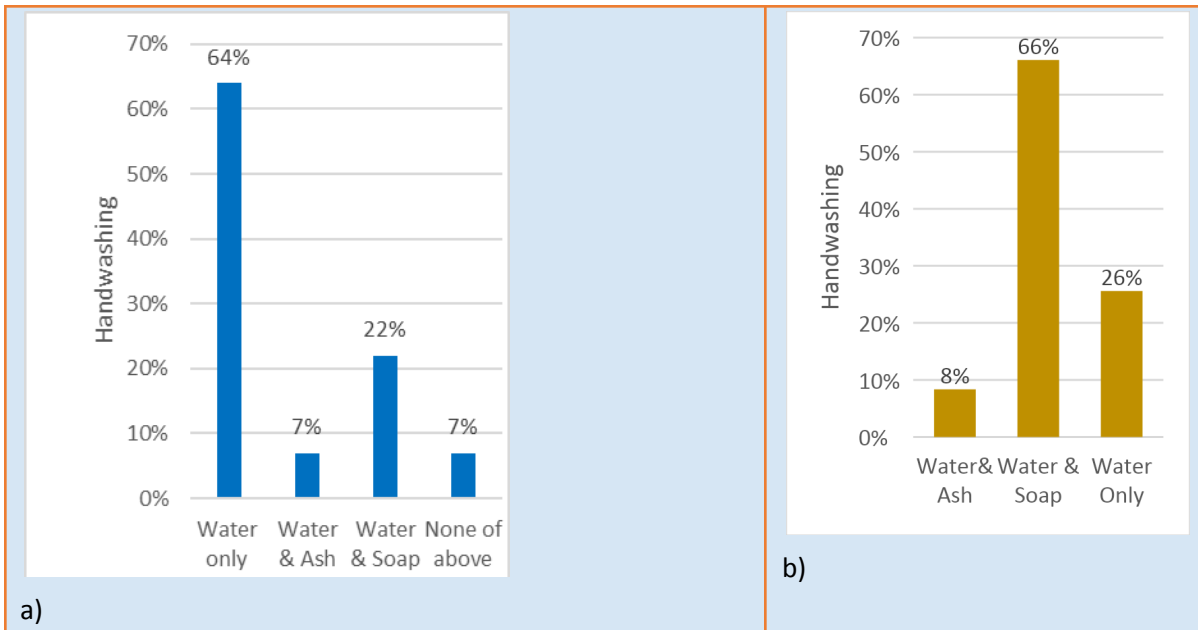


Figure 7: What is used for handwashing

Not many people knew how to correctly wash their hands and the situation was worse before the project was implemented. Only 6% demonstrated correct handwashing methods before project implementation. According to figure 8a and b, 81% households demonstrated correct hand process. Only 6% of households were able to demonstrate correct handwashing during baseline period. This shows that project made great positive impact on health and hygiene practices at household level.

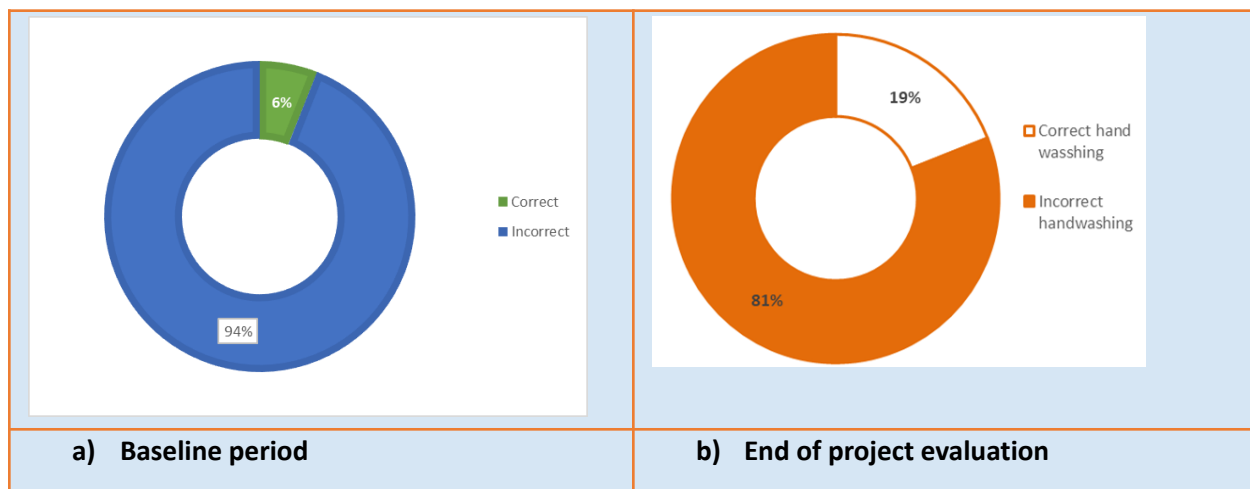


Figure 8: Handwashing demonstration

Regression analysis was carried out to assess if there was a relationship between hand washing practice and distance to water point and education level. The results show that there is a positive relationship between hand washing practices and walking distance to the water point ($p=0.025 < p=0.05$) and handwashing practices and education ($p=0.015$), both less than ($p=0.05$). It can be concluded that hand washing practices was significantly influenced by availability of water, value of water and the knowledge of the importance of handwashing. Youths during FDG in Ward 22 mentioned that the value of water was mainly influenced by the distance had to travel to the nearest water points. Therefore, the knowledge gained through the project helped improve the level of handwashing in the project area.

4.2.2.8 Health and hygiene

Members of the households were asked if any member had suffered from diarrhoea any time within a week before the survey. Only 7% of the respondents had household members who had suffered from diarrhoea within a week before the assessment. According to Figure 9, cases of diarrhoea were high (23%) during baseline period, but reduced to (7%) by end of project. Diarrhoea is usually caused by consuming contaminated food and water especially with faecal matter, poor sanitation and hygiene practices. Therefore, reduction of diarrhoea cases indicates improved health and hygiene practices at the household.

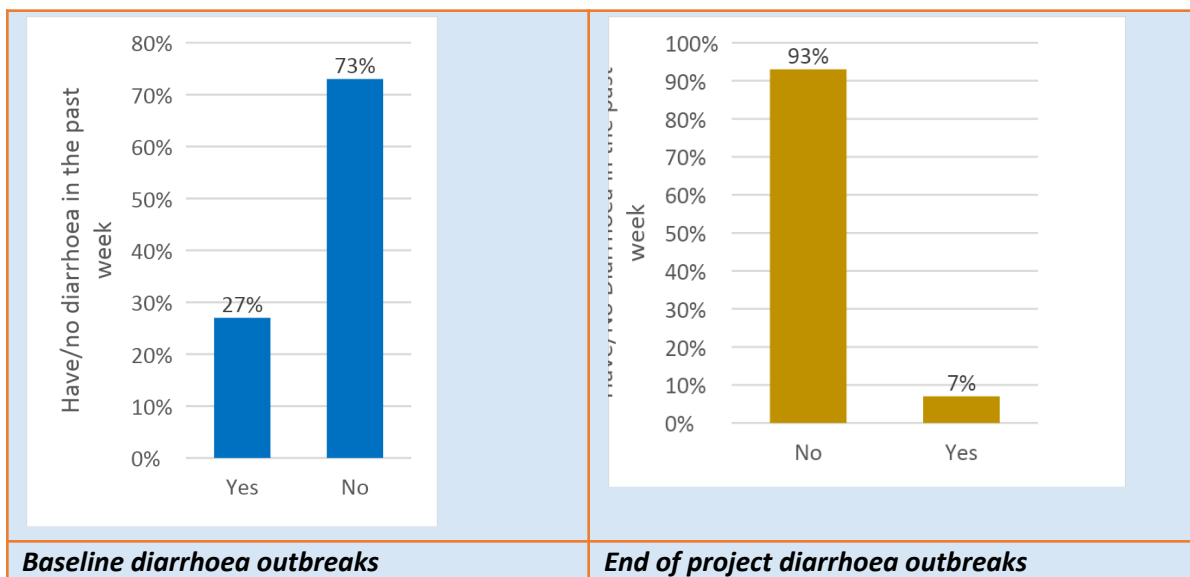


Figure 9: Effects of project intervention on disease outbreaks

4.2.2.9 Household waste management

Waste management is another indicator of sanitation and hygiene behaviour at household level. Table 8 shows that 79% of households have a pot rack, 93% had rubbish bin or rubbish pits and 83% reported that they separate organic from inorganic waste. During the baseline survey, 60.8% had pot racks and only 4% reported solid waste separation. Results in Table 9 show that the majority of the households significantly improved waste management and hygienic handling of kitchen utensils.

Table 9: Household waste management

Responds	Pot rack	Bin/Rubbish Pits	Separate Waste
No	21%	7%	40%
Yes	79%	93%	80%

A regression analysis was carried out to find out if household waste management was dependent on the age of household head. Results of the analysis ($p = 0.15 > p = 0.05$) show that there was no relationship between households with pot rake and age.

4.2.3 Women and girls have equal decision-making roles and responsibilities to men and boys in communities and schools to sustain WASH improved hygienic practices

During the project evaluation, it was established that the project was designed in such a way that it put women and girls at the centre stage of the interventions. Women and girls were capacitated in all the components of the project. By the time of the project evaluation, it was reported that there were more than 50% women and in some cases 80% in leadership of among the following committees and groups:

- Village Health workers
- Village Pumps Mechanics
- Community Health Clubs
- School Health Clubs
- Sanitation Action Group

Not only did the project supported women to be in leadership structures, but also encouraged them to occupy influential positions such as Chairpersons and Vice Chairpersons of committees. Household questionnaires asked respondents to indicate if their local water points were chaired by women or not. The same question was asked to determine the gender for the position of secretary. Figure 10 shows that 68% of WPCs were chaired by a woman. This makes sense because women carry the greatest responsibility of fetching water for the household.

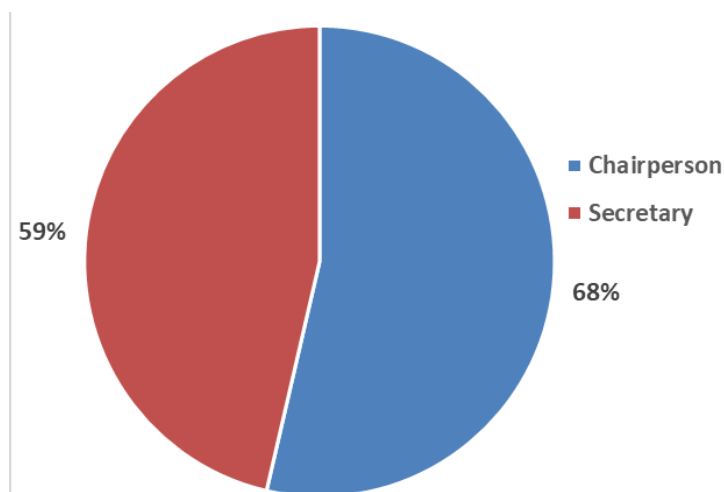


Figure 10: Position occupied by women in water point committee

4.3 Efficiency of the project

Assessing efficiency entailed examining the cost effectiveness of strategies that were used in executing activities under the project in comparison with alternative strategies. In this regard, it was generally concluded that implementation was efficient. The results of this exercise are outlined below:

4.3.1 Collaboration

The project was implemented in partnership with other key stakeholders and this enhanced sharing of some responsibilities and reduced some costs. Key to the project implementation were the government departments and institutions who are members of DWSSC. Consultations and partnering also helped in reducing several protocol barriers. For example, whenever CARE visited schools, they were either accompanied by an officer from the Ministry of Primary and Secondary Education. Therefore, CARE was able to collaborate with key government departments and local stakeholders and this contributed to successful implementation of the project. Without working with government departments in the district it was going to be difficult to progress. For example, there are procedures that were followed with Ministry of Primary and Secondary Education for schools to participate in the project.

Knowledge of the water situation in the district including the state of boreholes and extent of the intervention needed, was guided by District Development Fund (DDF). DDF trained VPMs with support from CARE. DDF is the government arm responsible for water infrastructure in rural areas and they had experience of working in the project area. Consultation helped the team not to make costly decisions.

Local leadership and communities played a critical role in the execution of the project. These included Ward Councillors, Village Heads, Health Workers and School teachers as health coordinators. There was no way that CARE was going to meet villagers without engaging and working with these leadership structures.

