End of Project Evaluation - CHIVI Water, Sanitation and Hygiene Project (CHIWASH)

{FINAL REPORT}

GROUNDWATER DEVELOPMENT CONSULTANTS (PVT) LTD

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List of Abbreviations

ACP	African Caribean and Pacific
AMCOW	African Ministerial Conference on Water
BVIP	Blair Ventillated Improved Pit Latrine
CBM	Community Based Management
CHIWASH	Chivi Water Sanitation and Hygiene
DDF	District Development Fund
DWSSC	District Water Supply and Sanitation Sub- Committee
EHT	Environmental Health Technician
EU	European Union
FGD	Focus Group Discussion
GOZ	Government of Zimbabwe
GWSI	Global Water and Sanitation Initiative
HP	Hygiene Promoter
IFRC	International Federation of Red Cross and Red Crescent Societies
JMP	Joint Monitoring Programme
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
NFI	Non Food Item
NGO	Non Governmental Organization
OD	Open Defecation
RDC	Rural District Council
SPSS	Statistical Package for Social Scientists
UN	United Nations
UNICEF	United Nations Children's Fund
VPM	Village Pump Mechanic
WASH	Water Sanitation and Hygiene
WHO	World Health Organization
WPC	Water Point Committee
ZIMSTAT	Zimbabwe Statistical Agency
ZRCS	Zimbabwe Red Cross Society

EXECUTIVE SUMMARY

The Project Description

The Red Cross movement , United Nations (through UNICEF) and several other development agencies have identified Zimbabwe as a country where consolidated efforts are required to meet the MDGs (UN Millennium Development Goals) especially those related to water, sanitation and hygiene promotion. In this regard the International Federation of Red Cross and Red Crescent Societies (IFRC) under the Global Water and Sanitation Initiative (GWSI) obtained an EU grant that was provided through the ACP-EU water facility third call to fund the implementation of the Chivi Water, Sanitation and Hygiene Project – CHIWASH. The Zimbabwe Red Cross implemented the project in 16 wards of Chivi District, whilst the British Red Cross and the Finnish Red Cross were partners and co-donors to the total project cost.

The project whose main objective was to contribute to sustainable improvement in health and well-being for vulnerable people in Chivi district through improved access to safe drinking water and improved sanitation was implemented over a four year period that started in August 2011[1]. It consisted of three key components that included the software, hardware and the capacity building components. The hardware aspects of the project mainly focused on rehabilitation of boreholes as well as drilling new ones. In the area of sanitation, the project had supported the provision of household and institutional latrines. Software aspects entailed training of water point committees, village pump mechanics, latrine builders and hygiene promoters while capacity building component sought to enhance the capabilities of Red Cross staff as well as staff from implementing partner organizations to effectively execute their roles on the project.

At the end of the project, the IFRC 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. This assessment was essentially carried out within the context of set performance factors that include program relevance, program efficiency, program effectiveness, program impact and program sustainability as spelt out in the Principles for Evaluation of Development Assistance as spelt out by the Development Assistance Committee and that have generally been used in assessing the performance of community development and humanitarian initiatives since 1991. This report therefore documents the findings of the evaluation team as well as lessons and suggestions that will be useful in informing other projects implemented by the IFRC and its wider global membership of Partner and Host national societies.

Terminal Evaluation of the Project

In carrying out this evaluation, the evaluation team applied a number of methods to collect quantitative and qualitative information; among them were (i) literature review (ii) administration of 209 household questionnaires (iii) 22 different focus group discussions with different community groups (iv) field observation (v) physical inspection of 23 rehabilitated and 7 newly drilled water points and (vi) key informant interviews.

This Executive Summary highlights the main findings, lessons learnt and recommendations from this evaluation.

Evaluation Findings

Programme Relevance

[1] Contribution Agreement start date, however the implementation started in November 2011 following key staff recruitment

- ZRCS mandate provides for service provision to satisfy basic human rights. UN General Assembly Resolution 64/292 of 2010 formally recognized access to clean water and sanitation as a human right and therefore called on states and international organizations to provide financial resources, build capacity and transfer technology particularly to developing countries in scaling up efforts to provide safe, clean, accessible and affordable drinking water and sanitation for all. Zimbabwe was among the countries that voted in favour of the above resolution and commitment to this was further demonstrated in the inclusion of clean water and sanitation as basic human right in the national constitution. This made the intervention relevant within the context of operational and policy guidelines for both ZRCS and the Zimbabwean Government. Furthermore capacity building of vulnerable communities for purposes of building their resilience against disasters falls within the realm of ZRCS' mandate. By implementing the project which put emphasis on community capacity building, ZRCS therefore enhanced the capacity of communities to fight such disasters as the 2008 cholera outbreak.

- The programme was also relevant within the context of adhering to Government of Zimbabwe (GOZ) policies. For instance, implementation was done within the framework of District Water Supply and Sanitation sub-committees which is in line with the decentralisation of the provision of rural water supplies.

- The program proved to be a response to the felt needs of the communities as relevant information had been provided through the initiation of baseline surveys and consultations with communities and government ministries in the district prior to the implementation of the project.

Programme Efficiency

- The project was implemented in an efficient manner as ZRCS worked with partners at both the community as well as of specialist government ministries level in the rehabilitation of boreholes as well as construction of latrines. Use of a contractor to execute activities would have been costly for the project.
- The programme ensured the sharing of resources between ZRCS and other stakeholders. Government Ministries conducted various relevant training programmes while communities provided labour for construction activities and venues for training initiatives.

- By conducting training of Water Point Committees (WPCs) in clusters the programme was efficient as executing this activity at the village or water point levels would have meant setting aside more resources for this activity.

Programme Effectiveness

- In terms of meeting planned physical targets the project was highly successful as targets for borehole rehabilitation and borehole drilling were met. A very small percentage of household latrines could not be achieved due to problems at the community level.

- Training and equipping of VPMs proved to be a major step towards the strengthening of the CBM concept given that most of the boreholes that had broken down after rehabilitation had been reported to and repaired by VPMs.

- Environmental Health Technicians in the project wards were enabled to reach more people than would normally have been the case as they were provided with fuel under the project.

- Through the training of community structures, the programme adhered to the principle of empowerment /sustainability.
- The project managed to improve access to borehole water for communities in Chivi district. At project inception 64% of households used borehole water and this was increased to 85% at the end of the project.
- The project managed to reduce walking distances as well as the time taken in collecting water.
- 10.7% of the households indicated that they did something to their water to make it safer to drink. This is probably due to the fact that many people regarded borehole water as safe and as such the project increased the proportion of households with access to borehole water. In this respect, an increased number of households were not treating their water as they saw no need for this since borehole water was generally believed to be safe
- About 95% of households used closed containers for water storage which was indicative of good hygiene practices.
- The project improved access to BVIP latrines from 22.1% at project inception to 50.5% after project implementation.
- While 44% of the households confessed to practising open defecation according to results from the same baseline survey, 55.9% of the households actually had no toilets and were therefore supposedly practising open defecation. The figure of households practising open defecation had been reduced to 35% by the end of the project.
- In the district, run to waste hand washing with soap/ash currently stands at 6.8 % against a baseline figure of 15%. The noted drop could be due to a combination of factors. Firstly it should be noted that the baseline survey was conducted just after the 2008 cholera outbreak such that a lot of emphasis was put on hand washing. This was therefore still fresh in the minds of community members just as was the loss of relatives through cholera. In addition, many organizations supported communities by distributing non-food items that included soap and since this was stopped the situation at the end of the project was different.
- The proportion of households disposing of infants' stool properly increased from 17% at project inception to 56% at the end of the project suggesting the effectiveness of hygiene promotion efforts under the project.

Programme Impact

- The programme enhanced opportunities for strengthening the communities' organisational abilities. This was evident in the programme roles that were executed through community organisation.

- The project has created an enabling environment for women and children to enjoy quality lives through the adoption of positive hygiene practices. Throughout the discussions that were conducted at community level there was generally consensus that communities had internalised the positive things that they had learnt on the project with emphasis being put on the fact that it was not easy to forget the things they had learnt as they had adopted these lessons and incorporated them into normal practices.

- Women and children who are the main collectors of water for domestic use have been afforded more time to engage in productive pursuits as the time required for a round trip to collect water has been reduced for an increased number of households.
- Working in groups has created a good foundation for the establishment of viable and sustainable community social support systems. In this respect, communities mentioned that in the execution of such tasks as institutional latrine building and head works construction that require community contribution, community members who were not in a position to contribute through either old age, illness or some form of incapacitation were excused with other members standing in for them.

- The cohesiveness or unity of purpose that has characterised the implementation of the project (traditional and religious leaders taking a leading role in enforcing health seeking behaviour) has generated momentum that can be exploited for the expansion of similar activities and the initiation of new community development interventions.

- In Hygiene Promoters as well as Community and School Health Clubs the project managed to create a local resource base for hygiene education. In this respect, while communities could continue to rely on these structures for hygiene information, they also provided an opportunity for the reinforcement of good hygiene messages which would in turn encourage behaviour change.

Programme Sustainability

Sustainability was made synonymous with a situation where communities continue to enjoy the same or increased level of benefits after external support has been withdrawn. Sustainability could therefore be achieved by building and strengthening problem solving capacities in communities so that they are enabled to solve problems whenever they arise. Sustainability was therefore analysed within the context of the communities' ability to organize and mobilize resources, take initiative, self-diagnose and resolve conflicts. The Consultant acknowledges that it was not feasible to achieve sustainability in so short a project time frame and through this intervention alone. Nevertheless, some commendable effort to ensure sustainability has been invested in this project, and it is expected that the fruits of this work will only be witnessed in years to come. For instance, in relation to water supply, the training and equipping of Village Pump Mechanics with tools is a positive move in terms of ensuring that down time of water points is removed. The establishment of a facility for procurement of borehole spares within the district should also be understood against this background. Similarly the training of latrine builders at the community level as well as the provision of tools for their use also ensured that the necessary skill would be available at the local level. This was a catalyst for sustainability given the observation that by the end of the project, a number of self- initiated latrine construction projects had been completed. In Hygiene Promoters, the project had managed to create a local skills resource base that can continue to encourage positive behaviour change. For these reasons, it can be argued that the project has put in place worthwhile strategies for ensuring sustainability.

Software

As one of its major components, the project sought to equip the communities with the requisite skills for effectively managing resources that were availed under the project. Training programmes that sought to make relevant skills available at the community level were therefore conducted against this background. These efforts saw Village Pump Mechanics (VPMs) being trained to repair water facilities, Water Point Committees (WPCs) being trained to manage the facilities as well as school health masters and hygiene promoters being trained to accurately and effectively communicate about health and hygiene issues. Communities therefore pointed out that through such efforts, the project had actually encouraged them to appreciate their potential in addressing common challenges as people from within their own communities who they had known and associated with for a long time were responsible for spearheading project activities. In this respect, taking initiative was identified to be the major starting point in driving this process and as such this approach could be adapted for use in addressing other community challenges. In this case, community based structures are the torch bearers who will continue supporting the processes.

In addition to the above observation, communities are very confident that they will continue to put into practice what they learnt through the project as they have internalised the information that was provided.

In introducing an initiative that addressed the felt needs of communities in the district given its prominence as a priority in the District Development Plan, the project had the characteristics of an intrinsically self-sustaining initiative on account of the existence of a shared vision between stakeholders. It is expected that these stakeholders will continue to provide technical and management support and co-ordination of this intervention whenever there is need. The momentum and enthusiasm that were generated in executing programme activities are expected to continue to drive efforts to protect communities against preventable diseases resulting from bad hygiene practices.

Traditional leaders wholly support this initiative and this acceptance of the project at that level has facilitated the scaling up of project efforts in the different communities in the district. In some areas, traditional leaders have made it a requirement that a latrine should be the first development that is made on all newly allocated residential plots.
Local income generating initiatives that are largely self-initiated during project tenure will continue to avail resources to maintain water points, improve home hygiene and construction of toilets among other things.

It was noted that most of the community groups and structures that were active in the execution of project activities are composed of Red Cross life members with inherent commitment to the operations of the organisation Resultantly, the likelihood of such structures continuing to promote relevant activities subsequent to the termination of the project was almost a given.

Institutional arrangements

Discussions with communities also revealed that the advent of VPMs had generally made the maintenance and repair of hand pumps relatively affordable and prompt as compared to the old system. It was pointed that their rates were lower than those that had been charged by the old DDF pump minders or Water Supply Operatives.

Collaboration with key stakeholders will ensure that communities continue to receive back-stopping support after programme support has been withdrawn. Spares provided to RDC for sale to the community will enable the communities to find the spares readily available and RDC able to support its constituency. The tool kits provided at ward level ensures availability of appropriate tools for use during service and maintenance of the boreholes.

Continued presence of ZRCS in the province also provides an opportunity for touch base with the District partners , community structures and leadership for continuity of momentum.

Hardware components in water and sanitation supplies

ZRCS has procured spares and stocked them in the Rural District council warehouse. Communities will come and procure form there using their savings for water point management and maintenance. The project also procured tool kits for the village pump mechanics and builders.

Albeit the efforts towards sustainability, some challenges are likely to occur which will dilute the sustainability momentum and subsequent outcome .Some of them are outlined below:

3.6 LESSONS LEARNT.

- Full engagement of grassroots participants contribute to success of projects.

- Spreading responsibility among extension workers builds sustainability and synergy.

- Cooperation of stakeholders brings oneness which ensures resolution of issues on time and in unison.

- Children can be effective agents of change if appropriately engaged.

- Visibility of community agents motivates them and increases community confidence in their work

- Project planning including resources available should involve all stakeholders to enhance transparency and accountability

Conclusions and Recommendations

Evaluation findings indicate that commendable progress was made in terms of creating the right conditions for ensuring adequate cholera preparedness and improving the health of communities. The above statement is applicable to both the hardware and software components of the projects. While it is too early to attribute any changes in behaviour to the project, it can-not be denied that the project has consolidated knowledge levels on health and hygiene in the communities. This knowledge can be used in the future for purposes of facilitating behaviour change. Against this background, it is suggested that future such initiatives should incorporate lessons from the project as detailed below:

- Future programmes should consider developing clear guidelines on the rehabilitation of water points based on the yield and the anticipated service levels of the water supply facilities. This would ensure that resources are directed where they are required most as opposed to the current scenario where some very low yielding water points were rehabilitated.

- The process of certification of completed works needs to be strengthened to ensure that resources are used efficiently resulting in a situation where rehabilitated works have a reasonable life span. This would obviously demand verification of work done by both program staff and beneficiaries thereby ensuring improvements in the quality of work.

- Future projects of this nature need to incorporate the mass distribution of safe water storage containers as a component of the Non-Food Items (NFIs) that can be distributed as dictated by realities.

- Given that positive behaviour change cannot be realized over a short period, projects of this nature should put emphasis on reinforcing relevant messages that encourage the expected changes in behaviour. In this regard, facilitators can be enabled to spearhead the process of monitoring behaviour change. This can be consolidated through the strengthening of peer review mechanisms at the community level. The provision of monitoring guidelines for this purpose can be considered against this background.

- Given that the water table in Chivi district has been receding over the past few years and that other options are more suitable as compared to boreholes in some parts of Chivi, future projects could put emphasis on other water provision options such as hand dug wells that have succeessfully been sunk in parts of the district. This also entails strengthening collection of baseline data on groundwater levels to inform community consultations and subsequent drilling and rehabilitation.

- Standards for the provision of girl friendly latrines need to be well defined and shared with relevant stakeholders so as to enable stakeholders to address existing service gaps.

- Projects of this nature should put in place strategies that ensure that community and school hygiene clubs that are created through project efforts do not die with termination of project activities. In addition, apart from ensuring their functionality, there is need to create an enabling environment to facilitate their effectiveness. Their acceptance as viable institutions at all levels would be important in this regard. This probably demands ensuring the existence of back stopping support from local community health experts (EHT) to ensure that these institutions continue operating to expectations.

- The development of strategies that build on the community identified most accessible sources of hygiene information should be given consideration in programmes of this nature. This should however also take into account community preferences on how hygiene information can be disseminated. Within this context, strenthening the capacity of the hygiene promoter to enable him/her to communicate accurately and effectively on hygiene would be worth considering.

- sustainability of maintaining the HPs (through payment of incentives) needs to be considered in future programming

1.0 INTRODUCTION

1.1 THE BACKGROUND

Recent years have witnessed an upsurge in diarrhoeal and other water borne diseases resulting in increased mortality rates from the same. 2008 particularly proved to be the peak year in terms of the incidence of cholera nationwide as 98 702 cases and 4 282 deaths were reported. (AMCOW Country Status Overview, 2011). This was against the background that in the light of the current economic meltdown in the country, government could not offer a response that was proportional to the crisis as it had been forced to reduce expenditure on social infrastructure. The impact of the epidemic has generally served as a reminder of the need to create conditions that promote prevention of similar outbreaks. In this respect, it has been observed that access to safe water supply and sanitation facilities is low, while most communities still practice high risk hygiene behaviours. This has been aggravated by the fact that the very low purchasing power of most households inhibits them from purchasing the necessary hygiene materials to practice good personal and domestic hygiene such as soap, disinfectant, buckets and jerry cans among others.

From the foregoing, the need to intervene remains paramount. Similarly the need to direct effort on preventive action in high risk areas has been evident, especially within the context of the background that should another outbreak occur, the country may not be in a position to adequately deal with the situation. The above situation prompted IFRC to initiate interventions focusing on mitigating the risk and impact of WASH related diseases.

1.2 PROJECT OPERATIONAL CONTEXT

The Red Cross movement , United Nations (through UNICEF) and several other development agencies have identified Zimbabwe as a country where consolidated efforts are required to meet the MDGs (UN Millennium Development Goals) especially those related to water, sanitation and hygiene promotion. In this regard the International Federation of Red Cross and Red Crescent Societies (IFRC(IFRC) under the Global Water and Sanitation Initiative (GWSI) obtained an EU grant that was provided through the ACP-EU water facility third call to fund the implementation of the Chivi Water, Sanitation and Hygiene Project – CHIWASH. The Zimbabwe Red Cross implemented the project in 16 wards of Chivi District, whilst the British Red Cross and the Finnish Red Cross were partners and co-donors to the total project cost.

The project whose main objective was to contribute to sustainable improvement in health and well-being for vulnerable people in Chivi district through improved access to safe drinking water and improved sanitation was implemented over a four year period that started in August 2011[2]. It consisted of three key components that included the software, hardware and the capacity building components. The hardware aspects of the project mainly focused on rehabilitation of boreholes as well as drilling new ones. In the area of sanitation, the project had supported the provision of household and institutional latrines. Software aspects entailed training of water point committees, village pump mechanics, latrine builders and hygiene promoters while capacity building component sought to enhance the capabilities of Red Cross staff as well as staff from implementing partner organizations to effectively execute their roles on the project.

At the end of the project, the IFRC 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. This assessment was essentially carried out within the context of set performance factors that include program relevance, program efficiency, program effectiveness,

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program impact and program sustainability as spelt out in the Principles for Evaluation of Development Assistance as spelt out by the Development Assistance Committee and that have generally been used in assessing the performance of community development and humanitarian initiatives since 1991. This report therefore documents the findings of the evaluation team as well as lessons and suggestions that will be useful in informing other projects implemented by the IFRC and its wider global membership of Partner and Host national societies. The Terms of Reference for the evaluation are attached to this report as Appendix I.

2.0 METHODOLOGY

The consultant applied several methods, which complemented each other, in order to obtain as much quantitative and qualitative information as possible, among them the following:

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

Data collection tools that were used in collecting the relevant information are attached to this report as Appendix II.

2.1 DESK STUDY AND LITERATURE REVIEW

A number of key documents were studied to get a deeper understanding of the project, main accomplishments, and challenges encountered. This exercise was important; as it was hoped that this would help the evaluation team to polish up its data collection instruments before embarking on field work. The document reviewed included the project proposal, Baseline Survey Report, Progress Reports, Mid Term Evaluation Report and other relevant project documents. This enabled the Consultant to utilize time efficiently as attention was then directed on those aspects that had not been sufficiently covered in the literature. In short it is the consultant's contention that literature review provided guidance in terms of what primary data collection had to focus on.

