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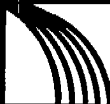

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Participatory Hygiene and Sanitation in East and Southern Africa

World Health Organization

Prospective Review of Participatory Hygiene and Sanitation Transformation (PHAST)

March - April, 1998

203.1-98PR-15881

This publication is a synthesis of the Report on the Regional Prospective Review on Participatory Hygiene and Sanitation Methods. The publication was edited by Elizabeth Obel-Lawson and adapted by Rose Lidonde for the Regional Water and Sanitation Group - East and Southern Africa.

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Participatory Hygiene and Sanitation in East and Southern Africa

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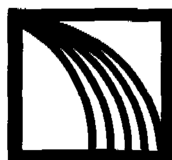

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Preface

Participation and community involvement are taken as critical factors for effectiveness and sustainability. This is particularly true for hygiene and sanitation which deal with social behavior and community norms. The development of methods and tools specifically designed to support participatory approaches to hygiene education and the promotion of sanitation has been undertaken from several fronts.

Since 1993, the UNDP-World Bank Water and Sanitation Program and World Health Organization (WHO) launched a joint effort under the PHAST initiative (Participatory Health and Sanitation Transformation); the PHAST method was piloted in six countries of Eastern and Southern Africa. The pilot phase was meant to disseminate the methodology and to set the stage for further development.

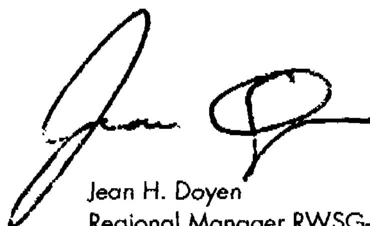
While PHAST was received enthusiastically by sector professionals, its dissemination beyond the pilot stage only took place in a limited number of cases. With this in mind, the Regional Water and Sanitation Group for Eastern and Southern Africa (RWSG-ESA) and WHO undertook a prospective review to assess the constraints to up-scaling at the country level and examine how participatory approaches to hygiene and sanitation promotion could be disseminated more broadly in the region.

The present report is a ***regional synthesis of the prospective review*** carried out over the first half of 1998. It draws on the six country reports as well as on the outcome of a meeting of regional experts held in July, 1998 in Nairobi.

The regional synthesis is meant to capture key points from the country reviews and specifically to support action planning at the country level. The regional synthesis should also help in defining the technical support and networking measures to be considered at the regional level.

The regional synthesis is a working document for use by practitioners directly engaged in assessing and planning the build up of capacity for broader application and further development of participatory methods for hygiene and sanitation promotion in communities, schools, etc. The report would also be of use to development professionals from the public sector, NGOs and private sector, with an interest in participatory methods centered on communities.

Eventually we hope that the present report will contribute to the goal of better hygiene and sanitation for all.



Jean H. Doyen
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Table of Content

List of Acronyms and Abbreviations ... iii
Acknowledgments ... v
Executive Summary ... vi

1 Introduction

Background to the Review ... 1
Methodology ... 1

2 Main Findings and Lessons Learned

Use of PHAST in the Region ... 2
Conceptual Understanding ... 2
Material Development and Adaptation ... 3
Training ... 3
Lessons Drawn on Training ... 4
Effects of the Use of PHAST ... 4
Lessons Drawn on Effects of PHAST ... 4
Strengths of PHAST ... 5
Problems Experienced with PHAST ... 5
Lessons Drawn on PHAST ... 5
Problems in the Application of Participatory methods ... 6
Institutional Arrangements for Participatory Methods ... 6
Lessons Drawn on Institutional Arrangements ... 6
Lessons Drawn on Implementation Arrangements ... 7
Monitoring and Evaluation ... 7
The Way Forward ... 7
Scope of Support at Country Level ... 7

3 Current Status of Participatory Methods

Historical Background of Participatory Methods ... 9
Institutional Arrangements and Policy Framework ... 10
Conceptual Understanding of Participatory Methods ... 11
Use and Application of Participatory Methods ... 11
Training in Participatory Methods ... 12
Effects and Impact of the Use of Participatory Methods ... 14
Case Examples of Behavior Change ... 16

4 Institutional Arrangements Supportive of Participatory Methods

Training Arrangements (by country) ... 18
Implementation Arrangements (by country) ... 21
Monitoring and Evaluation (by country) ... 23
Coordination of Participatory Methods ... 23

5 Policy Framework and Political Commitment

Community Participation 25
Indication of Political Commitment 25
Funding for Participatory Methods 26

6 Health and Sanitation Needs

Hygiene-enabling Facilities 28

7 Country and Regional Plans

Botswana 29
Kenya 29
Mozambique 30
Tanzania 31
Uganda 31

8. Proposed Regional Support Activities

Constraints and Enabling Factors in the Implementation of the Proposed Country Plans 33
Specific Support Requirements at Country Level 34

Annexes

Annex 1: Terms of reference 36
Annex 2: List of persons consulted 38
Annex 3: List of organizations using participatory methods 41
Annex 4: Proposed Zimbabwe Country Action Plan 44
Annex 5: Proposed Uganda Country Action Plan 45
Annex 6: Proposed Tanzania Country Action Plan 47
Annex 7: Proposed Kenya Country Action Plan 50

List of Acronyms and Abbreviations

ADPP	Organizacao Nao Governmental Ajuda De Desenvolvimento Do Povo Para Povo
AMREF	African Medical and Research Foundation
ARI	Acute Respiratory Infection
CBM	Community Based Management
CBO	Community Based Organizations
CFA	*Agriculture Training Institute*
CSO	Central Statistics Office
DANIDA	Danish Development Aid Agency
DDF	District Development Fund
DNA	National Directorate for Water
DEHO	District Environmental Health Officer
EHO	Environmental Health Officer
EHT	Environmental Health Technician
ESA	External Support Agency
EU	European Union
GOB	Government of Botswana
GOZ	Government of Zimbabwe
IRWSSP	Integrated Rural Water Supply and Sanitation Program
ITDG	Intermediate Technology Development Group
IWSD	Institute of Water and Sanitation Development
KEFINCO	Kenya Finland Western Province Water Supply Program
KIWASAP	Kilifi Water Supply and Sanitation Project
KWAHO	Kenya Water for Health Organization
LPSA	Learner-centered, Problem posing, Self discovery, Action oriented
MIS	Management Information Services
MLGRUD	*Ministry of Local Government, Rural and Urban Development*
MOH	Ministry of Health
MOH and CW	Ministry of Health and Child Welfare
NAC	National Action Committee
NETWAS	Network for Water and Sanitation International
NGO	Non - Governmental Organizations
NORAD	Norwegian Agency for International Development
OOPP	Objective Oriented Project Planning
PALNET	Participatory Learning Network
PHAST	*Participatory Hygiene and Sanitation Transformation*
PHE	Participatory Hygiene Education
PNSBC	Programma Nacional de Saneamento a Baxio Custo
PRA	Participatory Rural Appraisal
PRONAR	National Program for Rural Water
PROWWESS	Promotion of the Role of Women in Water and Environmental Sanitation Services
RDC	Rural District Council
RRA	Rapid Rural Appraisal
RUWASA	Rural Water and Sanitation Project
RWSG-ESA	*Regional Water and Sanitation Group-East and Southern Africa*
SARAR	Self-esteem, Associative strength, Resourcefulness, Action planning and Responsibility

SCF	Save the Children Fund
SDC	Swiss Development Cooperation
SHEWAS	Siaya Hygiene Education in Water and Sanitation
Sida	Swedish International Development Cooperation Agency
STD	Sexually Transmitted Diseases
SWAG	Story with a Gap
TB	Tuberculosis
TCWS	Training Center for Water and Sanitation
UNDP	United Nations Development Program
UNICEF	United Nations Children's Fund
VCHW	Village Community Health Worker
VIPP	Visualization In Participatory Process
WASHE	Water, Sanitation and Health Education
WATSAN	Water and Sanitation
WDR	World Development Report
WES	Water, Environment and Sanitation
WHO	World Health Organization

Acknowledgments

The review team would like to express their thanks and gratitude to all those who assisted in making this prospective review a successful reality. There were many potential obstacles, but through material and logistical support given, these were overcome. Acknowledgment and thanks go to:

- all the organizations and individuals within those organizations who found time to answer the questions through interviews and those who responded to the questionnaires.
- the Governments of Botswana, Kenya, Mozambique, Tanzania, Uganda and Zimbabwe for facilitating the prospective review and pointing the evaluation team in the right direction.
- the different organizations that provided logistical support, advice and took time to discuss the review. In particular, our gratitude go to Ministry of Health (MOH), WHO Kenya Country Office, PALNET, CARE Kisumu, SHEWAS project and the Regional Water and Sanitation Group for East and Southern Africa (RWSG-ESA) in Kenya; Directorate of Water Affairs (DWD), WaterAID, RUWASA project in Uganda; the United Nations Children's Fund (UNICEF) - Water, Environment and Sanitation (WES) Program, MOH, Ministry of Community Development, Women Affairs and Children (MOCDWAC), and Ministry of Water, Resources, Energy and Mines in Tanzania; UNICEF- WES and the Programma Nacional de Saneamento a Baxio Custo (PNSBC) in Mozambique; UNICEF-WES and the MOH, Family Health Division in Botswana; and UNICEF-WES, the Ministry of Health and Child Welfare (MOH and CW) and the National Coordination Unit (NCU) in Zimbabwe.
- Cavel Candido provided the much-needed Portuguese translation and interpretation.

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Executive Summary

Background

For many years, conventional messages on hygiene and sanitation have been known and largely understood by people. However, these messages have not translated to significant improvement in hygiene behavior.

In 1993, the World Health Organization (WHO) and the Regional Water and Sanitation Group for East and Southern Africa (RWSG-ESA) initiated the Participatory Hygiene and Sanitation Transformation (PHAST) methodology to address this concern. The following year, the methodology was piloted in Botswana, Ethiopia, Kenya, Uganda and Zimbabwe.

PHAST is an adaptation of an earlier participatory method known as SARAR (Self-esteem, Associative strengths, Resourcefulness, Action planning, and Responsibility). Like its predecessor, PHAST empowers community members - young and old, regardless of their gender and economic status - in a participatory process. The methodology assesses people's knowledge base, investigates the local environment, visualizes a future scenario, analyzes constraints, plans for change and implements an accepted program of action. For these reasons, PHAST relies heavily on the training of extension workers and development of toolkits. The toolkits are produced on-site to reflect the actual cultural, social and physical characteristics of the communities.

At the end of a six-month pilot phase, a regional workshop was held in Harare, Zimbabwe in December 1994 to review the PHAST program. Since then, several other countries in the region have adopted the use of this participatory methodology. The Harare workshop recommended the development of a step-by-step guide and a documentary video on PHAST. These two have been produced and can be obtained from WHO and RWSG-ESA. The workshop also called for a prospective review to be conducted in Botswana, Kenya, Mozambique, Tanzania, Uganda and Zimbabwe.

The Prospective Review

The review was a joint effort of WHO and RWSG-ESA, with country-level support from governments of the countries reviewed. Other partners included, the United Nations Children's Fund (UNICEF), Swedish International Development Cooperation Agency (Sida), Danish International Development Agency (DANIDA), Norwegian Agency for International Development (NORAD) and, local and international non-governmental organizations.

Apart from assessing the effectiveness of participatory methods for hygiene behavioral change, the review identified country support requirements for strengthening the use of the methods in government-sponsored programs. The review also prepared a preliminary plan of activities to strengthen participatory hygiene and sanitation at country level, *including budgets and timetable for* 1998 and 1999.

The review was conducted by the Network for Water and Sanitation International (NETWAS) and the Institute for Water and Sanitation Development (IWSD) in the East and Southern African countries respectively. Between March and April 1998, the review consultants spent five days in each of the countries. The methodology used included:

- literature review of policy documents, and monitoring and evaluation reports;
- interviews with key sector professionals and practitioners, and community leaders;
- observations during field visits and discussions with community members; and
- review of existing participatory tools and material.

Main Findings of the Review

Health and sanitation needs in the countries reviewed and the region as a whole are high. Diarrhoeal diseases and others related to poor sanitation, such as malaria, skin and eye infections are prevalent. At the same time, infant

and maternal mortality rates are also high. Therefore, improved water and sanitation are matters of priority concern to most governments in the region.

Introduced in the early 1980s, participatory methods are widely used in most of the countries reviewed. The methods range from SARAR, PRA[1], RRA[2] and DELTA[3] to VIPP[4], LPSA[5] and PHAST, to mention but a few. The common factor in all of them is that they seek to empower communities. They are also non-didactic and most of them use tools and techniques to stimulate participation. Their similarity has made it difficult to distinguish the differences between them.

In conceptual terms, participatory methods are generally well understood. They are widely viewed as communication processes that are learner-centered and aimed at achieving defined objectives.

Participatory methods are being used in diverse development sectors. Other than hygiene, health and sanitation promotion, the methods are applied in poverty alleviation, agricultural research and extension, community wildlife and environmental management.

Effects of participatory methods have not been monitored and documented systematically. The review could only obtain anecdotes relating to observed changes. In general terms, some of the observations are as follows:

At **professional level**, there has been noticeable change of attitude, self analysis, improvement in communication, a clear sense of purpose and improved image of technical staff at community level.

At **institutional level**, increased use of demand-responsive and team approaches has been noted. Visibility of hygiene and sanitation and expanded use of participatory methods has been observed. Strategic planning and greater community involvement has brought about improved management and targeting of services.

At **community and household level**, frequent hand-washing is practiced. Increase in hygiene-enabling facilities and improved water transportation and storage, combined with community actions has contributed to the reduction in water-borne disease outbreaks.

1 PRA - *Participatory Rural Appraisal*
2 RRA - *Rapid Rural Appraisal*
3 DELTA - *Development Education for Leadership Teams in Action*
4. VIPP - *Visualization in Participatory Process*
5. LPSA - *Learner-centered, Problem posing, Self discovery and Action-oriented*

Key Lessons Learned
On Success Factors:

- Enabling institutional arrangements and supportive national policy framework are important prerequisites to ensure successful application and monitoring of participatory methods. A decentralized framework that integrates water, sanitation and hygiene facilitates effective implementation and brings about desired behavioral changes.

- Most participatory hygiene and sanitation strategies are inclusive. For example, while training institutions and NGOs have played an important role of introducing participatory methods in communities, they have kept the process going, even in the face of limited government support.

- NGO involvement has provided a greater coverage in the application of participatory methods. Government projects should therefore utilize skills and knowledge of NGOs. Where NGOs have no capacity, governments and donors should support them.

On Training and Material Development:

- An articulated training strategy is of paramount importance for countries introducing or expanding the application of participatory methods. Training should be seen as a process that entails awareness creation and advocacy, and application of tools and techniques. More importantly, the process should be monitored.

- Training constitutes one of the largest expense items for a participatory process. Since most governments are unable to provide all training needed, NGOs and external support agencies have complemented their efforts. Cost of training workshops for various target groups, i.e. trainers, extension workers, community members, vary from one country to another.

- Development of material and their adaptation to suit local situations is time consuming and requires experienced development artists. Production of durable material that are laminated is a costly business for most organizations involved in the implementation of participatory methods at community level.

On PHAST:

- Each country was allowed to adapt the methodology according to its own environmental situations, institutional arrangements and resource capacity. This made it attractive and acceptable.

- Its application requires a lot of resources in terms of time commitment, human resources and financial support.

- PHAST has worked and is effective in the promotion of sustainable hygiene behavior and improved sanitation.

Country-specific Highlights
Botswana:

- The country strategy will shift its focus from training to actual application and implementation at community level.
- Due to misconception of PHAST as a training project as opposed to a process, the participatory method has not been institutionalized.