Moreover, while contractors could have been engaged to rehabilitate or construct head works and toilets, the project opted to utilize locally trained people, an apparent cost cutting measure that also ensured skills and resource retention in the community. The approach is also considered sustainable as the locally empowered artisans will be readily available for support even after the project comes to an end. District experts such as DDF, District School Inspectors and Environmental Health Officers were readily available as backstopping. They passed through two critical phases, including national elections and the COVID-19 pandemic. Without collaboration with other stakeholders it would have been difficult for CARE Zimbabwe to complete implementation.

During the end of project evaluation, senior government officials in the district such as the Office of District Development Coordinator, reported they were working well with CARE and provided needed support such as authorization to engage with communities.

It should be noted that at local level, even though the project worked well with local partners, NGO expectations were always high, especially from beneficiaries, and at times difficult to articulate the scope of the project. For example, even though the project was going to offer water supply support by only rehabilitating or repairing boreholes, the community also expected drilling of new boreholes.

4.3.2 Resource utilization

The project operated under a tight budget as the price of goods and services kept on changing, for example, it was reported that the project failed to rehabilitate all the targeted boreholes because the price of materials increased. In addition, some materials such as cement for toilets at one time were scarce. CARE Zimbabwe was also innovative in engaging N. Richards, a very big wholesaler to get cement at a fair price and CARE also got preferential treatment whenever a consignment was delivered. Such interventions enhanced continuity of the project.

4.3.3 Capacitating relevant people close to area of need

Capacitating key resource persons, who are local community members (VPMs, VHW, School Health Coordinators, SAGs, WPCs and SCH), was an effective but also efficient strategy, as the approach was cheap and easily accepted, because these people were already integrated in the community, for example, school children as members of the school health club could easily communicate with their peers. In addition, during project implementation, trained persons needed not travel long distances as they were already in the community.

4.3.4. Adoption of demand led sanitation approach

By adopting demand led sanitation, the project aligned itself to the vision and development trajectory of the country and guaranteed project support from government. In addition, even though not easy, the strategy capacitated the local community not to rely on donations. The villages which attained ODF status bear testimony to the success of this approach.

4.3.5 Trainings

Most trainings were held within the communities and this was cheap and cost effective. If they were all going to be conducted outside the district it was going to be costly to the project. In addition, trainings had lots of practical components, for example, during VPM training, participants had 3 days of theory training and 11 days of practical content training, including actual rehabilitation or repairing of boreholes. However, consultations with some School Health Coordinators revealed that in some schools they lacked support from their school heads. School heads should be encouraged to fully support the enhanced sustainability of WASH.

4.3.6 Reporting and monitoring

Annual reviews, interim reports and annual plans, helped the project to remain on track. As earlier communicated, Zimbabwe went through periods of unstable economic environment, which saw project costs rising; hence monitoring and review helped to strategise in consultation with key partners to achieve project goals.

4.3.7 Time management and working relations with stakeholders

Consulted stakeholders were asked if CARE was able to provide what they promised on time including times for meetings, supply of materials and demand led sanitation awareness and training sessions. 97% of interview participants reported that CARE was punctual on the support they were providing and the Table 10 provide some examples.

Table 10: Time management

Stakeholders	Comments
District Development Coordinator	We have good working relationship with CARE. They always tell us they program on time and they consult us before they do anything in the district. If CARE have visitors, they bring them for induction and do the clearance on time. We are also happy that they support us in some of our district programs like providing transport especially on programs that integrates with their activities. We are also happy with the amount of work they have done and they complimented and helped the government a lot.
School Health Coordinators	School health coordinators reported that CARE supported them with materials for girl friendly and wheel chair friendly toilets on time, for example, Chongobwe High School Deputy Head said, “We were provided with materials such cement, wires, paying builders, screen doors, mirror, locksets, wheelchair supporting bars and material for handwashing tank well on time. They even came for payment for builders on time”. In our cases we were delayed by our own builders who were contracted by schools. The school health coordinator from Nyahombe primary school mentioned that support that CARE provided was well on time and said, “ <i>We are so happy with the working relationship we had with CARE because now we have 2 girl friendly squat holes, 1 squat hole for disabled, 1 handwashing point, 2 litter holes 1 big for inorganic waste and 1 small for organic waste. Our only challenge is that our school have a very big enrolment (1736 children) in need of more girl friendly toilets and other general toilets as well.</i> ”
VHW, WPCs and SAGS	They reported that the CARE team was organised in the way they mobilised for meetings. They said they communicated well in advance allowing village leaders enough time to mobilise. They were also punctual in attending meetings. Two members of SAG in WARD 23 “ <i>There are programs that happens in our wards where people will wait for hours for the visitors, but CARE was always punctual and if they had any challenges they would communicate well in advance</i> ”
Members of DWSSC	They reported that according to their views the project was funded adequately and efficiently implemented. The District Schools inspector from the Ministry of Primary and Secondary Education mentioned that support

that CARE provided was as planned, timeously and handy even though COVID 19 pandemic derailed the momentum when schools were forced to close. The Ministry of Youths, Sports, Arts and Recreation mentioned that by identifying and training youths as VPMs and Latrine builders, the project capacitated the school leavers who had nothing to do with technical vocational skills. He said youths usually turn into bad habits like drug abuse because of having nothing to do (no jobs, no career or no businesses).

The other 3%, were village health workers and SAGs from villages that attained ODF and were waiting for CARE to support with promised steer (beef) for the celebrations. The other group of stakeholders who raised concern were the 6 latrine builders in Ward 26 who said they were so appreciative of the technical skills they gained from training by CARE.

4.4 Project relevance

Relevance was assessed in terms of how the project design and implementation addressed perceived and evidenced community vulnerabilities and government priorities, to what extent were communities satisfied with project implementation and their results. The consultant also looked at how fair and appropriate was the execution of the project, considering vulnerable groups, including women and people with disabilities.

The project was relevant to the priorities of the government of Zimbabwe. According to Sanitation and Water for All (SWA)⁹, government of Zimbabwe committed to;

- Reduce open defecation from 21.7 to 10% by 2025, by rolling-out a National Sanitation Strategy underpinning scaled-up demand led sanitation in all the 60 rural local authorities
- Achieve 80% access to potable water by 2025

Therefore, ANCP WASH project was contributing towards national WASH targets. According Section 73a and Section 77a of Constitution of Zimbabwe every person has a right to an environment that is not harmful to their health and wellbeing and right to safe, clean and portable water respectively. Project intervention was relevant in that it promoted target communities in Chivi District to realize these rights.

The project was relevant to CARE International's focus and principles. CARE International's focus says, 'We put women and girls in the center of our work because we know that we cannot overcome poverty until all people have equal rights and opportunities'. Some of the organisation's principles are; to promote empowerment, to work with partners, to do no harm and avoid discrimination and seek sustainable results.

The project was very relevant to the needs of the target communities, focusing on areas of vulnerability as reported in the baseline report. The project is relevant to the current national development agenda. According to National Development Strategy 1 under the infrastructure and utility pillar, the country has

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https://www.sanitationandwaterforall.org/sites/default/files/2020-12/2020%20Country%20Overview_Zimbabwe.pdf

a target of increasing access to portable water from 77.3% to at least 78.3% and expand access to improved sanitation facilities from 70.22% to 77.32% in both urban and rural areas, with particular attention to reducing open defecation in rural areas by 2025¹⁰.

The project was also relevant to national policies such as the National Sanitation and Hygiene Strategy. The strategy promotes equity and inclusion. The strategy promotes demand driven and community-based sanitation. This strategy was an anchor to the demand-led sanitation that CARE implemented in Chivi District.

At international level, the project contributed towards Sustainable Development Goal 6 which targets access to water and sanitation for all by 2030. UN General Assembly Resolution 64/292 of 2010 formally recognized access to clean water and sanitation as a human right. The project was relevant to CARE International’s vision and focus of overcoming poverty while putting women and girls at the centre. The demand led sanitation was designed in such a way that it deliberately empowered more women and girl children. Results in Table 9 demonstrates that more than 70% of project beneficiaries were women and more than 80% of trained leaders in SAGs were women. Women were also trained in areas predominantly occupied by men, like latrine builders and Village Pump Mechanics.

4.2.4 Satisfied by project implementation

The project is also considered effective as it managed to satisfy its target beneficiaries. Figure 11 shows that more than 80% of the households were satisfied by the implementation and results of the WASH project. This was evidenced by high response to demand led sanitation.

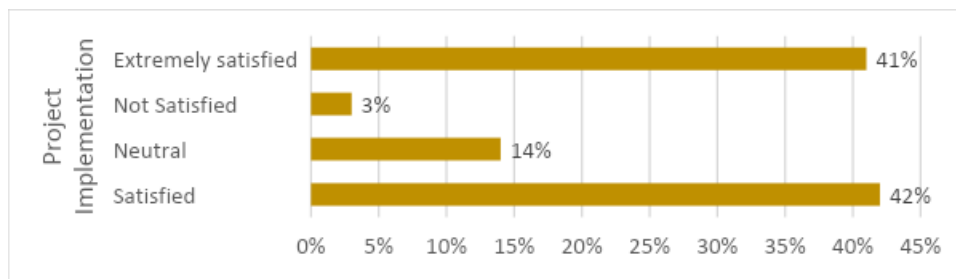


Figure 11: Household satisfaction

Women were previously shy of male dominated fields and society also did not give them a chance; hence they were vulnerable but the project capacitated both men and women and during stakeholder consultation it was revealed that it’s much better to train women VPMs and Latrine Builders as women stay longer in communities than men. It can be argued that one of the reasons why there was a positive response from women, is that the project created a conducive environment for them to be trained as artisans. Trainings were held within their locality reducing the burden of travelling and enabled them to have time to attend to other household chores after trainings. In addition, trainings for each day finished early to reduce burden on other responsibilities. FGDs and interviews with members of SAGs and VHW in Ward 29, Ward 23 and Ward 26 revealed that participants were able to follow and relate with the project because trainings were practical and held in familiar environment (in their local villages).

¹⁰ National Development Strategy 1; 2021

The strategy used in project implementation was relevant in that it aligned with government priorities and policies as its implementation was done within District Water Supply and Sanitation Sub-Committee (DWSSC) framework on rural water supply). The project used the government adopted strategy.



The Sanitation Focused Participatory Health and Hygiene Education (SafPHHE) which is a homegrown Zimbabwean strategy for the elimination of Open Defecation in Communities. The Consultant assessed the benefits of the approach and noted that implementation in collaboration with DWSSC composed of mainly government ministries, ensured compliance of the project with Government of Zimbabwe standards and guidelines. It was also reported that local WASH government structures were involved in the training of Village Pump Mechanics (VPMs) and Water Point Committees (WPCs) thereby ensuring backup support and continuity

Plate 6: Toilet that was constructed by female Latrine Builder in Ward 23

The project was also fair and appropriate in that it considered and deliberately gave attention to most vulnerable people such as people living with disabilities and girls. This was evidenced by the provision of disability and girl friendly toilets that were constructed in all the targeted schools, handwashing facilities in schools and support towards school health clubs.

Needs assessment was carried on schools before interventions were made. This helped in focusing the project and resources towards key challenges that the schools were experiencing.

The choice of Chivi district was relevant as it was one of the most vulnerable districts with many villages that were yet to attain Open Defecation Free (ODF) status. The project was also relevant to the target area needs as it is reported that designing and programming was informed by the baseline study that was carried out before the project started.

The project became even more relevant from year 2020 up to date as a result of the COVID-19 outbreak. During FGDs, some members of the communities reported that the project highly prepared them for the pandemic. By the time the COVID-19 pandemic landed, most villagers were already capacitated through demand led sanitation on good hygiene and sanitation at

"COVID 19 yakatiwana tatove neruzivo rweutsana, hazvinakutinetse nekuti takanga tatojaira kuti tinofanira kugeza maoko nguva dzose kunyanya wabva kushandisa chimbuzi kana usati wadya", Translated as, "COVID 19 found us already equipped with knowledge of health and hygiene. It was not difficult for us to adjust to preventative measures, for example we were already used washing hands after using toilets and before eating."

household level, including installation of handwashing facilities.

4.5 Impact of the project

There are two main ways that the project made an impact was in terms of change in lives of the local communities and capacity development and strengthening of local structures and related partner organizations.