2.2 PRIMARY DATA COLLECTION

2.2.1 Household Questionnaire Administration

A total of 209 household questionnaires were administered as part of this evaluation. The household questionnaires obtained quantitative data on various aspects of water supply, sanitation and hygiene practices from selected water users in the four wards that were covered during the exercise. Data collection was done through ODK. Information obtained through household questionnaire administration was analysed using version 23 of the Statistical Package for Social Scientists (SPSS).

2.2.2 Key Informant Interviews

In the field, the evaluation team interviewed community leaders, representatives of partner institutions such as EHTs, Nursing staff at selected Rural Health Centres, School Health Masters and other key informants that were identified through ZRCS staff who coordinated implementation on the ground. ZRCS and IFRC staff members were also interviewed. The List of Key Informants is included in this report as Appendix III.

2.2.3 Focus Group Discussions

Twenty two different FGDs were conducted with different categories of stakeholders in the field. The separate groups who were covered through focus group discussions include ordinary community members (men and women), community health clubs, children, theatre groups, latrine builders, water point committee

members, hygiene promoters and members of the District Water Supply and Sanitation (DWSSC) sub-committee who are responsible for coordinating WASH activities in the district.

The FGDs mainly collected qualitative information, and the findings from these discussions have been used to further analyse developments, challenges and issues arising from the implementation of this project. The evaluation team has also used FGDs to validate and triangulate some of the findings from the household questionnaires.

While a guide was used in focus group discussions with adults, a different tool was used to collect information from children so as to maximize their participation in the deliberations. In this respect the H-Analysis participatory tool was used. The H – Analysis participatory is a visual aid that facilitates the collection of relevant information. The tool allowed children to share information on their experiences both prior to and after the implementation of the project while also accommodating discussion of issues that children were not happy with on the project as well additional things that they thought should have been included on the project.

2.2.4 Physical Inspection of Water-Points

Physical inspection of water points that were rehabilitated as well as those that were drilled under the project was conducted with the view of checking the working condition of the hand pumps and the condition of the head-works. For this purpose a check-list was developed to allow a systematic examination of the hand pumps as well as assessment of the condition of the head-works.

Physical inspections entailed visiting each of the selected water-points and while on site, physical examination of all the above ground components was carried out to identify faults and worn out parts, physical pumping tests were then conducted to determine the condition of the down-hole components. The factors taken into account in determining the condition of the down-hole components included weight of handle, number of strokes before water is discharged and amount of water coming out per stroke. In addition the history of breakdown was obtained from the users of the facilities. The inspection however did not include the dismantling of pump-head and pulling out of down-the-hole components as the time allocated to the survey was inadequate.

2.2.5 Direct Field Observation

The evaluation team also developed and applied an Observation Guide, with a list of issues to look out for in the field; among them practices in the usage of water, practices at the point of fetching water, in transit to the home and during storage in the home were observed. Visits to the households further enabled the team to observe basic hygiene practices in the home. Things like the existence of a pot rack, toilet, hand-washing facility within the vicinity of the toilet or rubbish pit among others were therefore part of the observation.

2.3 SAMPLING METHODOLOGY

- **Household questionnaire Administration**

The original proposal was to select seven wards through the 30*7 multi - stage cluster sampling technique. In accordance with this strategy, a total of 210 households were earmarked for household questionnaire administration. After going through relevant literature the proposed sampling procedure was revised taking into account realities on the ground. Sampling was therefore done in four stages as detailed below:

- Stage 1: All clusters were included in the evaluation. For purposes of implementation, the 16 wards were divided into four wards with each cluster comprised of 4 wards. In addition each cluster was under the leadership of a Field Worker from ZRCS.

- Stage 2: Wards for inclusion in the evaluation were selected at this stage whereupon one ward was randomly selected from each cluster. This effectively means that 4 wards that were covered by the project were included in the evaluation over and above the control ward that was also randomly selected. It was hoped that the situation in the selected ward in each cluster would be representative of the situation in the other wards in the cluster given that relatively uniform activities were implemented in the different clusters. The wards that were selected through this process are presented in the table below:

TABLE 2.1: Selected Wards for CHIWASH End of Project Evaluation

Source Of Water	Ward Name
Cluster 1	16
Cluster 2	21
Cluster 3	31
Cluster 4	29
Control Ward	7

- Stage 3: Villages within the sampled wards that were selected at the second stage were randomly selected for inclusion in the evaluation. In this respect, it was the Consultant's intention to select 20% of the villages in the selected wards. In this case it was assumed that on average a ward has 30 villages which effectively means that 6 villages were targeted for inclusion.

- Stage 4: Subsequent to the selection of villages, the next stage was the selection of households for household questionnaire administration. The intention was to randomly select 60 households in each ward but realities on the ground led to the revision of the sample size in Ward 31. In this case, many families have been forced to move from the area by the construction of the Tokwe Mukosi Dam and this resulted in the sample size being revised to 30. In the other wards it remained unchanged. The revision of targets in ward 31did not compromise the data that was collected as more than half the original population has moved from the area.

❑ Key Informant Interviews

Key informants were purposively sampled in accordance with the list of informants outline in the methodology section above.

❑ Focus Group Discussions

Participants for the focus group discussions were selected from the communities in the villages where household questionnaire administration took conducted a minimum of three such discussions per day and this enabled him to conduct a total of 22 such discussions.

- ***Observation of Sanitation Facilities***

Observation surveys for household sanitation facilities were carried out for all the households sampled in the project wards. In addition, all the schools which have benefitted through construction of toilets and establishment of School Health Clubs falling within the selected wards were covered during the evaluation.

- ***Water-point Observation Surveys***

Water-point observation surveys were conducted within the villages sampled for the household interviews. 30 boreholes were accordingly randomly sampled and visited for purposes of the inspection. This sample was made of 23 rehabilitated boreholes as well as 7 newly drilled boreholes.

2.4 DATA ANALYSIS

Quantitative data for this evaluation was analysed using the Statistical Package for Social Scientists (SPSS) version 23, while qualitative information from the two four wards was manually extracted from notes of FGDs and key informant interviews, and analysed according to themes. Direct quotes from these discussions and interviews are presented to liven up the report, but the identity of the source of information has been protected the evaluation team considered this to be necessary. Using SPSS, the evaluation team was able to generate frequencies, create relevant tables and cross tabulations and make graphical presentations.

3.0 PROGRAMME EVALUATION ANALYSIS

In order to determine whether the project made a difference, the situation at project completion was compared to the obtaining situation in a ward that was not part of the project area (Ward 7). The impact of the project however proved difficult to measure given that another NGO, CARE are currently implementing a WASH project in the same ward since May 2014. Assessing whether the project made a difference was however still possible as baseline information for the project area was available. The results of the evaluation are therefore discussed in the following sections. In addition a summary table on achievements of the project is included in this report as Appendix IV while scoring for the evaluation criteria is also included as Appendix V.

3.1 PROGRAMME RELEVANCE

In assessing relevance of the project, the evaluation sought to establish three main factors that include the following:

- The process used in establishing the nature and magnitude of the problem in the district whereupon it would be imperative to determine whether there was a problem in the first place
- Whether the project was the best way of responding to the identified problems and
- Whether there was adequate information to inform programming

Within the above context, relevance was examined at three different levels that include relevance at the policy level, relevance at the strategy level as well as relevance at the project level as outlined below:

3.1.1 Relevance at Policy Level

The extent to which the project was implemented within operational policy guidelines for implementing water, sanitation and hygiene programmes by the major stakeholders who include Zimbabwe Red Cross Society (ZRCS) as well as the Government of Zimbabwe was given attention in assessing whether CHIWASH was a relevant intervention. ZRCS mandate provides for service provision to satisfy basic human rights. UN General Assembly Resolution 64/292 of 2010 formally recognized access to clean water and sanitation as a human right and therefore called on states and international organizations to provide financial resources, build capacity and transfer technology particularly to developing countries in scaling up efforts to provide safe, clean, accessible and affordable drinking water and sanitation for all. Zimbabwe was among the countries that voted in favour of the above resolution and commitment to this was further demonstrated in the inclusion of clean water and sanitation as basic human right in the national constitution. This made the intervention relevant within the context of operational and policy guidelines for both ZRCS and the Zimbabwean Government. Furthermore capacity building of vulnerable communities for purposes of building their resilience against disasters falls within the realm of ZRCS' mandate. By implementing the project which put emphasis on community capacity building, ZRCS therefore enhanced the capacity of communities to fight such disasters as the 2008 cholera outbreak.

There was also evidence that the project complied with government policies given that besides adhering to constitutional provisions, implementation was done within the framework of the District Water Supply and Sanitation sub-committee (DWSSC) which is in line with the Government of Zimbabwe's decentralization of the provision of rural water supplies. In addition, the project addressed one of the priority areas in the Chivi District Development Plan. This was further enhanced by the fact that implementation within the framework of the DWSSC, apart from ensuring adherence to national policy guidelines also ensured compliance with national standards. Furthermore, Part IV of the Public Health Act compels any local

authority to provide safe water to people in its area of jurisdiction and given that among other things, the project sought to address issues of water safety in the district, it was relevant. This resonates with the government's strategic direction towards achieving Millennium Development Goals where at national level, the objective is to reduce the number of people without access to safe water supply and sanitation by 50%.

3.1.2 Relevance at Strategy Level

At the strategy level, the Consultant assessed whether the implementation modalities that were pursued were the best way of realizing optimum results on the programme. The Consultant therefore explored whether there were any advantages in doing things the way they were done on the programme. It was noted that implementation in collaboration with government ministries ensured compliance of the programme with Government of Zimbabwe standards and guidelines. In fact, involvement of government ministries in the major activities under the programme, for instance, in the training of Village Pump Mechanics (VPMs) and Water Point Committees (WPCs) ensured that communities would continue to get back-stopping support and therefore continue to enjoy the benefits of the programme long after termination of the project. This also coincided with the fact that decentralisation of health monitors/promoters is a national strategic issue in light of shortages of manpower in Government ministries that offer extension services. Furthermore, the strategy of promoting the use of local people like VPMs and WPCs to spearhead programme activities made the programme culturally and socially acceptable as these were people whom the beneficiaries had been acquainted with for a long time. Similarly government personnel who implemented different activities on the programme had sufficiently interacted with local communities to acquaint themselves with local customs and cultural stereotypes. Under the above circumstances, introduction of project components that magnified the role of women in the daily lives of communities did not prove very difficult to sell. Over and above the foregoing, it is important to realise that the Millennium Development Goals acknowledge water and sanitation provision as basic human rights that also serve to reduce the incidence of diarrhoeal diseases. This essentially means that CHIWASH contributed towards a global strategic goal to which Zimbabwe as a country subscribes.

3.1.3 Programme Relevance at Programme/Project Level

At the programme/project level, assessment of relevance entailed examining how the nature and magnitude of the existing problems that were defined in the project proposal were determined. This was a pre-requisite to determining whether the programme addressed the felt needs of the communities in the district and as such whether it proved to be an adequate response to the problems that had been noted.

- Existing evidence indicates that there are reasonable grounds for concluding that comprehensive preparations for project implementation were conducted. This applies to the analysis of the problem as well as the design of an effective response in CHIWASH. In this respect, it should be noted that ZRCS had participated in a National Water Supply and Sanitation Assessment in preparation for the project. This was complemented by the commissioning and execution of Needs Assessment and Baseline Survey exercises on WASH in the district in early 2010. These exercises revealed that Chivi District was a WASH service deficient area whose problems required urgent attention. Over and above this, ZRCS had worked in Chivi for a sufficiently long period to have a comprehensive understanding of the problems in the district. This was enhanced by consultations with government departments that were given emphasis prior to project implementation. Having established viable partnerships with stakeholders over several years, ZRCS also had the benefit of being fully appraised on the developments in the districts. In terms of water supply, efforts were made to obtain comprehensive information prior to the design of the project. For instance, a survey was conducted in 2012 to obtain information on boreholes that dried up. Subsequent to this, DDF was tasked to carry out detailed investigations on the potential to improve yield. The information that was thereafter provided with respect to the performance

of boreholes was however sketchy as demonstrated by the fact that targets for borehole rehabilitation had to be revised from 350 to 318 as more information was acquired during implementation. Against this background, DDF was able to provide information on areas where it was generally difficult to exploit ground water resources due to unfavourable hydro geological conditions. Borehole drilling under the project therefore focused on such areas. All these efforts therefore provided the project with the basis for addressing problems that were real and in this respect ZRCS was better positioned to spearhead project implementation as she had experience in implementing WASH projects both inside and outside of the district. The likelihood of such experience benefitting the project was therefore significant.

- The programme was also conceived at a time most parts of the country were recovering from high case-loads of cholera with more districts under threat from the spread of the disease due to critical shortages of safe water supplies notwithstanding the government's lack of capacity to contain the epidemic. Additionally, "The Humanitarian Overview of 2008" for Zimbabwe had warned of the country's continued increase in cholera and other water –borne endemics which are associated with poor hygiene, sanitation and insufficient supply of safe drinking water. It was therefore not by coincidence that the project that was designed sought to contain cases of cholera where they were identified, arrest transmission of the disease and occurrence of new cases while also developing preparedness for future outbreaks. It is clear that there was adequate information to guide programming and in this case the programme was relevant at the programme level.

3.2 PROGRAMME EFFICIENCY

Assessing efficiency entailed examining the cost effectiveness of strategies that were used in executing activities under the CHIWASH 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:

- **Partnerships**

The project established strong partnerships with stakeholders and communities and this facilitated sharing of human and financial resources resulting in cost reduction and synergy. For instance, given the thin human resource base at the field level on the part of ZRCS, partnership with other stakeholders proved to be the most viable project delivery framework given the spatial coverage of activities in the different wards in the district. Additionally, given the staffing challenges that relevant government ministries generally experienced, the availability of health promoters, water point committees and traditional leaders who performed extension and monitoring functions ensured smooth running of operations without the ZRCS staff having to be on site every day. 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 resources retention in the community. This also induced a sense of ownership among community members which is a pre-requisite to sustainability. By stationing a Field Officer in each cluster, ZRCS enhanced coordination which in turn facilitated meeting of targets in the different wards. This also increased the chances of problems being resolved as quickly as possible.

At the operational level, partnership with government ministries seemed to have been strained by "unmet expectations" from government departments. For instance, though the project catered for allowances for government staff who played different roles on the project such as involvement in the training of community structures, government staff felt that something more could have been provided over and above what was provided for. This could have been due to the fact that some NGOs working in the district could be providing higher incentives. This could further have been aggravated by the common perception that the programme

did not stick to government guidelines with respect to the level of subsidies in the construction of household latrines. In this case government guidelines provide for a subsidy of one cement bag for household toilet construction and yet the project provided a subsidy of five bags. This was however in line with the guidelines in the national strategy to accelerate access to sanitation and hygiene of 2011 that provided for a subsidy of 5 bags. Government approach was however changed midway during the course of implementation as the guideline had been revised to provide for limited subsidy. While ZRCS was aware of this change in strategy, it was not possible to provide subsidy in line with the new approach as communities had already been informed that they would receive a subsidy of five bags from the beginning. Revision would therefore have made ZRCS an unreliable partner notwithstanding that it is very doubtful that much would have been achieved in increasing access to sanitation. This resulted in some form of discord irrespective of the fact that sticking to guidelines would probably have resulted in the project achieving far less than it actually achieved. The need for flexibility in project implementation therefore needs no emphasis in this respect. Against this background, the issue of subsidy appears to have been blown out of proportion given that CARE which is implementing a similar project in Ward 7 is providing a subsidy of six bags for latrine construction.

Despite the scenario described above, it must be noted that without the level of cooperation between ZRCS and government partners that was noted, the project would probably have suffered a still-birth. At the beginning of the project, DDF offered project staff two offices for use during the course of the project. The offer was however not taken up as more office space was required. Within this same context, it should be noted that DDF provided all storage space for project materials during the course of the project. In addition, water testing that was done as a joint exercise between ZRCS and the Ministry of Health and Child Care was further evidence of sharing of resources between partners. This was also demonstrated in that ZRCS Field Officers for the four clusters were provided office accommodation at health institutions

- **Community Participation and Contribution**

The project had a strong community contribution component where the project participants contributed bricks, sand, digging the pit and part payment for the builder in the construction of toilets. This cost sharing strategy enhanced not only community unity but stretched the budget to cover more families. This created a platform for the establishment of community social safety nets initiatives. This is apparent in the fact that it was common practice for those who could not contribute as expected for one reason or the other to get assistance from other community members. It was however noted that the level of community participation varied which would suggest that there was no insistence on achieving standards for as long as there was participation. This was apparent in the different ways in which communities constructed apron and spillway as part of the civil works at their boreholes. While others used standard forms as is current practice on WASH projects others used bricks.

While some communities contributed to buy fencing materials others left their water points either unfenced or poorly fenced. Such lack of uniformity suggests that though community participation was a central component of the overall strategy for executing project activities it compromised adherence to expected standards. This was also observed in the fact that the quality of headworks at the rehabilitated as well as newly drilled boreholes was not uniform. Figure 3.1 demonstrates some of the disparities in the quality of civil works at the boreholes that were rehabilitated and this further demonstrates that common standards were not adopted on the project.

(a) Well fenced borehole with apron and spillway intact

(b) Fenced borehole without apron and spillway

(c) Fenced borehole with complete apron and spillway

(d) Unfenced borehole with apron and spillway but with poor drainage

FIGURE 3.1: Disparities in the quality of civil works

❑ Borehole Drilling

In the drilling of new boreholes, one of the major conditions in the contract entered into with the Contractor was that payment would only be made for wet boreholes. This so called "wet hole contract" for drilling proved to be efficient as it eliminated the risk of paying for unsuccessful boreholes as would have been required had contracts for siting and drilling been separate. In the absence of the requisite capacity to supervise drilling within the project partnership, the adopted strategy however fell short when it failed to appoint an independent qualified supervisor to oversee the drilling operations. Alternatively, the certification process could have been strengthened through ensuring that a technically competent supervisor visits all the boreholes upon their completion as well as at the end of the warranty period so that all the boreholes that do not perform to expectations are not certified successful. Consequently, the drilling contractor was given room to take short cuts as well as to unilaterally declare success of the boreholes notwithstanding the need to achieve sustainable yields for hand-pump abstraction. The strategy that was adopted meant that the contractor could perform capacity tests on his own and unilaterally declare the boreholes successful. Against this background it was noted from the physical inspections of the drilled boreholes that 57% of the 7 boreholes checked during the survey were poor yielding given that they dried-up before delivering adequate water to all the users throughout the year. This suggests that the Contractor could have unnecessarily declared some extremely poor yielding boreholes as successful. This is against the background that according to existing records all the boreholes that were drilled had a yield of 0.25l/s or more and are therefore not expected to dry up at any time of the year.

- **Rehabilitation of Boreholes**

Rehabilitation activities included boreholes that are poor yielding, with some of the facilities drying-up throughout the year. While physical inspection of 23 rehabilitated boreholes indicated that only one borehole (4%) dried up throughout the year, 30.4% of the facilities tend to be extremely poor yielding during the dry season, the time which the respective communities solely rely on groundwater sources for their domestic water supplies. In this respect, resources were utilised on facilities that did not serve the intended purpose during certain times of the year or even throughout the year. For this reason the project could have considered alternative technologies especially in areas where deep wells or family wells could be constructed successfully. Such technologies have successfully been used in parts of the district. Alternatively, efforts to establish whether the possibility of maximizing the exploitation of the water column through addition of more pipes in the affected boreholes would improve the situation could be explored. Such efforts could also cover newly drilled boreholes that are not performing to expectations. It is however doubtful whether this would significantly improve the situation. A summary table on the status and performance of rehabilitated and drilled boreholes is attached to this report as Appendix VI.