Kenya:

- The Participatory Learning Network (PALNET), formed by NGOs in the country, will play a significant role in networking.
- The Government is in the process of strengthening institutional arrangements in the water and sanitation sector, with the Ministry of Health as the focal point for PHAST.

Mozambique:

- Capacity building through training and material development will be the focus for future activities. Efforts are being made to cut down the high cost of producing material by utilizing alternative cost-effective methods.
- Demand and scope for participatory methods exceeds the extension services, with the ratio of extension workers to the population estimated at 1:85,000.

Tanzania:

- Although the country was not involved in the piloting of PHAST, several programs, such as WaterAid in Dodoma, have successfully applied the method.
- The Ministry of Health plans to expand application of participatory methods by utilizing the PROWWESS core team of trainers in collaboration with other sector stakeholders.

Uganda:

PHAST has successfully been applied in project areas, such as Rural Water and Sanitation in Eastern Uganda (RUWASA) and WaterAid.

The country strategy for expansion aims at institutionalizing PHAST within a sector framework and scale it up to national level.

Zimbabwe:

- Participatory methods have been well institutionalized in the water, hygiene and sanitation sector. They are implemented through the Ministry of Health and Child Welfare.
- Training has been done at various levels. The country strategy is focusing on the consolidation of activities to ensure greater impact.

Proposed Regional Activities

- Advocacy and awareness creation at policymaking level.
- • Technical support for country-specific case studies.
- Documentation and dissemination of information.
- Technical support for monitoring and evaluation.
- Support to the capacity building processes (training and material development).
- Harnessing resources for country action plans.

While regional efforts may influence policy and developmental changes, they will be based on expressed demands from specific countries.

Prevailing Challenges

- Lack of management systems for effective application of participatory methods.
- New skills, institutional strengthening and awareness for evolving participatory methods.
- Considerable requirements for resources that include time, financial, human and material.
- Search for alternative cost-effective production of visual material.
- Lack of supportive policy with underlying principles of participation.
- Need for individual and institutional commitment.
- Country and regional partners who would support activities as a collaborative effort.

The Way Forward

Participatory methods addressing health problems brought about by poor water and sanitation conditions have changed their orientation from being donor-driven to being responsive to community demands. Increased numbers of countries and organizations are requesting for training and other technical support.

1. Introduction

Background to the Review

In 1993, World Health Organization (WHO) - Community Water Supply Unit (CWSU) and the Regional Water and Sanitation Group for East and Southern Africa (RWSG-ESA) introduced an initiative in which participatory methods earlier pioneered by the PROWWESS program were adapted for the promotion of hygiene and sanitation. While knowledge on hygiene existed, this knowledge had not translated to improved hygiene behavior. Furthermore, although a lot of hygiene material had been developed, there were still no significant improvements in hygiene behavior change. PHAST initiative was based on the SARAR methodology.

The initiative invited five countries (Botswana, Ethiopia, Kenya, Uganda and Zimbabwe) to pilot the methodology. The philosophy and implementation strategy adopted by PHAST was:

- based on localized adoption, adaptation and testing of participatory methods;
- geared to allowing participatory techniques and programs that would benefit from regional support;
- based on a process approach, mainstreamed into government hygiene education activities; and
- inclusive of all sector partners interested in supporting the initiative.

The initiative was supported by ministries of health and water, other partners, such as UNICEF, Sida, DANIDA, NORAD and NGOs.

After the piloting which ended with a regional review workshop in 1994, participating countries wished to continue with the use of participatory methods. Other countries have also started using them This regional prospective review is part of a strategy to support participatory hygiene and sanitation. Countries selected for the review were Botswana, Kenya, Mozambique Tanzania, Uganda and Zimbabwe. The selection criteria was in terms of countries that:

- were involved in the original piloting (Kenya, Zimbabwe, Uganda and Botswana);
- have been actively implementing participatory hygiene and sanitation;
- specifically indicated the need to carry out assessments (Mozambique); and
- are interested in starting PHAST initiatives (Tanzania).

Objectives

The purpose of the of the review was to:

- assess the effectiveness of participatory methods for hygiene behavior change;
- identify country support requirements for strengthening the use of participatory methods in government sponsored programs; and
- prepare a preliminary plan of activities to strengthen participatory activities at country level including proposed budgets and timetable for 1988 and 1999.

Methodology

The review was conducted through:

- literature review of policy documents, evaluation and monitoring reports;
- interviews of key respondents, sector personnel inclusive of government officials, community-based organizations (CBOs), NGOs, training institutions and community leaders;
- observation during field visits and discussions with extension workers;
- discussion with household and community members; and
- review of existing participatory tools and material.

One of the weaknesses was the short time given for the assessment. Five days in each country was not adequate in getting a wide cross section of views. The interview protocol was also found to be repetitive because some countries do not distinguish between PHAST and other participatory methods.

2. Main Findings and Lessons Learned

Use of PHAST in the Region

PHAST principles used in hygiene and sanitation are mostly based on SARAR. The tools were initially adapted and new ones developed during the introduction of the PHAST initiative in 1993. Several experts drawn from different countries contributed to the initial adaptation and development of the tools. To date, many more tools have been developed or adapted in line with country or local needs, culture and environment.

The introduction and subsequent take off of participatory methods has been linked to the institutional arrangements of a given country, the policy framework and availability of resources. The implementation strategy and philosophy adopted during piloting which allowed for each country to develop and adapt the use of participatory methods in line with each country's environment has had obvious advantages. The ownership of the process rests with each country or organization using participatory approaches. Rather than referring to PHAST, each country has mainstreamed them within their activities. In Zimbabwe, they are referred to as Participatory Hygiene Education (PHE). In Botswana, they are Participatory Hygiene and Education Material (PHEM), while in Uganda, Kenya and Tanzania, they are simply called participatory methods. What came out of the review is that the successful introduction of participatory methods largely depends on the following factors:

- *Enabling institutional arrangements and policy framework within a given country. An existing framework that integrates water, sanitation and hygiene may facilitate a faster implementation pace, as does decentralization.*

- *Protocol procedures being followed. If during introduction, emphasis is placed on individuals rather than the institution, it becomes difficult for those individuals to get institutional support. Furthermore if the methods are initially placed within an institution that is deemed as not having responsibility over hygiene promotion, then the rightful ministries feel alienated.*

- *Participatory hygiene and sanitation strategies that are inclusive rather than exclusive. For example training institutions and NGOs have played an important part not only in introducing participatory methods but also in keeping the banner burning even in the face of limited government support.*

- *The institutionalization of the use of participatory methods by the ministry responsible for hygiene and sanitation. This gives the methods the respectability needed and spurs other agencies to use them.*

- *Supportive external support agencies not only assisting with funding but willing to commit their time to technical support, exchange of information and advocacy.*
- *Broad ownership of the use of participatory methods leads to acceptance and support.*

Participatory methods are used for hygiene, health and sanitation promotion, and beyond the sector in development projects, such as poverty alleviation, wildlife and environmental management. Specifically, they are used for:

- training extension workers;
- community mobilization;
- planning at community level;
- material development;
- research; and
- evaluation and monitoring.

Conceptual Understanding

In general, there is wide understanding of participatory methods. They are seen as a communication process that is learner-centered and is aimed at achieving certain defined objectives.

Attributes of Participatory Methods

- Changing learning situations into sharing situations.
- Creating a non-threatening environment in which everyone regardless of class,age and sex can express their views.
- Involving communities in identifying their own problems and solutions.
- Creating an enabling environment which empowers communities.
- A methodological process that aims at achieving certain objectives.
- A way of exchanging information.

At the field level, conceptual understanding is linked to the actual physical tools. While this is appropriate, it creates a problem of inability to apply participatory concepts without the tools.

- they reflect local reality;
- they are locally acceptable; and
- inaccuracies in drawing are corrected.

The adaptation of material for hygiene and sanitation has opened up a scope and vision for further revision for use in such areas as community-based management.

Material development is one of the areas that required a lot of financial input. In Mozambique, for example, it costs as much as US$ 10 to produce a picture. If material are laminated, they become more durable but this may mean producing fewer toolkits due to the cost factor. Simple photocopied material are cheaper but less durable. Some of the material are didactic and negate the principles of participation. Support is also needed for skills development for both trainers and artists.

Community members holding some of the tools (maps and cards) used in a participatory method.

Material Development and Adaptation

In all six countries, it was reported that initial material have been adapted and new ones developed. The reasons for adaptation have been to ensure that:

- tools are suitable for the objectives and purpose;

Although most national toolkits have been developed, the process of adaptation at community level is continuous. In some countries, tools have to be adapted according to regional cultural differences and problems. Ideally, tools would be made district specific and community explicit, if resources were available.

Training

While the use of participatory methods is not a

training project, a large component of this process has been in training. There is training of trainers (TOT) in each country, followed by training of NGOs, extension and volunteer workers:

Observations

- The training period varies from country to country. In Uganda and Botswana, it is between one and three days, whereas it takes five days in Zimbabwe and Mozambique.
- The training of trainers' workshop has been consistently kept at 10 days. The rationale for reducing training time for extension workers is cost effectiveness. This has, in some cases, resulted in cutting down the content, especially the theoretical aspects leading to poor application of the approach.
- There is lack of distinction between training and awareness.
- The target groups for training are not always clearly defined between extension workers and community members.

Lessons drawn on training

- *For countries seeking to introduce or expand, there is need for a training strategy that will outline objectives, expected outputs and even articulate the content of such training. This will help clarify whether a training is for awareness creation, or skills development.*

- *Most training is for development of skills. Awareness implies being made conscious of an issue. As part of an advocacy strategy, decision and policymakers need to be made aware of the issues. Training should not be seen as an end product but as a means within a process of transferring knowledge and skills. It must balance the practical aspect with the principles and concepts of participatory methods.*

- *Training constitutes one of the largest expense items for a participatory process. Most governments are not able to support training without any external aid. In all the six countries, most of the training has been supported by external support agencies (ESAs) or NGOs. It is most likely that this trend will continue. The costs for training workshops vary from country to country. The review found out that the desired ten-day workshop is an expensive affair. Botswana has budgeted US $11 000 for five such training sessions. In Zimbabwe, the ten day training workshop cost ranges between US$ 2 000 - US$ 3 000, depending on venue. A training conducted by an institution like NETWAS may cost as much as US$ 35 000.*

Effects of the Use of PHAST

The effects of the use of participatory methods has not been systematically monitored or documented. *Without an initial baseline data, it becomes difficult* to point out the changes that have occurred. Recorded effects are therefore anecdotal. The following has been observed at various levels:

At professional level:

- Change of attitude
- Self analysis
- Improve communication
- Clear sense of purpose
- Improved image at community level

At institutional level:

- Increased use of demand responsive and team approaches
- Institutionalized use of participatory meth ods
- Visibility of hygiene and sanitation
- More strategic planning
- Greater community involvement
- Improved management and targeting of services in response to community felt needs .

At community level:

- Improved hand washing methods
- Increase in hygiene enabling facilities
- Improved water transportation and storage
- Community level monitoring
- Reduction in water-borne diseases

Lessons Drawn on Effects of PHAST

- Participatory hygiene has contributed to behavior changes both at the institutional and community level. When people are brought together, there is peer pressure to change. Hygiene is therefore not seen as an institutional and government problem, but rather as a household and community concern.

- There is need for systematic monitoring and documentation of the changes that are taking place at the community level. Documented case studies may be used for advocacy in communities that are beginning to adopt the methods.

- Most of the areas that are applying participatory methods did not carry out baseline surveys at the beginning of the process. This makes it difficult to compare changes and put up a convincing argument.

- The current demand for expansion or introduction of the use of participatory methods in new

communities and project areas may be attributed to the fact that there has been visible and tangible change elsewhere.

Strengths of PHAST

Countries that have mainstreamed PHAST acknowledge several strengths of the methodology. These include that it:

- provides a new philosophy and room for development of clearly defined objectives;
- focuses specifically on hygiene and sanitation sub-sector for the improvement of health status in the community;
- promotes improved behaviors of hygiene and sanitation in terms of usage, maintenance and management of facilities;
- raises the need and means for measuring progress and monitoring impact;
- raises the profile of hygiene and sanitation whilst creating awareness for the need to support these activities;
- re-focuses interest and harnesses resources in the direction of utilizing existing participatory methods and development of new ones;
- provides a new vision
- allows communities to participate fully, breaking down class and gender barriers; and
- allows for the discussion of sensitive issues in an environment where social strata and cultural taboos often make it difficult to do so.

Women gathering material for communal latrine construction

Problems experienced with PHAST:

- The material are expensive to produce. PHAST application largely depends on tools and this means developing toolkits for extension workers. Durable material are expensive to produce as they have to be laminated. Simple photocopies wear out easily.

- When the methodology is applied independent of water and sanitation program, it creates expectations at community level that are not fulfilled.

- The process is time-consuming and labor-intensive. It requires commitment and capacity to follow through.

- PHAST depends on the user's initiative, resourcefulness and creativity.

- The methodology is sub-sector specific and therefore, limits the scope of its application.

- The method works better when applied in group setting. In some countries, the nuclei community setting is breaking up and therefore it becomes difficult to apply the methodology. Mozambique and Botswana were particularly affected by this problem.

- It takes a long time to feel the impact.

Lessons drawn on PHAST

- The introduction of PHAST allows each country to adapt the methodology in relation to its environment, institutional arrangements and resource capacity. This has enabled the methodology to be easily acceptable. The ownership of the process rests with each country. The growth, breadth and scope of application of PHAST has been different in each country.
- Donor agencies play a vital role in intro-

ducing PHAST. It is however, important that once the method has been accepted, the countries should be supported to integrate these methods within their overall activities. This allows for sustainability.

- *The adaptation of participatory methods specifically for hygiene and sanitation has created new vision for other activities within and outside the sector. Other activities, like community based management (CBM) are also seeking to adapt participatory methods, making them specific to management issues.*

- *PHAST has positively influenced changes in the water, hygiene and sanitation sector. However, its application requires a lot of resources - specifically time commitment, human resources and financial support. While some countries may have human resources, the financial support has been from external agencies.*

Problems in the Application of Participatory Methods

Problems in the application of participatory methods are related to lack of institutional support, lack of resources, slow attitude change and no capacity for follow-up.

Despite these problems, the users feel that the methodology's advantages outweigh the problems. While some of the problems can be solved at country level, there are some that require external assistance and others that require a different operational strategy altogether.

Some of the problems that can be solved at country level are:

- weak conceptual understanding;
- lack of capacity for follow-up;
- lack of coordination within the sector;
- raised awareness and unfulfilled expectations;
- lack of managerial support;
- attitude change;
- poor commitment by volunteer workers; and
- lack of institutionalization.

While NGOs and ESAs may assist, the onus is on each country to come up with strategies for solving these problems.

Other problems have been identified related to inadequate numbers of extension workers at community level. Rather than focus on extension workers, the use of participatory methods could be promoted through schools, or health and hygiene clubs such as in Zimbabwe.

External support is needed for solving problems related to lack of skills, funding, material and even advocacy within countries. In their role as organizations that promote change, ESAs could influence institutional behavior change so that national institutions are supportive of participatory methods.

Institutional Arrangements for Participatory Methods

The institutional arrangements for participatory methods are different in each country. In some, the existence of inter-sectoral coordination teams and application of participatory methods in a coordinated manner has facilitated and enabled the application of the methods. Extension workers have facilitated the application of participatory methods at community level. In countries where extension services are weak, there is need to develop alternative implementation strategies such as the use of schools.

