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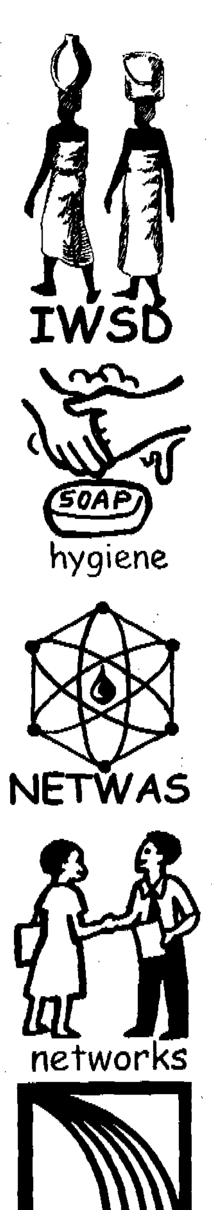
Participatory Approaches in Hygiene & Sanitation/ PHAST

Regional Workshop Report



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10 - 12 November, 1998

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This is an original report compiled from discussions and decisions at the
Participatory Approaches in Hygiene & Sanitation Regional Workshop.
The draft report was widely circulated for inputs and comments to all designated participant focal points in each country as well as to other stakeholders in the Region and beyond.
Ms Regina C. Faul-Doyle, with the review of the PH&SR Workshop Facilitation Team
and designated Country Focal Persons, wrote this report and provided the graphic design.

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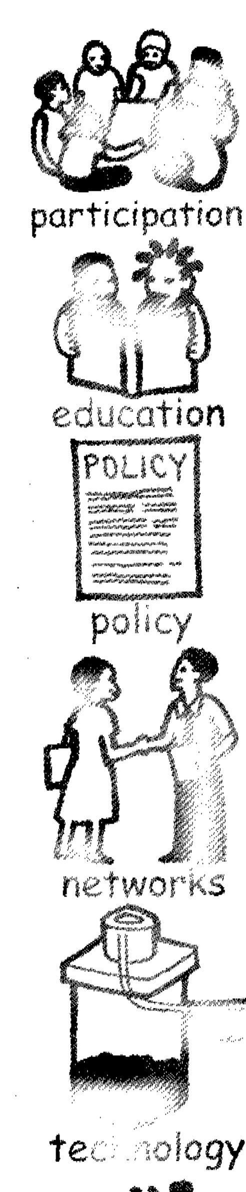

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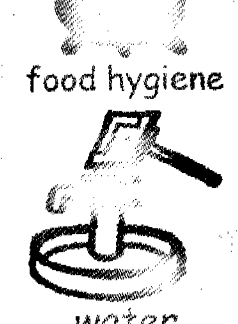

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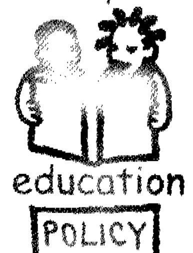
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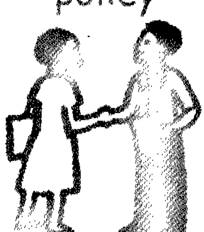
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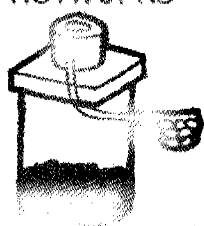
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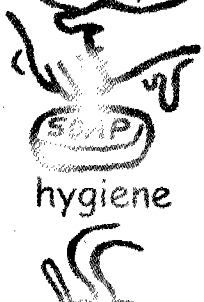

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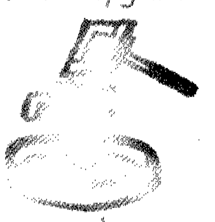
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Acknowledgements

The Workshop Facilitation Team thanks all individuals, organisations, donors and governments who made this Workshop possible. Genuine participation on the part of all contributors and attendees helped set the pace in finding a positive direction for hygiene and sanitation in the Region.

Our acknowledgements go to:

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The governments of Botswana, Kenya, Mozambique, South Africa, Swaziland, Tanzania, Uganda and Zimbabwe; Non-Governmental Organisations such as Africa Now International (Kenya), Intermediate Technology Development Group (Kenya), Mvula Trust, Mvuramanzi Trust and RUWASA Project (Uganda); and the Bi-Lateral Organisations of DANIDA, DFID, Irish Aid and Sida for sponsoring the appropriate level and number of participants who made the workshop a success.

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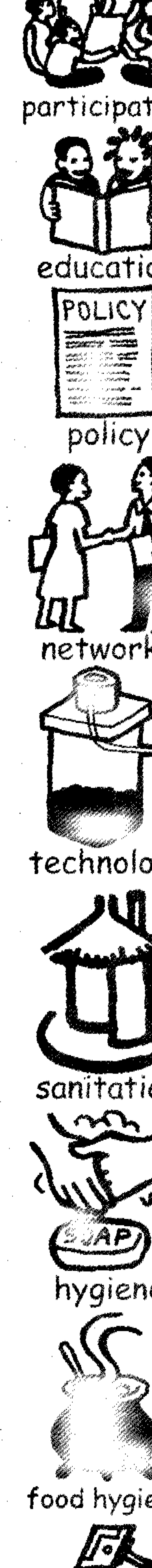

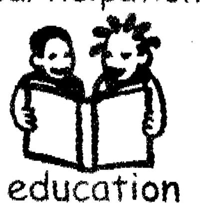

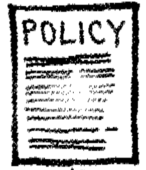

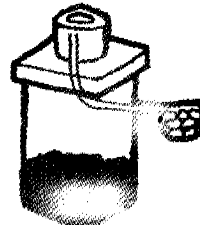

Preface

The days of providing water, sanitation and hygiene services to communities without their involvement in all aspects of planning, implementation and monitoring are thankfully, long gone. Outbreaks of democracy across the world and increasing shifts by governments towards decentralised systems, parallel and reinforce the rise of participatory approaches in development.

We know that where they are supported by political will in power-sharing and provided solid grounding in participatory training to manage their own systems, communities prove more than capable of discovering, deciding what is important, making plans and choosing what to do about their own situations. In these austere times of shrinking economies it also makes more and more sense to let communities themselves manage what few resources are available from local, government and donor sources.

Just as water has been a traditional entry point for other health initiatives into the hearts of communities, participatory hygiene and sanitation programming is already promising to become a successful entry point, not just for health but for broader development initiatives. Once properly understood, it is not difficult for people to see and accept that hygiene and sanitation is central to overall community and individual health. And once the concepts of participatory planning are grasped it is a natural step to use the same methods in dealing with other aspects of health, with poverty alleviation, environmental management, agricultural development and other sectors.

Time is the most expensive commodity necessary for ensuring that communities take up participatory methodologies in a lasting manner. But short cuts in the process of assessing people's knowledge, attitudes and beliefs, opportunities and constraints and of behavioural change can turn "participation" into "manipulation". But if we take the time to fully involve all stakeholders, the exponential health returns for the Region will make all the time invested in participatory methodologies for hygiene and sanitation worth the effort.

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Executive Summary

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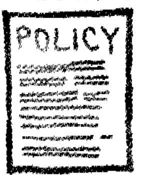

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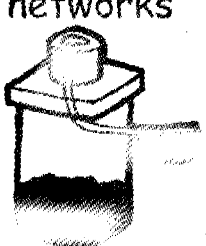
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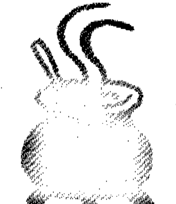
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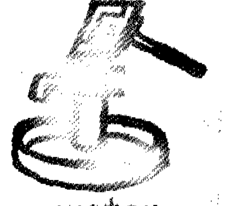
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Participation is essential to sustainable improvements in hygiene & sanitation

It is generally accepted in the Region that participation is essential for sustainable development. More needs to be done in advocacy, financial and technical support, monitoring and evaluation, networking and capacity building. But limited documentation, personal community-level experiences and our intuition tell us that this is the way to significantly advance health and development.

Participatory approaches are uneven but experience exchange is vital

Although enthusiastic about the use of participatory methodologies, countries such as Botswana, Mozambique and Tanzania are only just beginning to use it to promote hygiene and sanitation. Kenya, South Africa, Swaziland, Uganda and Zimbabwe still need support but are further along in establishing themselves. However all countries agree they will benefit significantly from an ongoing exchange of Regional experiences.

There is common enthusiasm as well as common Regional need for support

Each individual country needs specific supports. But overall they agree that funding for capacity building and regional level support, tools for advocacy and networking and technical support to develop policy, monitoring and evaluation indicators are needed. Everyone must document programming more strongly, develop and use better process and impact indicators, and continue advocacy at all levels.

