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40th WEDC International Conference, Loughborough, UK, 2017**LOCAL ACTION WITH INTERNATIONAL COOPERATION TO IMPROVE AND SUSTAIN WATER, SANITATION AND HYGIENE SERVICES****Improving WASH services in Zimbabwe: experiences from a rural WASH project***T. Ahmad, V. Kinyanjui, M. Jonga, H.R. Mashingaidze & A. Cole (Nepal)***PAPER 2620**

Rural WASH Project (2012-2016) was implemented in rural areas of Zimbabwe covering 33 of 60 rural districts in five provinces aiming at improving WASH services. This project was built over four thematic areas of WASH infrastructure, demand led sanitation & hygiene promotion, Public Private Partnership for Operation & Maintenance, and WASH sector governance. The project achieved almost of all the planned results by end of October 2016. The project resulted in massive capacity development of government and community based structures for sustainable delivery and management of WASH services. For the first time in the history of Zimbabwe, demand led sanitation mainly without subsidy was successfully implemented resulting in construction of over 107,048 latrines, and achieving 2,555 Open Defecation Free villages. The project is now being scaled up in other districts and provinces under the 2nd Phase of the Project.

Background

In the mid-1990s, Zimbabwe had attained a very high level of service delivery with respect to both rural and urban water supply, sanitation and hygiene. Water resources development also kept pace with demands across key sectors; irrigation, industry and mining among others. However, the economic downturn of 2000-2009 created not only a capacity gap to manage the aging infrastructure but also limited further expansion of the Water Sanitation and Hygiene (WASH) sector. The collapse of water revenues that started in the late 1990s and continued during the last decade led to a decline in all water supply and sanitation infrastructure, and services (i.e., drinking water from 79% in 1990 to 77% in 2015 while sanitation from 40% in 1990 to 37% in 2015). The collapse affected all parts of the country and all aspects of water supply and sanitation services provision, and water resources management and development. This has had a significant impact on the quality and reliability of services. The 2008-2009 cholera outbreaks which resulted in 98,592 cases and 4,282 deaths was the manifestation of deteriorated WASH services (UNOCHA, 2009).

In response to the cholera outbreak, the donor community invested in the sector for rehabilitation and provision of WASH services while the government with support from the development partners undertook major initiatives including development of National Water Policy (2013), National Sanitation and Hygiene Strategy (2011), strengthening coordination mechanisms, adopting a demand-led sanitation approach as opposed to the supply/subsidy driven approach that hitherto had been the approach for rural sanitation in the country, and piloting WASH Information Management System. In June 2012, a four-year major project was initiated in rural areas of Zimbabwe under the name of 'Rural WASH Project (RWP)' with total funding of USD 62 million provided by the UK Government (about USD 52 million), Swiss Agency for Development Cooperation (about USD 6 million) and UNICEF (USD 4 million). This paper aims at sharing experiences gained from the implementation of this large scale Rural WASH Project during the last four years.

Description of rural WASH project

Geographic target area

According to 2012 Census, Zimbabwe has a population of 13,061,239 people with 41 percent of the population below 15 years old and 67 percent living in rural areas (ZimStat, 2012). Zimbabwe has 10 provinces (8 rural and 2 urban) and 91 districts with 60 districts located in rural areas. The Rural WASH Project was implemented in 33 of the 60 Rural Districts in five selected provinces from June 2012 to October 2016. These five provinces were selected based on vulnerability criteria which included existing level of access to WASH services, prevalence of WASH related disease (e.g., cholera cases reported during the outbreak), and presence of any other ongoing WASH interventions.