- **Pump Fitting**

The adopted strategy on the project was that pump fitting for all the rehabilitated and newly drilled boreholes would be executed by the VPMs who were trained on the programme. All the newly drilled boreholes that were visited during the survey were functional thereby showing good workmanship with respect to pump installation. Information gathered during the survey indicated that 31% of the boreholes that were rehabilitated had broken down at least once after rehabilitation and yet only 4% were on breakdown during the evaluation. This could be symptomatic of the fact that the Operation and Maintenance system (O and M) is working very well.

- **Training Programmes**

Most community trainings were conducted in venues within the communities and this generally proved efficient. This was an efficient cost sharing strategy that led to the success of the initiative. Had such activities been executed at venues outside the district, the associated costs would have been much higher. In discussions with different community groups the absence of provisions for refresher courses for the various groups who were trained for relatively shorter periods was often cited as having the potential to dilute the level of success on the project. It however seems logical to assume that this was deliberate, taking into account the fact that most of the relevant community structures had received training on previous WASH programmes in the district. This therefore makes the strategy that was adopted efficient.

3.3 PROGRAMME EFFECTIVENESS

Effectiveness of the programme was assessed within the context of the programme's ability to deliver the expected outputs as presented in the Project Proposal. The assessment was therefore done in relation to all project components that include the following:

- Access to and utilisation of safe water sources
- Access to and utilisation of appropriate sanitation in homes and institutions
- Health and hygiene practices
- Capacity Building

3.3.1 Access to Water Supply Facilities

- ***Type of Water Source***

There were different sources of water for communities across the four wards that were covered in the evaluation. On average 77% of the residents across the four wards got their water from a borehole during the wet season whereas 85% used the same sources during the dry season and this compares favourably against the situation prior to project implementation where 64% of the respondents sourced their water from boreholes. This further indicates that less number of households used boreholes as their main source of water for cooking and drinking during the wet season. This was due to the fact that during the wet season they had access to other sources, both safe and unsafe. The situation pertaining to sources of water used by different households in the different wards is summarised in Table 3.1 below:

TABLE 3.1: Type of Water Source for drinking

Source Of Water	Average	Ward 16	Ward 21	Ward 29	Ward 31
Borehole	85.4	60,0	94.9	94.7	100.0
Protected dug well	0.5	1.7	0.0	0.0	0.0
Unprotected dug well	2.4	8.3	1.7	0.0	0.0
Protected spring	0.5	1.7	0.0	0.0	0.0
Unprotected spring	5.8	18.3	0.0	0.0	0.0
Surface water	4.4	10.0	1.7	3.5	0.0
Protected family well	0.5	0.0	1.7	1.7	0.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Results from the household interviews also show that the proportion of households who obtained water from improved water sources improved after project implementation as compared to the situation at project inception as presented in the baseline survey report for the project. In addition, the situation compares favourably against results from the Multiple Indicator Cluster Survey (MICS) report (ZIMSTAT, 2014) which indicated that 67.5% of the households in rural areas and 64.3% of the households in Masvingo Province used water from improved sources. According to categorizations of the WHO/UNICEF Joint Monitoring Programme (JMP) for Water and Sanitation, sources that are likely to be of suitable quality are regarded as "improved sources" while sources that are not of suitable quality are regarded as "non-improved sources.' From the foregoing, while it can be concluded that Chivi district compares favourable against the situation for Masvingo province of which Chivi District is an administrative component, figure 3.2 further indicates that the CHIWASH project improved access to improved water sources for most households. In this respect, the proportion of households using improved water sources as their main source of water for cooking and drinking by the end of the project vis a vis the situation prior to project implementation as well as in comparison with the situation across Masvingo Province (MICS) shows that there are fewer households accessing water from unimproved sources than they were at project inception as well as in comparison to the

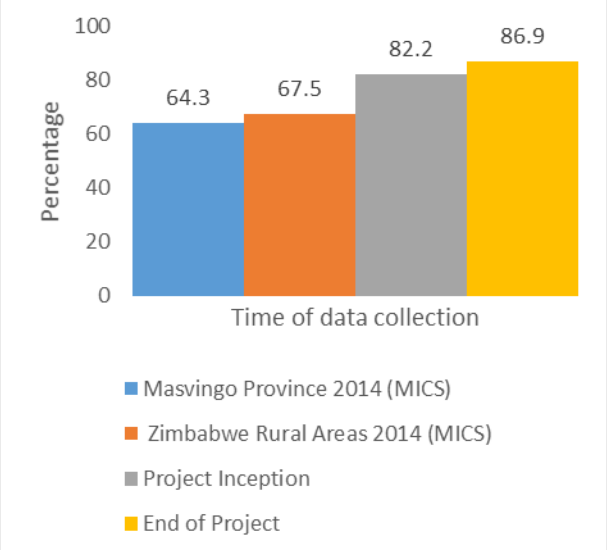

FIGURE 3.2: Proportion of households using improved water sources

provincial situation. This is an indication of the effectiveness of the project as it resulted in an improvement of the situation in the district.

- ***Distance to Water Source***

According to the National Definitions of Access to Water, Sanitation and Hygiene (National Action Committee for Water, Sanitation and Hygiene,2012) a standard walking distance to a water point of 500m is recommended for rural areas. In this respect, a sizeable proportion of households in Chivi District are either un-served or underserved as 70.9% of the households were travelling distances in excess of the recommended 500m to obtain water. While this is the case, it is important to note that for rural areas like Chivi this standard is difficult to achieve due to three major factors that include unfavourable settlement patterns, the mountainous terrain which demand a wider spatial distribution of water points not necessarily close to where people live as well as the hydro geological conditions that generally make the exploitation of ground water resources difficult.. Given that the water table in Chivi district has been receding over the past few years and that other options are more suitable as compared to boreholes in some parts of Chivi, future projects could put emphasis on other water provision options. The introduction of alternative options would however be dependent on the success of deliberations with the DWSSC which on this project insisted that other options are not viable. This is even more necessary taking into account that some of the existing boreholes are used by more than the recommended households which increases the frequency of breakdowns. The recommended borehole to population ratio for rural households is one borehole for 250 families/households. Table 3.2 provides an idea of the distances that people have to travel to get to their nearest water sources.

TABLE 3.2: Walking Distances to nearest water source

Distance to water source	Ward 16		Ward 21		Ward 29		Ward 31	
	Wet Season	Dry Season	Wet Season	Dry Season	Wet Season	Dry Season	Wet Season	Dry Season
Less than 500m	33.3	20.0	18.6	6.8	26.3	24.6	46.7	36.7
Between 500m and 1km	41.7	51.7	50.8	57.6	54.4	56.1	36.7	46.7
More than 1km	25.0	28.3	30.5	35.6	19.3	19.3	16.7	16.7
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

- ***Time taken to collect water from nearest source***

Within the context of the discussion on distance to the nearest water source, it should also be appreciated that the quantity of water used for domestic purposes is affected by the distance that one has to travel to access water. This is even worsened where one takes relatively long for the round trip for purposes of collecting water either due to the distance involved or conditions at the water point such as over-crowding, poor yield resulting in users having to wait for recharge or poor water discharge of the water lifting device among other reasons. In Zimbabwe, it has therefore been recommended that a round trip for purposes of collecting water for rural households should not exceed 30 minutes to accomplish. On average 46.1% of the households across the four wards spend up to 30 minutes to bring water home in the dry season while this

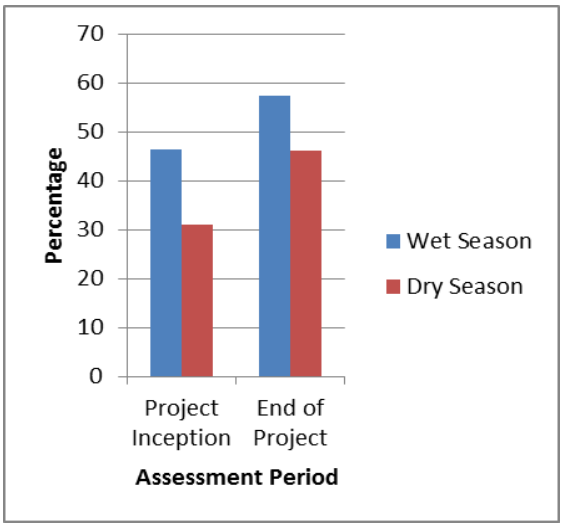

FIGURE 3.3: Households collecting water within 30 minutes

applies to 57.3% of the households during the wet season. At project inception 31% of the households collected their water within a time frame of 30 minutes in the dry season.

While it can be argued that the situation in the district needs improvement, it is evident that the situation for the district compares favourably against the national situation as presented in the MICS report. The MICS report indicates that 27.5% of the households in rural areas of Masvingo Province fetch their water within a time frame of 30 minutes. This figure is even lower than the current average for households in Chivi district in the dry season which stands 46.1% according to findings of the end of project evaluation notwithstanding that during the dry season, water supply sources are relatively further than they are in the wet season. In addition to this, results from the evaluation indicate that the number of households fetching water within a time frame of 30 minutes has increased after the project as compared to the situation at project inception. Figure 3.3 graphically captures the situation described above.

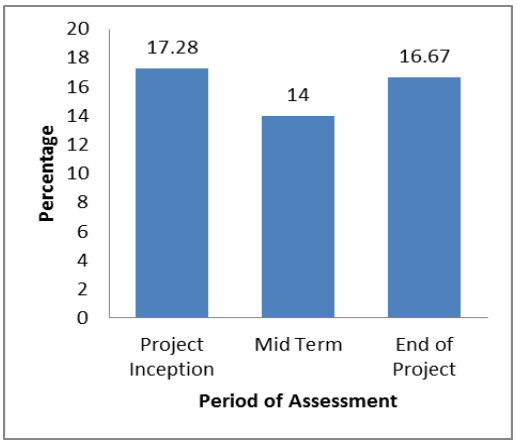

FIGURE 3.4: Quantity of water used per person per day

Under normal circumstances, the situation where a significant proportion of households walk long distances for periods in excess of 30 minutes in search of water undermines the utility of adequate water for domestic use at household level. According to recommended standards in Zimbabwe the minimum water requirement per household should be such that all household members should have access to a minimum of 20 litres per capita per day. The situation in the district prior to project implementation, at mid- term as well as at the end of the project is graphically presented in figure 3.4.

- ***Water Handling at Household Level***

Water Treatment

Among other aspects, the study also focused on safe water management at household level whereupon focus was on the water storage practices and behaviour as well as on water treatment practices. 10.7% of the households indicated that they did something to their water to make it safer to drink. While this is a small proportion of households, this also indicates that a proportion of the population does not regard the water that is provided as safe. From this perspective, where drinking water does not meet the expected quality standards, the majority of community members are exposed to the risk of water borne diseases. The methods that were used by those who treated their water across the 4 wards are indicated in table 3.3.

TABLE 3.3: Level of Utilization of Different Water Treatment Methods

Method of water treatment	Average	Ward 16	Ward 21	Ward 29	Ward 31
Boil	61.9	65.0	66.1	58.8	51.7
Add bleach/chlorine	0.8	3.3	0.0	0.0	0.0
Strain through cloth	4.8	3.3	3.4	0.0	3.4
Let it stand and settle	0.9	1.7	1.7	0.0	0.0
Water treatment tablet	31.6	26.7	28.8	41.2	44.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

The above scenario points to the need for positive behaviour change. In this respect, health and hygiene education probably need to put more emphasis on behaviour change as opposed to awareness. This is even

more necessary against the background that 73.1% of those who used water from unimproved sources did not do anything to their water to make it safe before they drank it. This is also emphasised in that the current practices do not compare favourably against the current practices for rural areas nationally as well as against the situation prior to project implementation as demonstrated in figure 3.5. From the focus group discussions that were conducted with both adults and children, there was evidence that communities were aware of the reasons for treating water prior to consuming it as well as with the different methods of treating water. This further buttresses the view that hygiene education efforts need to put more focus on behaviour change as opposed to increasing awareness. The low figures on water treatment could however be accounted for by the fact since more people now have access to borehole water as compared to the situation at project inception, they regard it as safe water and therefore they do not see the need to treat the water.

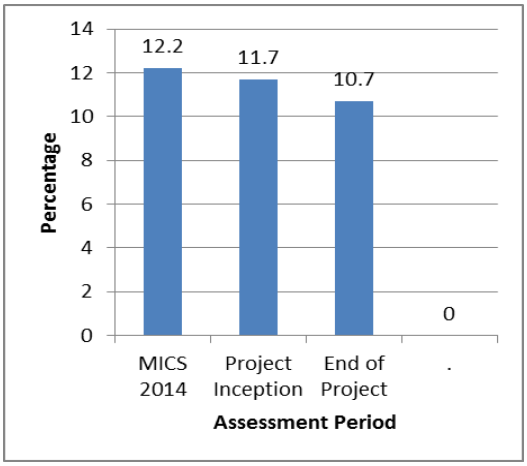

FIGURE 3.5: Households treating drinking water

Water Storage

Results from the evaluation indicated that the use of the same containers for fetching water as well as for water storage was the general practice in the district. In this respect, the communities were generally practising safe practices as 94.5% of the households were using closed containers. While it can be argued that some households might have used such containers to avoid spillage, a comparison of the situation at project inception vis a vis the situation at the end of the project would give the impression that the project actually made a difference in promoting good practices. This is demonstrated in figure 3.6. Given the small percentage of households that use containers without lids, the need to reinforce relevant messages as well as enhancing the capacity of systems and structures for supporting hygiene capacity building in the different communities is therefore imperative. The establishment of community hygiene clubs through project efforts is therefore a positive development as it becomes a platform for creating viable and sustainable community monitoring mechanisms which can lead to the adoption of positive hygiene practices.

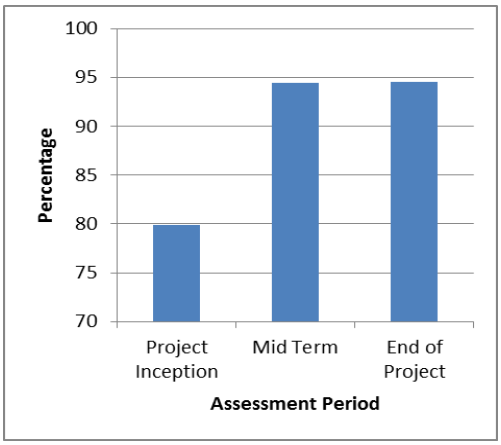

FIGURE 3.6: Households using covered water storage containers

3.3.2 The Status of Sanitation in the District

- ***Household Sanitation Facilities***

Household interviews as well as enumerators' observations indicated that 59.2% of the households across the district had access to a toilet of one type or the other with the remainder (40.8%) having no access to any type of facility and therefore supposedly sharing with neighbours or practicing open defecation. According to the results of the baseline survey that was conducted prior to the implementation of the project, 44.1% of the households in Chivi had access to some form of toilet and this figure improved to 59.2% after implementation of the CHIWASH project. In addition, while 44.8% of the households confessed to practising open defecation according to results from the same baseline survey, 55.9% of the households actually had no toilets and were therefore supposedly practising open defecation. The figure

of households practising open defecation had been reduced to 35% by the end of the project. In this respect, the project recorded improvements in terms of ownership of some form of toilet as well as reduction of the proportion of households resorting to open defecation (OD) as illustrated in figures 3.7 and 3.8

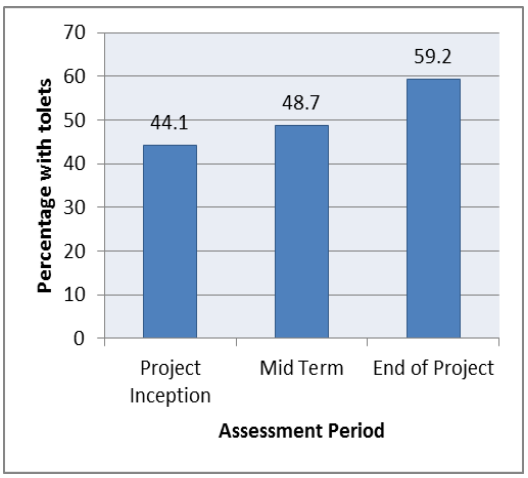

FIGURE 3.7: Households with some form of toilet

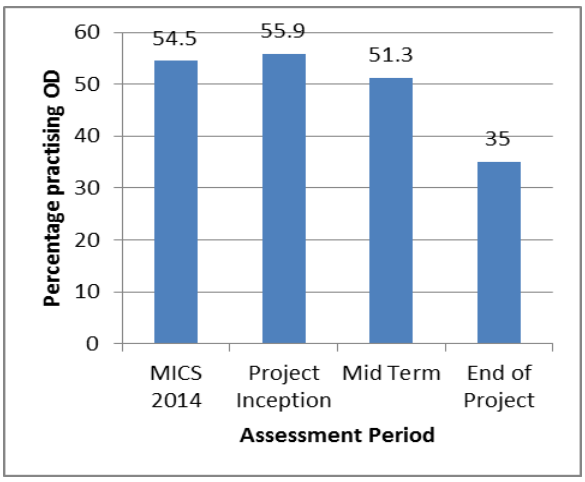

FIGURE 3.8: Households practising OD

The proportion of households resorting to open defecation was lowest in Ward 16 where 20% of the households indicated that they used the bush for human excreta disposal and highest in Ward 21 where 54.2% of the households resorted to open defecation. Details pertaining to ownership of toilets across the four wards covered in the evaluation are summarised in table 3.4.

TABLE 3.4: Distribution of toilets by type and ward

Type of toilet usedby the household	Average	Ward 16	Ward 21	Ward 29	Ward 31
Bush	35.0	20.0	54.2	35.1	35.0
Pit Latrine	13.1	10.0	10.2	10.5	13.0
BVIP Latrine	50.5	68.3	32.2	54.4	50.5
Neighbour's toilet	1.5	1.7	3.4	0.0	1.5
Total	**100**	**100.0**	**100.0**	**100.0**	**100.0**

The information presented above should be appreciated against the background that the BVIP latrine is the standard latrine technology that has been approved for use in the rural areas in Zimbabwe. In this respect, official statistics on the accessibility of BVIP for rural communities in Zimbawe indicate that 35.9% of rural households have access to this sanitation technology. (MICS, 2014). Within this context, 50.5% of the households covered during the evaluation were using the BVIP latrine which is an improvement from the situation at both project inception and mid term where only 22.1% and 29.6% were using the BVIP latrine. Figures obtained in the control ward indicated that about 29% of the households in Ward 7 were using the BVIP latrine. Apart from improvement of such a magnitude being attributable to the latrine construction component of the project, own initiated toilet construction that was influenced by peer pressure and follow up by Health Promoters can also be taken into account. Given the sizeable proportion of households that either use pit latrines or neighbours' toilet facilities, the chances of increasing accessibility to the BVIP latrine are high as such households have already taken the first step up the sanitation ladder. Some encouragement is therefore likely to see them adopting the recommended technology. Against this background, it is hoped that the presence of hygiene promoters and health clubs within the communities will encourage the anticipated changes with respect to utilization of toilet facilities for human waste disposal. This perception is not far- fetched given that in all the focus group discussions that were conducted, it was commonly asserted that self- supported toilet construction had increased dramatically as a result of appreciation of the latrines that were being constructed for selected households through project support. This is plausible given that the reasons for having a toilet were mainly linked to disease prevention for most respondents. In response to why they thought it was necessary to have toilet the following responses were given: prevent spread of diseases (79.9%), prevent environmental pollution (31.6%), it is hygienic (29.2%), it ensures privacy (9.1%) and enhance status in community (4.3%), The extent of the change in the use of the BVIP latrine at project inception as well as at the end of the project is visually presented in figure 3.9.