Changes in the lives of local communities *Increased knowledge of WASH*. Households were asked if they felt that the project increased their knowledge and capacitated them to deal with WASH related challenges. According to Figure 12, more than 80% of both men and women felt they have increased knowledge of sanitation and good hygiene as a result of the project. Some reported that the project also helped them to deal with the COVID-19 pandemic.

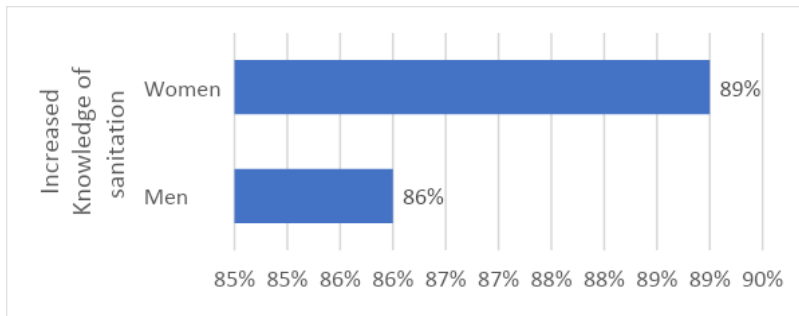


Figure 12: Increased knowledge of sanitation and hygiene

Families at household level changed the way they washed their hands after the project intervention. According to Figure 13, during baseline, many people mainly practiced handwashing before main meals like breakfast lunch and supper. Results at the end of project showed a change in behaviour and practices, with 78% now washing their hands before cooking, and over 58% after wiping off stool (poop) from children and before feeding children respectively. In addition, 81% of consulted household members were able to demonstrate correct handwashing.

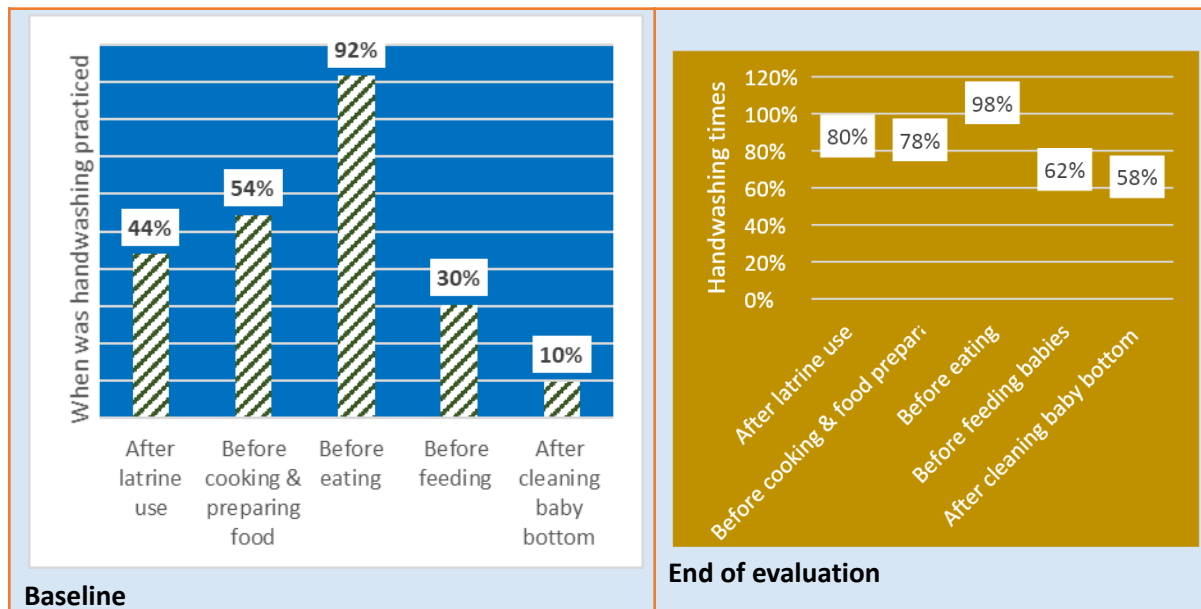


Figure 13: Practiced handwashing times

Increased knowledge and practice of sanitation as a result of CARE

- The project enhanced organizational ability for it became easier for schools to tackle WASH related challenges through the provision and use of hand washing facilities and toilets. In addition, the strengthening/formation of school health clubs increased hygiene knowledge in schools.
- Boosted local community confidence and collaborations, for example, SAGs and VHWs were able to mobilize resources at local level to construct toilets for the most vulnerable people in their villages. One village health worker in Ward 23 and another in Ward 22, said that the project made them realise that as communities we need each other more than what we thought. They said the project made them realise that having neighbours practicing open defecation exposed them as well to the risks of eating and drinking contaminated food and water respectively. The risk of contamination was caused by flies that could carry exposed faeces from open defecation to any unprotected food or water in the nearby households. Risk is also high because in rural set up some domestic pets and fowls are raised as free range and end up eating faeces from open defecation and or spreads them to objects and surfaces. As a result, in some villages they put their minds together, mobilise resources and assisted each household to have toilets; community relations improved as a result.
- Men FGDs in Ward 27 said the project made them realize that sanitation issues are not only for women, but for both men and women.
- The project made a huge impact to women and children as it capacitated them to take a leading role in dealing with WASH issues. One female latrine builder was so excited that she managed to build her own toilet and went on to build for others. This gave them a sense of self fulfilment. Female students were no longer absconding school because of menstrual hygiene related challenges and the use of girl friendly toilets and provision of reusable sanitary pads was making them feel important and confident.
- A Health Club Student at Nyahombe Primary School said the project influenced behaviour at their school in terms of sanitation, health and waste management. This was confirmed by the student narrating all the steps one should follow when they go to the toilet, including proper use of the girl and wheelchair friendly toilets (taking good care of components such as grab bars, mirrors, shelf/hook for hygienically storing belongings during usage and chambers).
- The project also assisted children living with disabilities who now have access to more accessible toilets.
- The project reduced burden of travelling long distances to the nearest water point for villages who had their boreholes rehabilitated.
- The model of project implementation created a platform for sustainable community social support systems.
- However, an area of need that was raised by stakeholders including villagers and schools was the distance to the water points. Schools shared water points with communities and they said this caused congestion at the water points. For example, at Nyahombe school there was only one borehole serving more than 1700 children and a large community.

4.6 Sustainability of the project

In assessing sustainability, Consultant looked at how the systems and benefits established by the project were going to continue after decommissioning of the project. It was also assessed based on how likely the outcomes were going to continue and be sustainable; ways by which the project was going to leave a legacy for its beneficiaries and the communities.

- The demand led sanitation strategy allowed the local community to take a leading role through using their own resources in addressing WASH challenges; hence it created a platform for project sustainability.
- Collaboration of local structures such as Village Heads, SAGs, VHW and latrine builders indicated potential for sustainability of ODF in some village.
- Capacity to rehabilitate/repair boreholes and building toilets- VPMs and latrine builders were provided with tools to use in the event of their needs. The strategy was sustainable in that these trained artisans were capacitated to provide service in their communities even after the project ends.
- *Capacity to pay for Pump maintenance*
Households were asked if they contributed money towards water point maintenance (WPM). Approximately 51% reported that they contributed. Those who contributed reported that they contributed US\$1 or R10. By being able to contribute money for WPM, it means water points with contributing households can be repaired. However, in one interview with VPM in Ward 26, it was reported that communities can only raise money for repairs but as expected cannot afford major repairs or rehabilitation. There the project achieved its objective in this area of community capacity to repair water points. Government through Community Based Management was supposed to rehabilitate and drill new boreholes.
- Capacitating School health coordinators was a good strategy that will ensure that even though members of the school health club may change as club members finish school, there will be training of new members. According to comments from the school health coordinators (SHCs), the project was an eye opener, especially on the need to support the female students and children living with disabilities. The Health Coordinator from Chongobwe Secondary school said the project is sustainable because it triggered/ motivated schools through their School Development Committees to do more for girl child and children living with disabilities.

She said, "After being impressed by CARE, the school through SDA was motivated and went on to tile the floors of the girl friendly toilets and painted the toilet"

 School
- During consultations in all participating schools, they appreciated the support of training school children to make RUMPs. They said this was going to impact even homes where these children were coming from, as some of them were going to use their acquired skills at home. However, a concern was raised threatening the sustainability of RUMPs initiative. Schools reported that material for making RUMPs was not locally available and schools were likely to face challenges if CARE moved out.

- The project is likely to be sustainable because all structures including government officers will remain in the area after project decommissioning.
- The project gained full support of traditional leaders and in some areas the village head and headmen made it a requirement that every household must have a toilet. This will help upscale the project and hence it will become sustainable. Enforcement of village WASH constitutions will go a long way in enhancing sustainability.
- Some women during FGDs said capacitating a woman was capacitating a village. Women are less mobile than men hence there were high chances that trained VPMs, VHWs and Latrine Builders will be in their respective communities for a longer time, offering their service to WASH infrastructural challenges.
- The project was in line with relevant government Ministry programs such as Ministry of Primary and Secondary Education, Ministry of Health and Child Care, Ministry of Gender and Ministry of Youth and as they will be implementing their programs in the district, they will contribute to sustainability of the intervention
- However, consulted members of the DWSSC pointed out that for the project to be sustainable, handover/takeover should be done properly to ensure that project activities can be taken over and sustained by other institutions who are also championing the same cause.
- Concern was also raised by VHW and one of the WPCs that frequency of visits to provide support which were being made by various government experts, such as health experts, will be reduced when the project close because of resource constraints and this may affect project sustainability.

4.7 Other cross cutting issues

4.7.1 Environmental Factors

The changing climate was a threat to WASH intervention in Chivi District in two ways. Firstly, recurrent droughts leave communities with very low disposable income. However, with harsh socio-economic related challenge the target communities were facing, communities are financing construction of latrine using demand led sanitation strategy. Secondly, extreme weather events like heavy rainfall storms and strong winds were a threat to WASH infrastructure especially poorly constructed latrines and uBVIPs. In qualitative interviews and FGDs these were some of the concerns raised by stakeholders. The lack of access to latrines because of these environmental factors caused some villages that had attained ODF to return back to the use of bush toilets.

Chivi is generally a dry region, hence recurrent droughts are a threat to water supply. During stakeholder consultations, recommendations were made exploring the opportunity of developing pipelines from Tugwi-Mukosi, the largest inland dam in Zimbabwe which happens to be located locally

4.7.2 Financial Factors

In as much as the project had made huge impact by triggering demand for sanitation, there were households that were seriously incapacitated and had limited access to no financial resources. This was a perennial challenge to the attainment of ODF. During discussions with SAGs, it was found out that some

households were keeping uBVIP structures as if they were permanent structures. This was caused by capacity challenges. Some dug pits for latrine construction but failed to construct the toilets. However, not all have capacity challenges, but some failed to upgrade because of negligence. During discussions, for example in Ward 23, the VHW reported that there was a village where households were not cooperating.

4.7.3 Disability

People with disabilities including children were mainstreamed in the programming of this project. They were considered in the designing and construction of wheel chair toilets in community and schools . At community level they were given first priority in terms of support. This led to some villages through SAGs constructing toilets for them to suit their needs. A good example has been given in the report where a rope was developed connecting the house and the toilet to help a man with visual impairment to conveniently visit the toilet whenever he needed. During focus group discussions with SAG members, they were of the view that toilets for people living with disabilities should not only be constructed at households with such persons. They however all reported that constructing a standard wheelchair friendly toilet with all components is a challenge because of capacity limitations.

4.7.4 Safeguarding

It can be reported that the project complied with DFAT Child Protection and Prevention of Sexual Harassment Exploitation and Abuse policies. Discussions with CARE Zimbabwe revealed that all CARE employees are compelled to go through the PSHEA course on CARE Academy. CARE staff in turn mainstreamed sexual harassment and child protection issues in all district and ward-based trainings. During stakeholder consultation questions were asked if there were ever any incidence of child abuse or sexual exploitation during project implementation and the response was there was never any.