PHAST is seen as both an initiative and methodology

PHAST is used by some in its "pure" form. Others use participatory methodologies to promote hygiene and sanitation, without using the term "PHAST". As an initiative it has been instrumental in focussing support for hygiene and sanitation where previous methodologies were too broad. As a methodology PHAST is seen as a core "kit" of tools borrowed from earlier models. It is being broadened to include more methodologies for hygiene and sanitation, and has the potential for adaptation at community level to address other development challenges (e.g. malaria and AIDS control).

Credit needs to be given where it's due

A guiding principle in developing and documenting participatory methods should be to openly acknowledge our sources. We recognise that in this field we build on and synthesise other's experiences to develop new tools, activities and programmes. Giving credit to governments, institutions or individuals encourages the sharing of experience, information and collaborative programming.

A Regional Task Force and additional workshops will strengthen programming

Under the direction of the member countries and supporting donor agencies and institutions, a Regional Task Force will be established. Its objectives will be to assist countries in meeting their stated individual and common needs as above. The Task Force will provide a "center" for the furtherance of participatory approaches in hygiene and sanitation promotion.

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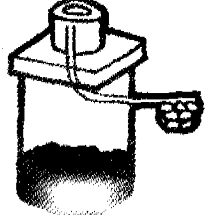

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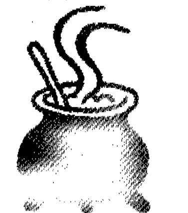

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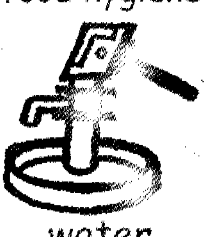

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Introduction

Background to participatory methods

Participatory methods in water and sanitation are not entirely new. Over the past twenty years they have been increasingly used by the sector to promote community involvement in planning, implementation, operation and management. Among other methods used have been PRA, RRA, VIPP, LEPSA, SARAR and DELTA in varying degrees of application.

What is new is PHAST, Participatory Hygiene and Sanitation Transformation. Whereas many other methodologies were developed for use in a wide variety of development programmes, PHAST was developed specifically to promote a transformation in sustainable hygiene behavior change and to improve sanitation. It was based on the principles of SARAR (Self-esteem, Associative strength, Resourcefulness, Action-planning and Responsibility), piloted under PROWESS through UNDP/WB.

The advancement of PHAST

As a programme PHAST started in 1993. Building on the participatory experiences of its partners (Government Ministries, NETWAS, IWSD, UNICEF-ESARO and Country Offices, Sida, DANIDA, FINNIDA and NORAD as well as many NGOs and other agencies), RWSG-ESA / UNDP-WB (WSP) and WHO looked at different participatory methods in active use. With advice from widely experienced colleagues in the field, tools and techniques were specifically adapted and "packaged" to encourage the participation of women, men and children in the promotion of their own improved hygiene and sanitation behaviours. PHAST required the training of local extension workers to be directly involved with communities and to use recommended pre-packaged "tool kits" of materials often adapted to suit different cultural situations.

PHAST was tested in six pilot-programme countries for six months between 1994 and 1998. In Botswana, Ethiopia, Kenya, Mozambique, Uganda and Zimbabwe, opportunities and constraints to the "New Approach to Working with Communities" were documented, the step-by-step Guide for rural and urban settings was tested and a PHAST promotional video was produced.

The Prospective Review of Participatory Methodologies

Information from the PHAST pilot programmes and countries where other methods were being used seemed to indicate that participatory methodologies were able to move hygiene and sanitation forward in a sustainable way. To confirm this and to determine if PHAST and other methods could indeed be "brought to scale" (reproduced nation-wide in pilot countries and supported in others) a Prospective Review was undertaken in March and April of 1998. The review intended to assess the effectiveness of participatory methods on hygiene behavioral change to look at what would be needed to strengthen their use in government-sponsored water and sanitation programmes.

The Governments of Botswana, Kenya, Mozambique, Uganda and Zimbabwe (where PHAST had been launched), and Tanzania (where other participatory methods were already in use), UNICEF, Sida, DANIDA, NORAD, local and international NGOs and WHO and WSP-ESA supported the Prospective Review. IWSD Harare, Zimbabwe and NETWAS International, Nairobi, Kenya, conducted the Review.

The Prospective Review (full details of which are available in a separate report) revealed that health, hygiene and sanitation needs in the Region are still high. However, participatory methods of all sorts are gaining more and more popularity, particularly because once implemented properly they are generally well understood and they have already been or have the potential to be applied to sectors beyond hygiene and sanitation.

The Participatory Hygiene & Sanitation Workshop

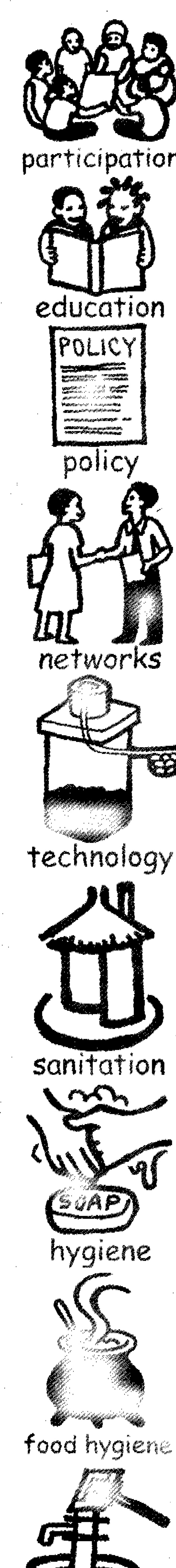
This workshop followed the Review as a way to share its findings and map the way forward for participatory hygiene and sanitation in Eastern and Southern Africa. Representatives of eight countries in the Region came together to share their experiences and discuss ways to scale-up, broaden, disseminate and enhance the quality and impact of participatory hygiene and sanitation in their own countries and in the Region.

Specific workshop objectives were to:

1. Share outcomes from the Regional Prospective Review.
2. Map out strategies for the way forward at country and Regional levels.
3. Identify mechanisms in support of future participatory hygiene and sanitation initiatives.
4. Identify strategies for partnership among collaborating agencies.

Expected workshop outputs included:

1. Compiling lessons learned from the Regional Prospective Review for use in further enhancing and disseminating participatory hygiene and sanitation methods.
2. Developing operational strategies and guidelines at country and regional level.
3. Identifying support needed for country and regional operational strategies and guidelines.
4. Defining strategies and principles for partnership among collaborating agencies.



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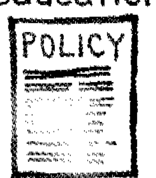

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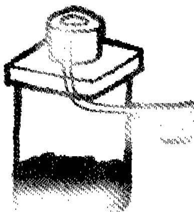

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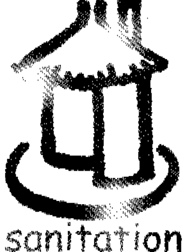

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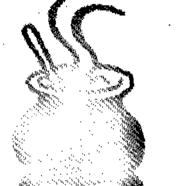

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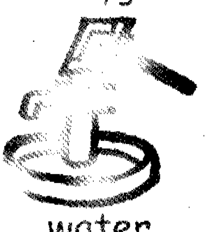

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Conclusion of the Workshop

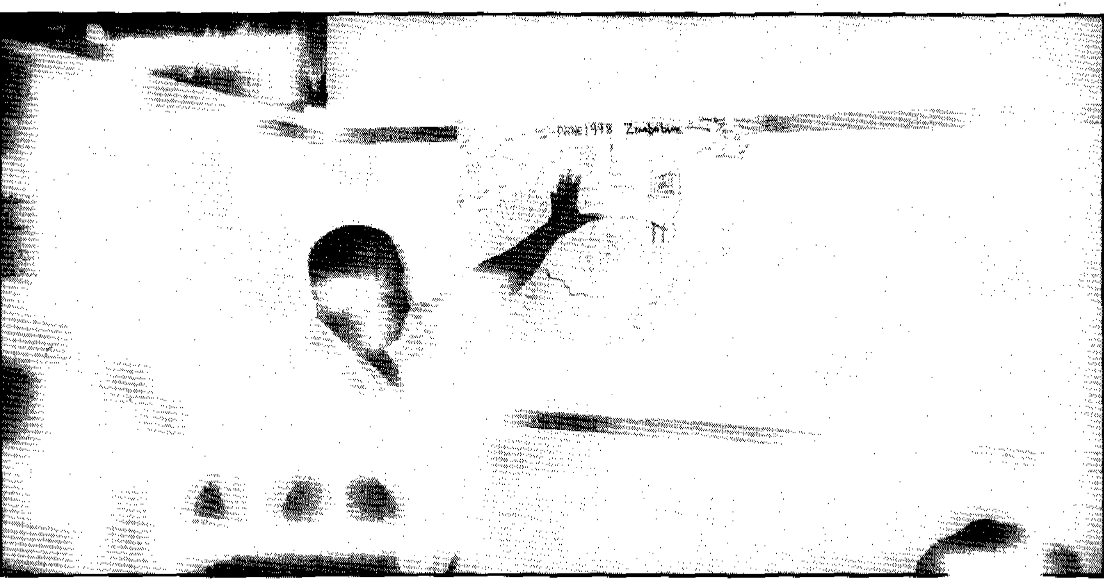
Participatory Approaches in Hygiene & Sanitation/ PHAST: the Way Forward

The workshop concluded with plans for the future at both country and regional levels.