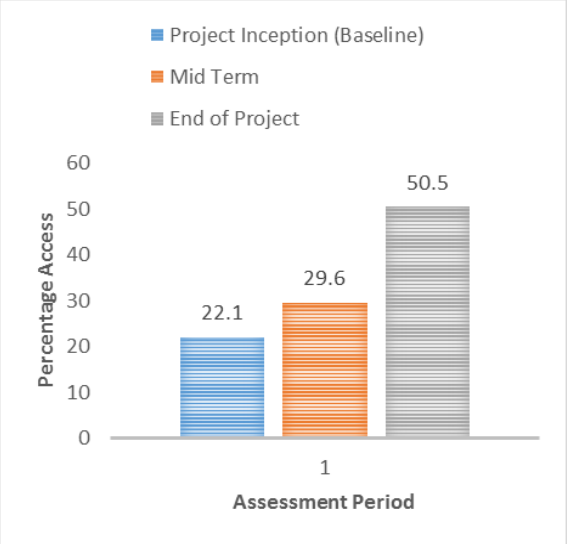

FIGURE 3.9: Households with access to BVIP

- ***Institutional Latrines***

The construction of toilets at schools and rural health centres was a planned activity in the project. In this respect, schools and clinics benefitted from the construction of toilet blocks. The Ministry of Health and Child Care which defines standards for latrines in accordance with the Public Health Act, recommends a standard of 25 children to 1 squat hole for boys and 20 children to 1 squat hole for girls. Information from the four schools that were covered in the evaluation indicates that there was an improvement for both boys and girls though for the latter the required standard was not achieved. While for boys, the ratio was 23 boys to 1 squat hole at project inception, this ratio had decreased to 19 boys to 1 squat hole at the end of the project. In this respect sanitation provision for boys fell within the recommended standards. At project inception the ratio for girls was 24 girls to 1 squat hole with the project managing to reduce it closer to the recommended standard at 22 girls to 1 squat hole. The ratio could even be lower but due to the requirement for self-contribution, some schools managed to contribute for lower number of toilets and the equity was provided according to their means. For Utsinda School, in the control ward (Ward 7) the pupil to squat hole ratio for boys is 31 to 1 while for girls it is 27 to 1. These ratios are way above the recommended standard and probably serve to demonstrate that the project made a difference in the 16 wards where it was implemented.

From the observations that were made, the quality of toilets that were constructed was very high and addressed a felt need within the different institutions. At inception of the project, it was observed that the immediate vicinity of existing toilets was littered with human waste as inadequacy of facilities and lack of hygiene inside existing toilets led to school children practising open defecation. The environment around the toilets was observed to be faecal free while the toilets were also clean at the time of the evaluation. This can be attributed to the increase in the number of squat holes that came with the project as well as hygiene education delivery that was spearheaded by school health masters and school health clubs that were established or revitalised through the project. One major area where improvement in quality was registered was in the construction of disability friendly latrines with ramps and wide entrances to facilitate easy entrance of people who are wheel chair bound. Figure 3.10 is an example of one such toilet that was constructed at Mawadze Primary School. While the project intended to construct girl friendly toilets, appropriate designs had not been received from the responsible authorities by the end of the project. The project however still made efforts to address this as at a number of schools toilet block were not only allocated by sex, but by age group as well. At Dzingirayi Primary School in Ward 31 the entrances to each cubicle at the girls toilets had gates that allowed girls to lock themselves in once they went inside. The need for guidelines for construction of girl friendly toilets however remains paramount.

FIGURE 3.10: Disability friendly toilet at Mawadze School

- *Extent of Achievement of Targets in Latrine Construction*

Despite activities being started later than previously anticipated, it is significant to note that the project made commendable progress in the achievement of physical targets in latrine construction.. The details pertaining to achievement levels in this respect are summarized in table 3.5.

Table 3.5: Latrine Construction Achievements

WARD	COMMUNITY		SCHOOLS		HEALTH CENTERS	
	Target	Achieved	Target	Achieved	Target	Achieved
16	215	215	20	20	1	1
17	142	142	27	27	0	0
18	211	209	8	8	0	0
20	184	184	58	58	0	0
19	202	200	72	72	0	0
21	116	115	60	60	0	0
22	236	236	68	68	0	0
32	181	181	47	47	0	0
23	141	141	42	42	2	2
24	97	97	24	24	4	4
25	290	290	64	64	5	5
31	44	44	0	0	0	0
26	204	204	39	39	3	3

27	167	167	17	17	4	4
28	203	203	25	25	0	0
29	156	153	31	31	0	0
Total Achieved Per Category	**2789**	**2781**	**602**	**602**	**19**	**19**

From the above table, it is noted that only a few household latrines had not been constructed at the time of the evaluation while targets for school and health center latrines were achieved. According to deliberations from focus group discussions, the reasons for the non-completion of some domestic latrines vary but include failure to mobilize resources required on the part of beneficiaries, movement of beneficiaries from the project area and failure to complete construction before the termination of the project.

3.3.3 Hygiene Knowledge and Practices

- ***Hand washing***

Hand washing has been proven to be one of the most effective ways of breaking the faecal-oral route of disease transmission. It has been cited as the most cost effective health intervention to reduce the incidence of both diarrhoea and pneumonia in children under five (Cairncross et al, 2006). In this respect, it has been observed that hand washing with soap and water reduces the risk of diarrhoea by 44% and ARI by 23% among children under the age of 5. (MICS,2014) Within this context, appropriate hand washing behaviour includes two dimensions: hand washing at critical times and hand washing techniques. Evaluation findings indicated that communities in the district fared badly in terms of both dimensions. In the district, run to waste hand washing with soap/ash currently stands at 6.8 % against a baseline figure of 15%. The noted drop could be due to a combination of factors. Firstly it should be noted that the baseline survey was conducted just after the 2008 cholera outbreak such that a lot of emphasis was put on hand washing. This was therefore still fresh in the minds of community members just as was the loss of relatives through cholera. In addition, many organizations supported communities by distributing non-food items that included soap and since this was stopped the situation at the end of the project was different.

Despite the scenario presented above, it cannot be denied that the project has been able to reinforce relevant messages on this aspect. In focus group discussions it was generally agreed that one of the major issues that was covered as part of project efforts was positive hand washing practices. This could probably imply that though relevant messages had been delivered the rate of up-take was low and as such there was need to put emphasis on monitoring behaviour. The introduction of health clubs at different levels through the project therefore becomes a positive development in this respect. What probably needs emphasis is ensuring that such clubs will not die with termination of project activities. In addition, apart from ensuring their functionality, there is a need to create an enabling environment to facilitate their effectiveness. Their acceptance as viable institutions at all levels would be important in this regard. This probably demands ensuring the existence of back stopping support to ensure that these institutions continue operating to expectations.

In terms of critical hand washing times, communities in the district gave the following indications: before food (25.9%), after food (65.1%), before breast feeding or feeding a child (89.0%), before cooking or preparing food (14.4%), after defecation or urination (22.5%), after cleaning a child that has defecated/changing a dirty nappy (65.6%). From the results, it is evident that the need for the adoption of positive practices in terms of observing critical hand washing times needs emphasis.

- ***Disposal of Infants' Stool***

Research has indicated that children's stool is one of the major routes in faecal-oral transmission and yet most WASH programmes remain silent on this important subject. To begin with, the prevalence of gastrointestinal pathogens is high in infants' stool such that the presence of infants' faeces on household premises and the failure to properly dispose of infants' faeces is closely related to increased incidence of diarrhoea in young children especially those under two years of age. The End of Term Evaluation therefore looked at the disposal of infants' faeces at household level. While the proper way of disposal of infant's stool is disposal into toilet, 56% of the households indicated that they used this method and this compared favourably with the situation for rural areas nationally as well as the situation prior to project implementation. Performance of the project in this respect is indicated in figure 3.11. Given that a significant proportion of households are still not following the recommended practices, the need to encourage positive behaviour change needs no emphasis.

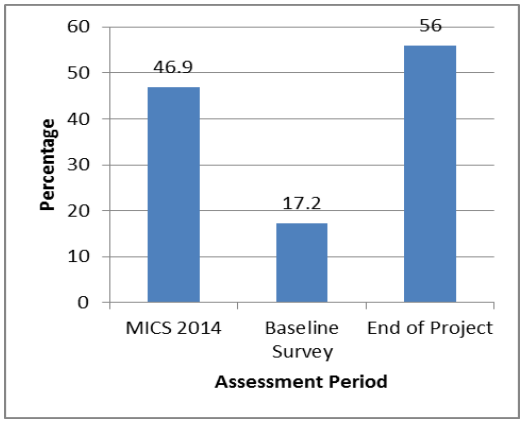

FIGURE 3.11: Households disposing of infant's stool properly

- ***Household Hygiene and Hygiene Enabling Facilities***

In assessing current hygiene practices, the evaluation also used the presence of hygiene enabling facilities as a proxy for the use of such facilities and therefore pursuance of positive hygiene practices. At face value the indications are that communities are pursuing favourable practices. A comparison with the situation at mid-term would however suggest otherwise as indicated in figure 3.12. Over and above the facilities included here, the evaluation also observed whether there were specific places for hand washing in the different households that were visited. This was deemed to be a reliable alternative to observations or self-reported behaviour. In this case, the presence of a specific hand washing place with water and soap or other type of cleansing agent would be regarded as proxy for correct hand washing practices. Results from the evaluation indicated that only 15% of the households that were visited had specific hand washing places. Of those that had these facilities, observations showed that water for hand washing was present in only 9.7% of the cases while hand washing agents were present in 7.3% of the cases.

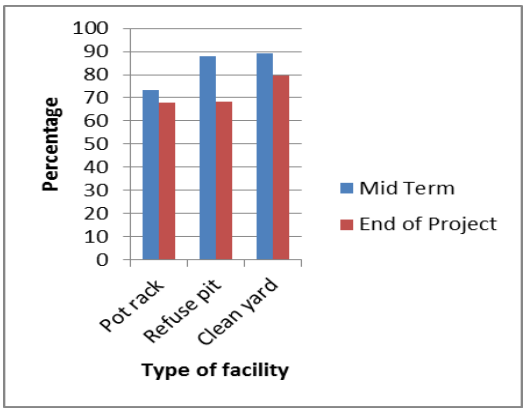

FIGURE 3.12: Households with selected hygiene enabling facilities

The scenario above therefore indicates that improvements need to be made on current practices for household hygiene in the community. While this is the case, discussions within the communities indicated that communities were aware of what needs to be done. In one focus group discussion, a woman participant remarked, "***Kana kune vachiri kupoya, ngavaise chigubhu gear vageze maoko vasati vasvika pamkova" (To those who still go out to the bush to relieve themselves, there is need to establish a hand washing station in the direction you normally take for such errands so that you are able to wash your hands on your way back before you get back to the house)***. Given that behaviour change is a process that requires time, the project cannot be expected to have influenced entire communities in the short period in which it was implemented. Within this context, the project should be commended for creating an enabling environment for behaviour change to ultimately materialize. Firstly, the strategy of using hygiene promoters who are resident in the communities as well as the establishment of community health clubs has created a local resource base that will always be present within the communities to continue encouraging behaviour change. In these structures, effective community monitoring mechanisms have been established and these will continue to

encourage positive behaviour change. The household competitions that are promoted through these structures will contribute to encouraging behaviour change.

In line with the above observations, chances of communities learning from each other after appreciating benefits of possession and use of hygiene enabling facilities are high. In this case it cannot be denied that communities have learnt positive things from the project. This was demonstrated in the fact that quite a significant percentage of household latrines have been constructed without support from the project after appreciating the benefits of the same. This was summarized in one focus group discussion where a participant remarked, ***"Tinotenda nekuuya kwakaita Red Cross nekuti munharaunda medu machena, hapachina vanozvibatsira pose pose. Kana isu tisina kuwana rubatsiro rwekuvaka matoilet takatovaka tega tawona manakiro azvo" (We are very thankful to Red Cross for teaching us positive practices as we now live in a faecal free environment. Even some of us who did not receive support in latrine construction have now constructed our own toilets after appreciating the benefits from those who were supported).*** It is therefore anticipated that this will continue to drive communities to adopt good hygiene practices as the knowledge is resident within the communities. For instance, communities that were visited exhibited a concrete understanding of good solid waste disposal practices, including the need for separation of waste. Figure 3.13 shows two household refuse disposal pits used in the separation of waste

FIGURE 3.13: Homestead with two pits for separation of waste

- ***Institutional Hygiene***

Apart from focusing on communities, the project also gave attention to institutions that included schools and Rural Health Centres. As is the case with communities, relevant messages on hygiene appear to have been effectively delivered as school children are aware of the recommended practices as well as with the attendant costs of behaving otherwise. Unlike in the communities, school children appear to have adopted positive practices with support from school health masters trained under the programme as well as health clubs that have been established in the different schools. In this respect, school children cited a fecal free environment as one of the benefits of the program. Moreover there was evidence that toilets were properly managed as none of the visited latrines was observed to be dirty. In all the schools that were visited, school children mentioned that regular maintenance of the school latrines was their responsibility.

School children also demonstrated awareness on the need to use water from safe sources as a way of preventing diarrhea. Similarly, it was apparent that hand washing after toilet use had been adopted as a way of life in the different schools. This was evidenced by the different types of hand washing facilities that children used. Use of such facilities was confirmed by school health masters who supported school health clubs to ensure that water as well as soap or other forms of hand washing agents were always available. In one of the schools soap for hand washing was catered for through levies as the School Development Committee had endorsed the decision to buy soap for hand washing. While this is the case, there is need to continue reinforcing messages that encourage good hygiene behavior. This is in light of the fact that in some of the school latrines that were visited it was apparent that some children used their bare hands for anal cleansing subsequent to relieving themselves and thereafter smeared the dirt on the toilet walls. The presence of a trained school health master and functional health committees present opportunities for the reinforcement of appropriate messages. Figure 3.14 shows the level of improvisation in the provision of hand washing facilities.

FIGURE 3.14: School girl replenishing water for hand washing

- ***Hygiene and Sources of Hygiene Information***

In most hygiene programmes, the presence of vibrant systems and structures for communicating accurately and effectively about hygiene is of paramount importance. The evaluation therefore sought to establish the sources of information that exist in the district for executing this role. In this respect, 71.4% of the respondents to the household questionnaire indicated that they had heard or read a hygiene message at some stage three months prior to the evaluation. Ward 29 had the greatest proportion of households (75.4%) who had received such messages while Ward 31 had the least (66.7%). Ward 21 and Ward 16 were in between at 71.2% and 70% respectively. A variety of messages were received including the following: wash hands with water and soap (7.7%), dispose of baby faeces in the toilet (23.4%), wash hands with ash (2.9%), need for water treatment (18.7%) and stop open defecation (21.1%). The results give the impression that the level of penetration of appropriate hygiene messages is low. Consequently, future similar initiatives need to consider innovative ways of communicating hygiene messages effectively. The strengthening of current systems and structures for hygiene education would be a worthwhile exercise.

Within the context of the above discussion, communities in the district indicated that they received information on health and hygiene from different sources as summarized in Table 3.6.

TABLE 3.6: Sources of Hygiene Information

Source of Hygiene Information	Percentage of population who benefitted from source
School children	1.1
Community health club	5.0
Health Promoter	40.0
EHT/VHW	8.3
Radio	1.7
Newspaper/pamhlet	1.7
NGO staff	8.3
Local clinic	5.6

Village meetings	1.7
Home/friends	1.1
church	1.1
Other	2.2
Not applicable	22.2
Total	**100**

The above results, essentially call for efforts that develop strategies that build upon the most accessible sources of hygiene information available within the identified community. This should however also take into account community preferences on how hygiene information can be disseminated. Within this context, building the capacity of the hygiene promoter to enable him to communicate accurately and effectively on hygiene would be worth considering. This is against the background 82.5% of the respondents to the household questionnaire indicated that there was a hygiene promoter in their neighbourhood. At the same time the visibility and functionality of community health clubs needs to be magnified. This is against the background that only 10.2% indicated that within their household, there was a member who belonged to a health club.

3.4 PROGRAMME IMPACT

Impact was assessed from two perspectives whereupon the qualitative changes in the lives of communities as well as capacity changes at the level of community structures and partner organizations became the major areas of focus. In this respect, it is important to note that focus was on outcomes of the project as opposed to outputs. Emphasis was on both the positive and negative aspects that could be attributed to the project. It is however difficult to isolate the impact of other interventions in the project area, and to fully attribute all the observed and reported changes to this intervention alone. Nonetheless, the evaluation team analysed the changes in relation to the results of the baseline survey that was conducted at the beginning of project implementation

- Discussions with stakeholders indicated that the project had enhanced opportunities for strengthening the communities' organizational abilities. For instance, it should be pointed out that Village Pump Mechanics and Water Point Committees were selected by communities using criterion that was developed at that level. Similarly, communities organized themselves to perform a variety of tasks on the project which was a sign that they had the ability to achieve results through their own efforts. Such tasks as the contribution of labour and locally available materials in the construction of school toilets and fencing of head works can be cited in this regard. It is hoped that through the emphasis on the need to observe water point committee constitutions that was a main feature of the project, communities will enhance local governance skills and transparency in the execution of all future community initiatives.

- The project has created an enabling environment for women and children to enjoy quality lives through the adoption of positive hygiene practices. Throughout the discussions that were conducted at community level there was generally consensus that communities had internalised the positive things that they had learnt on the project with emphasis being put on the fact that it was not easy to forget the things they had learnt as they had adopted these lessons and incorporated them into normal practices. This however does not necessarily mean that they are already pursuing positive practices. What cannot be denied, however, is the fact that awareness levels on good hygiene practices are high.

- Women and children who are the main collectors of water for domestic use have been afforded more time to engage in productive pursuits as the time required for a round trip to collect water has been reduced for an increased number of households.

- In addition to this, there was a negative side to it in that the reduction in time spent searching for water also led to loss of bonding time between the women since there is less interaction opportunities among them to consult/socialize adequately as before now that they have a borehole nearby

- Working in groups has created a good foundation for the establishment of viable and sustainable community social support systems. In this respect, communities mentioned that in the execution of such tasks as institutional latrine building and head works construction that require community contribution, community members who were not in a position to contribute through either old age, illness or some form of incapacitation were excused with other members standing in for them.

- Livelihood opportunities have been improved in the district as some communities have started nutrition gardens which have been used to augment family incomes. For instance, Chinjiva Village in ward 16 managed to establish a herbal garden whose aim was improvement in health and income through the sale of medicinal herbs. Moreover improving access to water supplies has also improved livestock watering opportunities and as such the project has enhanced opportunities for good animal husbandry. Over and above this, the establishment of income savings and lending groups were cited as one of the major spin offs of the project in a number of areas. This meant that with increased income earning opportunities communities had the chance to improve the quality of their lives.

- The project contributed to positive self-esteem. Those who constructed latrines were saved the inconvenience associated with compromised privacy that is synonymous with open defecation. Moreover, increased income earning opportunities have resulted in home improvements and the resultant enhanced self esteem has improved the level of socialization as demonstrated by one focus group participant who remarked, ***".Iko zvino hatichasvoda kupinza vaeni mumba nokuda kwekuti zvinhu zvese zvaringana, Dzimwe nhambo baba vanongouya neshamwari dzavo pavanodira nekuti havatarisire kuzosvoda" (Nowadays we do not feel uncomfortable at the prospect of welcoming visitors to our home as we have managed to put in place all the basic requirements in a home. Our husbands sometimes bring their friends home without warning as they are always certain that the home situation is not embarrassing)***

- The cohesiveness or unity of purpose that has characterised the implementation of the project (traditional and religious leaders taking a leading role in enforcing health seeking behaviour) has generated momentum that can be exploited for the expansion of similar activities and the initiation of new community development interventions.

- In Hygiene Promoters as well as Community and School Health Clubs the project managed to create a local resource base for hygiene education. In this respect, while communities could continue to rely on these structures for hygiene information, they also provided an opportunity for the reinforcement of good hygiene messages which would in turn encourage behaviour change.

- The project increased the level of interaction between Environmental Health Technicians (EHTs) and community members as fuel and transport for EHTs was provided for EHTs who are otherwise not mobile under "normal" circumstances that are dictated by the current economic realities. This therefore meant that communities had more access top specialised information on hygiene.