4.7.5 Summary of the challenges and gaps that still needs intervention in the project area

A summary of the gaps and challenges that were raised by stakeholders during FGDs and key informant interviews.

a) Water Supply

- In some areas water points are far and water levels are too low in some areas, such that when boreholes are drilled, they won't be able to provide water throughout the year.
- More boreholes need to be drilled in other wards, such as ward 29,27 and 21 to reduce walking distance to the water point. Households should not spend more than 30minutes fetching water
- Leather cups were not readily available locally and this may increase the time at which the water point is under breakdown.
- 20% of community members still use unsafe water sources.
- Villagers proposing exploring the feasibility of Togwe Mukosi dam as an alternative water source for the district

b) Demand led sanitation

- Collapsing uBVIP toilets is a cause of concern for communities as it does not only cause a challenge in terms of toilet access, but it's a potential hazard if it collapses with persons inside.

VHWs reported that some villages attained ODF status when uBVIP toilets were constructed, but lost the status when some of the toilets collapsed, for example 3 months later because of heavy rains.

- Climate change causing floods, cyclones and harsh winds, cited as a trend and cause of concern.
- The households headed by the older persons and children, had challenges in acquiring the resources for constructing their toilets.
- Resistant to change by some members of the community. Village heads misunderstanding VHW and refusing to support them and some villages refusing to adopt uBVIP were cited as some of the challenges.

c) *WASH in schools*

- Material for sewing reusable sanitary pads is not locally available. It is reported to be available from selected shops in Harare.
- Water access was a challenge in 7 of the 8 consulted schools. This was either in terms of the distance to the water point, poor boreholes yield especially in dry seasons and increased demand from both schools and communities.

4.8 Conclusion

It can be concluded that the project made significant progress in contributing and improving towards sustainable access to water, sanitation and hygiene in Chivi District. The project helped the target communities to improve their living conditions. The project was implemented in three parts; software, hardware and capacity building. Because of the harsh socio-economic environment, especially between 2017-2018 when the country was in a transition of money currency and experiencing high inflation, increased costs of goods and services and results in some planned outcomes being revised, for example, expected number of boreholes to be rehabilitated was revised down from a total of 120 to 100. However, despite the socio-economic constraints and the logistical challenges that were caused by the COVID 19 pandemic, the project achieved its ultimate goal, that is, ***'Increased equitable and sustainable access to and use of safe water supply, improved sanitation and hygiene practices among the rural population of Chivi District.'***

The project managed to achieve its mandate of rehabilitating/repairing existing boreholes, girl friendly and wheelchair friendly toilets. In addition, the project managed to capacitate through training all the key local services providers (VPMs, VHWs, Latrine Builders, School Health Coordinators, WPCs and SAGs). In addition, some were equipped with relevant tools such as latrine builders and VPMs. The project achieved intended percentage representation of women in decision-making structures such as VHW, and SAGs, but failed to achieve the same on trained VPMs and Latrine Builders and WPCs. It was however the consultant's opinion that the targeted percentage representation of women (80% in WPCs and 70% in VPM) was too high. This is against the background that the project also wanted to increase the participation of men and boys in WASH activities. For example, efforts that were made through Reflective Gender dialogues. Therefore, according to the consultant's assessment, the project's achievement of 50% women VPMs and 70% women in WPCs was realistic.

It can be concluded that the project made a huge impact through demand led sanitation helping the 10 Wards of Chivi district to reach 78% ODF status. This project was leaving the district on track towards attainment of complete ODF status. Intervention through uBVIP was the most practical approach, given that communities were not provided with materials. However, a gap that will need to be strengthened was to ensure that after construction of super structures with local materials, communities were capacitated to upgrade them to standard permanent structures. Feedback from communities also show that the demand led sanitation helped members of communities to improve their social relations as in some villages. Households were able to work together with VHW and SAGs to construct toilets for vulnerable members of the community.

The project strengthened inter-institutional relationships through DWSSC. According to discussion held with the CARE field team (and validated by different stakeholders) CARE was able to facilitate trainings on time and participants were selected in consultation with relevant stakeholders such as local leaders. Each respective government ministry was involved in its area of jurisdiction.

The project was able to bring spares for borehole rehabilitation, material for toilet construction in schools, supported schools with materials for sewing RUMPs and materials for handwashing facilities; and construction on time. WASH in schools was hugely successful through the construction of girl and wheelchair friendly toilets as well as health and hygiene education. Schools with active Headteachers

and School Health Coordinators developed motivated school health club members and went on to win schools competitions; for example, Nyahombe primary school. The project capacitated school health clubs to be able to make RUMPs, and with skills that can be transferred into the community. However, a gap that needed to be filled is availability of proper materials which was a challenge in Chivi District. Support in terms of water supply intervention was still needed both in schools and communities.

5.0 RECOMMENDATIONS

Based on the findings and discussions with stakeholders, the following recommendations were made:

- Future programmes should consider drilling of new borehole to reduce walking distance to the water point. Government through the DDF should drill more boreholes in Chivi district. Non-governmental organisations licenced to operate in the district like CARE are also encouraged to mobilise resources to support drilling of new boreholes.
- District leadership through DWSSC consider and explore alternative water sources, for example feasibility study for abstracting water from Tugwi Mukosi or other technologies like solar pumps for institutions like schools, river sand dam abstraction systems and water harvesting as it is difficult to get productive boreholes in some parts of Chivi.
- In future CARE, DWSSC and other development partners should promote Climate proof WASH response programming. That WASH programs should be designed and implemented grounded in comprehensive understanding of climate risks. This will help ensure that WASH infrastructure and services are sustainable and resilient to climate related risks, for example WASH infrastructure that can withstand floods
- DWSSC through Ministry of Health and Child Care should develop strategies of capacitating local communities to upgrade the uBVIP after initial constructions with temporary superstructure. Members of DWSCC should critically review the successes and related challenges of uBVIP upgrading. A key question for the WASH sector in Zimbabwe is, “Can the WASH sector continue to promote uBVIPs given the challenges associated with them across most districts?”
- To keep on working on behaviour change towards demand led sanitation, there should be reinforcement of key messages that encourage the expected changes in behaviour, for example, the use of the word ‘*dhodhi muchimbuzi*’, is a strong word in local language that shames those who practice open defecation.
- CARE should consider developing post project monitoring that will check and help on project sustainability.
- DWSCC should plan for a demand led sanitation refresher course.
- Ministry of Health and Child Care with support from other development partners and local leadership should explore alternative ways of making materials for RUMPS available in the local area.

6.0 LESSONS LEARNED

1. Construction of wheelchair friendly toilets was noble idea, however only schools were able to construct them with assistance from CARE. Feedback from consulted health workers was that people living with disabilities need the same support at home, for example, children were accessing wheelchair friendly toilets at schools but did not have access to the same facilities at home.
2. A lesson that was learned from some villages that were triggered by demand led sanitation and managed to attain ODF is that, using local materials like grass and poles to build toilets was good as a temporary/ emergency measure, but it is not sustainable in the long run. During consultations the consultant established that most of the toilets that collapsed were the ones that were constructed using local material.
3. Using uBVIP toilets was a good model in terms of easier uptake by the majority of households, especially those constrained by resources. However, households were facing challenges of upgrading them ranging from complacency and resource constraints. In terms of human behaviour, people have a tendency to relax, for example most of the toilets that collapsed were those that were constructed using local materials and meant for use in the short term but households ended up using them for a longer period and some treating them as permanent structures.
4. Demand led sanitation is a noble model of mainstreaming sanitation in villages, however it is influenced by local village governance. For example, most villages that attained ODF were those where local leadership made it mandatory for every HH to have a toilet.

APPENDICES

Appendix 1: Terms of Reference

Final Report Requirements

The report must include the following:

Title and Opening pages (front matter)-should provide the following necessary information:

- vi. Name of the project evaluated
- vii. Time frame of the evaluation and date of the report
- viii. Project location (districts and country)
- ix. CARE Zimbabwe logo
- x. Acknowledgements

Table of Contents-including boxes, figures, tables, and annexes with page references.

List of acronyms and abbreviations

Executive Summary

A stand-alone section of two to three pages that should:

- Briefly describe the project that was evaluated.
- Explain the purpose and objectives of the evaluation, including the audience for the evaluation and the intended uses
- Describe the key aspect of the evaluation approach and methods.
- Summarize principle findings, conclusions, and recommendations.
- Include a summary table displaying the figures (scores) for each indicator at baseline and at end line, with elaboration on the statistical significance of differences.

Introduction

- Explain why the evaluation was conducted (the purpose), why the intervention is being evaluated at this point in time, and why it addressed the questions it did.
- Identify the primary audience or users of the evaluation, what they wanted to learn from the evaluation and why and how they are expected to use the evaluation results.
- Identify the project that was evaluated
- Acquaint the reader with the structure and contents of the report and how the information contained in the report will meet the purposes of the evaluation and satisfy the information needs of the report's intended users.

Description of the Intervention

Provide the basis for report users to understand the logic and assess the merits of the evaluation methodology and understand the applicability of the evaluation results. The description needs to provide sufficient detail for the report user to derive meaning from the evaluation. The description should:

- Describe what is being evaluated, who seeks to benefit, and the problem or issue it seeks to address.
- Explain the expected results map or results framework, implementation strategies, and the key assumptions underlying the strategy.
- Link the intervention to CARE Zimbabwe national strategy
- Identify and describe the key partners involved in the implementation and their roles.
- Describe the scale of the intervention, such as the number of components (e.g., phases of a project) and the size of the target population for each component.
- Indicate the total resources, including human resources and budgets.
- Describe the context of the social, political, economic, and institutional factors, and the geographical landscape within which the intervention operates and explain the effects (challenges and opportunities) those factors present for its implementation and outcomes.
- Point out design weaknesses (e.g., intervention logic) or other implementation constraints (e.g., resource limitations).

Evaluation Scope and Objectives

Provide a clear explanation of the evaluation's scope, primary objectives and main questions.

- Evaluation scope-define the parameters of the evaluation, for example, the time period, the segments of the target population included, the geographic area included, and which components, outputs or outcomes were and were not assessed.
- Evaluation objectives-spell out the types of decisions evaluation users will make, the issues they will need to consider in making those decisions, and what the evaluation will need to achieve to contribute to those decisions.
- Evaluation criteria-define the evaluation criteria or performance standards used. The report should explain the rationale for selecting the particular criteria used in the evaluation.
- Evaluation questions-evaluation questions define the information that the evaluation will generate. The report should detail the main evaluation questions addressed by the evaluation and explain how the answers to these questions address the information needs of users.

Evaluation Approach and Methods

The evaluation report should describe in detail the selected methodological approaches, methods and analysis; the rationale for their selection; and how, within the constraints of time and money, the approaches and methods employed yielded data that helped answer the evaluation questions and achieved the evaluation purposes. The description should help the report users judge the merits of the methods used in the evaluation and the credibility of the findings, conclusions and recommendations. The description of methodology should include discussion of each of the following:

- Data sources-sources of information (documents reviewed and stakeholders), the rationale for their selection and how the information obtained addressed the evaluation questions.
- Sample and sampling frame-the sample size and characteristics; the sample selection criteria, the process for selecting the sample (e.g., random, purposive); and the extent to which the sample is representative of the entire target population, including discussion of the limitations of the sample for generalizing results.
- Data collection procedures and instruments-methods or procedures used to collect data, including discussion of data collection instruments (e.g., interview protocols), their appropriateness for the data source and evidence of their reliability and validity.
- Performance standards-standard or measure that will be used to evaluate performance relative to the evaluation questions (e.g., national or regional indicators, rating scales).
- Stakeholder engagement-stakeholders' engagement in the evaluation and how the level of involvement contributed to the credibility of the evaluation and the results.
- Background information on evaluators-the composition of the evaluation team, the background and skills of team members and the appropriateness of the technical skill mix, gender balance and geographical representation for the evaluation.
- Major limitations of the methodology-major limitations of the methodology should be identified and openly discussed as to their implications for evaluation, as well as steps taken to mitigate those limitations.
- Data analysis-procedures used to analyse the data collected to answer the evaluation questions. It should detail the various steps and stages of analysis that were carried out, including the steps to confirm the accuracy of data and the results. Data from the end line evaluation should be systematically compared with data from the baseline evaluation, and the difference between baseline and end-line values should be tested for statistical significance and discussed. The report also should consider the appropriateness of the analysis to the evaluation questions. Potential weaknesses in the data analysis and gaps or limitations of the data should be addressed, including their possible influence on the way findings may be interpreted and conclusions drawn.

Findings and Conclusions

Present the evaluation findings based on the analysis and conclusions drawn from the findings.