Country level

All representatives of countries who attended the Workshop agreed that in order to move forward in the promotion of participatory approaches in hygiene and sanitation/ PHAST they would:

- Identify resources within their own country in terms of technical support to the sector (policy, materials and curriculum developers, artists, trainers, etc.) in order to begin building a local knowledge base
- Begin documentation of past and current experiences and ensure that documentation is an ongoing and integral part of future participatory hygiene and sanitation/PHAST programmes
- Designate one or two temporary country contact persons from the Workshop to serve as a focal point(s) for the Region, to establish a Country Task Team where needed and possibly serve as member of the Regional Task Force
- Inform colleagues, network partners and others in the sector to the highest level possible of the outcomes of this Workshop at ongoing fora
- Meet with in-country groups responsible for national programming to advocate for the inclusion of participatory hygiene and sanitation/PHAST initiatives/methods, starting with tentative Plans of Action developed at this Workshop (which may not be synchronised with various existing plans)



Regional level

Representatives of regional agencies and institutions which support participatory approaches in hygiene and sanitation/PHAST (IWSD, NETWAS, UNDP/WB (WSP-ESA), UNICEF, WHO) at the request of country delegates present agreed to form a Regional Task Force and plan for the next Workshop. This will be done in a participatory manner in that drafts of documents, agendas or plans for the RTF and workshop will be circulated among regional as well as designated country focal points for inputs and suggestions.

Form a Regional Task Force

- Draft a mission statement, terms of reference, outline of the operational strategy and work plan for the Task Force
- Circulate draft of above and prepare for discussion and adoption at the next Participatory Approaches in Hygiene & Sanitation/PHAST workshop

Contact countries/organisations that did not have representatives at this Workshop

- Send workshop report and otherwise keep other countries (Angola, Burundi, Eritrea, Ethiopia, Lesotho, Madagascar, Malawi, Namibia, Rwanda, Somalia, Sudan and Zambia) and agencies (AWG, EADC, SADC, Sida and others) informed of participatory approaches in hygiene and sanitation matters

Facilitate a second Participatory Hygiene & Sanitation/PHAST Regional Workshop

- Determine funding sources, designate consultant to draft and circulate agenda (to be more focussed on sharing country experiences) and issue invitations tentatively for April 1999, possibly in Swaziland or Botswana

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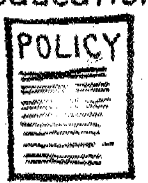

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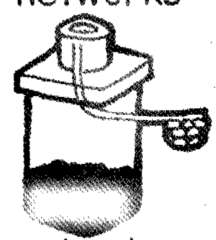
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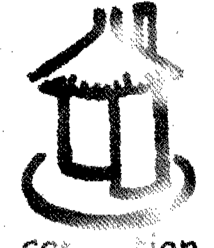

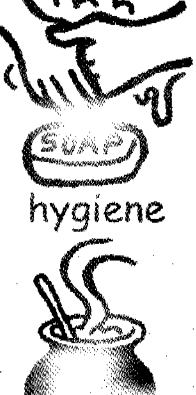

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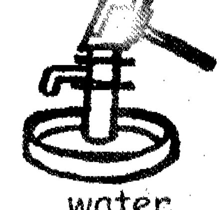
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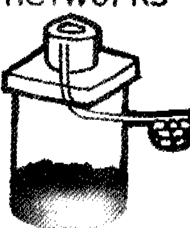

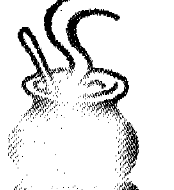

Putting Participation in Context

Shared beliefs: a fundamental starting point

Both at this workshop and beyond, a question needed to be asked at the beginning: are participatory approaches worth moving forward or scaling-up?

It was unanimously agreed, based on scientific research and collective work experience, that there is a strong link between improved hygiene and sanitation practices and behaviours, and better health. This fundamental idea underlies the use of participatory methodologies and all our work. More critically, the use of participatory methods in promoting improved hygiene and sanitation practices are key to community level understanding, acceptability and sustained positive behavioural change.

Our shared beliefs

- People are not only made poor, but they think of themselves, and others think of them as being poor if they don't have access to water supply and sanitation.
- Diseases related to poor water, sanitation and hygiene are major causes of sickness and death in the world, especially for children.
- Hygiene education greatly improves the health impact of water and sanitation interventions, whereas providing water alone has little or no impact. Knowing this, the cost of hygiene programmes may at first seem high, but are really reasonable in proportion to their enormous benefits.
- Community mobilisation and response to community demand are critical for the effectiveness and for the sustainability of rural water supply, hygiene and sanitation programmes.
- Participatory methods for hygiene and sanitation promotion are an effective way to help communities and households to mobilize, plan and carry out their own improvements.
- True participation is where decisions are genuinely made by the community and not programme-led. As well, communities are not homogenous so it is critical to ensure that participatory processes actually promote equity in decision-making by all social, economic, gender and other segments in a society.

Where We Are Now: A Big Picture of the Region

From a summary of countries represented at the workshop there is some level of staff and community level training and implementation everywhere, although it ranges greatly. Most countries are still struggling to influence or improve the implementation of policy, build capacity, advocate at all levels, develop participatory networks, coordinate programming and adapt tools.

From the Regional Prospective Review we know that health and sanitation needs in the Region are still critically high, however a wide range of participatory methods are being used in an effort to meet those needs. From both the Review and this workshop, participatory methods are generating enthusiasm wherever they are tried, winning converts and being adapted to suit needs beyond the hygiene, sanitation and water sector. There have been some inklings of "success" along the way where behaviours, such as hand washing and water storage practices, have improved as a result of participatory hygiene and sanitation education.

A great self-admitted weakness is in **documenting programme experiences.** Monitoring and evaluation is critical in order to refine strategies, find sponsorship for more pilots, to learn from past experiences and to provide the hard evidence needed to broaden the programmes nationally and Regionally.

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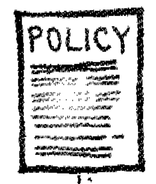

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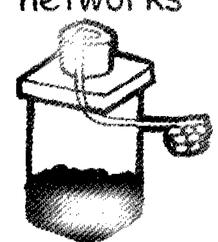

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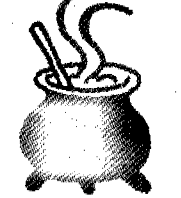

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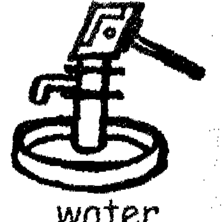

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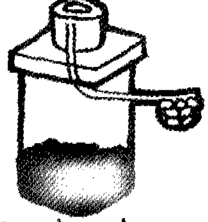


SOAP

hygiene

Where we are now: Country Snapshots

Botswana

In the "pilot" stage of PHAST with eight trainers, 36 facilitators and one artist trained thus far. Using PHAST to enhance sanitation and hygiene behaviour at community level but already starting to adapt PHAST for water and agricultural promotion.

Kenya

Different Ministries, NGOs and other agencies using PHAST in 20 Districts for water, sanitation and hygiene promotion in refugee camps, rural communities and urban slums. PALNET established and used to share participatory learning experience countrywide. Tools being adapted for use in malaria and STI (sexually transmitted infection) control programmes because of their significance to health and because of funding opportunities.

Mozambique

Has a policy for water but none for sanitation. Low political will for participatory methodologies in hygiene education, very few extension workers available, coordination between Ministries weak and participatory approaches little used in the country. Though Ministry of Health responsible for low-cost sanitation programming, not involved in participatory initiatives. Communities themselves lacking cohesiveness due to displacement during war. Use of methods limited to different individual activities. However, new interest in participatory methodologies since Zimbabwe team visit

Swaziland

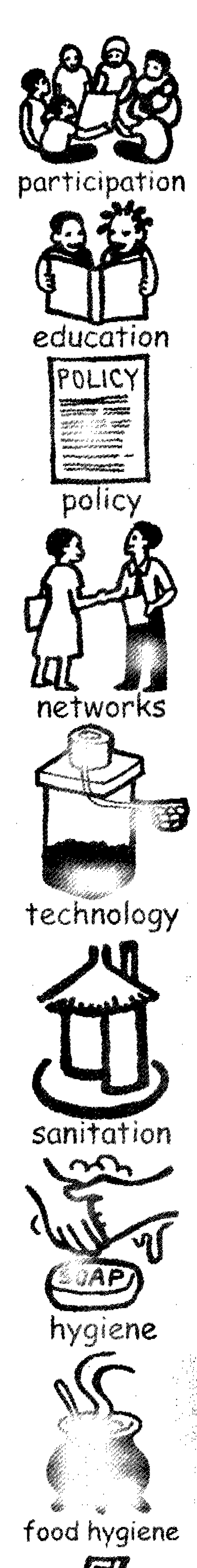
PHAST incorporated as national sector policy initiative for hygiene education. This policy along with formation of core team to carry out advocacy and sensitisation are helping to support school hygiene programmes, ongoing community training and tools development. Baseline studies being conducted in ARI, EPI, CDD, water supply and sanitation.