Planned results

The Rural WASH Project aims at delivering the following major results by the end of the project period:

1. Provision of access to improved sources of drinking water to 1,726,000 people in 33 districts through construction of 1,660 Bush Hand Pump equipped new boreholes and repair/rehabilitation of 8,200 water points including 33 piped water schemes;
2. Provision of sanitation services to 589,760 people through supporting communities for construction of household latrines and elimination of open defecation;
3. Reaching 1,272,000 people with hygiene promotion messages to facilitate adoption of healthier behaviour especially handwashing with soap at critical times, and use of sanitation facilities;
4. Provision of sanitation and handwashing facilities in 1,660 schools;
5. Strengthening the capacity of community based structures for O&M; districts and provinces for monitoring, supervision and sustainable delivery of WASH services; and
6. Establishment of Rural WASH Management Information System (RWIMS) in the 33 targeted districts.

Thematic areas and major activities

The Rural WASH Project (RWP) focuses on four major thematic areas/components of (i) Rehabilitation and New WASH Infrastructure, (ii) Demand-led Sanitation and Hygiene Promotion, (iii) Public- Private Partnership for operation and maintenance, and (iv) WASH Sector Governance. The first thematic area focuses on provision of new water points (new hand pump equipped boreholes), repair and rehabilitation of existing boreholes and piped water schemes in communities, schools, and clinics as well as provision of sanitation and hygiene facilities in schools. The second thematic area encompasses sanitation and hygiene promotion especially targeting communities and households for elimination of open defaecation through construction of improved latrines facilities and encouraging adoption of healthier behaviour especially hand washing with soap at critical times. This component also includes hygiene promotion at school level. The third component concentrates on sustainable community based operation and maintenance of WASH services through partnership/participation of the private sector. The fourth component aims at improving enabling environment through policy support, capacity building of government structures, and establishing a sector information management system (Government of Zimbabwe and UNICEF, 2012).

Implementing partners

The Rural WASH Project is being implemented through government structures with support from 10 Civil Society Organizations (INGO/NGOs) initially, with 2 dropping out after 2 years, while UNICEF Zimbabwe is responsible for overall management of the Project including managing funds and providing technical support. The selection of CSOs, from 32 who had expressed interest, was done through a transparent competitive process by a panel led by Government and comprising the Project Management Team (PMT), UNICEF and DFID.

Project implementation

Implementation mechanism

The main body responsible for coordination, planning and management of the WASH Sector at the national level is the National Action Committee (NAC), an inter-ministerial committee under the leadership of the Minister responsible for water. The NAC has three sub-committees responsible for (a) water resources management, (b) rural water supply and sanitation and (c) urban water and wastewater respectively. NAC has a secretariat called the National Coordination Unit (NCU) whose primary purpose is to provide day- to-day administration of the water and sanitation sector on behalf of the NAC. The RWP is managed through

two project committees (i) the Project Advisory Committee (PAC) mainly responsible for policy and strategic guidance; and (ii) the Project Management Team (PMT) responsible for technical support for the implementation of the Rural WASH Project. At the provincial and district levels there are sub-committees (inter-ministerial) known as Provincial Water Supply and Sanitation Sub-Committees (PWSSSCs), and District Water Supply and Sanitation Sub-Committees (DWSSSCs) with all relevant ministries and CSO duly represented. The major function of the PWSSSCs and DWSSSCs is to coordinate and assist in the management of rural water supply and sanitation activities in the provinces and districts respectively. The key government implementing agency at the district level is the Rural District Council (RDC) which is technically supported by DWSSSC. The WASH service delivery is anchored on community based management through community structures such as Sanitation Action Groups, Water Point Committees, Community and School Health Clubs and School Development Committees in order to promote ownership and sustainability. Ministry of Health is the lead Ministry at national, provincial and district level for implementation of the Sanitation and Hygiene Component. CSOs engaged through UNICEF are playing a facilitation role to the government at the district level especially with the sanitation and hygiene component. Under the Project, the government developed Implementation Guidelines which spell out the roles and responsibilities of all stakeholders.