Lessons drawn on institutional arrangements

- *The involvement of the MOH in the training of participatory methods is essential. The ministry's involvement makes the methods acceptable and gives them credence.*

- *While diversity in the training of participatory methods has the advantage of increased coverage and wider experience, the problem of quality control and monitoring of the training process arises. The review team found it difficult to obtain information on training programs and numbers of people trained.*

- *While the training in 'cascade' system may be the right approach for institutions, the further down the training goes, the less seems to be covered.*

- *Although there is need for cost-effective training, cutting down on the number of days to save funds compromises the training. Extension workers need more time for skills development.*

- *There is need for clearly articulated training strategies with objectives, target groups and expected outputs. The training strategies need to define the differences between awareness workshops and training workshops.*

- *The involvement of NGOs should be encouraged as they complement government institutions.*

- *To ensure sustainability, training in partici-*

patory methods should be part of the curriculum for the training of extension workers.

Lessons drawn on implementation arrangements

- *Generally, there are enabling institutional arrangements in most countries for the application of participatory methods.*

- *In countries where sanitation is a priority, the scope for expanded use of participatory methods is greater. The involvement of the MOH as the lead agency allows for acceptance of the methodology, greater expansion and use of the methods. For example, in Zimbabwe, the application of participatory methods in the MOH has become the norm rather than the exception.*

- *The involvement of NGOs offers greater coverage. The application of participatory methods should therefore not be limited to government projects but should seek to utilize existing NGOs. Where NGOs have no capacity, they should be supported (as is the case in Uganda where RUWASA supports other institutions). In Kenya, the widespread application of participatory methods is through NGOs although the government also plays a major role.*

- *Support from ESAs is needed in advocacy so that government institutions accept the use of participatory methods.*

- *The application of participatory methods through extension workers is not always feasible. Alternative implementation strategies are needed and schools are seen as a feasible option. Support is needed in the adaptation of material for use in schools.*

- *Sustainable implementation of participatory methods is partially a function of the training received. Training in participatory methods should be part of the training curriculum for extension workers and health personnel.*

Monitoring and Evaluation

Monitoring and evaluation of the use and effect of participatory methods has remained weak in all the countries which were assessed. Most of the information is anecdotal. While projects monitor their own activities, participatory hygiene and sanitation process and impact is not effectively monitored. There is an identified need to develop monitoring indicators for both process and impact, and to obtain both quantitative and qualitative data Training is also needed in participatory monitoring and evaluation.

The Way Forward

The main thrust in the region will be to expand the use of participatory methods. This will require:

- training of extension workers;
- training of trainers;
- production of tool kits;
- advocacy for policy and decisionmakers;
- consolidation of activities;
- development of monitoring indicators;
- strengthening of monitoring systems; and
- training in material development.

Scope of Support at Country Level

Most countries indicated that they do not have the budgetary allocations for planned activities and are therefore looking up to ESAs and NGOs for support. Where support exists, some of it has been linked to projects, for example in Uganda (through RUWASA) and Mozambique (through PNSBC). Government projects still need support in introducing or expanding the scope of participatory methods. Some of the support needed was identified as follows:

- **Botswana**

The country would like financial and technical support in training and material development, advocacy and case studies. Recognizing and acknowledging their limitations, the MOH would also like to have a participatory methods specialist attached to them.

- **Mozambique**

The MOH has not been trained in participatory methods. Financial, technical and material support is needed for the introduction and take-off of participatory methods within government projects and institutions, as well as local NGOs. Mozambique also identified the need to have participatory material translated into Portuguese.

- **Kenya**

Financial, technical and material support are needed for conducting training workshops, development of toolkits and advocacy workshops. The government allocations are not adequate to cover participatory activities. Strengthening of networking is needed through PALNET.

- **Tanzania**

Tanzania has not been trained in PHAST and has identified this as a priority. Financial, material and technical support are needed for training, material development and adaptation and advocacy among policymakers.

- **Uganda**

Projects like RUWASA and WES already have support from DANIDA and UNICEF respectively. Institutions, such as NETWAS, are demand-driven and would respond to specific capacity building requests. Support is therefore needed for the government, in terms of training, material development and regional networking.

- **Zimbabwe**

Having institutionalized the use of participatory methods, Zimbabwe's future plans are focused on consolidation of activities. Support will therefore be needed in the development of process and impact indicators. Networking will also need external assistance. Other ministries within the water and sanitation sector would like support in training. They would like to adapt material for such activities as community-based management (CBM). With changing country priorities and needs, support should not be limited to hygiene.

- **Regional**

At the regional level, support should go beyond financial resources to include commitment from support agencies. Policies within the sector are always changing and so are priorities and areas of emphasis. The support that is considered essential is commitment to hygiene and sanitation as areas of focus and priority, and to the use of participatory methods in promoting the sector. Support is also needed in technical expertise as this is necessary for skills development.

3. Current Status of Participatory Methods in the Region

Participatory methods are widely used in most of the countries that were assessed, having been introduced much earlier in the 1980s. A wide range of methods are in use such as SARAR, PRA, Learner centered, Problem posing, Self discovery, Action oriented (LPSA) and PHAST. The common factor among the different methods is that they are seeking to empower communities, are non-didactic and most of them use visual material to stimulate participation of all classes (poor, rich, young and old) and gender groups within the community. In some countries they do not distinguish between the different methods of participatory approaches. Certainly at the extension level it does not matter if it is PRA, SARAR, PHAST, RRA, LPSA all these are referred to as participatory methods.

Historical Background of Participatory Methods

Country	Chronology of Events
Botswana	• 1993: Introduction to Participatory methods through PHAST Regional Workshop held in Uganda. • 1994/95: Training activities within the country. • Methods did not take off as anticipated due to lack of institutional support and high staff turnover. • 1994 -1996: Some limited use of participatory methods. • 1994: Participation in the joint WHO/RWSG-ESA regional work shop to review the PHAST Pilot Phase. • 1997: Training through a WHO initiated regional workshop in Zimbabwe. • Currently planning for large scale training and implementation through the coordination of MOH. • Have requested for support in holding advocacy workshops for policy and decisionmakers.
Kenya	• 1970s: Introduction of the DELTA methodology by the Catholic Church. • 1980s: Introduction of PRA and PROWWESS program's SARAR. • 1993: PHAST was introduced. Kenya is recognized as one of the countries that have widely used participatory methods for different development projects, including water and sanitation. • Participatory methods have taken off at the project and program level under the banner of NGOs. PALNET has strengthened the use of the methods. • There is still need for advocacy at the central level, i.e. government ministries.
Uganda	• Early 1990s: Participatory methods introduced. • 1992: NETWAS and RWSG-ESA were instrumental in promoting participatory methods and a national training workshop organized through MOH. • 1993: The first PHAST Regional Workshop was held in Uganda. • Training has been going on and a significant number of trained

Country	Chronology of Events
	people are using participatory methods. • Implementation through NGOs and projects, such as RUWASA, SWIP, WaterAid and UNICEF-WES has been successful.
Tanzania	• 1988: Introduction of SARAR through the PROWWESS Program. • PRA had been started earlier. • Ministry of Water, Energy and Mines has been using participatory methods since 1992. • Participatory methods used in other development projects. • PHAST has not been introduced with limited support.
Mozambique	• 1994: The National Low Cost Sanitation Program was exposed to PHAST through the regional review workshop in Harare, Zimbabwe. • 1996: Training held and piloting started in peri-urban and rural areas. • Currently, scaling-up and have requested for support in terms of training. • Other organizations were exposed earlier to PRA, but there has been no large-scale implementation (except for the National Low Cost Sanitation Program).
Zimbabwe	• Early 1980s: Ministry of Community Development produced participatory manuals for community workers. • 1980s: Training for transformation. • 1987: Training through PROWWESS of the Farm Health Worker Program. • 1990 : TCWS and ITN incorporated the training on participatory methods as part of their program. • 1994: Introduction and piloting of PHAST. • 1995: Institutionalization of participatory methods (PHE). • To date, participatory methods are widely used in the overall WATSAN sector. • Methods have also been adapted for other developmental projects.

Institutional Arrangements and Policy Framework

The introduction and use of participatory methods is linked to the institutional arrangements and placements of the methods as well as political systems within a given country.

• Botswana
When participatory methods were first introduced in Botswana, the coordination was with Ministry of Local Government and Housing. The methods did not take off immediately since MOH, the agency in charge of health and hygiene promotion was not in the forefront.

• Uganda
Although participatory methods were introduced as early as 1986/87, the country was still facing civil war and therefore the political climate was not supportive of such initiatives. After the war, the country had many competing priorities, such as emergency supplies and the reconstruction efforts. At the moment, with gradual stabilization and favorable policies on decentralization and participation, there is an enabling environment for participatory approaches.

• Zimbabwe
The methods were introduced in 1987 at a time when government was still centralized in their operations. The water and sanitation programs were implemented in a top-down manner and even local authorities did not have much authority. The methods therefore did not take off until the early 90s when there was an introduction of institutional and policy reforms within the country in general and the water sector in particular.

• Kenya
In a free market economy, there are many actors and users of participatory methods. While this proc-

ess offers a diversity which is necessary for exchange of experience, it also poses problems of coordination, and quality assurance.

• **Tanzania**

The clearly defined institutional arrangements have facilitated the institutionalization of participatory methods and helped keep the methods afloat even when there has been no consistent funding.

Conceptual Understanding of Participatory Methods

Participatory methods are well understood as expressed in the following personal comments from a few selected sector practitioners and professionals:

- Mr. Mutaurwa of the MOH and CW in Zimbabwe points out: *"they are learner-centered, facilitate information sharing and assist in decisionmaking. The emphasis is on the participant and using his/her experience and resourcefulness to find solutions to their problems".*

- Mr. Peter Okaka from Kenya notes: *"...... is a quick way of learning from and with communities to investigate, analyze and evaluate constraints and opportunities, so as to make informed decisions regarding development issues".*

- Ms. Rebecca Budimu of Tanzania defines: *"...... a process whereby a group shares a situation, views a problem together and explores its causes, the extent and effects and looks for possible solutions and actions to solve the problem through collective efforts using simple available resources".*

- Mr. Winfred Ndegwa of WHO, Nairobi describes: *".....methodologies assist trainers to target the local people making it easier for actors to get information from the community and vice-versa".*

Use and Application of Participatory Methods

The scope and breadth of use of participatory methods largely depends on such factors as institutionalization, financial support and availability of human resources at the extension level.

The table below summarizes the status of use in each country:

Country	Status of Participatory Methods	Where Used
Kenya	Institutionalized within most project and program operations and within some ministries, such as MOH and Culture and Social Services (mobilization) PALNET is the focal point for the use of participatory methods.	• Health e.g. AIDS and home-based care promotion • Training • Monitoring and evaluation • Community mobilization • Hygiene and sanitation promotion • Promotion of community involvement in planning, implementation, operations and maintenance of water projects • In other development projects e.g. homes for the aged, improved housing, • Material development e.g. artists workshop. • Advocacy
Botswana	Participatory methods have not yet been institutionalized although the MOH is now taking a lead role. Plans have been developed for training and implementation. MOH is the focal organization for the application of participatory methods.	• Training • Research • Evaluations and assessments • Promotion of health, hygiene and sanitation • Home-based health care • Advocacy among community leaders

Country	Status of Participatory Methods	Where Used
Uganda	RUWASA has institutionalized the use of participatory methods. Although participatory methods are accepted and used by projects, there is still need for advocacy within the ministerial agencies. There is no lead/focal ministry. Other organizations actively using participatory methods are: Unicef-WES and Water Aid.	•WES projects •Training •Community-based health care training •Research and data collection •Monitoring and evaluation •Hygiene and sanitation (RUWASA)
Zimbabwe	Participatory methods have been institutionalized within the MOH and their use endorsed by the WATSAN sector policymaking body (NAC). Methods are also institutionalized by different NGOs within and outside the sector e.g. CAMPFIRE, IUCN, Mvuramanzi Trust, SCF (UK), Ministry of Lands and Agriculture. Currently seeking to consolidate activities and strengthen monitoring and evaluation systems.	•Training •Community mobilization •Environmental and wildlife management •Community-based maintenance. •Material development •Advocacy •Community involvement in planning, implementation, operations and maintenance of water and sanitation projects. •Other developmental projects e.g. land use planning, income generating projects, environmental protection.
Mozambique	The Low Cost Sanitation Program has institutionalized the use of participatory methods. There is still need to train and expose MOH. It is hoped that with the proposed integrated sector approach, the use of participatory methods will be "mainstreamed" within the sector.	•Training •Promotion of hygiene and sanitation •Other development projects such as poverty alleviation •Material development
Tanzania	Participatory methods are institutionalized within government - Ministry of Community Development and Ministry of Water operations. PHAST has just been recently introduced and there is still need for training and exposure. Tanzania has been using SARAR based principles	•Training •Community mobilization •Water and sanitation projects •Other development projects

(See Annex 3 on the various organizations in each country that are using participatory methods and the tools being applied).

Training in Participatory Methods

Training workshops are the main mode for passing information, awareness, and giving exposure to methods and skills development. Training arrangements differ from country to country. While some have opted for 'cascade' training (Tanzania, Botswana and Mozambique) others have opted for a cross cutting arrangement in which even a district person can train the provincial people. The focus is on those who posses skills and not so much on hierarchical level (Zimbabwe, Uganda, Kenya).

It has been difficult to accurately determine the extent of training, as records are scanty or non-existent. This is largely because implementation is sometimes project/program-based. Furthermore this assessment was rapid and did not consult all the users of participatory methods.

The lack of accurate data and access to the existing ones is indicative of the problems in monitoring and information management.

Zimbabwe

The training discussed here started in 1994 with the first TOT workshop in preparation for the piloting of participatory methods. Prior to this, the MOH had organized training workshops for their personnel in participatory methods within the general framework of programs. Some of this training was given by IWSD. The training figures below refer specifically to participatory methods for hygiene and sanitation (PHE):

- Provincial teams 8
- District personnel (MOH and CW and other agencies) 1 337
- NGO personnel supporting PHE 94
- Community leaders 649
- Teachers 507
- VHP 120
- Ward level extension workers (VCHWs, FHWs, Councilors) 4 690

It is estimated that 9 232 persons have been trained at district and sub-district levels.

Botswana

The figures for Botswana were not readily available mainly due to the staff turnover. However, of those who were originally trained in 1994/95, at least up to 90 percent have left. It is unclear if they are still using the methods elsewhere. The training figures refer specifically to participatory tools for hygiene and sanitation. There are other organizations training in PRA and Visualization In Participatory Process (VIPP).

- Number of trained persons 88
- Number of persons exposed 100

Mozambique

The Low Cost Sanitation Program has trained the following in participatory hygiene and sanitation:

- National level (regarded as the main trainers now 3
- Provincial level (these also work at district level) 50
- District level 4
- Other levels 40

PRONAR has trained 148 district level extension workers. It was unclear as to which participatory methods they were using.

Uganda

RUWASA have trained 1 651 people. Other organizations that have been conducting training and the type of persons trained are as follows:

- ***School of Hygiene*** — Health assistants and health inspectors
- ***Primary and Secondary schools*** — Pupils and students
- ***Polytechnics*** — Staff on special projects of water and sanitation
- ***National Institute of Community Development*** — Community development workers
- ***Nzamizi Institute of Social Development*** — Community development assistants; Community development officers

Tanzania

It was difficult to determine the number of persons trained at the community level due to lack of updated records. The following organizations have trained these number of persons at national, regional, district and other level respectively:

	National	Regional	District	Others
UNICEF	10	60	75	-
MOH	7	29	-	2
MCDWC	2	50	-	-

The training in Tanzania has been SARAR-based under the PROWWESS Program.

Kenya

It was difficult to establish the number of person trained in Kenya. Organizations that have received training and have themselves been facilitating training include:

- UNICE
- RWSG -ESA
- CARE International
- Africa Now
- KWAHO

- Ministry of Health
- Action Aid
- KEFINCO
- ITDG
- PALNET

Most of the senior staff in NGOs have been trained in participatory methods. The SHEWAS project has trained 1 000 community members.