Tanzania

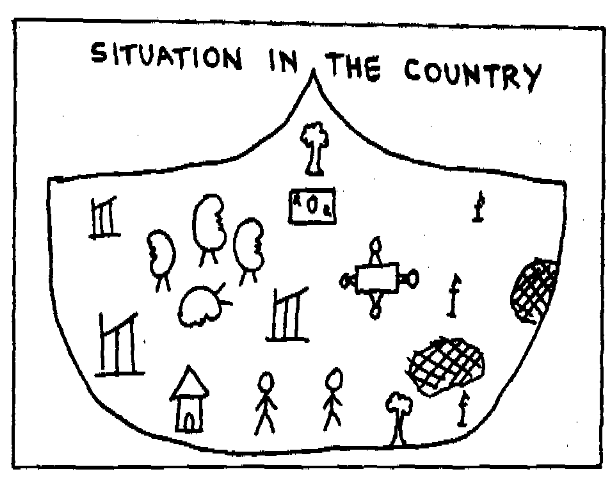
Only 25 trained staff to cover 34 Districts (and 30 million people). Inadequate data and information on hygiene and sanitation and capacity at District level. Low motivation and dominating leadership style hinder participatory approaches but enthusiasm is building slowly. Where participatory methodologies used, applied to general development, not specifically for hygiene and sanitation.

Uganda

Relatively long use of participatory methods as well as use of PHAST since its inception. Network of partners for advocacy, training, implementation, monitoring and evaluation established in Environmental Division, Ministry of Health. Committed national core team, well-established local councils, supportive water and gender policies, training institutions available for service providers, donor support and NGO collaboration available.

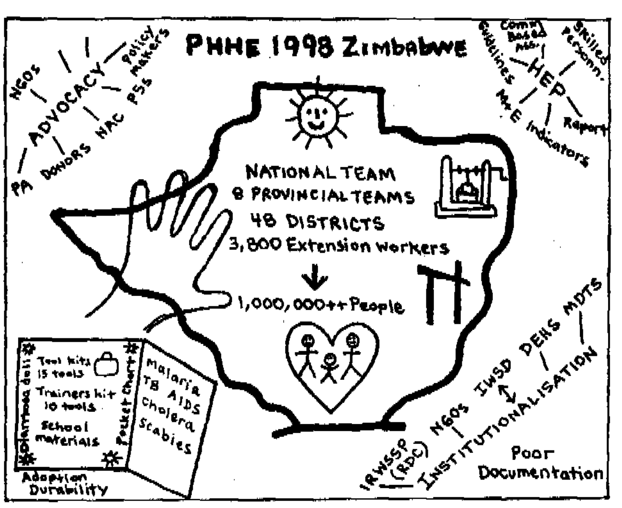


Focus on South Africa



South Africa is actively using PHAST to promote participatory hygiene and sanitation after Zimbabwe planted the initial seeds. They describe their situation as a "mixed masala" of capacity in terms of experience and support. They have held a workshop for artists who develop the tools and have ongoing cascade training for trainers throughout several Provinces with some follow-up. So far around 188 trainers have been trained and there is a PHAST Team established with members elected by Provincial Sanitation Task Teams. It is proving to be popular with communities who readily grasp and use its concepts. Some communities have already begun to use PHAST as an entry point for other interventions. The lead institutions in the implementation of PHAST are NGOs such as Mvula Trust and others.

Focus on Zimbabwe



Participatory methodologies are in wide use in Zimbabwe for hygiene education, although the term "PHAST" is not. A strong National Team and 8 Provincial Teams have been established to promote participatory hygiene education. 3,800 extension workers have been trained and cover 48 out of 57 Districts, reaching over a million people. Good advocacy has encouraged NGOs, donors, government up to parliamentary level and others to support programming. A variety of materials have been developed (a kit of 15 tools and 270 pictures so far) which are constantly being adapted such as for diarrhoea, malaria, AIDS and scabies prevention. Indicators of the success of hygiene education have been the noticeable change in behaviour from hand washing using a basin (which used to be the norm) to run-to-waste hand washing in many areas. And in some areas incidences of scabies are dropping. Partnership is strong within the country and Zimbabwe is finding itself becoming a resource centre for others in the region.

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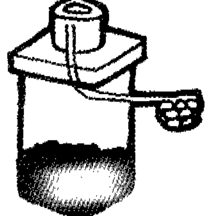
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Where we want to be in PH&S: A Big Picture of the Region

In general the Region wants to spread and use PHAST and other participatory hygiene and sanitation methods and initiatives farther and wider in each country in an effort to improve health. The ideal is to have it "institutionalised" (used on a day to day basis) in rural communities, schools, training institutions and service providers, government, NGOs, CBOs and donor agencies.

This entails increased and improved training for trainers and extension workers, better materials and tools, regular use of evaluations (to promote learning and experience exchange of "best practices"), implementation of policies, guiding principles and other supports. There is also a general desire that these participatory methodologies can be expanded or adapted for use towards improvements in other health and development sectors.

Where we want to be in PH&S: Country Snapshots

Botswana
Would like to adapt PHAST methodologies to promote AIDS, malaria and TB prevention, train more extension workers, expand into school health clubs, establish training teams, review the pilot phase, develop guidelines for lower level trainers

Kenya
Would like to expand PHAST into more rural/urban (slum) areas and have it included in a national sanitation policy, expand the core training team, and institutionalise PHAST into the curricula of water, health and teacher training institutions.

Mozambique
Would like to increase community demand and use of PHAST to reach fifty per cent sanitation coverage in peri-urban areas and obtain water, sanitation and hygiene services for clinics and schools and for education in schools.

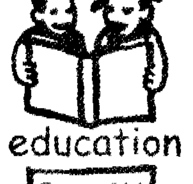
South Africa
Would like to increase the use of PHAST to enable communities to continue improvements in their sanitation, hygiene and water situation. They would like to see a participatory community-based decision-making approach replace the dangerous trend in unsustainable government subsidies and private company-led implementation of sanitation facilities in the country.

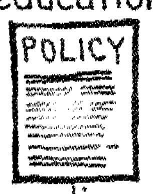
Swaziland
Would like to use PHAST as a tool for water, agriculture, sanitation, HIV/AIDS prevention and in school curriculum.

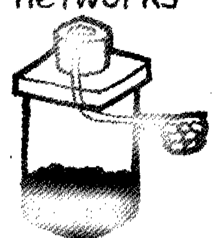
Tanzania
Want to generally strengthen knowledge and use of PHAST throughout Tanzania: its capacity, "service delivery" of materials and guidelines, information management system and advocacy.

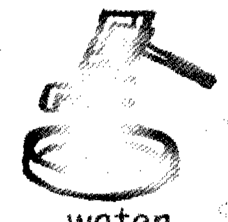
Uganda
Want to find a more permanent "home" for PHAST, develop participatory policies for hygiene and sanitation, strengthen service delivery staff capability, provide better support supervision, develop monitoring indicators and establish clear follow up and M&E.

Zimbabwe
Would like to cover more Districts (90 per cent by 2003), train more extension workers (up to 5,000) and cover peri-urban, urban and resettlement areas and schools to serve 5 million people with participatory health and hygiene education. Would like to institutionalise participatory methods in NGOs, teacher and nursing colleges and in Municipalities.