3.5 SUSTAINABILITY

Sustainability was made synonymous with a situation where communities continue to enjoy the same or increased level of benefits after external support has been withdrawn. Sustainability could therefore be achieved by building and strengthening problem solving capacities in communities so that they are enabled to solve problems whenever they arise. Sustainability was therefore analysed within the context of the communities' ability to organize and mobilize resources, take initiative, self-diagnose and resolve conflicts. The Consultant acknowledges that it was not feasible to achieve sustainability in so short a project time frame and through this intervention alone. Nevertheless, some commendable effort to ensure sustainability has been invested in this project, and it is expected that the fruits of this work will only be witnessed in years to come.

3.5.1 Software

As one of its major components, the project sought to equip the communities with the requisite skills for effectively managing resources that were availed under the project. Training programmes that sought to make relevant skills available at the community level were therefore conducted against this background. These efforts saw Village Pump Mechanics (VPMs) being trained to repair water facilities, Water Point Committees (WPCs) being trained to manage the facilities as well as school health masters and hygiene promoters being trained to accurately and effectively communicate about health and hygiene issues. Communities therefore pointed out that through such efforts, the project had actually encouraged them to appreciate their potential in addressing common challenges as people from within their own communities who they had known and associated with for a long time were responsible for spearheading project activities. In this respect, taking initiative was identified to be the major starting point in driving this process and as such this approach could be adapted for use in addressing other community challenges. In this case, community based structures are the torch bearers who will continue supporting the processes.

In addition to the above observation, communities are very confident that they will continue to put into practice what they learnt through the project as they have internalised the information that was provided. This was aptly summed up by one Ward Councillor who remarked that, ***"We acknowledge that we have been weaned off from Red Cross support but it will never be possible to wean us off the knowledge that we have acquired through project efforts."***

In introducing an initiative that addressed the felt needs of communities in the district given its prominence as a priority in the District Development Plan, the project had the characteristics of an intrinsically self-sustaining initiative on account of the existence of a shared vision between stakeholders. It is expected that these stakeholders will continue to provide technical and management support and co-ordination of this intervention whenever there is need. The momentum and enthusiasm that were generated in executing programme activities are expected to continue to drive efforts to protect communities against preventable diseases resulting from bad hygiene practices.

Traditional leaders wholly support this initiative and this acceptance of the project at that level has facilitated the scaling up of project efforts in the different communities in the district. In some areas, traditional leaders have made it a requirement that a latrine should be the first development that is made on all newly allocated residential plots. Given that traditional leaders are the custodians of the land and as such are responsible for its allocation, it is hoped that this will assist in enhancing the chances of the sustainability of the benefits from the project. Within this context one village head shared with the evaluation team that every community gathering in his area had been made an opportunity for monitoring the extent of OD as all the people would have to patrol the village as a group, particularly the secluded/ "private" places for purposes of establishing whether there were still people in the community who

practiced OD. This was confirmed by the EHT for the area. All this confirms the effective community monitoring mechanisms that have been developed and these are likely to ensure sustainability of benefits realized through the project.

Local income generating initiatives that are largely self-initiated during project tenure will continue to avail resources to maintain water points, improve home hygiene and construction of toilets among other things. Some water points had already raised significant amounts which they could utilize to purchase spares for borehole maintenance and repair. Considering the cost of the "small" maintenance spares, the amounts of money currently held in trust should be able to cover the cost. This might also take a while since most of the boreholes are new either by rehabilitation or new installation. At family level, significant savings are being done to keep families well - resourced for self- initiated and self-supported WASH actions. To confirm that good hygiene practices have become their way of life, one of the village heads concluded by saying **"*Chaunonzi regera ndechiri mumaoko, chirimumwoyo unofa nacho.*" (*This concept is so internalized that no one can take it out of me*)**

It was noted that most of the community groups and structures that were active in the execution of project activities are composed of Red Cross life members with inherent commitment to the operations of the organisation Resultantly, the likelihood of such structures continuing to promote relevant activities subsequent to the termination of the project was almost a given.

3.5.2 Institutional arrangements

Discussions with communities also revealed that the advent of VPMs had generally made the maintenance and repair of hand pumps relatively affordable and prompt as compared to the old system.. It was pointed that their rates were lower than those that had been charged by the old DDF pump minders or Water Supply Operatives.

> **"The VPM system has made the repair of water points in this community cheaper as we no longer have to mobilise resources for making a report in Chivi which is 150 km away"**

It was emphasised that the VPM system generally led to the reduction of the down time of water points as break downs would be attended to early given that VPMs were resident in the same communities. District Development Fund (DDF), Water Supply Operatives who under the old system had been responsible for attending to break downs sometimes had to extend their services to locations in excess of 20 kilometres (km) from their places of residence. These operatives sometimes served as many as four wards and therefore could not always be available when their services were required. CHIWASH trained VPMs per ward. A tool kit was provided per ward for use by the VPM team. Communities indicated that the services of a trained VPM could be accessed within a distance of 5 km. The above demonstrates that the VPM system has made a difference in terms of down time and preventive maintenance of the boreholes.

Collaboration with key stakeholders will ensure that communities continue to receive back-stopping support after programme support has been withdrawn. Spares provided to RDC for sell to the community will enable the communities to find the spares readily available and RDC able to support its constituency. The tool kits provided at ward level ensures availability of appropriate tools for use during service and maintenance of the boreholes.

Continued presence of ZRCS in the province also provides an opportunity for touch base with the District partners, community structures and leadership for continuity of momentum.

3.5.3 Hardware components in water and sanitation supplies

ZRCS has procured spares and stocked them in the Rural District council warehouse. Communities will come and procure from there using their savings for water point management and maintenance The project also procured tool kits for the village pump mechanics and latrine builders .

Albeit the efforts towards sustainability, some challenges are likely to occur which may dilute the sustainability momentum and subsequent outcome .Some of them are outlined below:

Challenges to Sustainability

- It is likely that the community and partner structures will eventually tire out because they need regular follow up and support. The principal partners (DWSSC) should provide the relevant backstopping support by conducting monitoring/support visits and maintaining presence at the local level to avoid relapse and boost community confidence. Perceived weak relationships among partners (government and Red Cross) might undermine the gains made to date.

- Availability Of spares has to be assured at a reasonable fee to ensure communities remain able to buy.

- The current level of motivation and opportunities to raise funds for water point maintenance has to be maintained.
- Without support for self-reliance the vibrant community groups will eventually collapse and the collective maintenance units will become redundant.

- The withdrawal of incentives for health promoters will reduce momentum as they increasingly have to use their own means for the good of the community.

3.6 LESSONS LEARNT

- Full engagement of grassroots participants contribute to success of projects.

- Spreading responsibility among extension workers builds sustainability and synergy.

- Cooperation of stakeholders brings oneness which ensures resolution of issues on time and in unison.

- Children can be effective agents of change if appropriately engaged.

- Visibility of community agents motivates them and increases community confidence in their work

4.0 CONCLUSIONS

Evaluation findings indicate that commendable progress was made in terms of contributing to sustainable improvement in health and well-being for vulnerable people in Chivi district through improved access to safe drinking water and improved sanitation. The project`s three key components software, hardware and the capacity building were implemented with lots of success especially looking at the targets. All the three components ` targets were met as planned. The hardware aspects of the project mainly focused on rehabilitation of boreholes as well as drilling new ones. The targeted numbers for both borehole rehabilitation and borehole drilling were met. In this respect the project managed to put in place institutional arrangements for sustainability though the training of village pump mechanics and Water Point Committees through backstopping support from DDF.. In addition, the project managed to bring spares for boreholes closer to the people. Under sanitation, the project supported provision of household and institutional latrines based on the stated equity from both the household and institution. Albeit the perceived economic challenges in the country, households and institutions have contributed their equity to as agreed showing a great level of commitment solicited through the awareness sessions conducted during programme sensitisation. Software aspects entailed training of water point committees, village pump mechanics, latrine builders and hygiene promoters while capacity building component sought to enhance the capabilities of Red Cross staff as well as staff from implementing partner organizations to effectively execute their roles on the project.

While it is too early to attribute any changes in behaviour to the project, it can-not be denied that the project has consolidated knowledge levels on health and hygiene in the communities. This knowledge can be used in the future for purposes of facilitating behaviour change. In this respect, similar future programmes` performance would probably be enhanced by embracing and incorporating additional measures that would facilitate addressing the identified gaps and incorporate lessons from the project as detailed below:

4.1 RECOMMENDATIONS

- Future programmes should consider developing clear guidelines on the rehabilitation of water points based on the yield and the anticipated service levels of the water supply facilities. This would ensure that resources are directed where they are required most as opposed to the current scenario where some very low yielding water points were rehabilitated.

- The process of certification of completed works needs to be strengthened to ensure that resources are used efficiently resulting in a situation where rehabilitated works have a reasonable life span. This would obviously demand verification of work done by both program staff and beneficiaries thereby ensuring improvements in the quality of work.

- Future projects of this nature need to incorporate the mass distribution of safe water storage containers as a component of the Non-Food Items (NFIs) that can be distributed as dictated by realities.

- Given that positive behaviour change cannot be realized over a short period, projects of this nature should put emphasis on reinforcing relevant messages that encourage the expected changes in behaviour. In this regard, facilitators can be enabled to spearhead the process of monitoring behaviour change. This can be consolidated through the strengthening of peer review mechanisms at the community level. The provision of monitoring guidelines for this purpose can be considered against this background.

- Given that the water table in Chivi district has been receding over the past few years and that other options are more suitable as compared to boreholes in some parts of Chivi, future projects could put

emphasis on other water provision options such as hand dug wells that have succeessfully been sunk in parts of the district. This also entails strengthening collection of baseline data on groundwater levels to inform community consultations and subsequent drilling and rehabilitation.

- Standards for the provision of girl friendly latrines need to be well defined and shared with relevant stakeholders so as to enable stakeholders to address existing service gaps.

- Projects of this nature should put in place strategies that ensure that community and school hygiene clubs that are created through project efforts do not die with termination of project activities. In addition, apart from ensuring their functionality, there is need to create an enabling environment to facilitate their effectiveness. Their acceptance as viable institutions at all levels would be important in this regard. This probably demands ensuring the existence of back stopping support from local community health experts (EHT) to ensure that these institutions continue operating to expectations.

- The development of strategies that build on the community identified most accessible sources of hygiene information should be given consideration in programmes of this nature. This should however also take into account community preferences on how hygiene information can be disseminated. Within this context, strenthening the capacity of the hygiene promoter to enable him/her to communicate accurately and effectively on hygiene would be worth considering.

- ustainability of maintaining the HPs (through payment of incentives) needs to be considered in future programming

APPENDIX I

TERMS OF REFERENCE

Terms of Reference for End Of Project Evaluation
Project Contract No. FED/ 2011/238-244

Chivi Water, Sanitation and Hygiene Project (CHIWASH)

ACP- EU Water Facility 3rd Call

September 2015

Project funded by the **European Union**

This project is implemented by the Zimbabwe Red Cross Society in partnership with the International Federation of Red Cross and Red Crescent Societies and supported by the British Red Cross and the Finnish Red Cross. The views expressed in this report do not necessarily reflect the views of the European Commission.

Acronyms and Abbreviations

Action	*Project*
ACP	*African Caribbean and Pacific Countries*
BRC	*British Red Cross*
CBO	*Community Based Organisation*
CHIWASH	*Acronym for the Action*
CHW	*Community Health Workers*
CTC	*Child to Child*
CWP	*Communal Water Point*
DWSSC	*District Water Supply and Sanitation Sub Committee*
EHT	*Environmental Health Technicians*
EU/EC	*European Union/ European Commission*
Federation or IFRC	*International Federation of Red Cross and Red Crescent Societies*
FGD	*Focal Group Discussion*
FRC	*Finnish Red Cross*
GWSI	*Federation's Global Water & Sanitation Initiative'*
HDI	*Human Development Index*
HH	*Household*
HP	*Hygiene Promotion*
HP's	*Hygiene Promoters*
HQ	*Headquarters*
IEC	*Information, Education and Communication*
IWRM	*Integrated Water Resource Management*
KAP	*Knowledge, Attitudes, and Practices*
KII	*Key Informant Interview*
MDG(s)	*UN Millennium Development Goal(s)*
MOU	*Memorandum of Understanding*
NGO	*Non-Governmental Organisation*
NS	*National Society (of the Red Cross)*
O&M	*Operation and Maintenance*
PHHE	*Participatory Health and Hygiene Education*
PWSSC	*Provincial Water Supply and Sanitation Sub Committee*
RC/RC	*Red Cross /Red Crescent*
ToT	*Training of Trainers*
WASH	*Water Sanitation and Hygiene*
WatSan	*Water and Sanitation*
WP	*Water Point*
WPC	*Water Point Committee*
ZRCS	*Zimbabwe Red Cross Society*

Terms of Reference (TOR) for:

Chivi Water, Sanitation and Hygiene Project

1. Summary

1.1. Purpose: The International Federation of Red Cross and Red Crescent Societies seeks to carry out an end of project evaluation for Chivi Water, Sanitation and Hygiene Project (CHIWASH) funded under the 3rd Water facility call by the European Union.

1.2. Audience: The Results of this evaluation will be used by the International Federation to inform ongoing long term projects under the Global Water and Sanitation Initiative (GWSI)

1.3. Commissioners: This evaluation is being commissioned by IFRC, Zimbabwe Country Representation Office.

1.4. Reports to: The Project Manager; Chivi Water Sanitation and Hygiene Project.

1.5. Duration: Maximum of 20 days

1.6. Timeframe: 14 September to 5 October 2015

1.7. Methodology summary: Will include desk review of project documents, meeting and interviewing action /project implementers at all levels, use of FDG's, Key informant interviews, household questionnaires and structured observations , photography and statistical analysis.

1.8. Location: Headquarters: IFRC and ZRCS Offices located in Harare and

Field: Ward 16-32 of Chivi District, Masvingo Province.

1.9. Application requirements:

- The team leader will be Senior expert with university education and extensive and relevant professional experience of at least 10 years in the water and sanitation sector in developing countries, preferably in Zimbabwe or any Southern Africa country.
- Excellent written and spoken English skills required in addition to excellent analytical, writing and presentation skills.
- The team leader would have carried out at least two mid term reviews/final evaluations of similar projects in the last 3-5 years.
- Understanding of current policies, strategies, trends and challenges in water and Sanitation in Zimbabwe. An understanding of global, regional trends and challenges in water, sanitation and hygiene promotion interventions will be an added advantage.

2. Background

In a response to a call for proposals by the EU, the International Federation of Red Cross and Red Crescent Societies submitted an application for Water Facility Actions in ACP-EU countries in June 2010 partnering with the British Red Cross, the Finnish Red Cross and the Zimbabwe Red Cross Society (ZRCS) as the implementing national Society.

In August 2011 the IFRC and EU signed a Contribution Agreement for CHIWASH project (herein after also referred to as *'action'*) with the implementation period for the four year project set as 16 August 2011to 15 August 2015. This project/action is one of the long term development projects being implemented within the last four years of the IFRC Global Water and Sanitation Initiative (GWSI). The GWSI as a ten years initiative (2005-2015) has a global target to reach over 10 million people with WatSan interventions as a contribution to the MDG's.

Project implementation started on the 1 November 2011 and has been ongoing over the last four years. The first year was primarily for inception activities such as staff recruitment, procurement of equipment and also software elements such as training of staff and community level artisans. The implementation of the software and major hardware activities have been ongoing

from the second year of the action. Following a late start of the action, and additional time required to facilitate a smooth exit and project closure activities , a five months no cost extension was requested from the EU.

After the inception period, the implementation of hardware activities commenced peaking in year three of the project and with a slight decrease in the fourth year. Along with the hardware, commensurate software activities have been implemented; always ensuring that the software activities are leading the hardware implementation.

Two EU ROM missions undertaken in 2012 and 2013 provided useful analysis and recommendations to streamline the implementation and ensure timely delivery of targets and action objectives. Similarly, findings and recommendations of a mid-term review undertaken in 2014 have been in cooperated into the implementation over the last one and half years.

With the action now coming to an end of its four year implementing timeframe, the end of project evaluation is being carried out to assess the level of achievements in the action meeting its intended objectives and expected result. The findings will be useful in informing other projects implemented by the IFRC and its wider global membership of Partner and Host national societies.

The evaluation shall be conducted and led by an external consultant in accordance with specifications established in these Terms of Reference (ToR) during the month of September 2015 and be completed by the 5 of October 2015.

2.1 Country Background

The water, sanitation and hygiene (WASH) sector in Zimbabwe is characterised by huge discrepancies between rural and urban areas. This dates back to independence in 1980 when the newly independent government of Zimbabwe (GoZ) took over a well-developed sector in urban areas and very little in rural areas. During the first 20 years of independence great efforts were made to improve access to WASH particularly in rural areas and access to improved water sources saw a significant improvement, less so in sanitation.

During the past decade however, rural WASH development has to some extent been in reverse and many water facilities have ceased to function due to lack of maintenance and repair despite increased investment, while the greatest need for improved access to sanitation continues to lag behind.

Officially 70% of all households[3] drink water from improved water sources today and in the major cities the figure is close to 100%. However, these figures simply reflect where water infrastructure has been put in place but do not take into cognisance that many neighbourhoods in the cities go without water for long periods and that at any given time around 75% of the 47,000 hand pumps installed in rural areas are not functioning[4] while 48% of the rural population practice open defecation with over 82%[5] of the poorest Zimbabweans practising open defecation.

In 2008 Zimbabwe was hit by unprecedented cholera outbreaks affecting both rural and urban areas in all 10 provinces, with more than 98,000 cumulative cases and 4,300 deaths with a crude case fatality rate of 4.3%[6] . The largest number of fatalities occurred in major urban areas and significant international support to urban infrastructure followed. After 2008, the sanitation cover in urban areas increased while it continued to decrease in the rural areas[7].

[3] 2013 ZimVAC report
[4] Zimbabwe National Water policy March 2013
[5] National Sanitation and Hygiene Strategy
[6] MoHCW epidemiology Bulletin 2008/9
[7] GoZ National Sanitation and Hygiene Strategy.

The first priority in government's National Water Policy of 2013 was to "arrest the continued deterioration of the water and sanitation sector and assets before they reached the point where they were beyond recovery".

The negative impact of this present WASH status in health (morbidity and mortality); wellbeing (productivity); human dignity and failure to provide the human right of access to WASH significantly undermines development efforts. The impact upon women and children, the disadvantaged and the poorest is particularly acute.

It is in this context that CHIWASH project in support of the Sanitation and Hygiene strategy and the national water policy focused primarily on rural water point rehabilitation (87.5% of planned interventions) as opposed to new water point construction which only targets communities in need that have no existing improved water supply alternative. The water source improvement was also complemented by a sanitation support intervention as well the promotion of behaviour change through the use of Participatory Health and Hygiene Education. Chivi Water, Sanitation and Hygiene Project (CHIWASH) was implemented in 16 Wards (16-32) of Chivi District, in Masvingo Province.

2.2 CHIWASH Project Summary

CHIWASH project consists of **three** key components as summarised from the detailed project proposal below;
Software: Interventions were to prepare and equip communities, stakeholders with skills, information and capacities that enable them to participate and engage at planning**, implementation and monitoring all action components.**

The software component includes:

- Hygiene and Sanitation promotion based on the PHHE methodology
- Training of 371[8] WPCs , 180 Hygiene Promoters, 50 Latrine Builders and 48 VPMs
- Formation of CHC's and SHC to drive the PHHE activities at community level reaching 100,000 people and at School level reaching 69 Schools respectively.
- Follow up and monitoring of PHHE activities – related to behaviour change and adoption of good hygiene practices which are critical for the prevention of communicable diseases.