Case Examples in Training

ZIMBABWE

The first training of trainers workshop held in 1994 was ten days and looked at the theoretical conceptual understanding of principles of participatory development and the use of practical tools. The workshop aimed at changing attitudes, creating awareness while also developing skills in the use of participatory methods. Subsequent workshops for extension workers were reduced to five days and there was less emphasis on the conceptual understanding through theoretical tools. The aim was skills development in application through practical tools. Review meetings have highlighted problems at field level whose cause is directly linked to lack of conceptual understanding. Some of these problems relate to:

- Inability of extension workers to use participatory methods beyond hygiene and sanitation;
- Inability to operate without the toolkit;
- Inability to contextualize participatory methods; and seeing participatory methods as an event rather than a process. The MOH and CW has subsequently decided to increase the number of workshop days to ten to cater for both theoretical and practical tools

BOTSWANA

When Botswana first introduced participatory methods, they limited their activities to training. Several training workshops (10 days) were held for agency staff and the three-day workshops held for community and extension workers. Due to inadequate numbers of toolkits, and misconception about their use in training, participants did not receive any tool kits for field level application.

Subsequently, the trained people did not always use participatory methods for community interface, seeing them as a "training project". Most people thought participatory tools were to be used during a workshop.

Effects and Impact of the Use of Participatory Methods

The effects of the use of participatory methods has not been systematically monitored and documented due to the lack of process and impact indicators. Most of the information related to the effects of participatory methods is anecdotal. However, the six countries concur that the use of participatory methods has changed the way development business is conducted at an individual professional level, institutional level, within and beyond the water and sanitation sector. Several benefits have been attributed to the use of participatory methods as outlined below:

Professional Functioning

At the professional level the use of participatory methods has promoted the following changes:

- ***Change of attitude***

There has been a change of attitude from seeing development workers as people who know everything to an appreciation of the knowledge, ability and capability that resides within communities. In Tanzania, respondents noted that the use of participatory methods had even made their jobs easier as the community contributed and they did not have to think of all the answers.

- ***Self analysis***

The methods have led to a self analysis leading to a recognition of the professional weaknesses.

- ***Improved communication***

Communication has improved with all levels of people, either within the community or the organizations.

- ***Sense of purpose***

Extension workers in Zimbabwe noted that hygiene education had become a routine activity that did not always show a definable output. This had led to lack of direction. Since the use of participatory methods, extension workers now have defined objectives and outputs.

- ***Improved image at community level***

Communities have now regained confidence in extension workers. In Kenya, communities were even writing proposals and seeking technical assistance from the extension workers. In Zimbabwe, the role of the extension workers is now seen beyond water and sanitation, with communities seeking advice on housing structures. Mozambique also noted that there is improved trust by the community in the extension workers.

Institutional Level

Different countries have different institutional ar-

rangements and it is these that have influenced the use of participatory methods and subsequent changes. Institutions that are using participatory methods (NGOs, government or donor agencies) have seen a change in the way development is conducted, as follows:

• ***Use of demand responsive approaches***
Hygiene enabling facilities such as water and latrines have previously been provided to communities using top-down approaches. The role of central government as a service provider has in the past been accepted and recognized. The use of participatory methods has had the effect of institutional changes from being service providers to facilitators responding to demand that is generated at the bottom. Furthermore, hygiene education has always been imposed on the communities with the educator deciding what the community need to know.

The use of participatory methods has meant that communities decide what they are at risk from and hence would like to learn more about. Institutions like RUWASA in Uganda, CARE International in Kenya, Mvuramanzi Trust and the Government of Zimbabwe, and PNSBC in Mozambique are increasingly becoming demand responsive.

• ***Team work***
Through multi-sector training, participatory methods have brought different institutions together. In Botswana where there is no integrated sector approach to water and sanitation development, different ministries have come together and conduct training as a team. In Zimbabwe health and hygiene is not seen as a preserve of the MOH but as a responsibility for the entire water and sanitation sub-committee which comprises different ministries and NGOs. In Kenya, users of participatory methods share experiences through a formal networking group – PALNET.

Institutionalization of participatory methods
One of the most important changes that has taken place is the institutionalization of the use of participatory methods either within government or NGO operations. In Kenya, through PALNET support, most NGOs use participatory methods. In Zimbabwe the MOH and CW, Environmental Health Unit, has institutionalized participatory methods for health, hygiene and sanitation promotion.

RUWASA in Uganda and PNSBC in Mozambique have also institutionalized the use of participatory methods. Similarly most UNICEF supported projects use participatory methods. In Tanzania, participatory methods are used at government level, even though there has been no systematic funding for the process.

• ***Visibility of hygiene and sanitation***
Within the water and sanitation sector, the emphasis has always been an on the hardware components and on water. The Low Cost Sanitation Program in Mozambique noted that in the past its main objective was to sell the slabs for latrine construction. Since the introduction of participatory methods, improved hygiene is now seen as an end and not a means to getting communities to construct latrines. Within the Zimbabwe Integrated Water and Sanitation Program, hygiene has become so visible that since the introduction of participatory methods, there has been an investment of almost two million US dollars. There has been renewed interest of sector personnel and institutions in hygiene promotion.

• ***Expanded use of participatory methods***
The fact that there have been some visible results in utilizing participatory methods has led to its rapid expansion within different institutions. There are more institutions interested in training and support on the use of participatory methods. The use of the methods has grown even beyond hygiene and sanitation.

• ***Improved targeting***
Through the use of participatory methods there is improved targeting of the felt community needs as opposed to the institutionally perceived needs.

• ***Strategic planning***
There is more strategic planning. Institutions, in conjunction with communities, identify problems which form a basis for developing objectives and expected outputs.

• ***Greater community involvement in planning***
Planning is now a bottom-up process and not top-down. Communities identify their own problems and solutions and plan for intervention. Institutions act as technical advisors. In Kenya, communities have been developing their own project proposals.

The Drinking Water and Sanitation Sector
One of the most important changes that have taken place is the visibility of hygiene and sanitation in the sector. Hygiene has in most cases always taken a secondary role to water. The use of participatory methods has created awareness on the importance of hygiene as an end rather than a means of achieving improved coverage. There has been renewed interests and vision which in turn has seen resources being channeled to hygiene and sanitation. Sector ministries have been brought together.

In Botswana, where ministries operate in isolation of each other, there now exists an inter–ministerial committee in charge of developing a plan for the application of participatory methods. Some of the changes in the water sector have included behavior change in water transportation, storage and handling, improved sanitation coverage and improved hygiene behaviors.

Case Examples of Behavior Change

In all the six countries participating in the prospective review, there were no documented case studies of behavior change. There were, however, some shared general observations and specific anecdotes including the following:

Some of the General Observations

- Improved hand-washing methods.
- Increased construction and use of hand washing facilities.
- Increased construction and use of hygiene enabling facilities such as latrines, dish racks/ pot racks, rubbish disposal pits, safe protected water facilities.
- *Improvement in environmental and house*hold hygiene.
- Improved water transportation and storage, using covered lids.
- Community level monitoring.
- Communities feel that they own the process of hygiene improvement and are willing to invest their own resources in the development of hygiene enabling facilities. Communities are changing their behavior to be more self-reliant.
- Attitude has changed from expecting government to provide.

Environmental cleanliness - Botswana

As a means of promoting improved environmental cleanliness, the government of Botswana holds annual national competitions. In Bobirwa district, only one village used to win the competitions. However, since the introduction of participatory hygiene and sanitation, more villages are now winning the national competitions. This is attributed to the application of PHAST since this is the only district in which application has been active.

Self-reliance in Gwanda - Zimbabwe

Gwanda district situated in Matabeleland South province is currently implementing and Integrated Rural Water and Sanitation Program (IRWSSP). The district is in a dry area and prone to periodic drought and generally regarded as poor. The program provides primary water facilities and subsidizes household latrines. The latrine subsidy does not cover all households. The program in Gwanda has focused on participatory hygiene education. This has resulted in some community members financing their own latrines and boreholes. Boreholes are generally seen as a government responsibility and it is rare for rural households to finance the drilling of this activity. To date there have been 83 boreholes drilled by a private contractor hired by the community. There are about 200 *household latrines constructed without a sub*sidy. Payment for services is either in cash or using domestic animals.

Disease Reduction - Uganda

In Uganda, control districts or areas have been used for comparative purposes. Changes have been noticed in areas where RUWASA has been using participatory methods. In Mukono, where hygiene education was intensified, there has been no cholera outbreak (1997). However, in Kampala and its neighboring districts, cholera outbreaks have occurred.

Noticing the changes, communities have appreciated that hygiene promotion that utilizes participatory methods is preferable to those methods in which one person lectured them.

Healthy Tit-bits - Kenya

- During a recent cholera outbreak, the SHEWAS project area where participatory methods are being applied was least affected.
- Most rural homes now have dish racks and water storage facilities.
- In Kajiado and Marsabit Districts, there *are improved houses and cooking stoves and* this has meant less smoke and fewer burns.
- Residents of Kibera, an informal settlement in Nairobi, have improved their environmental cleanliness by digging rubbish pits and latrines are now emptied much more frequently.

Remarkable Results - Mozambique

Chimoyi started piloting the use of participatory methods in September 1996, with the following objectives:

- Promotion of the purchase of slabs
- *Promotion of hand–washing*
- Promotion of safe rubbish disposal methods and general hygiene in households

A baseline survey was conducted before the start of the use of participatory methods and

by June 1997, the survey had recorded the following changes:

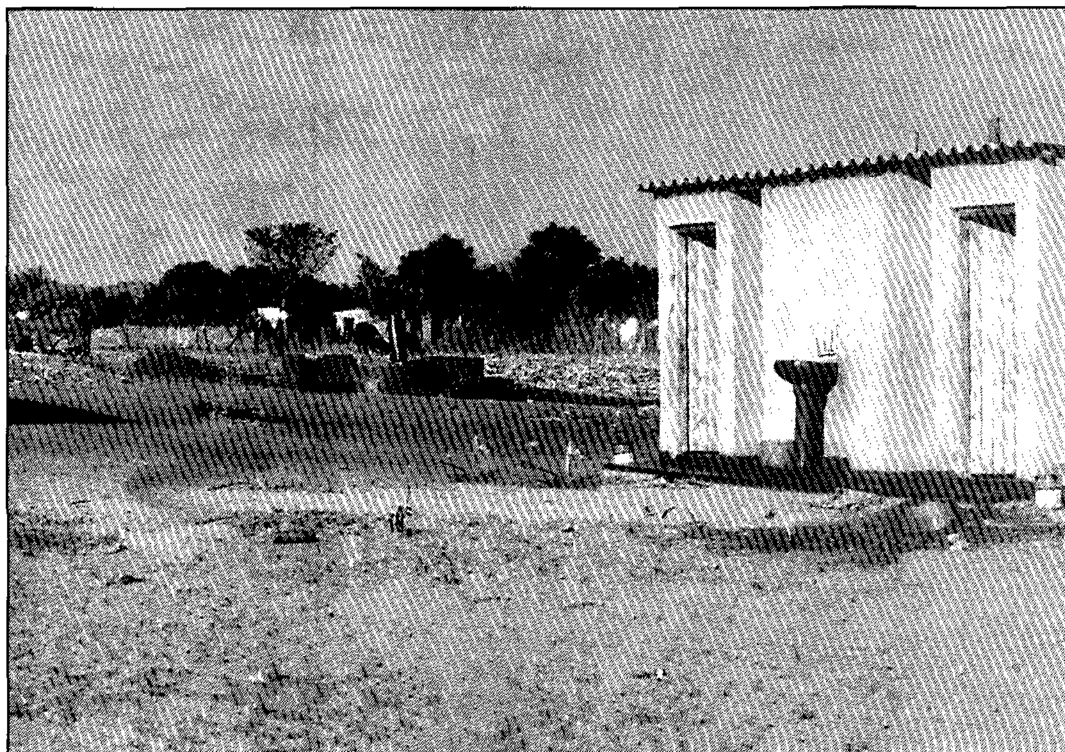
- Out of 34 households whose latrines had no lids, all had bought lids.
- Of the 55 households without latrines at the start of PHAST, 49 had constructed latrines by the end of piloting and four were in the construction phase.
- Three households had constructed septic tanks.
- Four households had constructed hand-washing facilities, whereas previously there was no single one.

Hand-washing Methods and Facilities - Zimbabwe

In rural areas of Zimbabwe, the most common method of hand-washing was the use of a communal dish or bowl. Water will be placed in the dish and the eldest person (normally the father) would wash his hands and move the dish on until it reached the youngest (children). The implication was that the persons most likely to be contaminated are the children who are the vulnerable group.

During funeral gatherings and weddings, one dish would be passed around and by the time the last person was washing their hands there is more contamination than there is cleaning. Through the use of participatory methods, communities have stopped using communal hand-washing facilities and are opting for what is called 'run to waste' or pouring methods. Water is placed in a container and poured over one's hands as they wash. This practice is religiously followed especially at gatherings. *"In Makoni District people are so concerned about hand – washing that they will not shake hands in the morning before washing them. In fact, people are now paranoid about hand – washing "*, observed Juliet Waterkyn.

There has been an increase in the number of latrines with hand-washing facilities. In some districts, a latrine is not certified complete if it does not have a hand-washing facility. Communities have come up with their own innovative designs ranging from tanks attached to the latrine and made out of cement, recycled material such as cans, to using a laddle which is grown in the fields.



Communal VIP latrines with a hand-washing facility.

4. Institutional Arrangements Supportive of Participatory Methods

The institutional arrangements for the application of participatory methods differ for each country. Some countries have clearly defined and coordinated water and sanitation sectors, making it easy for the application of participatory methods. In others, the sector is disintegrated and initiatives are mostly through NGOs. Similarly, in some countries NGOs act as channels for the promotion of participatory methods, while in others, NGOs are few. A summary of the institutional arrangements as they relate to training, implementation, monitoring and evaluation is discussed below:

Training Arrangements by Country

Country	Training arrangements	Comments
Botswana	• After the Uganda PHAST Regional Workshop, there was a training of trainers workshop. • Composition of training team was multi–sectoral. • The trainers then trained extension workers. • Due to staff turnover, the training component weakened. • At the moment, there is plan for training more extension workers and refresher courses for those who had been trained earlier. • Participatory methods have been placed in the MOH, health education unit • Training will be conducted as a coordinated effort with other ministries. •Training varied from a ten-day workshop for TOT to a three-day one for extension workers and community leaders. • The trained extension workers did not receive toolkits.	Botswana is reviving the use of participatory methods and a plan which includes training has been developed. At the start of participatory methods, training was one of the strongest components in the country leading to the perception that participatory methods were a training project. Most of the people that were initially trained 1994/95 have moved or changed jobs and it was difficult to assess if they are still using participatory methods. There is need for the country to define further their training strategy articulating their objectives, duration, expected outputs and target groups.
Kenya	• There are different organizations applying participatory methods and training arrangements are different within each organization • Training within organizations is as per need i.e. training them initially for the use of participatory	Kenya has a long history of training in participatory methods. Most extension workers have been using one or the other existing participatory methods. The training that has been needed has therefore to re–orient extension workers to PHAST method-

Country	Training arrangements	Comments
	methods and then giving refresher courses. In some organizations, consultants are used to offer training, e.g. Help Age. • Other organizations offer in-house training, e.g. Action Aid, AFRICA NOW. • SHEWAS program has had a TOT program (Oct. '97 and March '98). • There are other training institutions that offer training such as NETWAS. • RWSG–ESA gives training support on request (although they limit their activities, mostly to TOT). • MOH trains staff from other institutions	ology. This is mainly given by each implementing organization. While the diversity of organizations offering training is an advantage in improved coverage and wider experience, there is a problem of quality control. Different people will give different training and this may lead to poor quality. There is also an identified need for awareness and training within the Ministry of Health.
Tanzania	• Has been trained in SARAR. • Has not yet had training in PHAST. • There exists defined institutional arrangements that are decentralized to district levels providing an enabling environment for training. • MOH is developing a five-year plan which would involve training of District Health management teams. • Dar es Salaam City Commission is training extension workers on various participatory methods.	Tanzania has asked for support in training on PHAST. Clearly if the initiative was introduced in the country it would be demand driven. There is also need for support with skills development, funding, and material development. The institutional arrangements existing will be an enabling factor.
Mozambique	• The National Low Cost Sanitation Program is implementing participatory methods. • Training was initially given by IWSD to a few selected pilot areas and the national team. • These have formed the training team that has trained other extension workers. • Refresher courses have been given by the National team with support from IWSD. •There is an expressed need to have MOH trained.	There is still scope for training in participatory methods. Most organizations and MOH have not been trained in participatory methods. The ministry has requested for support in training of their staff. The country is also proposing sector reforms and it is perceived that once the sector is integrated (WASHE) this will enable systematic training and application of participatory methods.
Uganda	• Institutional arrangements for training vary and largely depend on organizational policies. • In WES, the project trains extension workers. They use cascade training. •The National Institute of Development trains community development workers. • The School of Hygiene trains health inspectors and health assistants. • There are other institutions conducting training, e.g. Nzamizi School of Social Development. • RUWASA trains District Management teams, who then train lower levels. They also trains other institutions. • Training period varies between 3 and 5 days.	MOH should be playing a lead role in training but at the moment that support from the ministry is lacking. There is diversity in training arrangements and while this is an advantage it also presents problems of quality control. There is still need for more training.