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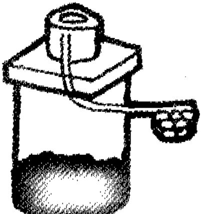


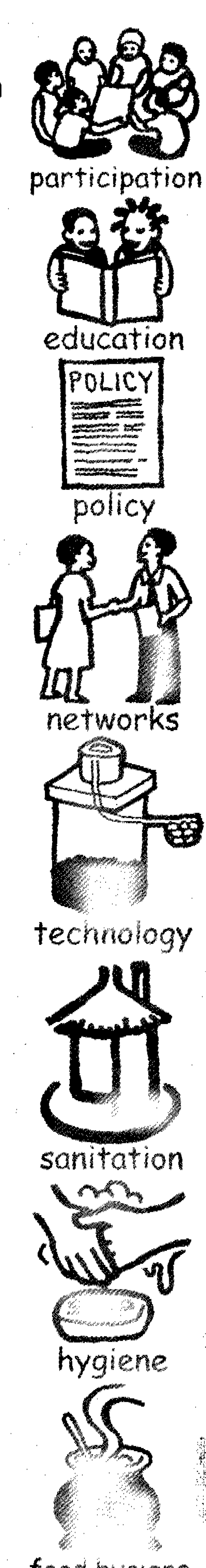
Outcomes of the Workshop

Getting where we want to be: A Big Picture of the Region

Countries at the workshop summarised common priorities to provide a partial picture of the Region's needs:

- **Advocacy** - need to continue, expand and accelerate at all levels from community to government and externally at every opportunity to generate support and use of participatory hygiene and sanitation methods and initiatives
- **Facilitators** - need to expand the core group, improve skills and follow-up with refresher training to build confidence and encourage active involvement with communities
- **Monitoring and Evaluation** - need to develop indicators relevant to communities and other stakeholders, establish and implement systems
- **Focal points** - need to appoint a person or group to act as coordinator for participatory hygiene and sanitation in each country and Regionally
- **Inter-sectorial promotion** - need to advance participatory methodologies and initiatives in other sectors
- **Tools development** - need to adapt and improve local and national level materials for the promotion of hygiene and sanitation
- **Curricula development** - need to create or adapt materials necessary for "*institutionalisation*" at all levels
- **School-based promotion** - need to develop strategy, policy, tools to expand participatory hygiene and sanitation into schools
- **Documentation** - need to conduct case studies, reviews and evaluations and in other ways report successes, lessons learned and obstacles for all aspects of participatory hygiene and sanitation initiatives
- **Regional networking** - need to develop a regional task force (the process, not a physical centre or event) to provide supports for all the above issues at regional level

Getting where we want to be: Country Snapshots



Botswana

Seek additional support, possibly from Red Cross. Advocate at existing quarterly institutional meetings and otherwise generally find ways to mobilise additional funding for programming.

Kenya

Document more case studies, develop a baseline impact survey of PHAST and develop sanitation policy and cross-cultural tool kits for trainers. Continue to strengthen partnerships among government, NGOs and other PHAST users through PALNET and set up forum to advocate for sanitation and hygiene at ministerial level.

Mozambique

Need stronger advocacy for government and private sectors; establish a consultative process at all levels; develop master plans for establishment and implementation of hygiene policy. Develop materials, expand training and attempt to break down the "silo" (vertical) approach between Ministries.

South Africa

Continue to develop/implement advocacy strategy to move PHAST forward at project, district, provincial levels. Ensure ongoing process of documenting field practices, developing field-level indicators, securing support for additional pilot projects (probably from AusAID). Use this to prove that participatory methodologies are more sustainable/ appropriate for SA than subsidies for sanitation and hygiene.

Swaziland

Need to place hygiene high on national agenda through implementation of policy, continued advocacy and commitment from partners. Need additional training and must review existing methods in use.

Tanzania

Needs to appoint focal point for PHAST in Ministry of Health, run refresher courses, develop a national strategy, project proposals, tool kits and M&E indicators. Continue advocacy to gain political will, build on existing participatory programmes, strengthen partnerships with NGOs, CBOs and private sector.

Uganda

Continue advocacy, documentation, support supervision, monitoring and evaluation in support of resource mobilisation for programme expansion.

Strengthen programme documentation; get established reporting format in active use to continue support, expand coverage. Develop guidelines and policy on participatory methodologies, disease-specific tools, field guides, school-health (including child-oriented tools and teacher training materials). Continue training, retraining, follow-up.

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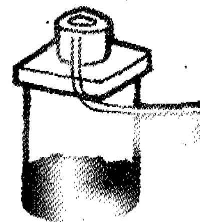
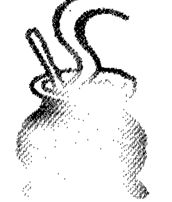
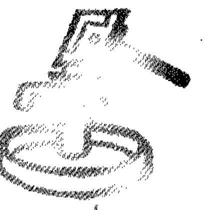






Opportunities and constraints: A Big Picture of the Region

A clear picture emerges from sharing country experiences at this Workshop and from the Regional Prospective Review. Participatory methodologies and initiatives are powerful ways to promote awareness and understanding, empower, mobilise and create expression of demand for improved hygiene, sanitation and health behaviours and facilities at community level.

Our collective experience contains many lessons in implementing participatory hygiene education. One can view these as "constraints" in reaching genuine participation or, more optimistically, see them as "opportunities" to fundamentally change the way institutions, governments and communities interact.

Participatory hygiene and sanitation needs a high level of collaboration, commitment, coordination, policy, planning and funding among the actors who work directly with communities.

Without this, it may be impossible to go to national scale even with successful pilots. An opportunity is that the introduction of participatory approaches can provide a starting point to strengthen institutional collaboration/coordination and provide policy direction where it does not exist. And where pilot programmes are well documented, they can help provide the necessary commitment and generate interest for finding.

PH&S is "labour intensive" in staff-days per community and can be "inputs intensive" for tools and support materials.

Participatory methodologies don't absolutely require materials "tool kits" but community-level staff time and quality, repeat training are critical. Advocacy opportunities come in documenting and evaluating impact costs. Investors seeking "value for money" may find greater initial investments for participatory methods compared to traditional didactic ways, but the end result (sustainable hygiene & sanitation practices and improved household health) are worth the inputs.

Field workers using participatory hygiene and sanitation methods require high-level skills and training.

Interactive rather than one-way transmission of information skills are demanding and must be available at community level and adapted to suit local conditions. As well, attitudes as well as skills and practices need improvement. But such skills are transferable to other sectors which go a long way towards "institutionalising" participatory methodologies.

Rare skills and tools are needed.

Not only to sensitise and train communities but to develop and adapt participatory training and teaching materials. This requires specialised training for trainers and materials developers. Again the opportunity is that once the skills and tools have been developed, they can serve as an entry point for other interventions.

Participatory hygiene and sanitation programmes need to be coordinated with service delivery programmes.

This is important because once participatory ideas take root, demand is generated and communities naturally expect immediate help in implementing their plans. At the same time, what ought to come out from such initiatives is that in some cases communities should reduce their dependency on government and others and where possible become more self-reliant. Where coordination between service delivery programmes is poor, there is an opportunity to create linkages with careful strategies to include multi-sectorial involvement.

Key guiding principles

Key guiding principles in the area of participatory approaches in hygiene and sanitation were discussed and will be used as the basis for future programming and the work of the proposed Regional Task Force.

Advocate

- **In countries**, advocacy should be carried out at all levels principally with communities using existing and specially created channels as needed
- **At Regional level** advocacy should be aimed at governments, regional economic and political bodies and among external support agencies and other institutions beyond reach of government extension workers

Collaborate and coordinate

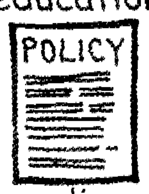
- **As much as possible** prior to entering the community there should be coordination of programme planning with service delivery, training and materials production activities
- **Partnerships** should be established to broaden support for participatory initiatives and methods
- **Networks** need to be established and existing fora used for participatory learning and experience exchange

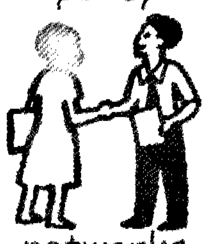
Monitor and evaluate

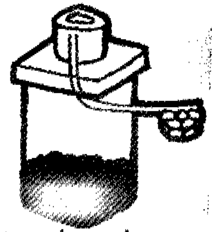
- **M&E** should be "institutionalised" at all levels, including in the community
- **Process and impact indicators** should be developed with participation of communities and should be meaningful and useful to them
- **Impact evaluations** need to be developed and carried out, not only to improve programming but to allow inter- and intra-sharing of experience and provide support for national level decision making for policy, strategies and resource allocation

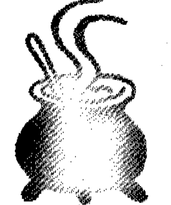
Develop policy

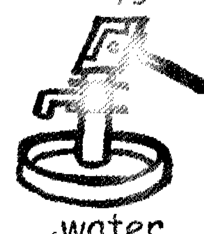
- **Policies** are needed which encourage and support participatory approaches











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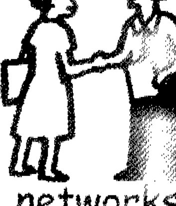