Findings-presented as statements of fact that are based on analysis of the data. The evaluation findings should be structured around the key evaluation questions and project indicators so that report users can readily make the connection between what was asked and what was found. Variances between planned and actual results should be explained, as well as factors affecting the achievement of intended results. The assumptions or risks in the project design that subsequently affected implementation should also be discussed.

Conclusions-this section should be comprehensive and balanced and highlight the strengths, weaknesses and outcomes of the intervention. The conclusion section should be well substantiated by the evidence and logically connected to the evaluation findings. It should respond to key evaluation questions and provide insights into the identification of and/or solutions to important problems or issues pertinent to the decision-making.

Recommendations-the Consultant should provide practical, feasible recommendations directed to the intended users of the report about what actions to take or decisions to make. The recommendations should be specifically supported by the evidence and linked to the findings and conclusions around key questions addressed by the evaluation. This should address the sustainability of the initiative and comment on the adequacy of the project exit strategy.

Lessons Learned: The report should include discussion of lessons learned from the evaluation, that is; new knowledge gained from the particular circumstances (intervention, context outcomes, even about the evaluation methods) that apply to a similar context. Lessons should be concise and based on specific evidence presented in the report.

Report Annexes

Annexes shall include the following to provide the report user with supplemental background and methodological details that enhance the credibility of the report:

- ToR for the evaluation
- Additional methodology-related documentation, such as the evaluation matrix and data collection instruments (questionnaires, interview guides, observation protocols, etc.) as appropriate
- List of individuals or groups interviewed or consulted and sites visited
- List of supporting documents reviewed
- Project results map or results framework

- Summary tables of findings, such as tables displaying progress towards outputs, targets, and goals relative to established indicators.

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HOUSEHOLD QUESTIONNAIRE

INTRODUCTION AND INFORMED CONSENT

Hello. My name is _____ and on behalf of Chivi District Water Supply and Sanitation Committee (DWSSC) supported by CARE International In Zimbabwe, we are conducting a baseline survey about water, sanitation and Hygiene issues in the district. We would very much appreciate your participation in this survey. The survey usually takes about 60 minutes to complete.

As part of the evaluation survey, we would first like to ask some questions about your household. Your responses will be treated as confidential. Participation in the survey is completely voluntary. If we should come to any questions you don't want to answer, just let me know and I will go on to the next question; or you can stop the interview anytime. However, we hope you will participate in the survey since your views are important for the successful implementation of the ANCP funded water, sanitation and hygiene project in Chivi District.

Are you willing to participate in this survey? If yes, I will proceed with questions.

GENERAL INFORMATION

Interviewer: _____	Date of interview: _____
District: _____	Start Time: _____
Ward: _____	End Time: _____
Village: _____	Household Number: _____

DEMOGRAPHIC INFORMATION

1a.	What is the gender of the HH head?	1= Male	2= Female	
1b.	What is the age of Household Head?	_ _ _		
1c.	Marital Status of HH head	1= Married 2= Single 3= Widowed 4= Divorced		
1.d	What is the sex of the responded?	1=Male 2= Female		
1.e	What is age of responded?	_ _ _		

1e.	What does household head do for a living? <i>Murikuitabasarei mukurarama kwenyu?</i>	1=Formal Salary 2=Vegetable Sales 3=Crop Sales 4=Casual Labour 5=Petty Trade 6=Small Livestock 7= Skilled Labour 8= Remittances 9=Other (Specify)							
1f.	What level of education did you attain? <i>Makasvika bhuku ripi mukudzidza chikoro chenyu?</i>	1= Primary 2= Secondary 3= Tertiary 4= No Schooling							
1g.	How many people live and eat with you? <i>Vanhu vangani vanogaranekubik apamwe nemi?</i>	Under 5yrs	5-18 yrs	19-60 yrs	Above 60yrs	Total			
1h.	Are there any orphans present in your household? <i>Pane nherera here dzamunogara nadzo?</i>	1= Yes 2= No							
1i.	If yes, how many orphans are present? <i>Kana dziripo vangani?</i>	_ _ _							
1j.	How many children of school going age in this household do not go to school? <i>Pavana vanogara pano vangani vasingaende kuchikoro?</i>	M _____ F _____ T _____							
1k.	What is the main reason for those	<table border="1"> <tr> <td>lack of money</td> <td>1</td> </tr> </table>					lack of money	1	
lack of money	1								

	who are not attending school? <i>sei vana ava vasingaendi kuchikoro?</i>	caring for sick parents and / or adults	2		
		caring for other children	3		
		have special needs	4		
		failed school	5		
		do not want to	6		
		child has to work for an income	7		
1l	Are there any chronically ill members in your household? <i>Pane vamunogaranavo vane chirwere chisingapere here?</i>	1= Yes 2= No			
HOUSEHOLD HEALTH					
2a	Has anyone in the household had diarrhoea in the last week? <i>Pambapano, pane akamboitamudu mbu (manyoka) muvhikirapera here?</i>	1= Yes 2= No			
2b	How many individuals have had diarrhoea? How old are these individuals? <i>Vangani vose vakahwamudumbu (manyoka)? Makore avo akamira sei?</i>	Under 5yrs	5-17 yrs	Above 18yrs	Total

WATER SOURCE / COLLECTION, STORAGE & TREATMENT						
3a	<p>From where did you collect your drinking water (the last time it was collected)? <i>Makachera /tekakupi mvurayenyuyekun wa</i> (payakapedzisirak ucherwa/tekwa)</p>	<p>1= Tap/piped supply 2= Borehole/Handpump 3= Protected Well 4= Open well/River/Pond 5=other specify _____ —</p>				
3b	<p>How far is the main water source from your household? <i>Kure zvakadini kwamunocheram vura yepamushauno</i></p>	<p>1= In household 2= Within 100m 3= Between 100m and 500m 4= Between 500m and 1km 5= More than 1km</p>				
3c	<p>Do you get your water from the main water source throughout the year? <i>Pane kumwe kwamunochera mvura here kusiri kwamareva mugore rimwe chete?</i></p>	<p>1 = yes 2 = No</p>				
3d	<p>Was this your source of water before support from Care Zimbabwe?</p>	<p>1= Yes 2=No</p>				
3e	<p>Is the water source user friendly for</p>	<p>1= Yes 2=No</p>				

	people living with disability?		
3f	What are the other uses of water that you collect? <i>Ndezvipi zvimwe zvamunoshandisa mvura yamunenge machera</i>	1 = washing 2 = bathing 3 = watering gardens 4 = Watering domestic animals etc 5 = None of the above	
3g	Who usually goes to this source to fetch the water for your household (where source is 100m or more from the homestead)? <i>Kazhinji ndiani anochera mvura yacho</i>	1= Adult woman 2= Adult man 3= Female child (under 15 years) 4= Male child (under 15 years) 5= Anyone 6= Other (specify) _____	
3h	Did distance you travel to water point reduce as a result of support by Care International WASH project?	1= Yes 2= No	
3i	When your household main water point breaks, how long does it normally take to get fixed?		
3j	Does your household contribute any money towards maintenance of water point? <i>Mhuri yenyu</i>	1=Yes 2=No	

	inobvisawo mari yekugadzirisa pamunochera mvura here?		
3k	If Yes how much do you contribute?		
3l	How much water do you use per day? <i>Munoshandisa mvura yakawanda zvakadii pazuva?</i>	1 = Less than 20 litres (less than 1 buckets) 2 = 20 –50 litres (1 – 2.5 buckets) 3 = 50–100 litres (2.5 - 5 buckets) 4 = More than 100 litres (More than 5 buckets)	
3m	May you show me where you store drinking water? <i>Mungandiratidza wo here pamunochengeter a mvura yenyu yekunwa?</i> Check with quick visual observation “safe” if narrow mouth (< 10 cm) with a lid or secured/fitted cover otherwise “unsafe”	1= Safe 2= Unsafe	
3n	Does your drinking water have an “acceptable” taste?	1=Yes 2=No	

3o	Does your water have any odor when you bring it from the water point?	1=Yes 2= No 3= Not sure	
3p	Do you do anything to treat your water to make it safe to drink? <i>Pane here zvamunoita here kumvura yenyu yekunwa kana muchida kuti ichene?</i>	1= Yes 2= No	
3q	What do you do/use to treat your water to make it safe to drink? <i>Munosevenzesa mushonga upi kuisa mumvura yekunwa kuti ichene</i>	1= Boiling 2= Filtration 3= Bleach 4= Waterguard 5= Nothing 6= _____ Other (specify)_____	
3r	What do you use when washing your hands to make them clean? <i>Munosevenzesa chii pamunogeza mawoko kuti anyasochena?</i>	1= Water only 2= Water and soap 3= Water and ash 4= None of the above	
3s	What are the most important times to wash your hands ? [do not lead. Ask 'any other time?' until the	1= After latrine use 2= Before cooking / preparing food 3= Before eating 4= Before feeding 5= after cleaning a baby's bottom	

	<p>respondent has no other times.]</p> <p><i>Ndedzipi nguva dzakakosha dzamunowanzoge za maoko enyu</i></p> <p>(Circle all that apply)</p>		
3t	<p>Can you show me how you usually wash your hands? [do not lead]</p> <p><i>Mungandiratidza wo here magezero amunoita maoko enyu</i></p> <p>“correct ” if all below steps are demonstrated</p> <ol style="list-style-type: none"> 1. Rub soap on the palms 2. Rub inside hands and between the fingers 3. Rub outside of hands and between the fingers 4. Rub the fingernails 5. Rinse hands under running clean water <p>Otherwise</p>	<p>1= Correct 2= Incorrect</p>	

	"incorrect"		
3u	<p>Is there a place for family members to wash hands? (if yes ask to see the place used for hand washing)</p> <p><i>Pane nzvimbo inogezzerwa maoko nevagari vepano here</i></p>	<p>1= Yes 2= No</p>	
SANITATION AND HYGIENE			
4a	<p>Where do you dispose of your excreta? (single choice)</p> <p><i>Komunodhotera kupi?</i></p>	<p>1= Bush 2= Toilet 3= Cat method 4 = Other (specify) _____</p>	
4b	<p>Do you have a toilet at your household? (Observe)</p> <p><i>Munechimbuzi here pachoto/pamush apenyu</i></p> <p>If yes, what type of latrine do you have ?</p>	<p>1= Yes 2= No</p> <p>1= Pit latrine 2 = Flush toilet 3 = BVIP latrine 4 = uBVIP latrine 5 = Other (specify)</p>	
4c	<p>Did you have a toilet before Care Zimbabwe WASH project?</p>	<p>1= Yes 2= No</p>	
4d	<p>What is the condition of the toilet facility? (Observe)</p>	<p>1 = good 2 = bad</p>	
4e	<p>Do you share this toilet facility with other households</p>	<p>1= Yes 2= No</p>	

	<p><i>Mune vemunoshandisa nawo here chimbuzi chenyu</i></p>		
4f	<p>Indicate your level of agreement on the following statement</p> <p>All households in our village should have and use latrines to prevent the spread of diseases like cholera</p> <p><i>Munobvumirana zvakadii nemashoko anotevera:</i></p> <p><i>Choto choga choga chirimuno mubhuku redu chinofanira kuvanechimbudzi chokudhotera kuitira kutizvirwere zvakaita secholera zvisaparadzirwa</i></p>	<p>1= Strongly Agree 2= Agree 3= Neutral 4= Disagree 5= Strongly Disagree</p>	
4g	<p>Does the household have access to a pot rack</p> <p><i>Chitanangare chiripo here uye chnoshandiswa here? (Observe)</i></p>	<p>1= Yes 2= No</p>	

4h	<p>How many rubbish pits does the household have access to? Do you separate your waste (biodegradable and non-degradable). Musha unemakomba mangani emarara? Munopatsanura marara here kuti zvinoora nezvisingaori</p> <p>(Observe)</p>	<p>1= one 2= two 3= none</p> <p>Waste separation 1 = yes 2 = no</p>	
4i	<p>Did you improve knowledge and practice of sanitation as a result of CARE project? Makawedzera ruzivo rwenyu nekuchengetedza utsaanana nekuda kwe CARE WASH project here?</p>	<p>1=Yes 2=No</p>	
4j	<p>If yes can you explain?</p>		
PARTICIPATION IN WASH ACTIVITIES			
5a	<p>How would you rate participation of women and girls in WASH programes Kana muchitarira madzimai nevasikana, vanoshanda/bata</p>	<p>1= Extremely Good 2= Quiet Good 3= Slightly Good 4= Neutral 5= Slightly Poor 6= Quiet Poor 7= Extremely Poor</p>	