Country	Training arrangements	Comments
Zimbabwe	• Training is conducted systematically through the MOH and CW. • There has been support from UNICEF. • Training is done through teams at national, provincial and district level. • There are no master trainers, but rather skills are identified from those who have already received training. • Initially, the first training was 10 days, but was later reduced to 5 days. • Due to problems in conceptual understanding training has been recommended to be 10 days. • Most of the districts have already received training and at times demand had outstripped supply. • After a training extension workers are given toolkits for use at community level • Training is not exclusive but includes all interested parties. • Other training institutions and NGOs have also been offering training. • Participatory training has been incorporated into MOH multi–disciplinary training institutions. • At the provincial level, training is offered to the water and sanitation committee, comprising of different ministries.	The reduced time from 10 to 5 days compromised the focus on conceptual aspects and there has been a recommendation that the training period be made 10 days. Although PHE is not seen as a training project, there has been a large input into training. Due to expanded training, there has been limited capacity for follow up and the future plans will be based on consolidation of activities. There is a clear differentiation between awareness (which is given to policy and decisionmakers) and training which is given to extension workers who are expected to apply participatory methods at community level.

Implementation Arrangements by Country

Country	Implementation Arrangements	Comments
Botswana	• Government agencies are largely responsible for the implementation of participatory methods. • SNV is also using participatory methods for home based care • Initially most of the interface was through community leadership workshops • There are future plans that clearly differentiate between training workshops and application at community level. • UNICEF-WES has also been active in implementation through their sanitation project.	Government Institutional arrangements are decentralized and development is carried out through local government and councils. There are also extension workers who are in a position to implement participatory methods. In terms of institutional arrangements, there is an enabling environment. Implementing participatory methods through leadership workshops is costly and may not be sustainable.
Kenya	• There are a lot of NGOs that are implementing participatory methods. • Most of these organizations work through extension workers who interface with the community. • The MOH has health workers at all levels • Experiences are shared through the PALNET. • Participatory methods have been applied in rural and urban poor communities.	There are a lot of activities going in Kenya and the existence of a number of NGOs offers scope for expanded implementation of participatory methods. There is an expressed desire to see the MOH in the forefront on the application of participatory methods. The existence of PALNET assists in sharing experiences. Implementation is done through extension workers.
Mozambique	• The Low Cost Sanitation program works through animators who apply the methods at community level (peri – urban areas). • In the rural areas, the methods are applied in a limited way through activists. • Some NGOs like CARE International also work through volunteer workers in the application of participatory methods. • PRONAR has also trained extension workers who operate at community level promoting improved management of water facilities.	Mozambique does not have many extension workers. The application of participatory methods using extension workers is therefore not an option. At the moment, a feasible solution will be to apply participatory methods through schools. The ministry of health has not been trained and it is perceived that if participatory methods was part of the nurses program, then they would apply them in their outreach programs.
Tanzania	• There are trained extension workers who apply participatory methods at community level. • There are NGOs operating in the country and they use extension workers for application. • Organizations using participatory methods are: UNICEF –WES, Water AID, WHO, HEWASA, DHV, MOH and Ministry of Community Development.	Tanzania has not received PHAST training and has requested for support in this activity. The institutional arrangements are supportive and would enable the application of PHAST. Tanzania operates through a decentralized government structure and the SARAR based methods have been applied through these structures.

Country	Implementation Arrangements	Comments
Uganda	• There are different organizations applying participatory methods at community level • Local councilors also play an important role in the transfer of information. • Personnel involved in the application of participatory methods are health assistants and health inspectors, schools, community development workers, and community development assistants. • Participatory methods have been applied in rural and urban poor communities.	Uganda is committed to the application of participatory methods and sanitation is a priority in the country. A sanitation policy is being drafted. Support that is given by the decision and policymakers creates an enabling environment for the application of participatory methods. There is an expressed need to see the MOH in the forefront of the application of participatory methods.
Zimbabwe	• The MOH and CW is in the forefront. • Communities are reached through the extension workers (EHT) who work at ward level. • The central office for the use of participatory methods at the national level is the Director of Environmental Health Services. • At the district level, most of the work is carried out by the Environmental Health Officer. • At a village level, the messages are channeled through the Village Community Worker (VCW and EHT). • Schools apply the methods through the School Health Master Program. • Other ministerial agencies are promoting hygiene, e.g. DDF through its community based management program. • NGOs work through government extension workers. • Health Clubs have also been piloted.	One of the institutional concerns is that the EHT is seen as being responsible for carrying out PHE at community level. There is no structure for carrying out hygiene education at community level. The VCW is under a different ministry and their primary role is to promote income generating projects. There have been attempts to use volunteer workers at the village level but these are only committed so long as there is no income rewarding jobs. Once they get paid employment they then leave. There is also need to bring the health education unit on board and this would assist in the application of participatory methods for health programs.

Monitoring and Evaluation by Country

Monitoring and evaluation is generally weak in all the six countries. A synopsis of each country reveals the following:

• Botswana
Weak monitoring and evaluation is a result of the fact that the application of participatory methods was based more on individual interest than on institutional interest. During the assessment it was difficult to get data on the number of people trained. No one seemed to have been responsible for monitoring the process. Currently the MOH is taking a lead role and this offers scope for monitoring of activities.

• Kenya
Given that there are different organizations implementing participatory methods, there are also different monitoring systems. CARE international involves the community in their monitoring using participatory tools. The MOH relies on quarterly reports. Help Age has developed progress indicators. Action Aid has developed tools that are used by the community. Consultants have also been used. Africa Now is in the process of developing monitoring and evaluation charts for use by their staff. The MOH conducts routine monitoring in line with all their other activities.

• Mozambique
Monitoring and evaluation is done within the overall program monitoring system. Coordinators are expected to submit monthly reports on the progress of the program. Since the introduction of participatory methods, animators are expected to report on the application (process) and effect (impact) of participatory methods. Monitoring is based on annual plans drawn by each province. Other monitoring methods include national level visits to each province every two months and an annual national meeting.

An assessment of the application of participatory methods in the rural sanitation program was done in July 1997. During this assessment, training in participatory monitoring and evaluation was identified as a need.

• Tanzania
Different organizations are using different monitoring systems. MOH indicated that in the WES Program monitoring forms have been distributed at all levels. Again the use of forms indicate that the information will be more quantitative than qualitative. Government has not conducted any evaluation of participatory methods.

• Uganda
While some organizations have been systematically monitoring the effects of participatory methods at community level, others are still trying to develop effective monitoring and evaluation systems. RUWASA for example have indicated that they would like to improve their monitoring systems. Most organizations felt that monitoring has not been taken seriously. Even in WES projects, monitoring still needs to be addressed. There has not been an evaluation of the use of participatory methods.

• Zimbabwe
Monitoring of PHE is done as part of the overall monitoring within the MOH and C W and within the overall Integrated Water and Sanitation program (i.e. for those districts that are implementing the program) It is felt that monitoring is still weak, with EHTs tending to report on quantitative aspects of participatory methods. Zimbabwe would like to develop monitoring indicators and would like to see both impact and process monitored. The current reporting system does not entirely capture all the activities taking place. Different support agencies have commissioned evaluations on the activities that they are supporting and these have included participatory hygiene (Australian Aid 1996, Irish Aid 1997). The government has documented the process (1996, Keith Wright).

Coordination of Participatory Methods

While in some countries coordination of the application of participatory methods for hygiene and sanitation rests with the MOH (Botswana, Zimba-

bwe), in other countries there are individual focal persons. In Tanzania, there are teams that have been developed at national, provincial and district level. The focus on an individual has the advantage that the person may have demonstrated an interest and has acquired skills in that direction. The main disadvantage is that if focus is on the individual, a gap is left when the person leaves. Furthermore, an individual may not have the means to promote participatory methods.

At the regional level, there is a need for an organization that will coordinate the application of participatory methods by linking countries up and up-dating them on what is happening. Experience with the PROWWESS program demonstrated that coordination which was provided by the RWSG-ESA was valued by different countries. Through that coordination, countries were informed of where they could get certain skills, they obtained material and were linked up to successful cases in application. This support is still needed in the application of participatory methods for hygiene and sanitation.

At a country level, coordination through a team effort is desirable, with the MOH taking a lead role. Furthermore, it is noted that participatory methods need a lot of commitment and management in terms of organizing workshops, supervising the development of material, distributing those material, analysis of reports, etc. Some countries have found it necessary to have a technical support person linked to the MOH. In Zimbabwe, while the ministry is the lead agency, they have UNICEF supporting them through UNICEF employed staff members who are attached to the ministry. The two staff members work full time on participatory methods. Botswana is also seeking WHO support in obtaining a technical support staff who will work full time on participatory methods. This strategy works as long as the ministry is a lead agency.

5. Policy Framework and Political Commitment

Policy has profoundly changed and continues to change in the region. Whereas the role of government as the provider of services was accepted, now government is generally viewed as a facilitator. From infrastructure service orientation, the emphasis is now on 'software'. Where once water was seen as a priority, sanitation is now gaining visibility in the sector. From a focus on institutional capacity building, there now is a concern over community management of the development process. In line with these changes in policy thinking, many countries have been making institutional changes and instituting sector reforms. In general there has been a shift from centralization to decentralization. **Mozambique** has started sector reforms that should see the integration of water, hygiene and sanitation as WASHE programs and are moving towards coordinated inter–ministerial implementation.

In **Uganda** an inter-ministerial committee has been formed to oversee sector changes and there is a proposal to develop a sanitation policy. In **Botswana,** a task force has been instituted to facilitate the process. **Tanzania** has institutionalized the use of participatory methods through the Ministry of Water Resources and has appointed a National PROWWESS Coordinator who is responsible for promotion of participatory methods. **Zimbabwe** has decentralized the implementation of water and sanitation projects and it is envisaged that communities will have more control and responsibility in the future.

Community Participation

In general, all the countries are committed to community participation to varying degrees and breadth of application. In **Tanzania** the policy on participation states that *"communities should be involved in planning, construction, operations and financing, depending on their ability"*. In **Mozambique**, some of the basic principles outlined in the National Rural Water Transitional Plan are:

The full participation of beneficiaries in planning, implementation and management of water supply and sanitation programs.

A demand-driven approach with changed government role from that of provider to that of a facilitator.

Kenya has been committed to participation as demonstrated by the scope of the use of participatory methods in the country. Community participation was encouraged and promoted through programs as the PROWWESS which sought to promote the role of communities in water projects.

The Government of **Botswana** is also committed to participation and hopes to achieve it through its decentralized local government structures.

In some countries, while participation is not clearly articulated in policy documents, it is implied.

While policy on community participation as a strategy is desirable, it does not outline in detail how the strategy will be implemented. It is therefore useful to translate the policy into strategies and specific activities in relation to participatory hygiene and sanitation.

Indication of Political Commitment

It is often difficult to measure political commitment to a process. In the countries that were assessed, local politicians are supportive of the process and often are used as a channel for hygiene promotion. In Uganda, Botswana and Zimbabwe, local councilors have been trained or made aware of participatory methods and have been disseminating hygiene messages.

Advocacy at the political level would lend hygiene and sanitation the necessary support. While in principle, there is support at political level, this has not been matched by the requisite resource allocation. Hygiene and sanitation and the use of participatory methods are largely funded by external support agencies.

Funding for Participatory Methods

It was difficult to get data on the financing of participatory methods for the following reasons:

- There are different organizations applying participatory methods.
- Where funding was indicated, there was a tendency to elaborate on funding for workshops and material only. Staff time is often not included in the financial figures.

Country	Amount spent	
Kenya	Africa Now	Kshs 30 000 – 40 000 in 1997 Kshs 70 000 in 1998
	Help Age	Kshs 2 million
	Ministry of Health	Kshs 1.8 million per district
	CARE Siaya	Kshs 200 000 for cholera material
	Exchange rate: 1 US$ is approximately Kshs 60	
Botswana	No data available	
Zimbabwe	Excess of US $ 2 million since participatory methods started in 1994.	
Tanzania	Ministry of Health indicated that they spent US $ 10 000 while conducting a PHAST workshop and development of toolkit	
Uganda	RUWASA	US $ 98 605
	Water Aid	Sterling pounds 2 500
Mozambique	No data available	

Although data on financial expenditure was incomplete, the application of participatory methods clearly requires heavy financial investment. The main areas of expenditure are in human resource and material development. With the escalating costs in accommodation and printing, the costs of running the workshops also increase. Material and tool kits seem to be the cornerstone of participatory hygiene and sanitation and it is therefore not feasible to expect extension workers to apply the methods without the tool kits. For an experienced participatory trainer, it becomes easier to work without the tool kit. This implies that any country seeking to use participatory methods will have to commit substantial resources to training and material development. The actual application at community level does not incur expenses as this is done in line with the daily activities. If a project introduces parallel structures expressly for participatory methods then there will be an added expense.

Two elders involved in a participatory planning process.