Selection processes for interventions

Districts in the five selected provinces were selected objectively through application of district selection criteria that included (i) drinking water coverage, (ii) sanitation coverage, (iii) number of non-functional water points, (iv) proportion of orphans and other vulnerable children, (v) proportion of female and child headed households, (vi) people living with disabilities, (vii) incidence of cholera, (viii) incidence of diarrhoeal disease, (ix) incidence of bilharzia, and (x) other WASH interventions in the district. The process led to transparent selection of 33 districts which scored highest against these indicators. The same selection criteria were used at sub-district level for selection of wards for intervention.

Within the selected ward, the selection criteria used for provision of water points (new boreholes) included eight indicators comprising (i) population to be served by the borehole, (ii) average distance from the nearest water source, (iii) distance from other boreholes within, (iv) quantity of water available from current water source, (v) condition of the current water source, (vi) siting and drilling attempted before, (vii) location of the selected site (community, school, clinic etc.), and (viii) participation of women and girls during initial siting. In order to further ensure neutrality and eliminate political influences at district level, final selection was done by the provincial and national team through a joint verification exercise involving physical assessment of all potential sites identified by the districts and applying the criteria objectively.

The selection process for school sanitation and hygiene interventions also followed application of criteria comprising of 11 indicators *viz.* (i) pupils squat hole ratio, (ii) status of handwashing facilities, (iii) condition of existing latrines, (iv) availability of trained health teachers, (v) status of school health club, (vi) availability of potable drinking water, (vii) source of drinking water, (viii) distance of water point from the school, (ix) number of cholera cases reported at the school, (x) prevalence of other diarrhoeal cases, and (xi) prevalence of bilharzia cases

The criteria for selection of most vulnerable (poor and labour-constrained) households for subsidized sanitation included categories of (i) child headed households, (ii) households with HIV infected/terminally ill heads, (iii) households with physically challenged members and (iv) households with very limited sources of income and productive assets. The last category was to be considered only if the first three categorized households are not present or exhausted in a given village. It should be noted that the project included subsidized latrines for the most vulnerable households (up to maximum 5%) which also serve as model latrines for the rest of the villages to replicate and also to train the latrine builders.

Major achievements

The Rural WASH project ended in October 2016 with a low cost extension for additional four months from 1st July 2016 to 31 October 2016. The major reason for extension of the project was to ensure achievement of planned target for sanitation component which was behind. On the water supply component, about 3.15 million people provided with improved sources of drinking water against the planned target of 1.73 million people with construction of 1,620 new boreholes (100% of target), repair and rehabilitation of 10,440 boreholes (127%) and 32 piped water scheme (100%). On the sanitation component, 116% of the planned target was achieved i.e., 681,862 additional people have access to improved sanitation facilities through

construction of 107,048 household latrines (about 92% with no subsidy) through demand led sanitation promotion. 2,555 villages achieved open defaecation free status against the target of 1,524 villages (167%) while 2.15 million people including school children reached with hygiene promotion activities. In addition, 1,691 schools (102%) provided with sanitation and hygiene facilities including hygiene promotion package. Capacity of 33 districts and 5 provinces on WASH service delivery was enhanced through various trainings and provision of supplies. Rural WASH Information Management system was established in 33. Various community based structures established and capacitated including 10,340 water point committees, 5,356 sanitation action groups, 3,759 community health clubs, 1,725 school development committees, 2,560 village pump mechanics, and 6,845 latrines builders, and 3,415 school health teachers.

Lessons learned

During the project implementation a number of important lessons were learned through various learning platforms. These included but not limited to quarterly review meetings at national level, district level monthly and quarterly meetings, monitoring mission and technical visits, mid-year and annual reviews, trial and error technique, independent external reviews, feedbacks from communities and stakeholders, actual results versus planned results, and through addressing programmatic challenges. Some of the major lessons learned are described in below sub-sections:

Communities willing to embrace new approaches

One of the major lessons that was learned during the implementation of the project was the fact that communities are willing to embrace new approaches and make significant contributions once they are convinced of long term benefit of proposed interventions no matter how poorer they could be. This was demonstrated by the communities who had a long history of dependency syndrome when it came to the construction of household latrines where government used to provide heavily subsidy. Under the demand led approach, the communities contributed a minimum of over USD 5 million for construction of over 98,335 improved household sanitation facilities without any subsidy. In addition, communities also contributed one-third of the total cost for construction of sanitation facilities in 1691 schools (i.e., over USD 1 million).