The hardware component includes:

- Construction and rehabilitation of physical infrastructure that provides communities with safe access to water supply and hygienic sanitation facilities.
- Rehabilitation of 318 water points and drilling of 50 new boreholes.
- Support to construction of 3410 BVIP latrines at household and institutional level.
- Water quality monitoring

Capacity Building initiatives undertaken

- Training of Zimbabwe Red Cross and local government staff on aspects of methodology such as PHHE, Community Based Management

[8] Revised from 400 to 371 due to lower number of boreholes to be rehabilitated

- Exchange visits for project staff (both government and ZRCS) to project areas implementing similar actions to enhance staff learning and experience sharing.
- Attending all district, province and national WASH sector fora to provide project feedback (plans and progress report) and support government in implementing its policies, strategies and guidelines in rural WASH.

2.2.1 Budget

The total budget was EURO 2,642,000 with the contributions pledged as follows:
European Union: EURO 1,981,500 or 75% of total budget and Red Cross Partners EURO 660,500 (25%) split as follows;

- EURO 330,250 from the British Red Cross.
- EURO 330,250 from the Finnish Red Cross.

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2.3 Objectives and Results of the Action

The Overall Objective: To contribute to sustainable improvement in health and well-being for vulnerable people in Chivi district through improved access to safe drinking water and improved sanitation.

The specific objective for Chivi Water, Sanitation and Hygiene Project:-To improve the health and quality of life of vulnerable communities through increased access to safe and sustainable community managed water and sanitation and support behavioural change through hygiene promotion to 100 000 people in Chivi district by 2015.
The verifiable indicators to measure of the action are:

- Increase of water supply coverage by 50% (from estimated baseline coverage of 34 % to 84%).
- Increase of sanitation coverage by 15% (from estimated baseline coverage of 22% to 37%).
- 80% of installed public water points and 90% of installed latrines are still operating three years after the project.
- 90 % of the 100 000 persons reached with hygiene promotion know the key issues at the end of the project.

3. Evaluation Purpose & Scope

3.1. Purpose (overall objective).

The purpose of the end of project evaluation is to systematically and independently assess the progress so far made in the implementation of planned activities and in achieving the objectives and expected results as described in the project documents. The evaluation is also expected to provide insight into the effectiveness[9] and efficiency[10] of project implementation as well as factors that enabled and constrained the achievement of results over the period under review. In addition, the evaluation will include questions of sustainability[11] and impact.

The evaluation will also compare progress made on key indicators established in the baseline survey (while also noting the progress made and reported in the mid-term review) in relation to the three components of Water Supply, Sanitation and Hygiene promotion.

Value added from this evaluation is expected to be achieved through lessons learned and recommendations that can be utilized by the IFRC and its wider global network of national societies in other future or ongoing long term projects (under GWSI) to influence implementation and project management as well as for advocacy purposes.

The evaluation will be led by an external evaluator/consultant with the participation of IFRC and ZRCS. From the stakeholders, it is envisaged that one (1) member of the Chivi DWSSC will accompany the evaluation team for the whole of the evaluation period.

3.2 Scope.

The evaluation scope focuses the evaluation by setting the boundaries for what will and will not be included in the evaluation.

- ***The unit of analysis to be assessed*** – The Action/project, Chivi Water Sanitation and Hygiene project, its planning, management and implementation in the target area.

[9] Effectiveness: achievement of results, comparison between target & results.
[10] Efficiency: timeliness, use of resources, participation, coordination (partnership-institutions/individuals).
[11] Sustainability: Partner capacity, empowerment of community, financial issues.

- ***The time period:*** From action start date - 1 November 2011 to date.
- ***The funds:*** actually expended at the time of the evaluation versus the total amount allocated.
- ***The geographical coverage:*** All the 16 wards (ward 16-32 excluding ward 30) where the action was carried out. The evaluator will select a sample of the wards to be assessed including one ward outside the project area for control purposes.
- ***The target groups:*** Beneficiaries: Households, community leaders, community level artisans such as VPMs, HPs, Schools and Clinics. Non-beneficiaries from the control ward

4. Evaluation Criteria – Objectives - Questions

The evaluation should cover all relevant activities and results achieved by the action to the present date, and also the potential impact and sustainability within the project area. The evaluation will be based on the Development Assistance Committee (DAC) guidelines for evaluating development programmes. The evaluation team is required to review relevant project documents and generate evaluable questions including those in reference boxes under each of the 5 evaluation criteria below

4.1 Relevance

- To what degree has the project succeeded /or is on track to succeed in its purpose (specific objective) and to what extent this is contributing to improved living standards of the population in the targeted areas?
- What is the progress and achievements to date of the water and sanitation action against the objectives and verifiable indicators?
- By improving the access to safe drinking water and improved sanitation will the project have a positive impact on health and quality of life in the target areas?
- What was the quality and appropriateness of the approaches and technologies employed to achieving the expected results from the project?
- Was the project design appropriate for the geographic area targeted?
- How was the management of the project? An assessment should be made of how well the real challenges and needs of the target beneficiaries have been addressed in the design of the action and to what extent local absorption capacities and the local implementation capacities were properly taken into consideration in the design. (Provide technical and operational feedback where deemed necessary)
- How was the quality, timeliness and efficiency of the construction of the civil works for both water supply and sanitation interventions?
- How were the software components of the project implemented, especially related to strengthening the capacities of local communities to choose options in hardware and also their ability to maintain them, i.e. assess the level of participation of the community in formulation and implementation of the activities that affect them?
- To what extent were the local communities participating in trainings (PHHE) related to hygiene promotion, and behaviour change and how does this relate to improved hygiene and sanitation practices?
- How were the monitoring, evaluation and reporting systems developed by the project to facilitate data collection, dissemination and flow of information from the community level to the donor and partners?
- Analysing to what extent the recommendations made in EU ROM and partners routine supervision missions have been acted upon.
- How were the following cross cutting issues integrated in the relevant districts: gender - have women equally benefited from the project as men? (assess including the quality and level of participation); vulnerable groups; Food Security; HIV and AIDS; and environmental Issues
- Documenting the strengths and weaknesses of the project and to develop recommendations for future implementation of long term developmental projects.

4.2 Efficiency

These are some of the questions that should be answered by the evaluation:

- Were the resources provided of acceptable quality and value?

- Were the outputs/outcomes of acceptable standards? (Analyse the relationship between the objectives sought and the strategies and methods used to achieve them.)
- Were the means/resources of the action (project personnel, infrastructure, equipment, training etc.) efficiently transformed through project activities into the various project results? Could the same or similar results have been achieved at lower cost?
- What is the assessment of the general organizational arrangements (structures, responsibilities and contractual arrangements).
- What is the assessment of the approach and methods used to implement the action and activities of the works/including any contracts including project personnel involved in the action? Assess how far the project helped to provide appropriate solutions and develop local capacities to define and produce results. Also how far costs of the project were justified by the benefits that have/will be generated (whether or not expressed in monetary terms), in comparison with similar projects or known alternatives.
- What was the quality of communication between the project and, the target beneficiaries, relevant government departments and other partners? What was the role played by the community and local leadership in implementation of the action and the nature and level of participation.
- What was the quality and nature of the relationship and coordination mechanism with partners/stakeholders and their effects on implementation?
- How did partner structures and systems affect project implementation – including commitment, motivation and resources?
- How well were the inputs (funds, people, materials and time) used to produce results?
- How was efficiency in terms of logistical support for any procurement done?

4.3 Effectiveness

The evaluation will analyse the relationship between the results and the project objective/purpose. It will identify the strengths, weaknesses, opportunities and threats of the action.

- What are the results obtained so far by the action and the number of beneficiaries?
- To what extents have the results contributed to achieving the project purpose, or can be expected to do so in the future?
- Have the planned benefits been delivered and received, as perceived mainly by the key beneficiaries, but also taking into account the views of responsible national Government authorities?
- More specifically, is there any national policy support lacking that has hindered the project achieving the planned results or available that has fast tracked the achievement of project results?
- To what extent have the recommendations from the two EU ROM missions been implemented/incorporated into the project?
- Have there been any major changes in action activities and focus over time?
- What are the perceptions of partners and beneficiaries of progress and achievements?
- What is the proportion of population/households accessing water and sanitation facilities such as communal toilets (for schools and clinics), household toilets, health and hygiene?
- How was ZRCS involved in the planning, implementation and monitoring of the Chiwash project? What monitoring tools were in place to give feedback to the implementation process? Were there any gaps for further improvement?
- Were beneficiaries and stakeholders able to provide feedback to the ZRCS/IFRC on the project implementation? How was information on the project shared with stakeholders and beneficiaries?

4.4 Impact

- What are the key achievements of CHIWASH project?
- What impact or potential impact has the project had on the solution of community needs, such as:
  - Strengthening the community based systems for health and hygiene?
  - Behaviour change occurring as a result of health and hygiene promotion and education?
- What potential effect will the project/action have on the standard of living of individuals, families, and the community? What other relevant actions are necessary to achieve this public health environment goal?
- Are there any current and potential environmental impact of the action?

4.5 Sustainability

The consultant will assess the extent to which the results of the project will be maintained at community level.
The analysis of sustainability will therefore focus on the following aspects:

- Ownership of objectives and achievements : to what extent were the stakeholders consulted on the objectives from the outset and whether they agreed with them.
- Policy support and the responsibility of beneficiary institutions: how far have the relevant national, sectoral and budgetary policies affected the project positively or negatively?
- Socio-cultural factors: e.g. was the project is in tune with local perceptions of needs? Did it respect local power-structures, status systems and beliefs?
- Financial sustainability of the services being implemented: Can the intended beneficiaries afford operational, maintenance and replacement costs for water supply, sanitation and hygiene promotion interventions? (Consultant will be expected to analyse current and projected costs)
- To what extend has environmental sustainability and technical sustainability been addressed during the implementation of the operation?
- What are the options for linking beneficiaries to other organisations and institutions that can offer continuous support?
- What is the current institutional set up and market environment that will be crucial in supporting long term operation and maintenance needs What are the future roles and responsibilities of the implementing partners?
- What aspects of the project exhibit sustainability? What characteristics do they exhibit?
- In what ways are communities, beneficiaries and local leaders supportive of continuation of achieved results?
- What capacity and learning gained through the action will be sustained?
- Has the project managed to put in place systems to enable sustainability e.g. in relation to the hygiene promotion components?
- How have the exit strategies put in place contributed to sustainability? If not, how can they be improved?

5. Evaluation Methodology

The specific methodology will be outlined by the consultant as part of establishing the evaluation work plan (see Section 7&9), this section sketches out the methodological approach that will blend quantitative and qualitative analysis. The evaluation will verify the results achieved in the project with regards to the project indicators.

In a first step, available quantitative monitoring and reporting data - provided by IFRC, and the partners will be compiled, structured and analysed in a systematic way. It is suggested that the evaluation team conducts in-depth discussions (in person or through other means) with relevant partners, stakeholders, co-donor and beneficiaries in the project area.

In carrying out this evaluation the team is expected to use the listed methodologies below and which are by no means exhaustive in order to address the evaluation purpose and criteria.

- ***Triangulation.*** The evaluators will be expected to use a variety of data sources, as well as data collection and analysis methods. The use of multiple data sources/methods increases the rigor of the evaluation.
- ***Quantitative & qualitative methods.*** Quantitative (numerical) and qualitative (categorical i.e. attitudes, knowledge, and views) approaches to data collection and analysis is a most basic distinction in evaluation methods. The use of both (mixed methods) should be employed to enhance the accuracy of the report..
- ***Use of primary and secondary data:*** The evaluators will be expected to make use of primary and secondary data and should ensure that secondary data is credible and reliable..
- ***Identify existing M&E data***: This data will be provided by the IFRC and ZRCS through written reports and interviews with the implementation team[12]
- ***Who is involved.*** The evaluation team will be led by an external evaluator and S/he takes overall responsibility of the accuracy of data and data gathering methodologies. In addition, the evaluation team is expected to carry out the following

5.1 Location

The evaluation will take place in Chivi District in the project area (see 11.2), and also include interviews with key project staff in Harare (IFRC and ZRCS headquarters).

5.2 Project related Documents

The following supporting documents are required as background information and before the evaluation exercise begins, they will be made available by the Federation Country Office in Harare and by the Zimbabwe Red Cross Society.

- Detailed proposal;
- Contributing partners agreement form;
- Revised Log frame;
- Revised Action Budget
- Baseline Survey Report
- Mid-term Review Report
- Annual Reports : Year1-3 and CHIWASH implementation update summary for years 4.
- Monthly, Quarterly progress reports from both HQ and the field;
- Any correspondence deemed appropriate with the contributing partners;
- ZRCS WatSan Policies/ strategies, HR and WatSan personnel job descriptions;
- Water Policy and Sanitation Strategy for Zimbabwe.
- ZRCS Strategies Policies.
- Federation Global Water and Sanitation Initiative (GWSI)
- Federation Water and Sanitation Strategy
- EU ROM reports

6. Deliverables (or Outputs)

- ***Inception report***. The consultant will produce an inception report upon notification of a successful bid. The inception report should demonstrate a clear understanding and realistic plan of work for the evaluation, checking that the evaluation plan is in agreement with the TOR as well as the evaluation manager and other stakeholders. The inception report includes the proposed

[12] Staff employed by CHIWASH

methodologies, a data collection and reporting plan with identified deliverables, draft data collection tools such as interview guides, the allocation of roles and responsibilities within the evaluation team, and travel and logistical arrangements for the evaluation.

- ***Debriefings – Lessons Learnt Workshop***. The consultant is expected to present the initial evaluation findings, conclusions and recommendations to the implementing partners (IFRC, and ZRCS) the EU and stakeholders and local leadership in Chivi . The IFRC and ZRCS take responsibility for the organization of the workshop, including inviting participants .

- ***Draft report***. the draft report should be produced within seven (7) days of the completion of the evaluation and shared at least three (3) working days before the lessons Learnt workshop (described above) for perusal and comments.

Final report. All comments gathered during the lessons learnt workshop, including those made by the IFRC and implementing partners will be considered for in cooperation into the final report.

The final report MUST be presented to the IFRC within three (3) working days after the lessons Learnt workshop. The final report shall be submitted to Federation/IFRC in 3 original hardcopies – spiral bound plus an electronic version before the consultant concludes the assignment and the final payment being effected. All data collection tools such as household questionnaires, KII guides etc. should be submitted together with the final report.

The **Final Report** should include - but is not limited to - the following components:

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Acronyms
Acknowledgements
Executive summary
Background: Description of the Project context of the intervention including policy and institutional context, outcomes, challenges faced by the IFRC/NS in implementation of the CHIWASH project. Description of the intervention logic and implementation arrangements
Evaluation methodology Introduction, purpose and objectives of the evaluation, scope of the evaluation, short statement on the evaluation methods used including sampling and any limitations
Findings of the evaluation: Presentation and interpretation of the factual evidence in relation to the evaluation questions
Lessons learned
Conclusions
Recommendations
Appendices

6.1 Timing and Cost

The evaluation is planned to take a maximum of 20 days. This is inclusive of preparation, working days field visit, debriefing, report writing and accounting for the mission. The cost for the consultancy must be quoted in US Dollars and broken down to the details clearly indicating costs of personnel, transport, etc.

7. Proposed Timeline (or Schedule)

The consultant shall provide an outline on a Gantt chat as part of the bid/proposal to be presented to the IFRC for consideration.- see section 10 below.

8. Evaluation Quality & Ethical Standards

The evaluator(s) should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people and the communities of which they are members, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a

transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards which include the following:

1. **Utility**: Evaluations must be useful and used.
2. **Feasibility**: Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.
3. **Ethics & Legality**: Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.
4. **Impartiality & Independence**; Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
5. **Transparency**: Evaluation activities should reflect an attitude of openness and transparency.
6. **Accuracy**: Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
7. **Participation**: Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
8. **Collaboration**: Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.

It is also expected that the evaluation will respect the seven **Fundamental Principles of the Red Cross and Red Crescent**: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these principles at: *www.ifrc.org/what/values/principles/index.asp"*

9. Consultant Qualifications

Expert profile

The evaluation team will consist of at least two members including the team leader who should be external to the IFRC/ZRCS. The team Leader bears the overall responsibility for carrying out this end of project evaluation.

The team should provide the following experiences and skills (complementary set):

- Experience in complex evaluations and the required quantitative and qualitative evaluation methodologies;
- Understanding of current policies, strategies, trends and challenges in Water and Sanitation in Zimbabwe. An understanding of global, regional trends and challenges in water, sanitation and hygiene promotion interventions will be an added advantage.
- Demonstrated capacity to work both independently and as part of a team.
- Strong interpersonal and communication skills.
- Excellent written and spoken English skills required; Excellent analytical, writing and presentation skills.
- Ability to interact with team members and stakeholders in a culturally sensitive and effective way.
- At least one member should have full knoledge of Shona to facilitate direct communication with the beneficaries.
- The team leader will be Senior expert with university education and extensive and relevant professional experience of at least 10 years in the water and sanitation sector in developing countries, preferably in Zimbabwe or any Southern Africa country.
- The team leader would have carried out at least two mid term reviews/final evaluations of similar projects in the last 3-5 years.

In addition, the evaluation team is expected to carry out the following

- Perform a desk review of the documentation provided to gain an understanding of the context and environment in which the IFRC project operates;

- Develop the end of project evaluation work plan[13] with a clear methodological approach. Each activity/ element of the evaluation MUST have estimated durations in days clearly indicated.
- Design the specific evaluation approach and details of the procedures to be used, within the budget and timeframe available;
- Encourage partners, stakeholders and beneficiaries to communicate concerns, ideas, questions and suggestions to the evaluation team during the evaluation process and actively solicit their views;
- Draft the report according to the reporting timeframe and template;
- Ensure a logical and plausible link between information gathered and analysed and results and recommendations presented;
- Address recommendations for action and outline possible implications;
- Record all aspects of methodological choices, assumptions, and limitations of the evaluation process and present a critical review during a debriefing with IFRC and Zimbabwe Red Cross as part of the evaluation report;
- Keep records of material collected and analysed, which will be submitted to IFRC for reference.

The team leader is accountable for delivering the products of the evaluation , which include an evaluation work plan, draft and final reports as well as a dissemination workshop (to be held in Chivi). The purpose of the dissemination workshop is to present a summary of the major findings and lessons learned to interested stakeholders and partners of the action. If required, the team leader will **facilitate an** analysis workshop among evaluation team members, which will compile, compare, and analyse data.

He/she is expected to ensure that the information provided in the report is valid and complete and that the evaluation team works in a coordinated and efficient manner, both when physically together, or as a "virtual" team.

10. Application Procedures

Having read the terms of Reference and its appendices the prospective consultants wishing to present to the International Federation of Red Cross and Red Crescent Societies (IFRC) a proposal for analysis prior to award of contract must fulfil the following conditions:

1. **Curricula Vitae** (CV) for Team Leader and Assistant applying for consideration. The team Leader and Assistant **MUST** demonstrate that they have previously undertaken joint evaluations.
2. **Cover letter** clearly summarizing your experience as it pertains to this assignment, your daily rate, and three professional references.
3. A brief description of your firm or institution (for applicants other than individual contractors).
4. **Technical proposal** (when appropriate) not exceeding five pages expressing an understanding and interpretation of the TOR, the proposed methodology, and a time and activity schedule.
5. **Financial proposal** itemizing estimated costs for services rendered (daily consultancy fees), accommodation and living costs, transport costs, stationery costs, and any other related supplies or services required for the evaluation.- see table 1 below
6. At least one sample of an **evaluation report** most similar to that described in this TOR.

Application materials are non-returnable, and we thank you in advance for understanding that only short-listed candidates will be contacted for the next step in the application process.

Submission of Proposal/Bid

All proposals /bids for the consultancy should be placed in the Tender Box in plain sealed packages clearly marked thus:-

project

PROJECT: FED/2011/244-238: CHIVI Water, Sanitation and Hygiene Project (CHIWASH)
`END OF PROJECT EVALUATION CONSULTANCY`

At the International Federation of Red Cross and Red Crescent Societies reception,

9 Cambridge Road, Avondale

Not later than 31st July 2015 @ 16.00 hours CAT

11. Appendices

11.1 Roles and Responsibilities of Parties involved in the end of project evaluation.

Roles of IFRC in the evaluation

- Enter into a contract with the consultant contracted to undertake the evaluation.
- IFRC will provide all documentation related to project proposal, including contribution agreement, progress reports, project contract signed between RC partners, GWSI and Federation WatSan Policy Documents as in section 5.2
- Coordinate and arrange for the interviews of staff and institutions (IFRC, EU, British and Finnish RC) in Harare, Geneva, London and Helsinki.
- Share the first draft end of project evaluation report with partners and the EU.
- Coordinate with partners initial comments on the draft report and share with consultant.
- Share final end of project evaluation report to all partners and the EU.
- Pay for all costs by ZRCS, Consultant related to the evaluation from project funds.