6. Health and Sanitation Needs

The region is still faced with many challenges. Sanitation in both urban and rural areas is poor. Hygiene behavior has still not improved to acceptable levels as evidenced by the prevalence of preventable diseases. Within the region, diarrhoearal diseases related to poor excreta disposal systems continue to be one of the major diseases among the under-five's. Malaria, skin and eye infections are rampant. Infant, under-five and maternal mortality rates have remained high. Improved water and sanitation are therefore areas of priority concern to most governments. The table below summarizes the country priority areas:

Country	Priority Focus	
Botswana	• Hand washing • Safe excreta disposal • Adaptation of material for health programs	• Improved water storage • Environmental Hygiene
Kenya	• Safe protected water • Hand–washing • Control of pollution	• Maintenance of facilities • Safe excreta disposal • Improved hygiene education
Mozambique	• Use of safe protected water • Proper water collection and storage • Personal hygiene	• Safe excreta disposal • Environmental sanitation • Hand–washing
Tanzania	• Improved sanitation • Control of pollution	• Safe and adequate water • Community involvement and partici pation
Uganda	• Improved latrine coverage • Hand washing • Improved hygiene	• Improved and adequate water • Capacity building
Zimbabwe	• Access to and use of protected water supplies • Construction and use of safe excreta disposal facilities • Kitchen hygiene	• Improved transportation and storage of water • Hand – washing • Environmental sanitation • Operations and Maintenance of facilities

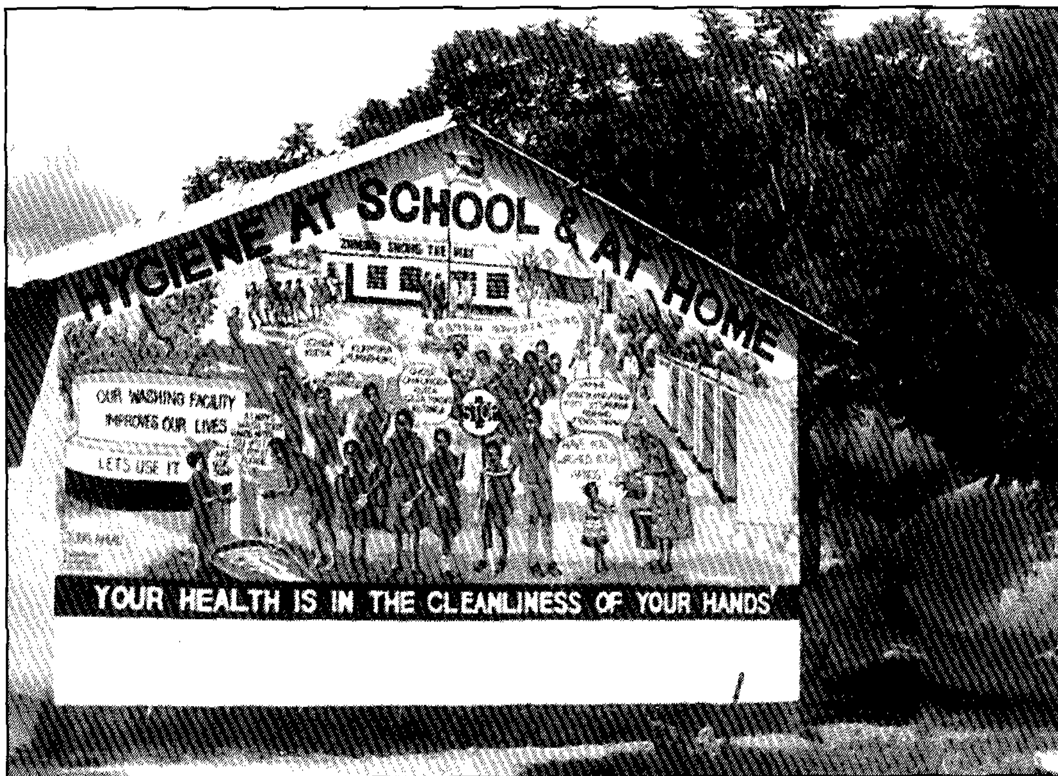
An analysis of the most prevalent diseases indicates that most of them could be prevented through improved hygiene and sanitation. In **Tanzania,** there was one cholera outbreak in 1997 which spread to all regions in the country. In **Uganda,** diseases related to water and sanitation account for 50 percent of child mortality. There was one cholera outbreak in 1997 which spread to several areas. In **Kenya,** there was one cholera outbreak in Nyanza province. While in **Zimbabwe** there was no cholera outbreak in 1997, many diseases are related to water and sanitation. In **Mozambique,** there are periodic outbreaks of cholera related to the rainfall cycle. In 1997, there were 500 reported deaths and up to 2 000 people were hospitalized.

Hygiene-enabling Facilities

Country	Access to Sanitation	Access to Water
	percentage of population with access	percentage of population with access
Kenya	77	53
Mozambique	21	32
Tanzania	86	49
Uganda	57	34
Zimbabwe	58	74
Botswana	N/A	N/A

Source: World Development Indicators for 1995
WDR, 1998/99

All countries noted that participatory methods should be applied in conjunction with a water and sanitation program. When applying participatory methods, one raises the expectations and awareness of a community who may not have the means for improving their situation.



A mural on a school wall carrying a hygiene message

7. Country and Regional Plans

Given the prevalence of diseases that are related to water and sanitation, participatory methods are clearly relevant in the region. Whereas at the beginning of their use, they were initiated and promoted by donor agencies such as WHO, UNICEF and RWSG-ESA, participatory methods are now demand-driven. Several countries and their organizations are requesting for training and support. The future areas of activities have been identified as:

- Institutionalization of participatory methods for those countries that have not done so
- Training and refresher courses in the use of participatory methods
- Development of skills in material develop ment
- Development of indicators for and skills in monitoring
- Advocacy at the decision and policymaking levels
- Material development
- Strengthening of coordination and manage ment teams
- Training of CBOs
- Carrying out baseline surveys and impact studies
- Strengthening networking at country and re gional level
- Documentation and dissemination of infor mation
- Translation of information into local lan guages

Specific country plans are discussed below:

Botswana

The main objective in Botswana is "to integrate the PHAST approach into existing health promotion and education activities to promote sustainable hygiene practices to reduce water and sanitation-related morbidity and mortality in selected areas"[6]

The future activities include:

- identifying a coordinator for PHAST activi ties;
- advocacy among policymakers;
- training of extension workers;
- refresher courses for trainers;
- development of a toolkit;
- development of a monitoring system; and
- implementation at community level.

Funding for these activities will come from external support agencies, namely UNICEF and WHO. The Government of Botswana will support the country plan through staff time.

Recommendations

It is recommended that Botswana develops a training strategy which will define the trainees, the duration of training, objectives of such training and expected outputs. The training strategy should also define the contents of each training for different target groups.

Furthermore, it is recommended that Botswana defines its implementation strategies to ensure that the use of participatory methods does not remain a training project. Such a strategy will look at the operational framework at community level.

Kenya

Ministry of Health

- Plan to recruit health technicians who will have a coverage area of 4 000 people each.
- Train the recruited health technicians and equip them with tool kits, guides and sup port material.

Africa Now

- Train 120 hygiene educators
- Develop new tool kits for hygiene promo tion
- Incorporate hygiene in water user commu nity training
- Establish task forces for facilitating child health in schools
- Orientate headmasters in school health pro grams

Action Aid

• Plan to integrate training of new initiatives in six development areas with Mombasa as a main area of focus due to its sanitation problems.

Help Age

• Plan to train district Help Age teams who will be used to train others
• Develop tool kits for all trained personnel.

CARE Siaya

- Develop guide and curriculum for training
- Train master trainers
- Develop more tool kits
- Conduct training workshops
- Review and up date of training manuals
- Monitor for progress and impact.

Recommendations

The proposed country plan for Kenya is more of a reflection of aspirations of various organizations and not a national blueprint.

See Annex 7 for the Proposed Kenya Country Action Plan.

Mozambique

The Low Cost Sanitation Program is preparing a new project strategy for hygiene and sanitation that will address issues of sustainability. Some of the identified areas for strengthening hygiene and sanitation are:

• The use of integrated approaches within the sector. Future proposals are for an integrated WASHE program implemented under the umbrella of DNA. This will have the advantage of improved coordination and use of standard policies and approaches among different sector agencies.

• The expansion and use of participatory methods among different institutions. The review noted that the MOH is still not exposed to the use of participatory methods, and that rural sanitation and participatory hygiene is only operational in three out of ten provinces.

• Objective-oriented promotion of hygiene, targeting priority areas of access to and use of safe water, proper water storage, safe excreta disposal, hand-washing, environmental and personal hygiene.

• Working with institutions, such as schools and local NGOs. There are limited extension services for hygiene and sanitation promotion, and given the current economic situation and priorities of a country coming out of war, it will be difficult to increase the extension services. A sustainable approach will be to promote hygiene through schools and NGOs.

• Decentralization of implementation of activities to regional and sub-regional levels.

• Sanitation has to be implemented as a demand-driven activity with the private sector involved in the production of slabs. Sanitation, although subsidized has been demand driven but implemented through PNSBC.

• Revision of the training manual for extension workers so that it becomes generic and has a wider usage rather than being targeted only for extension workers.

The use of participatory methods

Although some institutions are already utilizing participatory methods, this has not been widely accepted as an approach in the sector. Different organizations are using different methods and while this provides the necessary diversity, sometimes there is lack of quality control. Future plans are in the following areas:

• *Training for the MOH personnel.* If the ministry is trained and are using participatory methods as their strategy, this will lend the necessary support, respect and acceptance of methodology at a national level.

• *Refresher training courses* for those already trained so as to consolidate the use of participatory methods. The refresher training to include participatory monitoring and evaluation.

• *Development of a strategy for introducing participatory methods in schools.* With the shortage of extension services, schools become an appropriate channel for hygiene education. Furthermore retention and behavior change is higher when introduced at an early age.

• *Production of a field guide* that will be used for field application and a training guide for training in participatory methods.

• *Production of more toolkits for use at extension level.*

• Inclusion of participatory methods within the curriculum for health personnel.

• Development of coordinating teams that will be the focal group for participatory methods.

Other Areas

Other areas that were identified in terms of support to participatory hygiene ad sanitation were:

- *Focus on research.* The research will gener ate information that could be used to fur ther improve hygiene and sanitation.
- *Advocacy.* There is still need for advocacy at the institutional levels, policymaking levels and within the overall sector. At the moment there is no policy relating to the use of participatory methods and therefore no obligation for any agency to utilize participatory methods. It is in this area that research results become an important advocacy tool.
- *Information sharing.* There is weak information sharing among different sector agencies and institutions locally and regionally. Mozambique has the added disadvantage of language barrier as material are often produced in English and often institutions have the added expense of translating documents for effective use in the country.
- *Monitoring and Evaluation.* There is weak monitoring and evaluation within the sector making it difficult to follow up activities. Implementing agencies may monitor their individual projects but there is no database for activities in the country.

Tanzania

The government through MOH would like to conduct advocacy meetings to sensitize decisionmakers on the use of participatory methods, to modify, adapt and translate participatory tools and guides into Kiswahili, to support and facilitate district training workshops to conduct follow up visits and to develop a curriculum for training. Specifically the individual organizational plans are:

UNICEF–WES plans to:

- rebuild and strengthen national teams of trainers followed by district teams; and
- support development of district plans and implementation of those plans.

Other organizations would like to:

- conduct refresher training courses;
- be trained in PHAST;
- expand in field application;
- develop material;
- up-date an inventory of personnel trained; and
- conduct an impact assessment.

Recommendations

Tanzania has not been trained in participatory methods for hygiene and sanitation (PHAST). However, it is noted that there are a lot of people trained in and with experience in the application of participatory methods based on the SARAR principles. Although individual organizations have articulated their plans, it is recommended that Tanzania focus on the following activities if they are to introduce PHAST.

See Annex 6 for the Proposed Tanzania Country Action Plan.

Uganda

Plans vary between organizations and are influenced by whether it is a government project, NGO or donor assisted. The key institutions that have been promoting participatory hygiene and sanitation are RUWASA, UNICEF-WES and WATER AID. Their plans are summarized below:

RUWASA

- Promotes sanitation through schools
- Aims at promoting improved traditional la trines
- Expansion on participatory methods will be geared towards training, material develop ment and field application.

WaterAid

The plan is to integrate water supply hygiene, sanitation facility management and capacity building in all the projects that it supports.

- Hygiene will be promoted through the use of participatory methods
- 10 percent of budget funds will be spent on hygiene education
- Capacity building will involve training and 10 percent of budget funds will be spent on this activity
- An artist has been employed for develop ment of participatory methods.

UNICEF-WES

UNICEF expects to increase their resource support on hygiene especially in primary schools. Some of the plans include:

- Refresher training courses
- Support for national training institutions
- Expanded training
- Material development
- Expansion in field application

WHO

WHO is targeting schools health, urban health and water quality in rural areas. There are no plans for the expansion of participatory methods.

NETWAS – Uganda

NETWAS would like to be the focal institution for participatory methods in Uganda. Expansion will take place in:

- Training
- Material development
- Field application
- Monitoring and evaluation

See Annex 5 for the Proposed Uganda Country Action Plan

8. Proposed Regional Support Activities

Based on the outcome of the country review and proposed action plans, the following regional activities were proposed:

Regional Advocacy Workshop

The objective to create awareness at policy and decisionmaking levels on the need to support participatory hygiene and sanitation methodologies in the sector.

Country and Project Assessments

The purpose is to develop a framework for the measurement of the effects of participatory hygiene and sanitation on improved health and living conditions. Such assessments can be undertaken as case studies. The region is supposed to assist with the operational framework and give the technical support.

Suggested countries are: Zimbabwe and Kenya

Technical Support

In countries that are just introducing participatory methods, it is necessary to build the capacity of institutions. One of the ways is to appoint and attach to the MOH, a technical support person with skills in participatory hygiene and sanitation. The region is expected to assist in the identification of those skills and funding of the post(s).

Suggested countries: Botswana, Tanzania and Uganda

It is suggested that such an undertaking be a joint responsibility among collaborating partners (WHO, UNICEF, RWSG-ESA)

Support in Material Development

There is a lack of or weak skills in material development. While some countries have tool-kits and would like to improve on them, others do not have tool-kits and would like to start developing them.

Countries needing to start on tool-kits: Tanzania, Botswana

Countries needing support in improving tool-kits: Uganda, Zimbabwe, Mozambique and Kenya.

Monitoring and Evaluation

Development of Monitoring Indicators

While there has been intensive implementation of participatory methods, process and impact monitoring remains weak. There is need for technical support in the development of monitoring indicators at all levels.

Countries that have expresses the need are: Zimbabwe, Uganda, Kenya and Mozambique.

Training and Adaptation of Participatory Tools for Monitoring and Evaluation

This will be followed by country specific monitoring activities

Technical Support in Training

Technical support is needed for undertaking training of trainer's workshops (TOT) in those countries that are starting the process. While in some countries there are different initiatives being implemented through NGOs, there is still need to initiate them in the ministries.

Countries starting up: Tanzania

Countries where MOH needs training: Botswana, Mozambique

There are countries that were not involved in the pilot phase and regional review, but would benefit from such training support. These countries are: Zambia, Malawi, Swaziland, Lesotho, Namibia, and Eritrea.

Documentation, Translation, Dissemination and Networking

The regional partners are recognized as having the skills, capacity and capability to document case studies, experiences and new initiatives. It is rec-

ommended that they become the focal point for participatory hygiene and sanitation documentation and dissemination.

The Eastern and Southern African countries have both English and Portuguese speaking countries. It is recommended that the documentation be undertaken in both languages. It is also proposed that where possible, translation into local languages, for example, Kiswahili, Shona, Bemba, Shangani be undertaken. For local languages, local capacity should be tapped on.

While countries have proposed to either develop or strengthen their national networks, it has been noted that a Regional Network is important. It is recommended that RWSG-ESA be the focal point for participatory health and hygiene, and sanitation networking. This is on the bias of their involvement in networking for the PROWWESS initiative.