Recognition of sanitation ‘champions’ and involvement of leadership important

Feedback by community based Sanitation Action Group (SAG) members revealed that recognition of their actions in promoting latrine construction and use was a key motivating factor for them to continue facilitating promotion of latrines. Interestingly, they were happy to have T-shirts or similar symbols of their roles and not necessarily cash rewards.

During the extension period of the RWP, the involvement of community level leadership as well as district level government officers was increased in the follow up after triggering. This contributed to the significant jump in latrine construction during this period, with 30% of the total RWP latrines being constructed during this four month period and ODF villages increasing from 1,011 to 2,555. It is thus important to include leadership from both government and communities to increase motivation of communities to construct and use latrines as these are part of the communities’ reference group which influences their motivation.

No quick fixes for WASH issues

Another major lesson learned was that there are no quick fixes for addressing WASH issues as due processes must be followed especially for interventions requiring behavioral changes. Long term aspects of sanitation improvement should be acknowledged rather than attaching same level of expectation for results as to be achieved with water supply (which is a felt need of the communities and usually provided free) while sanitation requires self-motivation, strong drive, and resources from the beneficiaries.

Transparent and systematic monitoring mechanism is key for success

Transparent and effective rigorous monitoring systems involving systematic sharing of progress on monthly basis with all stakeholders increase accountability and performance. Under the Rural WASH Project an innovative monitoring and tracking system was operationalized to measure the progress on key indicators, identify bottleneck and link the progress with fund utilization. This led to compilation and sharing of monthly status report. A unique feature of the status report was to summarize the progress on a single page DASHBOARD for 4 indicators across 33 districts using traffic lights system showing % achievement for

each of the indicator and district. The mechanism was introduced in early 2014 and regular monthly report produced and shared till end of the project (Ahmad, 2016). The government is planning to scale up of the monitoring mechanism to monitor progress on the similar project.

Implementation through government structure adds to sustainability.

Implementation of the project through government structures with minimal external support created enabling environment with increased capacity which will be a key factor for sustainability of the WASH intervention beyond the project life.

Strategic joint monitoring visits

This has proved to be a valuable tool/means of providing supportive monitoring to the project from national level and contributing to national level oversight. Additionally, it provided a means of transferring knowledge across various project districts and its inter-ministerial nature and composition means it can leverage the inputs/strengths of various ministries as and when required.

Need for inception period

The kick off for the sanitation component of the RWP in the first phase was significantly delayed; it is important not to be 'shy' but provide an adequate period for project inception comprising sensitization, site identification, develop programme documents etc. The time spent on getting things right in the inception period is key to success and managing expectations from donors in terms of timelines and results.

Project based assigned roles should be formalized

Operationalization of the newly introduced automated Rural WASH Information Management System (RWIMS) required periodic collection of data (related to functionality of boreholes, sanitation and hygiene status) at village for updating the system. The line department responsible for WASH sector at district and sub-district level had no presence at grass-root level and hence it was decided to engage human resources from other ministries and departments who had close interaction with communities such as Environmental Health Workers from the Ministry of Health. This approach initially worked very well but later the timeliness of updating of RWIMS had been slow for some districts. One of the factors for this has been that the enumerators come from various sectors and do not necessarily feel obliged to report in a timely manner or on a priority basis as this may be a secondary assignment for them. Thus some high level coordination is required amongst the various institutions especially to include collection of WASH data as an additional responsibility as formal part of their job description. Similarly, RWIMS should be able to demonstrate the reports generated from the information systems are equally important for other ministries and should be linked with health data e.g., WASH service with disease prevalence data etc., and access to WASH services in health centres and schools to the Health and Education Information Management Systems.