Roles of ZRCS

- Provide all documents related to the project in its custody, including plans and operational reports, staff contracts, contracts with service providers in respect of this action, correspondences and any records of equipment and materials procured the action.
- Coordinate and arrange for the interviews of staff and institutions and stakeholders relevant to this action and based in Zimbabwe at national, provincial and district/field level.
- Responsible for in-country logistics to project sites in the district and government departments.
- Coordinate and arrange for interviews with local leadership, and community level artisans such as Hygiene, Promoters, Latrine builders and Village Pump mechanics.
- Provide office accommodation for the evaluation team while in Harare, Masvingo and the field in Chivi.
- Coordinate with consultant the presentation of evaluation findings with stakeholders in the field in Chivi (in a one day workshop) and Harare.

Table 1 The Evaluation Team will consist four members

Team member Description	ORGANISATION	Bid and Cost implications
Evaluator 1 (Team Leader)	External Consultant	All professional Fees, Cost of Accommodation, vehicle/travel , enumerators costs etc. SHOULD BE included in the bid/proposal to be presented to IFRC

Evaluator 2	External Consultant- acts as assistant to the Team Leader	All professional Fees, Cost of Accommodation, vehicle[14]/travel , enumerators costs etc. SHOULD BE included in the bid/proposal to be presented to IFRC
Evaluator 3	IFRC (Signatory to CA with EU)	Must not have been involved in the direct implementation of the Action. -All costs related to the evaluator SHOULD **NOT** BE INCLUDED in the bid/proposal to be submitted by the bidder. All Costs to be met by IFRC.
Evaluator 4	ZRCS (Implementing Partner)	Must not have been involved in the direct implementation of the Action. -All costs related to the evaluator SHOULD **NOT** BE INCLUDED in the bid/proposal to be submitted by the bidder. All costs to be met by IFRC
	DWSSC Member (Government Representative at District level)	All arising costs to be met by IFRC- He/She will be expected to accompany the evaluation team, but is not part of the evaluation team . The evaluation team will benefit from DWSSC members local WASH knowledge and understanding of the context.

11.2: Map of Chivi district

[14] IFRC wishes to inform bidders that they should ensure that the lead and Assistant evaluator have their own vehicle for movement in the field


Masvingo- Chivi District Overview Map
ICRC
Legend
Main City
Primary School
Town/Populated Place
Health Facility
Settlement
Airport_Aerodrome
Road
River
Rail
WaterBody
Ward Boundary
Chivi
Muzhwi
Mushandike
Tokwe
RUNDE
TOKWE MUKOSI
Manyuchi
Tokwane
Data Sources:
Elevation ESRI
Admin Boundaries UNGIWG
Activities
Filename HAR1200603_ZW_GEN_BM_A3_15.10.12
Prepared by: WatHab GIS Harare/WAM
Date:15.10.12
Scale 1 : 5'000'000 (A3)
0 2 4 8
Kilometers
For internal use only
This map is for information purposes only
and has no political significance

APPENDIX II

DATA COLLECTION TOOLS

Questionnaire No	

CHIWASH HOUSEHOLD QUESTIONNAIRE

Location: **Ward Numbe** **VillageN**

DEMOGRAPHIC INFORMATION

1.0 Sex of Respondent . 1. Male 2. Female

2.0 Age of respondent

3.0 Type of household 1. Male headed.2. Female headed. Child headed

4.0 How many people normally live in this house

4.1 HOUSEHOLD SIZE

Household Member	Age	Sex

5.0 Are there any members of the household who are the under age of five

1. Yes 2. No

6.0 What is the highest level of education attained by respondent

1. Non formal education.
2. Primary
3. Secondary
4. Tertiary

7.0 What is the source of livelihood for this household head?

1. Formal employment

2. Trade
3. Subsistence farming
4. Remittances
5. Causal labour
6. Other specify

8.0 Are there any physically challenged persons in this household?

1. Yes 2. No

HOUSEHOLD WATER SOURCES

9.0 What is the main source of drinking water for members of your household?

9.0A During wet season

1. Borehole
2. Protected Dug well
3. Unprotected Dug well
4. Protected Spring
5. Unprotected Spring
6. Surface Water (River/dam/pond)
7.piped water
8. Protected family well.
9. Unprotected family well10. Other

9.0B During the dry season

1. Borehole
2. Protected Dug well
3. Unprotected Dug well
4. Protected Spring
5. Unprotected Spring
6. Surface Water (River/dam/pond)
7.piped water
8. Protected family well.
9. Unprotected family well10. Other

9.0 How reliable is the main water source?

1.Perennial
2. Seasonal
3. Frequently breaks down
4. Don't know
5. Other.(specify)

10.0 What is the main source of water used by your household for bathing and laundry?

1. Borehole
2. Protected Dug well
3. Unprotected Dug well

4. Protected Spring
5. Unprotected Spring
6. Surface Water (River/dam/ pond)
7. Other

11.0 What is the alternative source of drinking water in this household?

1. Borehole
2. Protected Well
3. Unprotected Well
4 Deep well
5. River
6. Tap
7. Protected family well
8. Unprotected family
9. Other

12.0 How far is the main source of water during the wet season?

1. < 500m 2. 500 –1 km 3. >1km

13.0 How far is the main source of water during the dry season?

1. < 500m 2. 500 –1 km 3. >1km

14.0 How long does it take to fetch water during the wet season?

1. <30minutes 2 .30mins-45 mins 3. 45mins -1hr . 4. more than 1hr

15.0 How long does it take to fetch water during the dry season?

1. <30minutes 2. 30mins-45 mins 3. 45mins -1hr . 4 more than 1hr

16.0 Do you do anything to the water before you drink?

1. Yes 2. No

17.0 If yes, what do you do?

1. Boil
2. Add beach/chlorine
3. Strain through a cloth
4. Use water filter
5. Solar disinfection
6. Let is stand and settle
7 Water treatment tablet
8. Other (Specify)……

18.0 Which water treatment methods do you know?

1. Boil
2. Add
3. Strain beach/chlorine through a cloth
4. Use water filter

5. Solar disinfection
6. Let is stand and settle
7. Water treatment tablet 8. Other (Specify)……

19.0 What type of container do you use to collect water?

1. Container with lid 2. Container without lid 3. Both

20.0 What is the size of the container used for collecting water (litres)?

21.0 How many such containers does the household use per day? (number)

22.0 Who normally collects water for domestic use?

1. Male age <15 yrs.
2. Female age <15yrs
3. Male under 15
4. Female under 15
5. Both Male and Female members of the household

23.0 What containers do you use to store water?

1. Narrow mouthed Container with lid
2. Narrow mouthed Container without lid
3. Wide mouthed container with lid
4. Wide mouthed container without lid

24.0 What was the original use of the container?

1. Food Storage
2. Chemical Storage
3. Fuel
4. Don'tKnow
5. Containers bought specifically for water
6. Other

25.0 How do you draw water for drinking from the storage container?

1. Single cup
2. Ladle
3. Double cups
4. Calabash
5. Pour from container

26.0 Is there a water point committee for the water source you mainly use?

1. Yes 2. No

27.0 What are its duties?

1. Collecting money for repairs.
2. Organising cleaning of the water point.
3. Caring out preventive maintenance.
4. Don't know

28.0 What is the composition of those who look after your water-point in this village?

1. Men only 2. Women only

3. Men and Women
4. Children
5. Other (Specify)
6. Not Applicable

29.0 What do you do if your water point breaks down?

1. Report to Water point Committee
2. Report to RDC
3. Report to DDF
4. Report to pump minder/ mechanic
5. Report to Village head
6. Nothing

30.0 How long does it normally take for the water point to be repaired when it breaks down?

1. Less than three days
2. More than 3days but less than a week
3. More than a week but less than a month
4. More than a month

Does your household contribute towards water point maintenance?

1. Yes 2. No

HOUSEHOLD SANITATION

31.0 Where do members of the household relieve themselves? (Single choice)

1. Bush
2. Pit latrine
3. Cat method
4. Flush toilet/pour flush
5. BVIP latrine
6. Ecological sanitation toilet
7. Other (specify)

32.0 Does the household have a toilet?

1. Yes 2. No

33.0 If yes what type of toilet

1. Bush
2. Pit latrine
3. Cat method
4. Flush toilet/pour flush
5. BVIP latrine
6. Ecological sanitation toilet
7. Other (specify

34.0 Do you share this toilet facility with other households?

.

1. Yes 2. No

35.0 Only for the household with under fives) How do you dispose stools for young children (0-5)? Multiple choice)

1. Thrown into toilet/latrine
2. Thrown outside the dwelling
3. Thrown into the rubbish pit
4. Thrown outside the yard
5. Buried underground
6. Wash away
7. Left where it is
8. Child always use the toilet/latrine
9. Not applicable
    a. *Note by observation*

36.0 Why do you think it is necessary to have latrines in your household? (Multiple answers)

1. To prevent the spread of diseases
2. To prevent environmental pollution
3. It's hygienic
4. Privacy
5. To enhance one's status in community

General Hygiene

37.0 In your opinion when should people wash their hands? (Multiple answers)

1. before eating
2. after using the toilet
3. before preparing food
4. after eating
5. after handling children's faeces
6. Before breastfeeding
7. After breastfeeding
8. When need arises
9. Other (Specify)……

38.0 Why do you wash your hands? (Single choice)?

1. To clean hands
2. To avoid diseases
3. Common practice
4. To remove smell
5. Other (specify)

39.0 How do members of your household normally wash their hands? (Single choice)

1. Run to waste method without soap
2. Run to waste with soap
3. Communal dish without soap
4. Communal dish with soap
5. Father uses own dish and the rest share one dish without soap
6. Father uses own dish and the rest share one dish with soap
7. Other (specify) ……..
8.

40.0 Has any member of your family suffered from diarrhoea in the last two weeks?

1. Yes 2. No

41.0 If yes, proceed with the next question, if no go to NO. 45.

42.0 How many of those who had diarrhoea were children under 5 years? .....

43.0 How did you overcome this problem for the under 5 years? Multiple choice)

1. Visited the clinic/health providers
2. Gave SSS
3. Visited the traditional healer / faith healer
4. Used home remedies
5. Prepared home fluids
6. did nothing
7. Other (Specify)……
8. Not applicable

44.0 List water related illnesses you know.

1. Diarrhoea
2. Skin condition
3. Dysentery
4. Typhoid
5. Scabies
6. Bilharzia
7. Cholera
8. Malaria

45.0 Has any member of your family suffered from any of these illnesses during the past month?

1. Yes 2. No

46.0 If yes, which illness did they suffer from

Type of Illness	**1 =Yes 2= No**
Diarrhoea	
Skin Condition	
Dystentry	
Typhoid	
Scabies	
Bilharzia	
Cholera	
Malaria	

47.0 How do you handle food that is not for immediate consumption?

1. Covered 2. Uncovered

48.0 Have you heard or read any hygiene messages within the last 3 months

1. Yes 2. No

49.0 What hygiene messages did you hear or read

Message	1=Yes 2 =No
Use toilet for defecation	
Dispose baby faeces to toilet	
Water treatment	
Wash hands with soap	
Bath regularly	
Stop open defecation	
Use of ORS	
Other (Specify)	

50.0 Where did you hear or read this/ these messages

Source	1=Yes 2 =No
School children	
Community health club	
Health promoter	
EHT	
Radio	

Newspaper/pamphlet	
NGO staff	
Local clinic	
Other (specify)	

51.0 Are there any Health Promoters in this community?

1. Yes 2. No

52.0 What are their roles?

1. Health and Hygiene Promotion
2. Advice on hygiene
3. Promotes health seeking behavior
4. Other

53.0 Are there Community Health Clubs in this community?

1. Yes 2. No

54.0 What is their roles? (multiple response)

.

1. Health and Hygiene Promotion
2. Advice on Nutrition
3. Advice on hygiene
4. Don't know5 Other

55.0 Does any member of the household belong to the Health Club?

1. Yes 2. No

56.0 What issues are discussed during the Health Club Meetings?

1. Health education
2. Community organisation
3. Community projects
4. N/A
5. Don't know

57.0 Does any child within the household belong to school health club?

1. Yes 2. No 3. Don't know

58.0 If yes have children ever shared what they learnt in school health clubs with family members?

1. Yes 2. No 3. Don't know

59.0 Has your household benefited from the CHIWASH project?

1. Yes 2. No

60.0 If yes, how did you benefit?

1. Latrine

2. Protected Well
3. Community Borehole
4. Health and hygiene education
5. Other(Specify)……

Chivi WASH
Focus Group Discussion: Water Point Committees

- Compositions of the Committee.
- Roles and responsibilities
- Functions performed during/after implementation of project activities
- Successes recorded by the committee.
- Evidence of capacity building efforts received including the
    - provision of tools
    - success of training initiative/Application of what was learnt, are roles being executed effectively
- Other aspects that training should have covered to make structures more effective/additional things they would train if given chance.
- Convening of meetings and issues discussed
- Record keeping
- Relationship with other levels of management
- Support requirements of community management structures
- Availability and reliability of the backup/support services from other higher levels.
- Challenges being faced by the committee (availability of spares, resource mobilisation, lack of technical capacity to carry out maintenance works etc)
- What unintended results have you seen? (Need to probe for positive and negative unintended results from the project)

Focus Group Discussion: VPM. HP and Latrine Builders

- Roles and responsibilities
- Successes recorded
- Nature of support received / required
    - What difference have you made in the community
    - What difference has this training made in your life/ additional things they would train if given chance.
- Perceptions on voluntarism
- Level of interaction with communities/ community leadership and results of interaction. Relationship with other levels of management
- Availability and reliability of the backup/support services from other higher levels.
- Challenges being faced in executing their roles.
- What extra support should have been given by the project (that was not given)?

Chivi WASH

Focus Group Discussion: CHC and Theatre Groups

1. What are your roles in this community?
2. What strategies do you use :effectiveness/ weakness
3. What training have you received :effectiveness/ weakness
4. What benefits have communities realised because of your intervention.
5. What support / resources would you require to improve your effectiveness.
6. Successes
7. Challenges faced

Chivi WASH

Focus Group Discussion: School children

Knowledge of and membership of School Health Clubs; get average length of time children have been members of the health clubs
Functions / usefulness of School Health Clubs.
Performance of School Health Club and proposals for improving Schools Health Clubs.

In this school what do you like or dislike about

- Water supply source
- Latrines
- Hand washing facilities
- Cleanliness of school surrounding.

Use of alternatives and reasons why

Have you received messages on hygiene. (source, frequency and content.)
What have you learnt about Hand washing. Is it easy to apply to what you have learnt.
Relay of hygiene messages to others in the community – establish if this is done by the children, how?

Chivi WASH
Focus Group Discussion: Community

- Community involvement in project planning
- Community awareness of major components of the program
- Outline of main uses of water in the communities and establish whether the source of water varies for each usage mentioned.
- Description of situation before and after introduction of project – give details on the extent to which the initially noted problems were resolved and why changes can be attributed to the project.
- How problems particularly affected children and how project has addressed to their needs.
- Timing of initiative.
- Role of communities in project (from problem identification through implementation and monitoring)- include women and children in analysis
- Benefits of project, list them (changes in quality of life)
- Existence of relevant community management structures and whether they fulfill roles and how? – Define roles and whether these are being satisfied.
- Perspectives on sustainable ways of managing and maintaining program benefits.
- Problems encountered during implementation and views on how problems could have been avoided.
- Enumerate what has been learnt on health and hygiene and appraisal on methods of delivery of messages as well as their appropriateness.
- Use of knowledge on HHE. (How does what has been learnt help communities)
- Community Mechanisms for monitoring household and community behaviour with respect to health hygiene.
- Presence and effectiveness of community based workers. EHTs, HPs and CHCs

- Sustainability issues – Perspectives with respect to capacity building i.e whether communities were effectively equipped with relevant skills.
- Community views on voluntarism.
- Lessons learnt from project that can be used to strengthen implementation of other community projects particularly those focusing on improving the situation of children
- Negative and positive unintended results of this project

OBSERVATION HOUSEHOLDS

- Type of Container used for fetching and storage of water ☐ 1. Closed 2. Not Closed
- Cleanliness of container ☐ 1. Clean 2. Not clean
- Withdrawal method ☐ 1. Laddle 2. Single Cup 3. Pour from Container 4.

  Other
- Cleanliness of withdrawal utensil ☐ 1. Clean 2. Not clean
- Presence of handwashing facility for use after toilet use ☐ 1. Present 2. Absent
- Functionality of handwashing facility visit ☐ 1. Water available at time of

  2. No water at time of visit
  3. No handwashing facility
- Availability of washing agents at the handwashing facility

Agent	Availability
Soap	
Ash	
Other	

1. Available 2. Not available 3. Not applicable

- Type of latrine ☐ 1. Pit latrine 2.Flush latrine 3.VIP latrine

  4. Other 5. None

  Cleanliness of latrine ☐ 1. Clean 2. Somewhat clean 3. Not

  Clean 4. Not Applicable
- Is the toilet appropriately sited ☐ 1 Yes 2 No

  Is the toilet disability friendly ☐ 1 Yes 2 No
- Homestead faecal free ☐ 1. Yes 2. No
- Is the homestead hygienic (swept or not) ☐ 1. Yes 2. No

HYGIENE ENABLING FACILITIES

(a) Pot rack ☐ 1. Available 2. Not available 3. Not applicable

(b) Rubbish pit ☐ 1. Available 2. Not available 3. Not applicable

(c) Siting of rubbish pit ☐ 1. Correct 2. Wrong 3. Not Applicable

(d) Stage of kitchen utensils ☐ 1. Available 2. Not available

(e) Environmental hygiene (grass cut or not) ☐ 1. Good 2. Somewhat good 3. Not good

Is the environment litter free? ☐ 1. Yes 2. No

School Health Master/ School Head Questionnaire

School Name _____

Ward number _____

School Level*(primary/secondary/mixed)* _____

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

_____

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

_____

Student Population No. of boys ☐ No. of girls Tota☐ ☐

No. of Shifts ☐

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

Teachers No. of male ☐ No. of Female ☐ ☐

Does the school have a Parent Teachers Association *(yes/no*)? 1 =Yes 2 = N**o** ☐

2.0 WATER SUPPLY

2.1	What is the main water supply source for the school?	☐	1=Borehole 2=Piped water 3=Protected Well 4=Unprotected Well 5=Surface Water
2.2	Where is the water supply point of consumption located?	☐	1=Within the School 2=Outside the School 3=N/A
2.3	When the main water source is not functional, what is the alternative used?	☐	1=Borehole 2=Piped water 3=Protected Well 4=Unprotected Well 5=Surface Water 6= Bring own water from home
2.4	Does the main water supply source provide enough water for the schools needs?	☐	1=Yes 2=No
2.5	Besides drinking, for what other purposes is the water used for?	☐	1=Cleaning 2=Hand washing 3=School projects 4=Others (Specify) ……..
2.6	Do you share water with community members or other institutions?	☐	1=Yes 2=No
2.7	If yes, Does the school share the water source with	☐	1 community 2 institution

2.8 Who maintains the water supply source for the school? [ ] 1=School Committee 2=DDF 3=ZINWA 4=Other (Specify)

2.9 Did ZRCS construct any water facility in this school? [ ] 1 Yes 2 No

2.9.1 If yes, what was done? [ ] 1 Drill new water point. 2 Rehabilitate existing water source

……...