Constraints and Enabling Factors in the Implementation of Proposed Country Plans

Country	Constraints	Enabling factors
Botswana	• Lack of funding as the application of participatory methods is largely depended on external support. • Overlapping duties – officers responsible for participatory methods have other activities • Weak coordination among sector ministries. • Lack of monitoring of progress. • Lack of institutional support	• Participatory methods are now a felt need and this will enable their ex pansion. • Institutional placement of participa tory methods within FHD is a positive move. • There is a lot of donor support at the moment for participatory methods. • Existence of extension workers will ensure field application.
Kenya	• Inadequate number of trained and skilled personnel • Lack of incentives for extension workers • Limited number of tool kits • Lack of adapted tools for other development areas e.g. income generating projects	• There is a lot of donor interest in participatory methods, hygiene a nd sanitation • Existence of NGOs ensures the rapid and varied application of participatory methods. • Existence of PALNET ensures that there is exchange of experience
Mozambique	• Weak and almost non–existent extension service. • Poor networking • Dependence on external support • Material are expensive to produce • Disintegrated sector • Weak institutional linkages • Lack of resources.	• Commitment from external support agencies • National policy on participation • Participatory methods are a felt need
Tanzania	• Delays in decisionmaking • Inadequate number of trained and skilled personnel • Lack of incentives for extension workers • Inadequate assessment and planning	• Enabling institutional arrange ments which includes decentral ized structures to the lower levels • *Participatory methods are demand driven* • Donor support and interest in hygiene and sanitation

Country	Constraints	Enabling factors
Zimbabwe	• Lack of time Lack of human resources Traditional performance appraisals based on outputs/ targets • Ownership of process and inability to let go • Lack of financial resources	• Institutional support • Acceptance of methodology standardization of approaches i.e. use of participatory methods • Donor support • Existence of skilled personnel • Availability of finance which is assured as long as donor policy support participatory health education
Uganda	• Inadequate • Lack of time • Inadequate finance	• Policy support • Donor support and interest • Sanitation is a felt need and a priority • Institutional support

Specific Support Requirements at Country Level

Most of the support needed by countries is for material development and training. The seemingly non-involvement of some ministries may be linked to the non-availability of funds for start-up. In Mozambique, participatory methods are project-based and the MOH is not using them even though they have expressed a need to do so. In Uganda again the application of participatory methods is project-based, as is the case in Kenya. Supporting the MOH in each country will be opportune as it will place participatory methods within those institutions. In the interim, the start-up of participatory methods largely depends on external support. In the long run, and for sustained use, participatory methods should be budgeted for within the overall government activities. Participatory methods should not be seen as a project but part of the health and hygiene activities.

Botswana

Participatory methods have not been institutionalized. One of the factors affecting expansion is the conceptualization of participatory methods as a training project. The country strategy should therefore move away from training into the application and implementation at community level.

Community members going through the Participatory Rural Appraisal.

• *Advocacy*
There is need for a three day advocacy workshop targeted at decision and policymakers. Botswana feels that such a workshop will gain respect and attendance of the target group as it is supported by ESAs.

• *Participatory Hygiene and Sanitation Specialist*
Given that participatory methods are time consuming, need follow up and the process need to be managed, the country would like support in recruitment of and payment for a technical assistant.

• *Training workshops*
Support is needed in training workshops for extension workers.

• *Case Studies*
Support is needed in terms of information on best practices in the application of participatory methods.

Kenya

NGOs have played a significant role in the application of participatory methods in hygiene and sanitation, leading to the formation of PALNET. However, institutional arrangements supportive of PHAST in government need to be strengthened.

Kenya is seeking support in the following activities:

- development and production of tool kits;
- funding of a symposium for exchange of ideas;
- strengthening of PALNET activities; and
- advocacy activities for decisionmakers.

Although most of the support needed is financial, it is not clear where this support will be channeled, given the number of implementors in Kenya. If the MOH has to be in the forefront, then the ministry should be supported as the focal point.

Mozambique

Implementation in Mozambique is still project based in the PNSBC. There is need therefore to support as a matter of priority, training within the MOH. Other areas for support include:

- material development and production;
- training for local NGOs in participatory methods;
- training in material development; and
- training in participatory monitoring and evaluation.

Tanzania

Tanzania has not yet had training in participatory methods. Support is therefore needed in introduction of PHAST. The introduction will entail advocacy awareness workshops at policy and decisionmaking level, training workshops and material development. Specifically support is needed in:

- training of trainers in PHAST;
- training of extension workers;
- development and adaptation of participatory tools; and
- technical support in terms of a hygiene and sanitation specialist.

Uganda

Although the success of PHAST has been demonstrated in specific NGO projects, countrywide coverage is still very limited. The way forward should therefore be the institutionalization of PHAST.

In Uganda, the implementing organizations have allocated financial resources for their planned activities. The MOH would benefit from support in:

- training of extension workers;
- development and adaptation of material; and
- linking the country with other countries in the region applying participatory methods. This would facilitate exchange of ideas.

Zimbabwe

Participatory methods have been well integrated into the water, sanitation and hygiene sector, and institutionalized in the MOH and CW. Scaling-up has been successfully achieved through a well organized training strategy. Future plans are thus focused on consolidation of activities for more impact.

Zimbabwe has some financial support channeled through UNICEF. This support covers material development and training of extension workers. Since training workshops are inclusive, NGOs are also trained during the ministry workshops. Specific identified need for support is in the area of technical skills for development of process impact monitoring indicators , and for material development.

Zimbabwe would also benefit from a network and coordination at the regional level.

Annexes

ANNEX 1: Terms of Reference for Prospective Review of Participatory Methods, including PHAST in East and Southern Africa

Background

In 1993 the UNDP-World Bank Water and Sanitation Group, RWSG in Eastern and Southern Africa and the World Health Organization, Office of Operational Support in Environmental Health, initiated a developmental and applied research activity to strengthen hygiene behavior change. This activity later was named PHAST: Participatory Hygiene and Sanitation Transformation. From the beginning various partners in the field were sought and included NETWAS, IWSD, UNICEF in three countries, various NGOs and was funded primarily by SIDA, DANIDA, WHO and the UNDP/World Bank Water and Sanitation Program. For further background information, see The PHAST Initiative, a new way of working with communities, WHO, 1996 (WHO/EOS/96.11).

In 1994 the pilot phase of the PHAST Initiative ended. Since then the five countries involved (Botswana, Ethiopia, Kenya, Uganda and Zimbabwe) have tried to carry on participatory activities and incorporate them into governmental and non-governmental water and sanitation programs.

In addition, a number of other countries have sought assistance from UNICEF, WHO and the UNDP-World Bank Program to initiate participatory activities in their county programs. Demand for assistance from various countries has led to a joint decision by WHO and the UNDP-World Bank Water and sanitation Program to conduct a prospective review in the region focusing on the countries where demand for future assistance is highest.

The countries selected for the prospective review are Kenya, Mozambique, Tanzania, Uganda, Botswana and Zimbabwe.

Aim

To assess what has been achieved through PHAST and other participatory methods and to propose how to move forward with the use of participatory methods in the sub-region.

Objectives

To assess the effectiveness of participatory methods on hygiene behavior change through the use of interviews and field visits.

- To identify country support requirements for strengthening the use of participatory methods in government-sponsored water supply and sanitation programs. This will include identifying needs in policy development, training, material development, and institutional arrangements.

- To prepare a preliminary plan of activities to strengthen participatory activities at the country level, including a proposed budget and timetable for 1998 and 1999.

- The information collected by this activity will be used by WHO and the UNDP-World Bank Program to make decisions about future resource allocations for participatory methods. The objective of this resource allocation will be to maximize the benefits of further investments in PHAST and other participatory activities.

Dates of the prospective review

The review will be carried out for 25 days between 1 March and 30 April 1998, with the final report due by 30 April 1998.

- 10 –15 days to cover the data collection in three countries (including drafting reports for each country).

- 5 – 10 days in Nairobi combining the reports, information, meeting with WHO and the UNDP-World Bank Water and Sanitation Program and concluding the assignment.

Scope of work
The contractor will:

- conduct interviews with key individuals in the water supply and sanitation sector, using the interview protocol developed for the review;
- conduct field visits, as needed or indicated, in order to obtain a more complete picture of the achievement and needs of the countries to strengthen the application of participatory methods; and
- prepare a preliminary plan for supporting country-identified activities for 1998 and 1999 including timing and budget

(See annex : guidelines for preparing a plan for activities).

Reporting
The contractor will:

- prepare a report (see Annex 2 for outline of final report) for each country visited regarding current activities in participatory methods, policy development, training, material development, institutional development and any other issue of relevance.
- attach the preliminary plan of activities, justified on the basis of the findings from interviews and other material; and
- make final recommendations to WHO and the UNDP-World Bank Program on follow-up activities for these countries.

Preparation and presentation of final report
The reports will be presented in oral and written form to the Program and WHO in Nairobi. The oral report will be given during the third week of April and the written report is due by April 30. The reports will be provided in WordPerfect 5.0, 4 paper copies, 2 diskette copies.

Contractor profile
The contractors who will be drawn preferably from Eastern and Southern Africa shall have a good knowledge of the PHAST methodology and other participatory methods, understand national or local policies required to make participatory methods work in countries, training needs, the institutional requirements and the level of funding required for training workshops and back-up support to people applying these methods at community level.

Contractors should have excellent writing skills in English and should have attended at least one SARAR master trainer's workshop, and observed at least one field site where participatory activities are taking place.Contractors should have a good knowledge of the water supply and sanitation sector and government structures for water and sanitation, and should have at least 5 years of experience in this sector.

Annexes to TOR
1. Outline of final report
2. Interview protocol

ANNEX 2: List of Persons Consulted by Country

BOTSWANA

Name	Position and Organization
Dr. Gema	Resident Representative, WHO
Michael O. Walebowa	Graphic Designer, Ministry of Health
Mrs. Makgautsi	CHO, family Health Division
Mr. Andrew Chalinder	Consultant, UNICEF
Mrs. Motseme	Family Health Division, Ministry of Health
Mrs. Manenyeng	Deputy Director, Primary Health Care
Ms. T Kedikilwe	African Development Bank
Mr. M. Sambo	SEHO, Ministry of Health
Ms Kwezi Mbonini	SNV, Home Based Care Coordinator
D.M.Tsamai	EHO
Ivan Makati	EHO, Family Health Division
Household members	Bobirwa Area
Dr. Tshabalala	Former Resident Representative, WHO
Dr. D.K. Malanguka	SDMO
Dr. Mboya	SDMO

KENYA

Name	**Position and Organization**
Dr. Paul Chuke	Resident Representative, WHO
Mr. Wilfred Ndegwa	Sanitation Expert, WHO
Mr. Zahirul Karim	Officer In Charge, WES Country Office, UNICEF
Ms Salome Mwenda	Project Officer, WES, UNICEF
Ms Jane Maina	Training Coordinator, Help Age
Ms. M. Mwaura	Project Officer, Help Age
Mr. J. Waithaka	National Coordinator, Environmental Health Program
Julian Ongonge	Action Aid, Kenya
Mrs. T. Kodo	Water Health Assistant, Kibera Project
Janet Musinga	Care Siaya
Meshack Ajode Owira	Extension Officer, Central Alego Location
Peter Mboyia Okaka	Project Manager, Africa Now
Stephen Machooka	Managing Director, Lake Basin Development Authority
Mr. Rolf Winberg	Sida
Mr. Tore Lium	RWSG –ESA
Ms Rose Lidonde	RWSG-ESA
Mr. Jean Doyen	Regional Manager, RWSG –ESA

TANZANIA

Name	**Position and Organization**
Dr. Dirk Warning	Resident Representative, WHO
Suzzane Verver	WHO
Ms Rebecca Budimu	Project Officer, WES, UNICEF
Martin Kitilla	Coordinator, Dar Es Salaam City Commission
Ms Onike D. Mrema	SDP Program, Dar Es Salaam City Commission
Mr. P.S Tarimo	Head, CBHC Support Unit, Ministry of Health
Ms Mary Swai	Snr. Health Officer, Environmental Health Division, Ministry of Health
Mr. Honest Anicetus	Health Officer, Environmental Health Division
Mr. Gideon Mwita	Health Officer, Environmental Health Division
Ms Getrude Iyatu	Executive Engineer, Ministry of water Resources, Energy and Mines

MOZAMBIQUE

Name	Position and Organization
Carlos Noa Laisse	PNSBC
Candido Cavel	PNSBC
Vincent Makamo	PNSBC
Anna Mateleza	PNSBC
Domingoes Maluarte	PNSBC
Pedro Pimentel	PNSBC
Mark Henderson	Project Officer WES, UNICEF
Dermot Carty	Consultant, UNICEF
Derek Ikin	DNA (National Directorate of Water)
Manuel Thurnhffer	DNA (National Directorate of Water)
Rowland Roome	Care International
Paulo Montiero Oscar	Country Representative, RWS –ESA
Guy Mulin	LINK -NGO FORUM
Jonas Chalufu	Ministry of Health
Mariam Pangah	Ass. Res. Representative, UNDP
Edda Collier	UNDP
Diego Milagre	Institute of Agriculture
Americo Humulane	Institute of Agriculture
Arsenia Chisano	Animator, PNSBC
Lucia Rosifina Muzime	Animator, PNSBC
Relita Lamga	Animator, PNSBC
Jose Naene	Animator, PNSBC
Manuel Macamo	Animator, PNSBC
Sofia Barbosa	Animator, PNSBC
Tomas Elia Impaia	PRONAR (Rural Water)
Teodomiro Pedro	PRONAR (Rural Water)
Eunice Mucache	Red Cross
Armado Machiana	Red Cross

UGANDA

Name	Position and Organization
Monica Kunihira	Coordinator, Water Aid
E. Bwengye-Kahororo	Asst. Project Officer, UNICEF, WES
Eric Engstrom	Technical Advisor, RUWASA
Mogens Mecht	Sector Advisor, DWD
Mr. Collins Mwesigye	Community water and Sanitation Advisor, WHO
John Odolon	Program Officer, NETWAS, UGANDA
David Mukama	Hygiene and Sanitation Specialist, RUWASA
Mr. Sam Mutono	RUWASA Project
Director	KUDEP
Tom Mwebesa	Chief Public Health Officer, Entebbe
Mr. Kisembo	Small Towns Project
Mr. Kamau	Jinja Wetlands Project

ZIMBABWE

Name	Position and Organization
Dr. Tshabalala	WHO Regional Office
Ms T. Dooley	Project Officer, UNICEF-WES
Mr. Rajibhandari	Project Officer, UNICEF-WES
Mr. S. Khuphe	Ass Project Officer, UNICEF
Dr. P. Taylor	Director, IWSD

ZIMBABWE

Name	Position and Organization
Mr. Samaneka	Tech Advisor, Save the Children (UK)
Mr. D. Proudfoot	Director, Mvuramanzi Trust
Mr. Chibanda	WHO – Country Office
Mr. George Nhunhama	National Coordinator, NCU
Ms Latiso Dlamini	Provincial Coordinator, Matabeleland Province
Mr. Lawrence Ndebele	CEO, Bubi District
Mr. J. Mutawurwa	SIDA project officer, MOH&CW
Mr. Rukasha	Principal Environmental Officer, MOH&CW
Mr. Mapuranga	Project Officer, MOH&CW
Mr. C. Chimani	Project Officer MOH&CW (NORAD)
Household members	Bubi District
J. Waterkyn	Zimbabwe AHEAD
Mr. R. Muzamhindo	Chief water Engineer, DDF
Mr. L. Nare	EHO, *Matabeleland South*
Mr. Mupa	Provincial Coordinator, Masvingo District

Annex 3: List of Organizations using Participatory Methods by Country.