	<i>zv kadini mune maprogramme ezvemvura neutsanana</i>		
5b	<p>Indicate your level of agreement on the following statement</p> <p>“Women and girls should be given equal opportunities and play a leading role in wash projects for example as chairpersons of WPC”</p> <p><i>Munobvumirana zv kadini nemashokoaya: Madzimai nevanasikana vanofanirwa kuwanamukana wekutungamirira makomitie emaprojects ezveutanosemuen zaniso chairperson wewpc</i></p>	<p>1= Strongly Agree 2= Agree 3= Neutral 4= Disagree 5= Strongly Disagree</p>	
5c	<p>Why should women and girls be at the center of wash and health projects (multiple answers)</p> <p><i>Nemhaka yei madzimai navanasikana</i></p>	<p>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)</p>	

	<i>vachifanirwa kuvachiruvi munehurongwa hwoutsanana</i>						
WASH GOVERNANCE							
7a	Does your village have a Water Point Committee (WPC)? <i>Bhuku renyu rine komiti yezveutsanana here?</i>	1= Yes 2= No					
7b	If yes to the question above, what positions are occupied by women? <i>Kana iri hongu ndezvipizvi zvigzro zvinotungamirirwa nevanhu kadzi</i>	1= Chairperson 2= Vice Chairperson 3=secretary 4=treasure 5=committee member 6=none					
7c	How would you rate your satisfaction with existing WPC? <i>Munogutsikana zvakadini nekomitiiripo ikozvinoye WPC</i>	1= Extremely Satisfied 2= Satisfied 3= Neutral 4. Not Satisfied 5= Extremely Not Satisfied					
7d	To what extent are overallly satisfied with the implementation and results of the Care Zimbabwe WASH project?	1= Extremely Satisfied 2= Satisfied 3= Neutral 4. Not Satisfied 5= Extremely Not Satisfied					
7d	How many of these Skilled community	Build ers	Pum p Mec	Villa ge Heal	Ho me Bas	Extension Workers	

	members are present in your community (village)		hanic	th	ed		
	<i>pavashandi</i>			Wor	Car		
	<i>Vanotevera</i>			kers	e-g		
	<i>mungandiudzawo</i>				ive		
	<i>here vanogara</i>				r		
	<i>mubhuku renyu/</i>						

Appendix 3: Water Point Committee FDG guide

Key Informant Interview Guide

Date: Time:

Time:.....

1 What is the leadership structure of the Water Point Committee

Title	Gender	Education
President		
Vice President		
Secretary		
Vice secretary		
Treasure		
Committee Members		

2. When was water point established?
3. How many water points does the WPC oversee?
- 4 Is the WPC functioning? Yes/No.....
5. Does the WPC have written constitution/ bylaws? Yes/No.....
6. Is the WPC recognised by local government? Yes/ No?
7. Explain the role of WPCs
.....
.....
- 8.What causes WP break downs
9. When WP breaks down how long does it take to recover?
10. Who pays WP maintenance and repairing costs?
11. Is water point secured (e.g fenced)?
12. Is WP far from the toilets? What is the distance from the toilets?
13. Is the WP environment kept clean?
14. Who is in charge of daily management of waterpoint?
15. How is the maintenance of the WP financed?

16. How many Households are served by the water point?
17. Is there water point fund? If yes what are the sources of funds?
18. Does the WP have bank account
19. In the event that Care Zimbabwe decommissions WASH project, will the WPC able to maintain the WP

Appendix 4: Sanitation Group FGD Guide

DATE

VENUE:

TIME

- 1 What is the role of SAG?
- 2 How do you ensuring that there is no open defecate in the household?
- 3 Were you trained on your duties?
- 4 What is the approximate date of ODF certification/completion? (If applicable)
- 5 Is your community still ODF? Y/N
- 6 Do all households have access toilet/latrine? Yes/No
- 7 Do all members of the local community use the toilet/latrine for defecation? Yes/No
- 8 If NO what are the reasons?
- 9 Are there any households who are not able to construct their own toilets/latrines?
- 10 What is needed to ensure everyone uses a toilet every time they defecate?
- 11 Is household toilet construction driven by donors or by community?
- 12 In your opinion how can sanitation in your local community be improved?
- 13 In your opinion what is the role of a) government b) local community to achieve ODF status
- 14 To what extend did the support provided by CARE WASH project helped the local community improve on sanitation? Very High, High, Average, Below Average, Poor
- 15 In the event that CARE WASH project is decommissioned, will the local community that attain ODF status be able to uphold their status?

Appendix 5: School health club FGD Guide

1. Does the school have a functional health club? If yes what are the functions/responsibilities of the club
2. What is the role of school health club?
3. What support did the school received from Care Zimbabwe
4. Where did you get your drinking water from?
5. Is the water always available throughout the year?
6. If not, what is the cause of occasional or irregular availability of water?
7. What is the alternative source of water when school facility is not working and school children's perception of the source/ source of drinking water where school doesn't have one/school children do not like water quality etc.
8. What is the level of utilization of school toilets (always, sometimes, never)
9. If not always, what are the reasons for non-utilization?
10. What alternatives are used when toilets are not accessible/available
11. Given the chance to change one thing about school toilets what would it be?
12. Does the school have disability friendly and girl friendly toilets? If yes, does it have a lockable screen door, mirror, water buckets, soap and sanitary pads? What are the problems associated with menstruation?
13. Describe how menstrual hygiene management issues are being handled at your school (are you aware of the reusable menstrual pads)
14. What is the level of the cleanliness of toilets (whose responsibility is it and how does it affect use)?
15. Have you ever been exposed to hygiene education in the school? If yes how and what was covered?
16. What is the critical hand washing times and what is used for hand washing?
17. Does the school have any hand washing facility?
18. How many rubbish pits does the school have and what are they used for?
19. Are there any changes brought about by school health clubs in the school? If yes what are they?

Appendix 6: Latrine Monitoring checklist

The following check-lists have been developed to monitor water and sanitation infrastructure development in rural communities.

1. Location

	Yes	No	Action to take if “yes”
1. Is the latrine located in a low-lying zone?			Make an embankment around the latrine to prevent rain water from flooding the pit. If there is much risk of flooding, think of transferring the latrine.
2. Is there any risk of water stagnation around the latrine?			Make an embankment around the latrine
3. Is there any lateral infiltration of water into the pit?			Seek out where there is any lateral infiltration and make these areas impermeable, make embankment around the latrine, etc.)
4. Can you smell the latrine from the house/School?			If possible, change the location of the latrine and place it beyond the houses so that the dominant winds blow the smell away from the houses.
	Yes	No	Observation
Total/4			If the number of “Yes” is high the sanitary risk is high for this sanitary point.

2. The slab

	Yes	No	Action to take if “yes”
1. The latrine slab is not smooth / it has cracks.			Make the slab smooth or fill the cracks with mortar to allow for easy cleaning of the slab.
2. The latrine slab permits urine to pool.			Correct the slopes on the slab with mortar in order to facilitate the urine to flow towards the

			defecation hole.
3. The sides of the defecation hole are not smooth.			Smooth the sides of the defecation hole with mortar in order to facilitate the cleaning of faeces that may be found there.
	Yes	No	Observation
Total/3			If the number of “Yes” is high the sanitary risk is high for this sanitary point.

3. Superstructure

	Yes	No	Action to take if “yes”
1. Does the superstructure permit privacy?			Correct the superstructure construction so that it permits user privacy.
	Yes	No	Observation
Total/1			If the number of “Yes” is high the safety risk is low for this sanitary point.

4. Use/Maintenance

	Yes	No	Action to take if “yes”
1. Are there a lot of flies?			For the non-VIP (Ventilated Improved Pit) latrine, cover the defecation hole after having used the latrine. For a VIP latrine, create the conditions to have semi-darkness in the latrine so that the flies are attracted to the light via the vent pipe.
2. Is there much smell?			Pour ash on the faeces after defecation. For the VIP latrine, assure that the air is circulating correctly (entering into the pit by the slab hole and

			going out by the ventilation pipe).
3. Is the latrine used as a shower?			Ask the owner to build a separate shower in order to avoid filling his latrine quickly.
4. Is the interior of the cabin dirty (urine on the slab, faeces around or on the defecation hole sides, etc.)?			Ask the family to clean the latrine slab (daily) in order to avoid any contamination.
5. There is no hand washing facility for the latrine?			Sensitize the family on the sanitary risk due to transmission of faeces to food and invite them to put a hand washing facility in place.
6. There is no cover of the slab hole(non-VIP latrine)			Sensitize the family on the importance of the use of a cover over the slab hole as a barrier against the transmission of contamination through flies.
	Yes	No	Observation
Total/6			If the number of “Yes” is high the sanitary risk related to safe use is high for this sanitary point.

5. Efficiency of the management

	Yes	No	Action to take if “yes”
1. Is there any other opening on the superstructure (apart from door)?			Block these openings.
2. The latrine superstructure does not provide semi-darkness (the time for the eyes to accommodate to the dark is less than 10 seconds)			Create the condition for semi darkness inside the latrine: install a door if it is missing, diminishing the opening of the front door.
3. The door is not placed on the side of the dominant winds.			If possible, move the door to the side of the dominant winds.

4. Is the height of the ventilation pipe less than 50 cm above the highest part of the superstructure?			Increase the height of the ventilation pipe so that it will be at least 50 cm higher than the highest part of the superstructure.
5. Does the ventilation pipe have any opening or cracks?			Change the ventilation pipe or block the openings or cracks.
6. Is the diameter of the pipe less than 150 mm?			If possible, change the ventilation pipe (to diameter of at least 150mm. The diameter of the ventilation hole must also be increase to around 150mm).
7. The ventilation pipe is placed to the side that receives most sun during the day			For future new VIP latrine construction, place the ventilation conduct on the equator side of the superstructure to get maximum sun.
8. Is the ventilation pipe not well fixed / loose?			Fix the ventilation pipe (with concrete or mortar) so that it is steady
9. Is the ventilation pipe inclined (not vertical)?			Change the ventilation pipe fixture and position in order that it can be vertical and permit the sun light to reach the pit.
10. There is no fly screen on the top of the ventilation pipe.			Place a fly screen on top of the vent pipe to trap and eliminate the flies trying to exit from the pit via the vent pipe.
11. The fly screen has some holes.			Change the fly screen.
12. The fly screen is loose and does not fit tightly on to the ventilation pipe?			Tighten the fly screen so that it fits tightly on to the ventilation pipe.
13. Is there a cover for the latrine pit?			Remove the cover because the air must enter into the pit via the pit hole and flow out via the ventilation pipe.

	Yes	No	Observation
Total/13			If the number of "Yes" is high the sanitary risk related to management of sanitation point.