3.0 SANITATION

3.1 What type of toilets do school children use? [ ] 1=Flush Toilet 2=VIP Latrines 3=Pit Toilet 4=Others (Specify)

……...

3.2 How many functional squat holes are there in the School?

USERS	**FUNCTIONAL**	**PARTIALLY FUNCTIONAL**	**NOT FUNCTIONAL**
Exclusively for ECD Girls			
Exclusively for ECD Boys			
Exclusively for Girls			
Exclusively for Boys			
For boys or girls			
Exclusively for female staff			
Exclusively for Male Staff			

Key: i. Functional – Toilet 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 can not be used.

3.3 Who is responsible for cleaning school toilets for children and staff? [ ] [ ] [ ] 1=School Children 2=School Grounds man 3=Teachers 4=Other (Specify)……...

3.4 Did ZRCS construct any sanitation facilities in this sc [ ] 1 Yes 2 No

3.5 How many squat holes? [ ]

4.0 HYGIENE

4.0 Is hygiene taught at the school? [ ] 1=Yes 2=No

4.1 How is hygiene taught at the school? [ ] [ ] [ ] 1=As a component of the core Curriculum 2=Through school sponsored Extracurricular activities e.g School Health Clubs 3=Sporadically/Informally/ Occasionally

4.2	Who conducts hygiene lessons in the school?		1=School Teacher 2=EHT/Ministry of health officials 3=NGOs 4=Parents 5=School Health Master 6=School Health Clubs 7=Other (Specify)……..
4.3	Does the school have a trained School Health Master?		1=Yes 2=No
4.4	Did ZRCS offer training to teachers/students in this school?		1Yes 2 No
4.5	Is there a provision for a hand washing facility in the school?		1=Yes 2=No
4.6	From your observation, what is the level of utilization of facility?		1=All children use it at all times 2=All children use it sometimes 3=Some children use it 4=Facility is never used
4.7	If no, what sometimes prevents children from washing hands when you feel it is necessary?		1=water is not always available 2=Washing agents not always available 3=Inappropriate design of handwashing facility 4=Sometimes there is pressure at the handwashing facilities 5=Facility is not available in school 6=N/A
4.8.	What agents do children use to wash hands?		1=Soap 2=Ash 3=Other (Specify)……..
4.9	Is it always possible to wash hands when it is deemed necessary?		1=Yes 2=No

---

5.0 WASTE DISPOSAL

5.1	Have children been taught about solid waste disposal in		1=Yes 2=No

this school?

5.2 Which solid waste disposal methods would be appropriate for this school? [ ] [ ] [ ] 1=Rubbish pit 2=Burying 3=Burning 4=Disposal into toilets pits 5=Collection for disposal in a central place 6=Other (Specify)……

5.3 How is solid waste disposed of in this school? [ ] [ ] [ ] 1=Rubbish pit 2=Burying 3=Burning 4=Disposal into toilets pits 5=Collection for disposal in a central place 6=Other (Specify)……

5.4 Did the ZRCS project dig/construct any waste disposal facilities in this s [ ] 1 Yes 2 No

---

6.0 SCHOOL HEALTH CLUBS

6.1 Is there a School Health Club in this school? [ ] 1=Yes 2=No 3=Don't know

6.2 If available, what are the roles? [ ] [ ] [ ] [ ] 1=Ensuring Watsan facilities Are working 2=Health and hygiene Promotion 3=Advice on nutrition 4=Advice on hygiene 5=Don't know 6=Other (Specify)…….

6.3 What do you think are the benefits of a school Health Club? [ ] [ ] [ ] [ ] 1=Knowledge on Health and Hygiene 2=Source of entertainment 3=Provides opportunity for interaction outside the classroom 4=Other (Specify)……..

6.4 Has there been any training given for the health club [ ] 1 Yes 2 No

---

7.0 OBSERVATIONS WATER SUPPLY

7.1 Is the main water supply source functional now? [ ] 1=Yes 2=No 3=Partially

7.2 How do children withdraw water from source? (Vessel Used to drink water? [ ] [ ] 1=Palms 2=Own Container 3=Shared Container 4=Other (Specify)…….

7.3 Cleanliness of withdrawal method e.g do they clean containers before drinking? [ ] 1=Yes 2=No

7.4	Distance of nearest water source from school?		1=Within 500m 2=More than 500m
7.5	Is the water supply point accessible to children with disabilities?		1=Yes 2=No

8.0 SANITATION

8.1	What is the condition of toilets?		1=Good 2=Satisfactory 3=Bad
8.2	How clean are the toilets for use by school children?		1=Clean 2=Somewhat clean 3=Not clean
8.3	Are girls individual toilet compartment lockable from inside?		1=Yes 2=No
8.4	Are toilets suitable for young children and children with disabilities?		1=Yes 2=No
8.5	Are there functional hand washing facilities for use by children ? 1=Yes 2=No		
8.6	Are hand washing agents available (at time of visit)?		1=Yes 2=No
8.7	Are hand washing facilities suitable for small children and children living with disabilities?		1=Yes 2=No
8.8	Are the school grounds faecal free?		1=Yes 2=No
8.9	General cleanliness of school grounds?		1=Clean 2=Somewhat clean 3=Not Clean
8.10	Personal hygiene of children?		1=Smart/clean 2=Dirty
8.11	Appropriateness of solid waste disposal methods		1=Appropriate 2=Not appropriate
8.12	Where there is rubbish pit, appropriateness of its siting.		1=Good 2=Not good.

Checklist No	

CHIWASH - Water Point Observation Checklist

1.0 Identification and Location Details

1.1 Name of Water-point (Wpt)

_____

1.2 GPS Coordinates (UTM)

_____

1.3 Village where Water-point is Located

_____

1.4 Ward where Water-point is Located

_____

1.5 Date of Inspection

_____

2.0 Hand-pump Installation Information for Water-point

2.1 Type of Water-point (borehole or hand –dug well) ☐

2.2 Project activity for the water-point; **{**1. Rehabilitation 2. ☐

2.3 Date of Rehabilitation/drilling and installation ☐

2.6 Depth of borehole/well ☐

2.7 Total number of pipes/rods installed in the borehole/well ☐

2.8 If rehabilitated list the new components installed

Description the New Hand-Pump Component	Number of units	Comments

3.0 Water-Point Physical Inspection Information

3.1 Condition of Above Ground Components

Hand-Pump Component	Condition of component			Remarks
	1 Good	2 Needs Attention	3 Poor	
a) Wooden Block and Handle				
b) M24 Bolts – Hinge Pins				
c) Pump Discharge Unit				
d) Pump Stand and U-Bolts				
e) Floating Washer and rubber buffer				
f)U-Brackets (for securing to casing)				
g) Short Casing				

3.2 Assessment of down-hole components

(a) Number of strokes before discharge ☐

(b) Weight of handle:
① Normal ② Heavy ③ Very Heavy ④ N/A

(c) Quantity of water discharged per stroke:
① Normal ② Very Little ③ N/A

3.3 General Condition of Hand-pump

(a) Above ground components
① Good (2) Needs Attention (3) Poor ④ Broken

(b) Down-hole components
① Good ② Needs Attention ③ Poor ④ Broken

(c) Overall Functional status of pump
① Good ② Needs Attention ③ Poor ④ Broken.
⑤ *N/A*

(d) If broken down, what caused the breakdown?

_____

_____

3.4 Quality of Water drawn from borehole/well

(a) Taste

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

(b) Appearance

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

(c) Comment on the water Quality

_____

3.5 Head-works Condition

Headworks Component	**Condition of component**				**Remarks**
	1 good	**2 needs attention**	**3 poor**	**4 Non-existent**	
a) Apron/Spillway					
b) Fence					
c) Soakaway					
d) Cattle Trough					

3.6 Sanitary Condition at the Water-point

① Clean ② Needs Attention ③ Poor

3.7 If not Clean, Comment on Sanitary Condition

_____

4.0 Community Based Management Information

4.1 Who uses the water point?

① Village ② School ③ Clinic ④ Business center
⑤ Other; Specify

_____

4.2 Number of households that use the Water-point

① Less than 25 ② 25 – 50 ③ 50 – 100 ④ More than 100

4.3 Distance of the nearest user

① Less than 250m ② 250 –500m ③ 500 – 1Km ④ More than 1km

4.4 Distance of the furthest user

① Less than 250m ② 250 –500m ③ 500 – 1000m ④ More than 1km

4.5 Other uses of water

① Livestock ② Gardening ③ Cattle dip ④ Industry
⑤ Other; Specify: (6) None

_____

4.6 Does the village have a trained Pump Mechanic?

① Yes ② No ③ Don't know

4.7 Does the Village Pump Mechanic have access to tools?

① Yes ② No ③ Don't know ④ N/A

4.8 Distance of the nearest trained Mechanic

① Less than 1km ② 1 – 2km ③ 2-5km

4.10 Does the water point have a Water-point Committee?

① Yes ② No ③ Don't know

4.11 If yes, is the water point committee trained?

① Yes ② No ③ Don't know ④ N/A

4.13 How many times did the hand-pump breakdown after rehabilitation or drilling and installation

① Nil ② Once ③ Twice ④ More than twice
⑤ N/A

4.14 Who repaired the hand-pump when it was broken down?

① Pump minder (former DDF) ② VPM ③ Other. Specify:_____
④ N/A

4.15 For rehabilitated boreholes, was the Water -point functioning prior to repairs?

① Yes ② No ③ Don't know ④ N/A

4.16 If the water-point was broken down or newly drilled, where did the community get water prior to the repairs and drilling of new borehole?

① Other protected water points ② Unprotected wells ③ River/dam

④ Others, Specify; _____
⑤ *N/A*

4.17 Distance travelled to obtain water during breakdown

① Less than 5000m ② 500m- 1km ③ 1 – 2Km ④ More than 2 Km

4.18 Distance to nearest other protected water-point

① Less than 500m ② 500–1000m ③ 1 – 2Km ④ More than 2Km

4.19 Yield reliability of water point

① Good ② Poor

4.20 If it is poor, when does it dry up?

① Throughout the year ② Dry season only ③ N/A

4.21 How much water is obtained before it dries in the morning?

① Less than 200 lts ② 200 –500 lts ③ 500–1000 lts ④ more than 1000 lts
⑤ *N/A*

The End.

APPENDIX III

LIST OF KEY INFORMANTS

List of Key Informants

Name	Designation	Office
Mr Mavengano	Councillor	Ward 21
Mrs Gurwe	Health Promoter	Ward 21
Mrs Zigonde	Health Promoter	Ward 16
Mr Dzviti	Village Head	Dzviti Village Ward 21
Mrs R David	Health Promoter	Ward 21
Mr Makuvire	Councillor	Ward 29
Mr Chipika	Assistant PA	Masvingo province
L Gasa	Sister in Charge	Chivi Rural Hospital
Mr Rambanepasi	EHT	Ward 16
Mr Pwanyai	Councillor	Ward 16
Mr Muposi	EHT	Ward 31
Mr Fukuzeya	ZRCS Field Officer	
Chief Shindi	Chief	
Mr Chitoro	Sabhuku	Village 8B
Mr Bheke	EHT	Ward 29
Mr Gutukunhuwa	Provincial Coordinator	DDF
Mrs F Maregedze	Provincial Programme Manager	ZRCS
Mrs Gumbo	Field Officer	ZRCS
Ms T Manike	Software Officer	ZRCS
Mr Nyamadzawo	Hardware Officer	
	School Health Mistress	Mawadze School
	School Health Mistress	Rushangarumwe School
Mr Hadzirabwi	District Administrator	Chivi District

APPENDIX IV

INDICATOR TRACKING TABLE

Indicator Tracking Table

Indicator	Situation at Project Inception	Situation at Project Termination
Percentage getting drinking water from a borehole	64	85
Percentage of households collecting water within 30 minutes	31	46
Households using closed water storage containers	79	95
Households with access to a BVIP	22	51
Households practising open defecation	60	35
Households disposing of infants' stool safely	17	56
Households with access to some form of toilet	44	59

APPENDIX V

EVALUATION SCORES

	Score Notation[15]	Comments[16]	Recommendations[17]
Relevance / Appropriateness	A	Overall the project is considered to have been relevant for the identified needs of the communities in Chivi District. In this respect, a lot of consultations were made with targeted communities as well as with district communities such that the required information to inform programming was available. Apart from enabling ZCRS to fulfil its mandate the project complied with government of Zimbabwe policies.	
Efficiency	C	The project was generally efficient as it adhered to cost effectiveness strategies. Sharing of resources with partners including DWSSC members and community structures enabled the project to achieve more than it would have achieved had a different strategy been adopted. The project however appears to have fallen short in terms of defining standards for headworks construction. Moreover the procedures used in assessing rehabilitation requirements for boreholes resulted in some boreholes that would otherwise have been excluded being included. Similar problems were experienced with drilled boreholes where some very low yielding boreholes were certified as successful.	1. Future similar projects need to consider engaging technical supervisors to supervise drilling activities. Alternatively the certification process could be strengthened by ensuring that each borehole is visited upon completion or prior to the expiry of the warranty period. 2. There is need to define proper standards for completed works so that quality and durability are ensured. 3. Future similar initiatives should ensure that proper guidelines for rehabilitation requirements assessment are agreed to by all parties prior to the execution of rehabilitation activities/
Effectiveness	B	Apart from largely meeting planned targets the project made life easier for communities in the district in several ways. The proportion of households getting water for drinking from boreholes during the dry season increased from 64% to 85%. This effectively reduced distances to the nearest water sources as well as the time taken for a round trip to collect water for domestic use. In terms of sanitation, the percentage of households practising open defecation was reduced from 44% at project inception to 35% after project implementation. While the standard latrine technology that has been approved for use in rural areas in Zimbabwe is the BVIP, the project managed to improve access to this type of latrine from 22% to 51%. At school level the project managed to significantly improve the pupil to squat hole ratio in that for boys the recommended standard was achieved while for girls there was movement towards the recommended standard. Efforts were also made to ensure that school latrines were disability as well as girl friendly. While good structures for delivering hygiene messages were put in place by the project (as was reflected in the knowledge levels on hygiene), hygiene practices were not always positive for most households.	1. Hygiene interventions need to put more emphasis on behaviour change as opposed to raising awareness on hygiene in future similar initiatives. 2. Future similar projects need to create an enabling environment for ensuring community structures that focus on hygiene promotion continue functioning after the termination of project efforts. Among other things this includes the development of community behaviour monitoring mechanisms with well- defined indicators.
Impact	B	Assessment of impact focused on the qualitative changes that have resulted from project implementation with emphasis being put on both negative and positive changes. On the whole there is evidence that the project managed to change the quality of lives for communities in the project wards. For instance, the project empowered the communities in terms of enhancing the capabilities of communities to address common challenges. It also provided them with the requisite opportunities for improving their health through providing them with important information as well as health enabling facilities.	1. Future development efforts should build on the momentum, unity of purpose and cohesiveness that have been generated on this project.
Sustainability	B	Mechanisms are in place to facilitate a timely maintenance of broken water points if and when the situation arises. Training of VPMs, Water Point Committees as well as the provision of spares closer to communities and pump repair kits per ward all create an enabling environment for the reduction of down time for water points. Communities have already started building financial resources for use in the maintenance of boreholes. In the Hygiene Promoters and Health Clubs at different levels the project created local resource people who can continue encouraging positive behaviour change. The presence of ZRCS in the district provides an opportunity to continue collaborating with DWSSC on WASH issues.	1. Strategies for ensuring that HPs are adequately motivated after termination of project support need to be developed and adopted in future similar initiatives.

[15] A: Highly satisfactory (fully according to plan or better);
B: Satisfactory (on balance according to plan, positive aspects outweighing negative aspects);
C: Less than satisfactory (not sufficiently according to plan, taking account of the evolving context; a few positive aspects, but outweighed by negative aspects):
D: Highly unsatisfactory (seriously deficient, very few or no positive aspects).
Each rating should be stated as part of the conclusions for each of the five criteria.

[16] Comments shall be included to explain the notation in case it is estimated necessary.

[17] Top 3 recommendations ranked in term of importance.

APPENDIX VI

PERFORMANCE OF BOREHOLES

WATER –POINT INSPECTION SUMMARRY LIST

No.	Ward No.	Name of Village	Name of Borehole	Type of Work-Rehab/Drilled	Yield Reliability	Time of the Year Borehole Dries-up	Date of Inspection	Remarks
1	16	Musongo	Musongo	Drilled	Poor	Dry season only	30/09/2015	Dries up after pumping 500-1000 litres in the morning
2	16	Tadious	Tadious	Rehabilitated	Good	N/A	30/09/2015	-
3	16	Mwarire	Mwarire	Rehabilitated	Poor	Dry season only	30/09/2015	Dries up after pumping >1000 litres in the morning
4	16	Manika	Manika	Rehabilitated	Poor	Dry season only	30/09/2015	Dries up after pumping <200 litres in the morning
5	16	Manika	Nyamakwe	Rehabilitated	Poor	Dry season only	30/09/2015	Dries up after pumping 200-500 litres in the morning
6	16	Pwanyai	Pwanyai	Drilled	Poor	Throughout the year	30/09/2015	Dries up after pumping <200 litres in the morning
7	16	Mhuka	Mhuka	Rehabilitated	Good	N/A	30/09/2015	-
8	16	Batsire	Batsire	Rehabilitated	Good	N/A	30/09/2015	-
9	16	Chinodyenyama	Chinodyenyama	Rehabilitated	Good	N/A	30/09/2015	-
10	21	Chishavakadzi	Chishavakadzi Sch	Drilled	Poor	Throughout the year	01/10/2015	Dries up after pumping <200 litres in the morning
11	21	Majoni	Majoni	Rehabilitated	Good	N/A	01/10/2015	-
12	21	Dzviti	Dzviti	Rehabilitated	Poor	Throughout the year	01/10/2015	Dries up after pumping <200 litres in the morning
13	21	Mutapwa	Chomuruvati	Rehabilitated	Good	N/A	01/10/2015	-
14	21	Wonekai	Wonekai	Drilled	Good	N/A	01/10/2015	-
15	21	Rushangarumwe	Rushangarumwe	Rehabilitated	Good	N/A	01/10/2015	-
16	31	Zunga	Zunga Pr Sch (old)	Rehabilitated	Good	N/A	01/10/2015	-
17	31	Muzvimwe	Neruvanga Sec Sch	Rehabilitated	Good	N/A	01/10/2015	-
18	31	Urayai	Zunga Pr Sch (New)	Rehabilitated	Poor	Dry season only	01/10/2015	Dries up after pumping 200-500 litres in the morning. Collapsed/blocked- pipes not installed to original depth.
19	31	Imbayago	Imbayago	Drilled	Good	N/A	02/10/2015	-
20	31	Gomana	Gomana	Rehabilitated	Good	N/A	02/10/2015	-
21	31	Zinhungo	Zinhungo 2	Drilled	Poor	Throughout the year	02/10/2015	Dries up after pumping <200 litres in the morning
22	31	Zinhungo	Zinhungo	Rehabilitated	Poor	Dry season only	02/10/2015	500-1000 litres obtained before drying up in the morning
23	29	Village 11 A	Village 11 A	Drilled	Good	N/A	02/10/2015	-
24	29	Village 11	Village 11	Rehabilitated	Good	N/A	02/10/2015	-
25	29	Village 11	Tokwe Pr Sch	Drilled	Poor	Throughout the year	02/10/2015	Dries up after pumping <200 litres in the morning
26	29	Village 9 B	Village 9 B	Rehabilitated	Good	N/A	02/10/2015	-
27	29	Village 9 A	Village 9 A	Rehabilitated	Poor	Dry season only	02/10/2015	500-1000 litres obtained before drying up in the morning
28	29	Village 9 C	Village 9 C	Rehabilitated	Good	N/A	02/10/2015	Hand-dug well, good yielding
29	29	Village 8 A	Village 8 A	Rehabilitated	Good	N/A	02/10/2015	-
30	29	Village 7 A	Village 7 A	Rehabilitated	Good	N/A	02/10/2015	-