BOTSWANA

Organization/Agency	Method	Tools	Purpose
MOH and MLGLH SNV UNICEF Ministry of Education Ministry of Finance (Rural development Unit) Botswana Orientation Center University of Botswana	PHEM/PHAST PRA/ PHAST VIPP/PHAST PRA/VIPP PRA PRA PRA PRA	Unserialized posters SWAG Faecal Oral Route and Faecal barriers Sanitation Ladder Mapping Task/target analysis Photo parade Pocket Chart Seasonal calendar Dr. Damuchu	• Training, situation analysis. • Baseline data and assessment • Sensitization on causes and effects • Identification of common excreta disposal systems and planning for change • Identification of patients, assess ment of health problems and for information gathering. • For analyzing community roles and responsibilities • Training and influencing attitude change • To assess family planning practices • For information gathering and planning • To create Aids awareness

MOZAMBIQUE

Organization	Method	Tools	Purpose
PNSBC	PHAST	• Pocket chart • Sanitation ladder • Three pile sorting • Faecal oral route • Nurse Felicidade • Johari's window • Resistance to Change	• To promote latrine construction. Sanitation ladder is normally used together with pocket chart. • To create awareness about good and bad hygiene behavior. • Awareness creation on causes and effects. • Training, promoting attitude change. • Training.
Red Cross	LPSA	• Mapping • Ranking of problems	• To identify community needs and problems
CARE International	PRA/RRA	• Mapping • Voting	• For problem identification. • For planning
PRONAR	PRA	• Mapping • Diagnostic rapid appraisal	• needs identification • promotion of operations and maintenance of facilities • promotion of payment for water
Institute of Agriculture	PRA/RRA	• Ranking tools • Qualitative and quantitative tools	• For training different agencies

KENYA

Method	Institution	Area Where Applied
PRA	Action Aid Africa Now CARE Lake Basin Development Authority KWAHO KENFICO KIWASAP	Project areas of Eastern /Coast Nyanza/Western Provinces
PHAST	Africa Now CARE – Kisumu KWAHO CARE – Kenya Ministry of Health	Various regions
SARAR	KENFICO Africa Now Action Aid KWAHO CARE Kenya ITDG Ministry of Health	Different regions
ZOPP/OOPP	CARE –Kisumu Action Aid Help Age KIWASAP	Siaya, Kakamega Kilifi

TANZANIA

Method	Institution	Area Where Applied
LPSA	AMREF Dar es Salaam	Rukwa, Kilombero Per-urban areas
PRA	Finland water DHV HEWASA Water Aid	Mtwara, Lindi, Morogoro, Shinyanga, Kagera, Mara, Mwanza, and Dodoma regions.
SARAR	Min. of Water/Health and Community Development. HEWASA/Water Aid/DHV WES donor funded program	Rural Areas Program areas
OOPP	Min. of Health	Local Council Level

UGANDA

Method	Institution	Area Where Applied
SARAR	Water Aid RUWASA School of Hygiene	WES project Areas Projects in rural areas All training activities
PHAST	UNICEF	WES projects
PRA/PAR/VIPP	KUDEP /UNICEF/WES	WES projects
Log Frame	UNICEF	WES projects

ZIMBABWE

In Zimbabwe, it was difficult for organizations to distinguish which method they are using since they use most of the methods inter–changeably. It is however clear that most methods used are SARAR and PHAST based. The methods that are known and are in use are PRA, SARAR, RRA, VIIP, PHAST, and Child to Child. Most of the participatory methods are applied in rural areas. In a few instances, they have been applied with the urban poor (peri–urban).

Organization	Purpose
Ministry of Health and Child Welfare	Training of extension workers, promotion of health and hygiene at community level, planning for interventions
District Development Fund	Training for community-based management, promotion and awareness of community based management.
Agricultural Extension Services	Land uses planning, environmental protection and other agricultural projects.
Ministry of National Affairs, and Cooperatives	Training, water and sanitation projects, developing con sultative based inventories.
Institute of Water and Sanitation Development	Community mobilization for development and in promot ing water and sanitation projects.
SCF(UK)	As a training approach for training participants, research, carrying out consultant work, conducting office meetings.
AFRICARE	Training, promotion of development at community levels such as food security, promotion of health and in carry ing out evaluations.
Mvuramanzi Trust	Training and promotion of hygiene and sanitation.
Zimbabwe AHEAD	Training and promotion of health and hygiene, promo tion of income generating projects
Plan International	Promotion of community management of facilities and development in general.
UNICEF	Training, material development, conducting meetings
WHO	Water and Sanitation projects, such as in the AFRICA 2000 initiative.
CAMPFIRE	Community mobilization, awareness creation for environ mental and wildlife protection
Multi–disciplinary Schools	For training environmental health technicians
CARE International	Promotion of development and environmental issues.

Annex 4: Proposed Zimbabwe Country Action Plan

PROPOSED COUNTRY OPERATIONAL, INSTITUTIONAL AND LEARNING ACTION PLANS				
Objectives	**Activity**	**Recommendations**	**Responsibility**	**Time frame**
• To develop skills in the use of participatory methods for health and hygiene.	• Training in PHE for remaining districts/ extension workers. Needs Assessment.	•Training for extension workers should be 10 days. Carry out a needs assessment.	MOH/UNICEF **Source of funding:** UNICEF/ GOZ.	1998 Ongoing
• To strengthen extension workers using participatory methods.	• Refresher Workshops.	• Training should be seen as a process. • RWSG-ESA should support the initiative.	MOH and support from RWSG-ESA. **Source of funding:** UNICEF/GOZ	
• To develop and strengthen skills in material development.	• Workshop on material development.		MOH/EDUC/ UNICEF	1998 On going
• To utilize other institutions as channels for hygiene education. •	• Consultative Meeting. • Adaptation of participatory methods for schools.	• Utilize school health masters who have background of participatory methods and knowledge of school curriculum. • Utilize local skills on material development.		
• To provide a means for quality criteria at implementation.	• Development of field guide.	• Develop a guide with clear flexibility in application.	MOH/UNICEF	
• To systematically monitor the use and effects of PHE.	• Development and adaptation of participatory monitoring tools. • Development of monitoring indicators. • There is need for clarity in what people wish to monitor.	• Develop national level and community based monitoring indicators. • Training in participatory monitoring.		
• To learn the process of PHE. • To assess the impact of PHE. • To strengthen PHE teams.	• Impact Assessment Study.	• Carry out an impact assessment study (document result).	MOH and funding partners, UNICEF, RWSG-ESA, WHO.	1999
• To strengthen networking among participatory users.	• Formation of participatory learning network.	• Form participatory Learning Network. LINK WITH PRA. ITN Center to host.	MOH: - UNICEF NGOs, WHO, IWSD. **Source of funding:** UNICEF RWSG-ESA WHO, GOZ.	1999

Annex 5: Proposed Uganda Country Action Plan

PROPOSED COUNTRY OPERATIONAL, INSTITUTIONAL AND LEARNING ACTION PLANS				
Objectives	**Activities**	**Recommendations**	**Responsibility**	**Time frame**
• Institutionalize participatory methods at • MOH, MOLG and MOWR. • Sensitize the government line ministries to vote funds for participatory training.	• Advocacy for policy and decision maker.	•Needs Assessment necessary. Advocacy workshop could be part of the regional effort • Training strategy.	MOH with support from UNICEF, RUWASA, NETWAS **Source of funding:** GOU/UNICEF/ DANIDA/ NGOs/ RWSG-ESA.	1998/99
• To strengthen skills of participatory users. • To develop skills on use of participatory methods.	• TOT courses • Training of extension workers. • Train MOH staff • Refresher courses for all trained. • Conduct refresher courses for trained staff. • Make follow-up of staff programs and govt. projects.	• To conduct needs assessment to determine who has been trained, what gaps and what training.	MOH will support from partners. **Source of funding:** GOU/UNICEF/ DANIDA/ NGOs/ RWSG-ESA.	
• MOH in collaboration with sector partners to take a lead in the finalization of National Tool Kit (NTK).	• Consultative meeting • Develop a training guide • Develop an implementation guide • Production and dissemination of National Tool Kit (NTK).	• The training guide will detail possible duration, content and tolls. It should be flexible for different usage. • The field guide should be detailed, yet flexible and easy to follow.	MOH will support from UNICEF/ DANIDA/ RWSG-ESA/ NETWAS. **Source of funding:** GOU/UNICEF/ RWSG-ESA and other funding partners.	
• Introduce quality control mechanisms in implementation and training.				
• To conduct situation analysis.	• Baseline survey.	• The baseline surveys should be on sample basis, based on regional differences. • Implementation at field level should utilize baseline data.	MOH and partners. **Source of funding:** Sida/UNICEF/ DANIDA/GOU.	1998/99

Objectives	Activities	Recommendations	Responsibility	Time frame
• To provide incentives on use of participatory material.	• Study tours • Arrange certification of the training course.	• The application of participatory methods will need resources. Extension workers need resources. • GOU to explore the issue of certification as an incentive.		1999
• To identify a focal person within the Ministry.	• Appoint a participatory focal person.	• The focal person should be working with the team.		
• To provide coordination among sector partners.	• Define roles and responsibilities within the framework of participatory hygiene partners	• To utilize the PCU which was representative from other activities. • In scaling up in Uganda should tap into existing NGOs based in DWD.	M O H / M O W R MOH/MOWR **Source of funding:** RWSG-ESA	1998
• To enhance capacity of the Ministry.	• Appoint a technical support person for Participatory Methods.	• In appointing this person, tap into existing local skills capacity.	**Source of funding:** RWSG-ESA NETWAS UNICEF/ DANIDA/ MOH	

Annex 6: Proposed Tanzania Country Action Plan

PROPOSED COUNTRY OPERATIONAL, INSTITUTIONAL AND LEARNING ACTION PLANS				
Objectives	**Activity**	**Recommendations**	**Responsibility**	**Time frame**
• To develop participatory methodologies for use in schools and training institutions	• Curriculum development for training institutions and schools	• The curriculum should be reviewed as a guide and not a blueprint	MOH/MOED	
• To ensure quality and standardization of training. • To create awareness and sensitize policymakers on the need to incorporate participatory methods in national policy.	• Hold advocacy symposium for policymakers and decision makers. •	The advocacy should be part of the regional initiative.	MOH/MOED/MOWR	
• To assess what has been realized in health education and promotion through the use of participatory methods.	• Case Study	• The RWSG-ESA is seen as having a supportive role.		
• To revive the National participatory core trainers team.	• Call a meeting of the three principal collaborating ministries (MOH, MLDWA & C and MOW).	• Tanzania has been demanding for training in PHAST. Advocacy will be needed to bring all the different people on board.	Ministry of Health and collaborating partners. **Source of funding:** UNICEF/GOT/RWSG-ESA to provide technical support.	1998
	• Advocacy workshop.		MOH/ collaborating partners and ministries. **Source of funding:** UNICEF/ILO/DANIDA.	1998
• To conduct a baseline survey that will identify problems, what has been done and gaps.	• Baseline survey. • Prioritize training needs. • Prioritize districts.	• It is noted that a baseline survey will be necessary to establish the existing hygiene problems. The training, the training needs, what has been achieved and the gaps. The baseline survey is the basis by which progress will be monitored.	MOH and collaborating partners and ministries.	1998

Objectives	Activities	Recommendations	Responsibility	Time frame
• Develop skills in the use of participatory methods.	• Training of trainers. • Training of extension workers. • Training community based organization.	• It is important for the country to develop a training strategy which will detail who will be trained, how long and the content of the training.	MOH with support from collaborating ministries, core team of trainers. **Source of funding:** UNICEF/ DANIDA/ RWSG-ESA to give technical support, WHO.	1998/99 on-going process that may intensify after pilot.
• Strengthen the skills of participatory methods.	• Refresher course for those already trained in participatory methods.	• The baseline survey shall guide the refresher courses (who needs to be trained and in what?).	MOH with support from RWSG-ESA. **Source of funding:** UNICEF/WHO/ GOT/DANIDA.	1998/99
• To develop a national participatory hygiene and sanitation toolkit.	• Pre-planning workshop before the training of trainers. • Pre-test the tool kits at community level for field application.	• The development of a tool-kit is a process. The National tool-kit gives a guide and will continue to be adapted to suit regional differences and reflect different problems.	MOH with support from RWSG-ESA. **Source of funding:** UNICEF/WHO/ GOT/DANIDA.	1998/99
• Develop an operational/implementation plan	• As a workshop output for TOT or training of extension workers they develop an *implementation* plan.	• The implementation plans should draw on the baseline surveys.	MOH	This will depend on the workshop.
• To develop skills in material development • To introduce quality control measures	• Workshop on material development. • Develop a field guide • Develop a training guide. • Define the training curriculum • Develop a training strategy. • Application of participatory hygiene at field level.	• It is recommended that the national core team of trainers and local artists to attend such a workshop. • The field guide should be detailed but used with the understanding that there should be flexibility.	MOH, core team of trainers. **Source of funding:** UNICEF/ DANIDA/ GOT/ support from RWSG-ESA. MOH/ core national team, collaborating partners e.g. UNICEF/ RWSG-ESA. **Source of funding:** UNICEF/ DANIDA/ ILO/ GOT/Technical support from RWSG-ESA.	1999 After piloting, quality control measures may be implemented.
• To select an area for piloting the use of participatory methods for hygiene and sanitation.	• Monitoring of the process and changes.	It is recommended that Tanzania start with a pilot area which will be monitored and used as a case study for scaling up.	MOH **Source of funding:** UNICEF/ILO/ DANIDA.	1998

Objectives	Activities	Recommendations	Responsibility	Time frame
• To develop monitoring systems for participatory hygiene.	• Develop monitoring indicators. • Workshop on participatory monitoring • Adapt and develop participatory tools for monitoring and evaluation. • Design MIS for use by collaborating partners and ministries.	There is need to monitor both the process and the impact. The national level may consider developing their own indicators with the local level developing another set of community based indicators. The community based indicators will feed into the national monitoring system.	MOH **Source of funding:** UNICEF/GOT/ ILO/ DANIDA/ RWSG-ESA.	The process may start as soon piloting starts but will be refined when scaling up takes place.
• To promote coordination among sector agencies.	• To form a sector collaborating committee. • To define the operational framework for the committee. • Define roles and responsibilities. • Identify and develop a database of users. • Exchange experiences on the use of participatory methods. • Facilitate exchange visit.	• There already exists a framework of sector collaboration and coordination which is enhanced by the decentralization process. However, it is necessary for a lead agency to show commitment and willingness to take action.	MOH	1998
• To strengthen capacity of the Ministry of Health and collaborating ministries.	• Identify and appoint a focal person that will be attached to the ministry.	• This is a technical assistant position which will be for a limited period.	MOH/RWSG-ESA and UNICEF will assist. **Source of funding:** RWSG-ESA/ WHO/ UNICEF.	1998/99
• To review the use of participatory methods based on pilot experiences.	• Review workshop. • Recommendations on scaling up.	• A pilot time frame of six months is recommended.	MOH **Source of funding:** UNICEF/ DANIDA/ ILO/ RWSG-ESA.	Will depend on the pilot period.

Annex 7: Proposed Kenya Country Action Plan

PROPOSED COUNTRY OPERATIONAL, INSTITUTIONAL AND LEARNING ACTION PLANS				
Objectives	**Activity**	**Recommendations**	**Responsibility**	**Time frame**
• Organize a meeting to review the role of PALNET. • To provide forums for PALNET members to exchange ideas and map out strategies for strengthening participatory methods.	• Hold a meeting. • Hold symposium for reflection and exchange of idea.	• Urgency of the meeting is important before members loose sight of the Networks role.	PALNET committee members.	Aug.– Sept. 1998 1998-99
• Provide skills to trainers on the use of participatory methods. • To enhance skills on the use of participatory methods.	• Training of participatory monitoring and development of indicators. • Training of trainers. • Extension workers, others and CBOs. Conduct refresher courses.	• There is need for a defined duration		
• To provide a stadardized prototype toolkit and develop material for use	• Revise the existing Baringo PHAST toolkit.	• This should be seen as a continuous process.	MOH/PALNET members Source Fundings NGOs/UNICEF/ Sida/GOK	1998/99

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