Challenges

During the implementation of the Rural WASH Project, many challenges and constraints were encountered as the planned results were not fully achieved during the first 18 months of the implementation with most of the milestones being below 50% of the planned targets. Therefore, thorough analysis of the situation led to identification of major challenges. Consequently, efforts were made to address/reduce the impact of challenges on programme performance through various capacity building initiatives and changing/modifying the implementation strategies. Below are some of the major challenges that were encountered during the first initial phase of implementation (i.e., during the first 18 months):

1. Limited capacity of private sector for drilling new boreholes,
2. Inadequate capacity of government structure at district and sub-district level especially in the areas of monitoring and supervision of drilling works, sanitation and hygiene promotion activities,
3. Quality of hand pumps and related spare parts and inadequate capacity of manufacturing industries,
4. Delayed implementation of the sanitation and hygiene component due to the slow process of paradigm shift among practitioners, especially in the Ministry responsible for sanitation and hygiene,
5. Limited choice of technologies for sanitation, and
6. High levels of open defecation practices and the slow paradigm shift from supply driven approach to demand led sanitation.

Conclusion

Despite many challenges and complex operating environment, the Rural WASH Project was successfully implemented achieved all the planned results. Improved processes and mechanisms were successfully operationalized for proper targeting of the interventions minimizing the chance of politically influenced decisions in allocation of resources; and to ensure transparency and achieve sustainability of WASH services through empowering communities. The project contributed to the significant capacity development of government and community based structures covering various aspects of WASH including monitoring and supervision of boreholes, demand led sanitation and hygiene promotion, financial management, monitoring, and operation and management of WASH services. The project also successfully demonstrated large scale implementation of the demand led sanitation by replacing the traditional heavily subsidized approach for sanitation which had failed to produce tangible results. Absence of cholera outbreaks in Zimbabwe for the last few years could be attributed to overall improvement in WASH services in Zimbabwe. The Rural WASH Project is being scaled up in other provinces and districts under the second phase of Rural WASH Project which started from November 2016. This will help accelerating the progress on water sanitation and hygiene in the rural areas.

References

- AHMAD, Tameez et al (2016) *Rural WASH Project in Zimbabwe: Monitoring and feedback mechanism for accelerating progress*, Paper Submitted for 39th WEDC Conference, Kumasi, Ghana, 2016
- Government of Zimbabwe (2011) *National Sanitation and Hygiene Strategy: Accelerating Access to Sanitation and Hygiene, July 2011 – June 2015*. Government of Zimbabwe
- Government of Zimbabwe and UNICEF (2012) *Improving Water, Sanitation, and Hygiene in Rural Areas of Zimbabwe: Strategic Concept Note and Programme Design*, June 2012-2016.
- UNOCHA (2009) *Zimbabwe Cholera Update*, Situation Report 15 July 2009
- ZimStat (2012) *Census 2012, National Report*, Zimbabwe National Statistic Agency.

Note

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Contact details

Dr Tameez Ahmad is a former Water, Sanitation, and Hygiene (WASH) Manager with UNICEF Zimbabwe and now currently Chief of WASH with UNICEF Nepal while Mr Victor Kinyanjui is a Chief of WASH with UNICEF Zimbabwe.

Dr Tameez Ahmad
UN House, Pulchowk, Lalitpur,
Kathmandu Nepal
Tel: +977 -1-5523200 (Ext.-1190)
Email: tahmad@unicef.org
www: www.unicef.org

Mr Victor Kinyanjui
06 Fairbridge Avenue, Belgravia,
Harare, Zimbabwe
Tel: +263 4 703941/2 ext 2480
Email: vkinyanjui@unicef.org
www: www.unicef.org