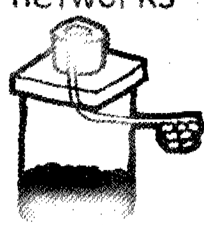

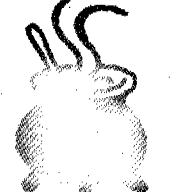

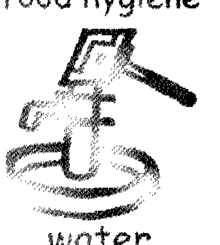

but which are flexible enough to change as programmes progress (e.g. not locked into prescribing specific tools)

Adapt tools

- **Ensure that materials** used in participatory hygiene and sanitation education are locally relevant (are sensitive to cultural, religious, gender, economic, physical needs and situation)
- **Search for ways to make materials**, especially for community level as durable and as creative as possible
- **Give credit** to the originator of materials and ideas adopted/adapted where credit is due

Ensure quality of facilitation

- **Training, monitoring and evaluation** of extension workers, trainers, programme developers, etc. should emphasise attitude as much as skills
- **Skills** should include listening, asking questions, remaining neutral, building agreement, etc.
- **People who have been trained** must be "followed-up" (contacted, visited or observed in the field) relatively soon after training and on a regular basis not only to determine refresher training needs but to build confidence in trainees to implement their skills

Build genuine community participation, ownership & empowerment

- **Build** on the existing knowledge, positive cultural beliefs and practices, skills and structures of communities and cultures where they advance hygiene and sanitation practices
- **Respond** to communities felt needs wherever feasible
- **Ensure** that all "stakeholders" (people with a vested interest in the programme or activity) are consulted at all levels by gender, social, economic, urban/rural status

Establish a process, not an event

- **Participatory hygiene and sanitation** methodologies and initiatives require time to create awareness, build capacity, form consensus & partnerships, refine methods/tools and follow-up after training to build confidence

Coordinate with service delivery

- **All anticipated community support groups** need to be aware of participatory hygiene and sanitation programmes plans ahead of time to avoid vertical programming and creation of demands that can not be fulfilled
- **Where possible** ensure that participatory approaches to social mobilisation and hygiene and sanitation education come ahead of service delivery (e.g. for water and sanitation facilities)

ANNEX I:

Participants and Facilitators

*(*Designated temporary country focal point for participatory hygiene and sanitation)*

BOTSWANA		
1. **Mrs. Matsae Balosang*** *(did not attend workshop but designated as focal point)*	Family Health Division Health Education Services Ministry of Health	P.O. Box 992, Gaborone Tel: 267-353561 Fax: 267-302092
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3. **Mr. Ivan Makati**	Family Health Division Health Education Services Ministry of Health	P.O. Box 992, Gaborone Tel: 267-353561 Fax: 267-302092
4. **Ms Tuelo S. Mphele**	Family Health Division Health Education Services Ministry of Health	P.O. Box 992, Gaborone Tel: 267-353561 Fax: 267-302092
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5. **Mr. Jean Doyen**	Manager, WSP-ESA UNDP/World Bank	P.O. Box 30577, Nairobi Tel: 254-2-260300/6 Fax: 254-2-260380/6 e-Mail: *rwsg-ea@worldbank.org*
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7. **Mr. John Kariuki***	Ministry of Health	P.O. Box 30010, Nairobi Tel: 254-2-717077 Fax: 254-2-72820
8. **Ms Sarah Kiambi**	Task Assistant, WSP-ESA UNDP/World Bank	P.O. Box 30577, Nairobi Tel: 254-2-260300/6 Fax: 254-2-260380/6 e-Mail: *rwsg-ea@worldbank.org*
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10. Ms Rose Lidonde	Task Manager, WSP-ESA UNDP/World Bank	P.O. Box 30577, Nairobi Tel: 254-2-260300/6 Fax: 254-2-260380/6 e-Mail: *rwsg-ea@worldbank.org*
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12. Ms Salome Mwendar	UNICEF Kenya Country Office	P.O. Box 44145, Nairobi Tel:254-2-622186/88 Fax: 254-2-215584 or 622746 e-Mail: *Salome.Mwendar@Unicef.unon.org*
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16. Mr. Isaac K. Ruttoh	Ministry of Health	P.O. Box 5, Kapsabet District Hospital, Nandi Tel:254-326-2380/2261/2005 Fax: 254-326-2081
17. Mr. Samuel M. Wambua*	Special Programs Ministry of Water Resources	P.O. Box 16742, Nairobi Tel:254-2-716103 ext. 422731
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18. Ms Julieta Felicidade Afonso*	Community Education Officer, Rural Water Department (DAR)/DNA	Av. Ed. Mondlane no 1392 40 andar P O Box 2847 Maputo, Mozambique Tel: 258-1-423269 or 430203 Fax: 258-1-430110 e-Mail: pronar@dnam.um.mz
19. Mr. Carlos Macoo	Director, Professional Training Centre for Water and Sanitation (CFPAS)/ DNA	Av. Trabalho 1441 P.O. Box 2847 Maputo, Mozambique Tel: 258-1-400653 Fax: 250-1-400168

20. Ms Ana Matelcza	Information Officer, Low Cost Sanitation Programme (PNSBC)	Avenue Acordos de Lusaka 2115 C.P. 1310 Maputo Tel: 258-1-465850 Fax 258-1-465886 e-Mail: pnssbc@mail. Tropical.co.mz
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22. Mr. Nilton Trindade	Rural Water Department (DAR) DNA	Caixo Postal 1254, Beira Tel:258-3- 328811 Fax: 258-327932 e-Mail: drcp.beira@teledata.mz
SOUTH AFRICA		
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24. Mr. Shadrack Dau	Mvula Trust	P.O. Box 4538 Pietersburg 0700 Tel: 27-15-2912405 Fax:27-15-2911270 e-mail: *shadrack@ mvulapth.co.za*
25. Ms Mosabala Lipholo	Department of Water Affairs & Forestry	P.B. X11259, Nelspruit Tel: 27-13-7524183 Fax: 27-13-7551678
26. Ms Lungisa Mangisa	Limakhozu Training Agency	19 Amatola, 31 St. Peters Road Southernwood East London SA Tel: 27-15-431-29522 Fax: 27-431-29522
SWAZILAND		
27. Ms Poppy Dlamini*	Rural Water Supply Branch, Ministry of Natural Resources	P.O. Box 961, Mbabane Tel: 268-41231/2 Fax: 268-44330
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TANZANIA

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30. Ms. Gertrude Lyatuu	UNICEF / MOW	P.O. Box 9153 Dar-Es-Salaam Tel: 255-51-117153-9 Fax:255-51-118075
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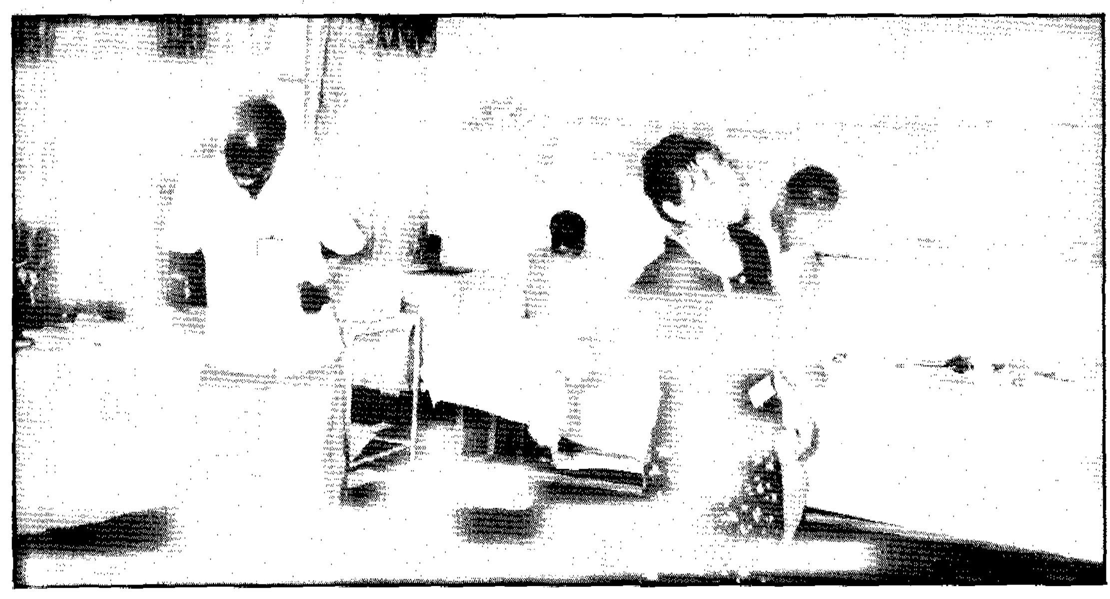

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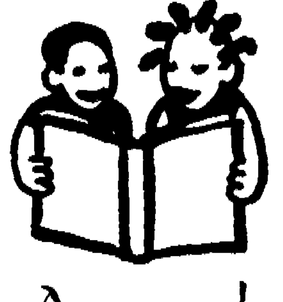