Comments

Appendix 7: Waterpoint Assessment Checklist

1.0 Identification and Location Details

- 1.1 District _____
- 1.2 Village (where water-point is locate _____
- 1.3 Ward (where water-point is located) _____
- 1.4 Name of Water-point _____
- 1.5 Date of Survey _____

2.0 Water-point Observations

2.1 Type of Water-point (*Examine the Water Point*)

- ① Borehole
- ② Hand-dug well

2.2 Year when drilled/dug (*Check records and also confirm with the users*)

- ① Period before 2012
- ② 2012 and period after

2.3 Is Water-point Functional? (*Observe and inspect the Water Point*)

- ① Yes
- ② No

2.4 Operation and Maintenance Indicators

2.4.1	All bolts and nuts for the hand pump tightened	① Yes	② No
2.4.2	Moving parts of hand pump greased	① Yes	② No
2.4.3	Cleanliness around the water point	① Yes	② No
2.4.4	Stagnant Water near to the water point	① Yes	② No

2.5 Condition of down-the-hole components for hand pump (cylinder/foot valve) - *count number of strokes before water is discharged*

① Good	② Needs Attention	③ Poor	④ N/A
5 strokes and less	6 – 20 strokes	Above 20 strokes	Broken down

2.6 Quality of Water drawn from borehole/well

2.6.1 Taste (*taste the water by drinking it upon pumping*)

- ① Acceptable for Drinking
- ② Bitter/Salty but Acceptable
- ③ Bitter/Salt and Unacceptable
- ④ N/A

2.6.2 Appearance (*physically examine the appearance of the water in a transparent container*)

- ① Clear
- ② Muddy
- ③ Rusty
- ④ Milky
- ⑤ N/A

2.7 Head-works Condition

2.7.1 Condition of Apron (*inspect the structure*)

① Good	② Needs Attention	③ Poor	④ Non-existent
Apron is intact without any prominent cracks	Apron has prominent cracks that are repairable	Apron is broken or has large and very wide cracks or structure is substandard	No apron was constructed

2.7.2 Condition of Drainage Channel (*inspect the structure*)

① Good	② Needs Attention	③ Poor	④ Non-existent
Channel is intact without any prominent cracks	Channel has prominent cracks that are repairable	Channel is broken or has large and very wide cracks or is short (less than 3m)	Channel has not been constructed

2.7.3 Condition of Fence (*inspect the water-point*)

① Good	② Needs Attention	③ Poor	④ Non-existent
Fence is intact and does not allow	Fence allows entry of only small	Fence broken and missing in places	Fence completely missing

animals inside the water point	animals (eg goats) but is repairable	allowing entry of all sizes of animals	
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Appendix 8: School Health Teacher Questionnaire

1.0 Interviewer/Interviewee Information

1.1 Interviewer/Surveyor Name

1.2 Interviewee Name

1.3 Main Interviewee Designation

1.4 Date of Interview

2.0 School Information

2.1 School Name

2.2 School Location (Province/District/Ward)

2.3 School Level (primary/secondary/mixed)

2.4 School Management (public/private/religious-mission)

2.5 School Type (day school/boarding school/other)

2.6 Student Population (including ECD) No. of boys No. of girls Total

2.7 No. of Shifts

2.8 Students with Physical Disabilities No. of boys No. of girls Total

2.9 Teachers No. of male No. of Female Total

3.0 Water Supply

3.1 What is the main water supply source for the school? (mark one) (where necessary use observation)

- ① Piped water
- ② Borehole/ dug well with handpump
- ③ Unprotected dug well
- ④ Protected dug well
- ⑤ Other Specify

3.2 Where is the water supply point of consumption located? (If necessary, observe)

- ① Piped water in school buildings
- ② Within school yard
- ③ Outside the school yard less than 200m away
- ④ Outside the school yard between 200 and 500m away
- ⑤ Outside the school yard more than 500m away
- ⑥ N/A

3.3 What is this water source used for? (mark all that apply)

- ① Drinking
- ② Hand washing
- ③ Flushing or pour-flushing toilets
- ④ Cooking
- ⑤ Any other purpose (*specify*) _____

3.4 How often has the water source not been functional during the past one year? (mark one)

- ① Never
- ② Once only
- ③ Twice
- ④ Three to four times
- ⑤ More than four times
- ⑥ N/A

3.5 Is the main water source functional now? (Mark one) - OBSERVE

- ① Yes
- ② No
- ③ Partially

3.6 If the main water source is *not or partially* functional *now*, how long has it been in this state?

- ① Less than one week
- ② More than one week and less than two weeks (a fortnight)
- ③ More than two week and less than one month
- ④ More than one month

3.7 When the water source is functional, does it provide enough water for the needs of the school, including water for drinking and hand washing? (mark one)

- ① Yes
- ② No
- ③ Don't Know
- ④ N/A

3.8 Is there an acceptable alternative school water supply available (*that meets both basic drinking and hand washing needs*) when the main supply is non-functional? (Mark one)

- ① Yes
- ② No
- ③ Don't Know
- ④ N/A

3.10 Do you treat water from the source you use at school in any way to make it safer to drink?

- ① Always
- ② Sometimes
- ③ Never

3.11 If water is not always treated, why not? (mark all that apply)

- ① Because the water sources are considered safe

- ② Because the school does not capacity to treat water
- ③ Others Specify.....

3.13 Cleanliness of water withdrawal method e.g do they clean containers before drinking?

- ① Yes
- ② No

3.14 Can the youngest children in the school get drinking water by themselves? -OBSERVE

- ① Yes
- ② No

3.15 Are drinking water facilities accessible to children with physical disabilities? (mark one)

- ① Yes
- ② No

3.16 If answer to 3.15 is no how do they get the water

- ① Ask friends
- ② Arrangements are made by the school to provide them with water
- ③ Bring their own water from home
- ④ Other, Specify _____

3.17 Who has the primary responsibility to maintain and repair the school water system? (ask the headmaster)

- ① ZINWA
- ② DDF
- ③ RDC
- ④ School Committee/School itself
- ⑤ Doesn't know

4.0 Sanitation

4.1 What type of toilet facilities are there in the school? (mark all that apply) -OBSERVE

- ① Flush / Pour flush
- ② Ventilated Improved Pit latrine (VIP)
- ③ Pit latrine with slab
- ④ Pit latrine without slab / Open pit
- ⑤ No Facility, Bush, Field

4.2 How many functional toilet compartments are there in the School? - OBSERVE

Users	Functional	Partially Functional	Not Functional
① Exclusively for Girls			
② Exclusively for Boys			
③ for boys or girls(communal)			
④ Exclusively for female staff			
⑤ Exclusively for Male Staff			

⑥ for male or female (communal)			
⑦ for anyone in the school (students or teachers, male or female)			
Key: i. Functional – Toilets are not physically broken and can be used ii. Partially functional - Can be used but there are problems e.g with physical infrastructure and require repairs iii. Not functional – Toilets exist but are badly damaged - cannot be used.			

4.3 How clean are the toilets for use by school children? - OBSERVE

- ① Clean (*not smelly, no visible faeces in or around the facility, there are no flies and no litter*)
- ② Somewhat clean (*some smell and/or some sign of faecal matter and/or some flies and/or some litter*)
- ③ Not clean (*a strong smell and/or presence faecal matter and/or fly problems and/or lot of litter*)

4.4 Are girls' toilet facilities separate from boys' toilet facilities? (mark one) -OBSERVE

- ① Yes
- ② No
- ③ Partially

4.5 Are girls' friendly toilets available with fixtures and fittings? (mark one) - OBSERVE

- ① Yes
- ② No

4.6 Does the school provide reusable menstrual pads (RUMPS) to the learners? If so, who is responsible for that?

4.6 On average how many days do learners miss per month due to menstrual periods?

4.7 Are toilets accessible to young children and children with disabilities? -OBSERVE

- ① Yes
- ② No

4.8 Who is responsible for cleaning school toilets facilities? (mark all that apply)- ASK HEADMASTER

- ① School Children
- ② School caretaker/cleaning staff and staff?
- ③ Teachers
- ④ Other (Specify) _____

4.9 If children clean toilets, what are the responsibilities of girls or boys? (mark all that apply): -FROM SCHOOL HEADMASTER

- ① Girls usually clean their own toilets
- ② Boys usually clean their own toilets
- ③ Girls usually clean boys' toilets
- ④ Boys usually clean girls' toilets
- ⑤ Girls usually clean teachers' toilets
- ⑥ Boys usually clean teachers' toilets

4.10 Are toilet cleaning duties assigned to children as punishment for misbehaviour or poor school performance? (mark one only)

- ① Yes ② No ③ Sometimes ④ Don't Know

4.11 Who is responsible for ensuring cleanliness of toilets in the school? - ASK HEADMASTER

- ① Designated Staff member
- ② School Health Master
- ③ School Prefects
- ④ School Caretaker
- ⑤ Another body (specify) _____

4.12 Who has the primary responsibility for maintenance and repair of the school's sanitation facilities? (mark one only) -FROM SCHOOL HEADMASTER;

- ① The RDC or Municipal authorities
- ② The Ministry of Education
- ③ the school itself
- ④ Other Specify

4.13 Are the school sanitation facilities successfully maintained/repared when required? (mark one) y) - FROM SCHOOL HEADMASTER

- ① Yes ② No ③ Partially ④ Don't Know

4.14 Are the available toilets always suitable for use?

- ① Yes ② No

4.15 If they are sometimes not usable, what alternatives do children have?

- ① Teachers' Toilets
- ② Back-up VIP Latrines
- ③ Bush
- ④ Other body (specify) _____
- ⑤ N/A

5.0 Hygiene

5.1 Is hygiene taught at the school? - ASK HEADMASTER

- ① Yes ② No

5.2 How is hygiene taught at the school? (mark all that apply) - ASK HEADMASTER

- ① as a component of the core Curriculum
- ② Through school sponsored extracurricular activities e.g school Health Clubs
- ③ Sporadically/Informally/Occasionally
- ④ Other methods (Specify) _____

5.3

5.4 Does the school have a trained School Health Master? - ASK HEADMASTER

- ① Yes ② No

5.5 Does the school have health clubs? - ASK HEADMASTER

- ① Yes ② No

5.6 If health clubs exist what are their roles and responsibilities within the school? (mark all applicable) –FROM SCHOOL HEADMASTER)

- ① Ensuring WASH facilities are working
- ② Health and hygiene Promotion
- ④ Advise on hygiene
- ⑤ Advice on nutrition
- ⑥ Don't know
- ⑦ Other (Specify) _____
- ⑧ N/A

5.7 Are there functional hand washing facilities at the school? -OBSERVE

- ① Yes
- ② No

5.8 What kind of hand washing facilities does the school have? (mark one only by choosing the system normally used by most of the children)

- ① Running water from a piped system or tank (such as a faucet and sink, or a standpipe/tap)
- ② Hand-poured water system (such as from a bucket or ladle)
- ③ Basin/bucket (hand washing is done in the water, i.e. water is not running or poured)
- ④ Improvised tank (e.g., five litre plastic container with plug)
- ⑤ Other (specify) _____
- ⑥ N/A

5.9 At the time of the visit, was water available at the hand washing facilities? (mark one; visit all or most of the hand washing facilities in the school) -OBSERVE

- ① Yes, in all facilities
- ② A few of the facilities had no water.
- ③ Most of the facilities had no water
- ④ No water was available
- ⑤ N/A

5.10 At the time of the visit, was soap (or ash) available at the hand washing facilities? (mark one) -

- ① Yes, in all facilities
- ② A few of the facilities had no soap/ash.
- ③ Most of the facilities had no soap/ash
- ④ No soap/ash was available in all cases
- ⑤ N/A

5.11 From your observation, what is the level of utilization of facilities? (only applicable if water and soap is always available)

- ① All children use them at all necessary times
- ② All children use it but not always
- ③ Some children use it
- ④ Facility is never used
- ⑤ N/A

5.12 Are the hand washing facilities accessible to children with physical disabilities? -OBSERVE

- ① Yes, all facilities are accessible
- ② Some are

③ None are

5.14 Are hand washing facilities close to or inside the toilet?

① Yes

② Yes

6.0 Waste Disposal

6.1 When solid waste is being disposed of, is biodegradable solid waste (e.g. food) separated from the rest of the solid waste (eg plastic, glass, metal)

① Yes

② No

6.2 How is the biodegradable solid waste (garbage, rubbish) for the school disposed of? (*Mark one; use observation if necessary*)

① Thrown on a garbage dump/open pit within or near the household yard

② Buried within or near the household yard

③ Burned within or near the house yard

④ Collected and taken away by a waste disposal service

⑤ Other (specify) _____

6.3 How does the school dispose its non-biodegradable solid waste? (*mark one; observe if necessary*)

① Thrown on a garbage dump/open pit within or near the household yard

② Buried within or near the school yard

③ Burned within or near the school yard

④ Collected and taken away by a waste disposal service

⑤ Other (specify) _____

Appendix 9: Village Head interview Guide

1. Name of the Village
2. What did your village benefit from CARE international?
 - a. (Latrines Material,
 - b. Water Point Committee trainings
 - c. Borehole Rehab
 - d. Others Explain
3. Are the boreholes still functional?
4. Did you receive any training from CARE on WASH issues?
5. Did they provide all what they promised to do?
6. Did they provide the support on time?
7. Where does the community prefer to get its drinking water?
8. Is this source available all year? When is the critical period?
9. What are the main problems on drinking water access?
10. What type of sanitation facilities exist in the village?
11. Are there any households without latrines in your village?
12. What are the main problems on a) water points and b) sanitation?
13. Are there any conflicts at water points?
14. How are they resolved?
15. Are you able to continue with your work without donor support?
16. What do you recommend Care to do to improve?