Agenda

Tuesday, November 10

Session 1: Setting the stage

Chair: Mr. George Nhurnhama
National Co-ordinator for Rural Water Supply & Sanitation, NCU, MLGNH, Zimbabwe

8:30-9:00am	**Informal welcome** *by Ms Noma Musabayane* **Self-introductions** *led by Mr. Lerato Nare*
9:00-9:20am	**Formal welcome and opening** *by Mr. George Nhurnhama*
9:15-9:20am	**Introduction** *by Ms Rose Lidonde*, **Remarks** *from Mr. Jean Doyen*
9:20-9:30am	**Background / introduction to the workshop** *by Ms Rose Lidonde*
9:30-9:40am	**Importance of participation in hygiene education** *by Mr. Veli Aalto*
9:40-9:50am	**Participatory approaches in water, hygiene and sanitation** *by Mr. Brendan Doyle*
9:50-9:55am	**Introduction to the PHAST video** *by Ms Rose Lidonde*
9:55-10:10am	**Video: PHAST – Healthy communities through participatory hygiene and sanitation**
10:10-10:35am	**Discussion of video** *moderated by Mr. George Nhurnhama*
10:35-11:00am	**Break**

Session 2: Workshop objectives

Chair: Mr. George Nhurnhama
National Co-ordinator for Rural Water Supply & Sanitation, NCU, MLGNH, Zimbabwe

11:00-11:30am	**Workshop objectives / shared beliefs** *by Mr. Jean Doyen*
11:30-11:55am	**Workshop programme and objectives** *by Ms Rose Lidonde*

Session 3: The Regional Prospective Review

Chair: Ms Phoebe Baddu
Community Mobiliser & Training Specialist, W&ES, DWD, Uganda

11:55-12:00	**Introduction to the regional review** *by Ms Phoebe Baddu*
12:00-1:30pm	**Overview/discussion of regional prospective review: key points and lessons learnt** *by Ms Beth Karanja and Ms Noma Musabayane*
1:30-2:00pm	**LUNCH**

2:30-2:40pm	**Housekeeping remarks: contingency in the event of a work stayaway** *by Ms Noma Musabayane*

Session 4: Country experience in scaling-up

Chair: Mr. Odolon John
NETWAS Uganda

2:40-3:15pm	**Republic of South Africa country presentation** *by Ms Lungisi Mengisa and Mr. Shadrack Dau*
3:15-3:30pm	**Zimbabwe country presentation** *by Mr. William Rukasha and Ms Therese Dooley*
3:30-4:00pm	**Discussion of presentations** *moderated by Mr. Odolon John*
4:00-5:30pm	**Small group discussions and preparation for presentations on lessons from the regional prospective review; issues, constraints and opportunities in participatory methods; guiding principles**
5:30pm	**Participant bus departs from ZESA centre to Oasis Hotel**
7:00pm	**Reception at Oasis Hotel**

Wednesday, November 11

8:30-9:50am	**Continuation of small group work from previous day**
9:50-10:40am	**Small group presentations**
10:40-10:55am	**Discussion of presentations** *moderated by Mr. Odolon John*
10:55-11:00am	**Discussion of proposed Session 5 (cancelled due to time constraints): panel discussion on guidelines for country programmes** *moderated by Mr. Brendan Doyle*
11:00-11:30am	**BREAK**

Session 5: Country Team Planning

Chair: Mr. Ned Breslin
Mvula Trust, South Africa

11:30-11:40	**Organisation of country teams for small group work** ***Topic: a picture of where you are now, where you will be in 2003, what steps you will take to get there, what your opportunities/resources and constraints are (and what is PHAST and how can you motivate it in your country)***
11:40-1:15pm	**Country team small group work**
1:15-2:00pm	**LUNCH**
2:00-3:15pm	**Country team small group work continued**
3:15-5:30pm	**Country team presentations: Botswana, Uganda, Tanzania, Swaziland, South Africa, Kenya**
5:30pm	**Participant bus departs from ZESA to Oasis Hotel**

8:25-9:20am	**Country team presentations continued: Mozambique, Zimbabwe**
9:20-9:40am	**Discussion of country presentations moderated by Mr. Ned Breslin**
9:40-9:50am	**Categorising priority country needs: key priorities by country in small groups** *introduced by Mr. Ned Breslin*
9:50-11:05am	**Country and regional team small group work**
11:05-11:12am	**Winner of best country team presentation** *announced by Mr. Ned Breslin*
11:12-12:45pm	**Country and regional team presentations**
12:45-1:00pm	**Remarks on participation** *by Mr. Shadrack Musingarabwi*
1:00-1:15pm	**Synthesis of country priority needs** *by Ms Salome Mwendar*
1:15-2:30pm	**LUNCH**

Session 6: Regional Support

Chair: Mr. Shadrack Musingarabwi

Director Environmental Health Services, Ministry of Health & Child Welfare

2:30-2:45pm	**Brief country overviews for the Regional Director, WHO**
2:45-3:10pm	**Closing remarks** *from the Regional Office WHO for Africa by Dr. Ebrahim M. Samba, Regional Director*
3:10-3:20pm	**Comments following RD's remarks / group photograph**
3:20-3:45pm	**Discussion of regional support / regional task force** *by Ms Noma Musabayane*
3:45-4:00pm	**Regional task force objectives / designation of temporary country delegates to the RTF** *by Ms Noma Musabayane*

ANNEX III:

Summary of Key Speaker's Remarks

"The Transformation Process in Participatory Hygiene and Sanitation"

by Mr. George Nhurnhama
National Co-ordinator for Rural Water Supply & Sanitation, NCU, MLGNH, Zimbabwe

18 years ago the International Drinking Water Supply and Sanitation Decade (IDWSS) developed noble objectives: to provide universal coverage of water supply and sanitation for all by the year 2000. Since then there has been a lot of activity in water and sanitation, mainly in construction using mechanical approaches. A lot of structures went up but were not necessarily used or kept up appropriately. The result was to make coverage "reasonable" but not complete. So the Decade's goals will not be met and need extending into another decade.

If we are to succeed we must refine lessons learnt from the Decade and look closer at the "software" side. The focus was rightly on women and children and initiatives were being taken to empower them, but there needed to be more involvement and ownership by communities, more knowledge as to what benefits they would accrue and emphasis made on the *transformation process*.

In Zimbabwe, Ministry of Health spearheads participatory health and hygiene education initiatives with the co-operation and involvement of other Ministries. Other countries need to find a focal point to put participatory ideas into action. For Zimbabwe hygiene has been central to the success of participatory education. Projects with emphasis on participatory approaches have stimulated interest beyond hygiene as people in communities contribute more than expected and make the demand for hygiene go up. Our experiences with PHAST and other participatory approaches have gone a long way to help this and we have examples that show how hygiene status has been improved.

Another component has been sustainability of infrastructure as most of Zimbabwe's water is from underground sources. The challenge has been to sustain clean environments around homes, which goes with care of facilities. A lot needs to be learnt about community-based approaches although they have already assisted us. Involving people and getting them to see the benefits has helped them manage

facilities on a self-help basis. Though we are at early stages yet, we can see benefits increasing. It's a good chance to make a positive impact for those without water as they learn to analyse own situation and solve their own problems.

The danger is if we move responsibilities to the community too quickly and without any planning, training or exposure and say "good job" and move on. Instead we need long-term sustainable participatory support. When developing such structures, local authorities should be knowledgeable about participatory approaches and it should be given more attention at political level. This can better lead to improved hygiene, sanitation and water services, especially for the disadvantaged. It's clear that Water and Environmental Sanitation, including hygiene education as a part of health care will help people avoid long queues, health bills and other expenditures. We hope each country in the Region will carry home and try out participatory approaches learned here.

"The Importance of Participation in Hygiene Education"

by Mr. Veli Aalto
WHO Regional Advisor for Environmental Health
Africa Regional Office for the World Health Organisation

Water and Environmental Sanitation is necessary for good public health, which is why the World Health Organisation has been interested in WES for the past 50 years. In the beginning the concern was with the engineering side of WES. But water supply alone has not had the desired impacts on health and it is now known that hygiene education needs to be added to WES.

"Community participation" in the old days meant that communities gave materials and labour. With the advent of Primary Health Care, participation was improved and communities were involved not only in providing labour but in participating in discussions, having a role in planning and being involved in programme, not just project implementation. Initiatives came and went over the years and not all goals were achieved but we learned quite a lot as people became more and more involved in maintenance and management.

In 1994 African Ministers for Health declared as part of the Africa 2000 initiative that community participation was important along with sanitation, as with water supply alone there are few benefits. UNDP, World Bank, UNICEF and many other partners developed the PHAST initiative co-ordinated by WHO Geneva. Many WHO Regional offices thought PHAST looked wonderful and wanted to take it over from Geneva immediately.