Appendix 10: Village Pump Minder Interview Guide

1. What is the role of Village Pump Minders?
2. Did you receive training from CARE?
3. If yes, explain training you received from Care?
4. Have you rehabilitated any pumps since you started? If yes, how many?
5. What type of water points did you constructed/ rehabilitated?
6. How many water points do you cover?
7. What are most common causes of borehole breakdowns?
8. How long do you travel to the furthest water point?
9. What are the common causes of borehole break down?
10. Do you have tools for pump maintenance?
11. Did you receive tools from Care?
12. Are the tools adequate?
13. Do you get pay for your services?
14. If yes who pays?
15. Any challenges you experienced working with CARE?
16. Any challenges you experience working with community?
17. Are you able to provide services without donor support?
18. Any recommendations?

Appendix 11: Latrine Builder Interview Guide

1. What is the role of latrine builders?
2. Did you receive training from CARE?
3. Explain training you received from Care?
4. Have you rehabilitated any latrines since you started? If yes, how many?
5. What type of latrines did you construct?
6. How many villages or latrines do you cover?
7. How long do you travel to the furthest latrine for maintenance?
8. What are the common causes of latrines failure?
9. Do you have tools for latrine construction?
10. Did you receive tools from Care?
11. Are the tools adequate?
12. Do you get pay for your services?
13. If yes who pays?
14. Any challenges you experienced working with CARE?
15. Any challenges you experience working with community?
16. Are you able to provide services without donor support?
17. Any recommendations?

Appendix 12: Village Health Worker Interview Guide

1. What is the role of VHW?
2. Did you receive any support from CARE?
2. If yes explain support you received from Care?
3. How have you been working with villagers?
4. What type of latrines did you construct?
5. How many villages or latrines do you cover?
6. How long do you travel to the furthest latrine for maintenance?
7. What are the common causes of latrines failure?
8. Do you have tools for latrine construction?
9. Did you receive tools from Care?
10. Are the tools adequate?
11. Do you get pay for your services?
12. If yes who pays?
13. Any challenges you experienced working with CARE?
14. Any challenges you experience working with community?
15. Are you able to provide services without donor support?
16. Any recommendations?

Appendix 13: Members of DWSSC Interview Guide-DDF

Administrative information

District Name: _____

Ward Name: _____

Department/Organisation: _____

Date: _____

Interview DWSSC

1. Explain the structure and role of DWSSC?
2. Explain the role of your Ministry/ Department in the District
3. How did CARE WASH project compliment government efforts or align with your Mission
4. How CARE ANCP WASH project complimented your role?

Access to Water DDF

5. What is the water situation in Chivi?
 - a) Comment on water quality
 - b) Comment on water availability
6. What changes did CARE Chivi WASH bring in the target wards? Positive and negative
7. What was the level of water access before CARE ANCP WASH project?
8. What is the current level of water access?
9. Is WASH infrastructure in the project use friendly to a) women, b) elderly and c) people living with disabilities
10. What are the recommended water supply infrastructure? Which ones were supplied by CARE?
11. Do you know number of rehabilitated boreholes or water points? How many/% are still functional?
12. Are the water points still functional?
13. Were you involved in the selection and training of Village Pump Minders? If yes what was the criteria of selections? Was it fair on gender?
14. Do you know how many VPM are actively involved? How many are women?
15. Comment of the effectiveness of CARE CHIVI WASH project?
16. How efficient were CARE workers in executing their duties (did they met time on deliverables and meeting)
17. Can you comment on your working relationship with Care during project implementation?
18. Did they meet project promises on water supply interventions? Very much _____ Average _____ Poor _____
19. Who is monitoring water points?
20. In the event that CARE Zimbabwe decommissions this project?

Appendix 14: Members of DWSSC Interview Guide- Ministry of Health and Childcare

Administrative information

District Name: _____

Ward Name: _____

Department/Organisation: _____

Interview

1. Explain the structure and role of DWSSC?
2. Explain the role of your Ministry/ Department in the District
3. How did CARE WASH project compliment government efforts or align with your Mission
4. How CARE ANCP WASH project complimented your role?

Sanitation

1. What is the current level (%) of Open Defaecation Free in the District?
2. How did the project area improve towards reaching ODF?
3. Which areas are most vulnerable in terms of water access and sanitation?
4. Why do you think these areas are the most vulnerable?
5. To what extent do men and women (and girls and boys) have equal access to sanitation and hygiene services?
6. Did you encounter diarrhoea outbreaks and cholera outbreaks during the last 6 months?
7. When? And Where?
8. Are there local NGOs, institutions, organizations which working on water and sanitation in your areas? If so, state them
9. How did the gender-responsive WASH interventions contribute to achieving the desired gender impacts, such;
 - a) Improving school attendance and learning for girls,
 - b) Raising awareness of hygiene practices e.g. menstrual hygiene practices,
 - c) Increasing participation of girls and women?
10. Comment of project support towards WASH in schools
11. What is the government recommended squat hole ratio in schools? To what extend did CARE WASH project helped to achieve the target?
12. Do you have toilets design that are user friendly to people with a) disabilities b) children, c) the old people?
13. To what extent did people with disabilities, including women with disabilities specifically, meaningfully participate and benefit from the project?
14. What are the strengths and weaknesses of approaches sand strategies used in implementing different project components?
15. What has been done/ can be done to ensure that the benefits from the project are sustained.?
16. To what extent do men and women (and girls and boys) have equal access to project benefits?
17. Were there any cases of violence or conflicts during project implementation? If yes explain what happened and how was/were they resolved

Cross cutting

18. Was there any environmental damage during construction of WASH infrastructures?
19. To what extent did people with disabilities, including women with disabilities specifically, meaningfully participate and benefit from the project?
20. To what degree was the intersection between gender and disability considered throughout the project?

21. What is your government/department policy towards gender equality?
22. To what extent do men and women (and girls and boys) have equal access to project benefits?
23. Were there any cases of violence or conflicts during project implementation? If yes explain what happened and how was/were they resolved?
24. Was there an incidence of child abuse during project implementation? If yes was/were they caused by CARE staff?
25. Was CARE able to keep its promises? How efficient were they in executing their duties? e.g way ahead of time, always late, sometimes late?
26. In the event that the project is decommissioned do you think the local communities will be able to sustain it? What do you think should be done to sustain the project?

Appendix 15: DWSSC Interview Guide- Ministry of Youths, Arts, Sports and Recreation

Administrative information

District Name: _____

Ward Name: _____

Department/Organisation: _____

Interview

1. Explain the role of your Ministry/ Department in the District
2. How did CARE WASH project compliment government efforts or align with your Mission
3. How CARE ANCP WASH project complimented your role?
4. What is the current level WASH services in Chivi District?
5. Which areas are most vulnerable in terms of water access and sanitation?
6. Why do you think these areas are the most vulnerable?
7. To what extent do young people (girls and boys) have equal access to sanitation and hygiene services?
8. Did you encounter diarrhoea outbreaks and cholera outbreaks during the last 6 months?
9. To what extent were youths involved and participate in those selections?
10. What challenges are faced by young people and how did the gender-responsive WASH interventions contribute to achieving the desired gender impacts, such;
 - d) Improving school attendance and learning for girls,
 - e) Raising awareness of hygiene practices e.g. menstrual hygiene practices,
 - f) Increasing participation of girls and women?
11. Were you involved in selection and or training of participants for;
 - a) Village Pump minders
 - b) Latrine Builders
 - c) Water point Committees
 - d) Village Health Workers
12. Comment of project support towards WASH in schools
13. What are the strengths and weaknesses of approaches sand strategies used in implementing different project components?
14. What has been done/ can be done to ensure that the benefits from the project are sustained.?
15. Were there any cases of violence or conflicts during project implementation? If yes explain what happened and how was/were they resolved?
16. When? And Where?
17. Was there an incidence of child abuse during project implementation? If yes was/were they caused by CARE staff?

Appendix 16: Member of the DWSSC Interview guide- Ministry of Women Affairs, Gender and Community Development

Administrative information

District Name: _____

Ward Name: _____

Department/Organisation: _____

1. Explain the role of your Ministry/ Department in the DWSSC
2. How did CARE WASH project compliment government efforts or align with your Mission
3. How CARE ANCP WASH project complimented your role?
4. What is the current level WASH services in Chivi District?
5. How did the project area improve towards reaching ODF?
6. Which areas are most vulnerable in terms of water access and sanitation?
7. Why do you think these areas are the most vulnerable?
8. To what extent do young people men and women have equal access to sanitation and hygiene services?
9. What WASH related challenges are faced by women?
10. How did the gender-responsive WASH interventions contributed to achieving the desired gender impacts, such;
 - a. Improving school attendance and learning for girls,
 - b. Raising awareness of hygiene practices e.g. menstrual hygiene practices,
 - c. Increasing participation of girls and women?
 - d. Capacitating women in technical areas such as latrine building and pump maintenance
5. Were you involved in selection and or training of participants for;
 - e) Village Pump minders
 - f) Latrine Builders
 - g) Water point Committees
 - h) Village Health Workers
6. Was selection giving room for women to be capacitated?
7. What are the strengths and weaknesses of approaches and strategies used in implementing different project components?
8. What has been done/ can be done to ensure that the benefits from the project are sustained.?
9. Were there any cases of violence or conflicts during project implementation? If yes explain what happened and how was/were they resolved?
10. To what degree was the intersection between gender and disability considered throughout the project?
11. In the event that the project is decommissioned do you think the local communities will be able to sustain it? What do you think should be done to sustain the project?

Appendix 17: Focus Group Discussion- Men

1. Are aware of the support provided by Care in your Ward/ Village?
2. If yes can you explain the support provided?
3. Did access to water improved as a result of Care support? Explain
4. Did access to sanitation improved as result of CARE support? Explain
5. Are there any WASH challenges you are still experiencing?
6. At household who goes to fetch water most? Men/ Women?
7. Who cleans the toilets and yards?
8. Who mostly constructs toilets in your Ward/Village? Men/women
10. What is your view towards capacitating women to be VPM and Latrine builders
11. Are you able to keep on using knowledge
12. What are the gap or short comings of the whole project?
13. What do you recommend improving future programs?

Appendix 18: Focus Group Discussion- Women

1. Are aware of the support provided by Care in your Ward/ Village?
2. If yes can you explain the support provided?
3. Did access to water improved as a result of Care support? Explain
4. Did access to sanitation improved as result of CARE support? Explain
5. Are there any WASH challenges you are still experiencing?
6. Who is most affected by WASH challenges? Men/women/ youths; Explain why?
7. At household who goes to fetch water most? Men/ Women/ youths?
8. Who mostly cleans the toilets and yards?
9. Who mostly constructs toilets in your Ward/Village? Men/women/ youths
10. What is your view towards capacitating women to be VPM and Latrine builders
11. Are you able to keep on using knowledge
12. What are the gap or short comings of the whole project?
13. What do you recommend improving future programs?

Appendix 19: Focus Group Discussion- Youths

1. Are aware of the support provided by Care in your Ward/ Village?
2. If yes can you explain the support provided?
3. Did access to water improved as a result of Care support? Explain
4. Did access to sanitation improved as result of CARE support? Explain
5. Are there any WASH challenges you are still experiencing?
6. Who is most affected by WASH challenges? Men/women; youths? Explain why?
7. At household who goes to fetch water most? Men/ Women/ youths?
8. Who mostly cleans the toilets and yards at household level?
9. Who mostly constructs toilets in your Ward/ Village? Men/women/ youths
10. What is your view towards capacitating youths to be VPM and Latrine builders
11. Are you able to keep on using knowledge?
12. What are the gap or short comings of the whole project?
13. What do you recommend improving future programs?

Appendix 20: Field work interviews photos



Plate 1: Interview with Pump Minders



Plate 2: Interview with Village Health Coordinator



Plate 3: Interview with Ward Councillor



Plate 4: Interview with School Health Coordinator

Appendix 21: Focus Group Discussion Photos



Plate 5: Focus Group discussion with men



Plate 6: Focus Group Discussion with women



Plate 7: Focus group Discussion with youths



Plate 8: FGD with school health club



Plate 9: Focus Group discussion with members of SAG and Village Health Workers



Appendix 22: Examples of WASH infrastructure through CARE support