But there were two problems, technical and political. First there was a lack of tools to use in motivating community participation. Second there was a lack of trust by the "technocrats" who wondered how anyone could dare allow decision-making processes to communities because they might make the wrong decisions. But technocrats and politicians make wrong decisions and even bigger blunders, so eventually it was realised that communities must have a chance to do the same. With political will and the development of tools, PHAST sold like hotcakes and now WHO is happy to promote it Regionally.

"Participatory Approaches in Water, Hygiene and Sanitation"

by Mr. Brendan Doyle
UNICEF Senior Regional Advisor
Sanitation & Hygiene Policy and Programming

As an example of how participation has advanced into mainstream development practice, 25 years ago a Primary Health Care programme in Bangladesh included road construction to allow health services to come in and people's produce to go out. But the big decisions about the PHC programme were made at District level. For efficiency, roads were often constructed right across small plots of farmlands without consulting the small farmers. This eventually made the roads unsustainable. If the small farmers had been consulted, the roads would have meandered but been more sustainable. Sustainability and behaviour change can't happen unless people in communities are involved.

Over the next few days as we exchange experiences, let's look at genuine participation which can be measured on a scale: on one end "participation" becomes manipulation and on the other, it encourages ownership. We need to look at whom, when and how people participate. Where does ownership and control lie? Let's keep this in mind as we deliberate during these next few days. And how do we involve all stakeholders in planning, documenting, etc. The tools are important but our own attitude and intentions are equally important as they can have a strong impact.

We also need to understand why small projects work but may not be ready to be brought up to scale. There is often weakness in documenting experiences, with a bias towards success without fully analyzing constraints. And we need a better understanding of measuring "success". No two communities are the same or homogeneous. There may be common interests, social and economic classes, but people are not all the same.

We need to know what works on a small scale that can be taken to a large scale. It may be possible to replicate some programmes in other small settings but not nationally. What are the cultural and physical settings necessary?

In this week, we need to plan for the future with a Regional perspective and bring this experience together. This is to benefit the others in the Region, but also find out how institutions can support you. We need to identify ways to strengthen partnerships in order to enhance learning as well as attract more funding. Many are struggling with limited resources. Can we identify ways the Region can support them? Can we do this together in a network at different levels? Donors are tending to go more and more this way. Maybe we can develop a framework on this as the workshop goes on.

"Shared Understanding and Beliefs towards Participatory Hygiene, Sanitation and Water Programming"

by Mr. Jean Doyen
Regional Manager
WSP-ESA, UNDP/World Bank, Kenya

1. Lack of access to water supply and sanitation and exposure to water borne diseases are important causes and determinants of poverty.
2. 2. Water borne diseases are a major cause of morbidity and mortality especially for children.
3. Hygiene awareness and education enhance considerably the health impact of water and sanitation interventions.
4. Community mobilisation and responsiveness to community demand are critical for the effectiveness and for the sustainability of rural water supply.

Participatory methods for hygiene and sanitation promotion are an effective way to help communities and households to mobilize themselves and plan and carry out improvements.

"Strengthening Collaboration in the Region to Promote Participatory Health and Hygiene Education"

by Mr. Shadreck Musingarabwi
Director Environmental Health Services
Ministry of Health & Child Welfare, Zimbabwe

Plans and policies for improving the hygiene, sanitation and health situation of the people in our Region are only worth something if they can be implemented. Over the past 30 years there has been a shortfall of policies, guidelines, infrastructure and the people needed to implement them to go forward in this area. Not only that, at times there has been a "tug-of-war" between UNICEF and WHO as to who will be in the lead!

To solve this there needs to be a co-ordinating agency, some leadership arrangement with a common goal to help in programming. A Regional co-ordination body could support workshops, the drafting of project proposals or other ways. Perhaps like the Collaborative Council and Africa 2000, a political initiative or collaborative club is needed through which we in the sector can meet and discuss pressing issues such as:

Partnership approaches. Others in the Region want to try what Zimbabwe has done in the area of participatory hygiene education. The Ministry of Health doesn't limit the tools and methods to health-issues only because otherwise non-health groups would find it difficult to use. It's important to create partnerships to empower the community, which everyone wants.

Capacity-building. Each country should decide who are the key players in building capacity and looking for ways to strengthen community initiative and involvement.
Implementation. This involves both communities and technocrats. Resources are scarce (even in Zimbabwe) so when choosing a focal institution, it must be influential enough to be able to stimulate government to mobilise resources.

Monitoring and evaluation. M&E involve documenting issues to help communities and politicians at all levels shape policy. M&E also helps our donors understand how their money is being spent. It is also a way we can learn from each other's experience.

Experience exchange. While we all want technocrats to visit other technocrats it is important to help community leaders visit other community leaders within a country from District to District. This can stimulate and encourage others and enhance partnership approaches.

At the centre of all of this is community involvement. The beneficiaries themselves need to be involved and communities allowed to take the leadership role. If this happens it will help sustainability and promote development.

"Taking Time to Implement Participatory Programming"

Dr. Ebrahim M. Samba
Regional Director
Africa Regional Office for the World Health Organisation

Many communities in the Region suffer from a lack of hygiene, sanitation and water supply. People walk miles for water, they urinate and defecate in the bush and cut firewood to cook. They need to understand the connection between lack of hand washing and latrines and diarrhoea. They must also be able to decide for themselves how to break the cycle. They know that cutting trees damages the environment but need to know how to decide and what to do. Participatory programmes involve the mass of the population in understanding how their own behaviour affects their health.

Donations and funding are usually mentioned first in any programme proposal, but we know from experience exchange that availability of money can be a handicap in genuinely participatory initiatives. Participation takes more time. Donor driven programmes typically ask communities to do the work without participating. This may be quicker to implement but never succeeds. Funds and resources necessary to promote participatory hygiene and sanitation should therefore be realistic to its pace.

Experiences need to be exchanged and made into plans at country level. Participatory initiatives take time and need translating into local languages. We can't eat a menu of ideas --- they have to be turned into "meals" that can be digested and used. Regional partners such as UNDP, UNICEF and WHO will support countries that have participatory hygiene and sanitation programme plans and strategies, and more importantly can show their "track record". The days of just preparing papers and receiving money from donors are over. Countries need to document and share experiences and use them to build sustainable programmes.

WHO is interested in supporting participatory initiatives because 70 per cent of health problems are related to hygiene and water. Development can't happen if a significant number of people are unwell. Populations can't progress without good health, and health can't be good without hygiene, sanitation and water together. We have spent some time thinking, now we must act.

Let's do it for Africa, which is well endowed with human resources that only need to be better used for the benefit of its people.

ANNEX IV:

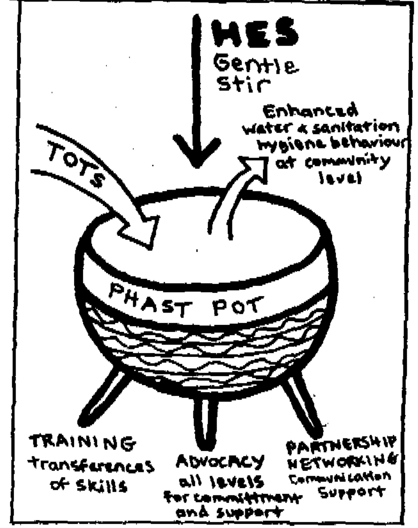
Country Presentation Summaries

BOTSWANA

A major constraint is funding for more materials. But Botswana has already started expanding PHAST into Agriculture and the Water for Africa 2000 initiative. Further advocacy meetings are currently planned for Institute of Health Sciences (IHS), PHC Department and other stakeholders.

Where we are now in Botswana?

- **Capacity:** 8 Trainers / 1 Artist / 36 Facilitators
- **Collaborative Team:** formed of stakeholder agencies to work with communities
- **Advocacy meetings:** held with Permanent Secretaries, Directors of Ministries/Departments, District Management/Local Authorities of pilot Districts, Heads of Divisions/Units in MoH, councillors.
- **Institutionalisation:** currently at National but need to reach District level
- **Adaptation of tools:** being adapted for AIDS, Malaria and TB
- **Policy:** have for Health, Sanitation, Community Based strategy (since 1977)
- **Pilots:** in farming areas (Africa 2000 recommendation)
- **Funding:** from donors, Government of Botswana, NGOs
- **Consultative meetings:** yearly with trainers and facilitators, ongoing quarterly institutional meetings will be used for



What is PHAST?

An initiative to improve sanitation practices. PHAST is like a "pot" into which Training of Trainers is added and gently stirred by HES. The pot is supported on the three legs of "training (transference of skills)" "Advocacy" (all levels for commitment and support) and "Partnership/networking" (for communication support). From this we get "Enhanced water & sanitation hygiene behaviour at community level".

Where do we want to be in 2003 in Botswana?

♦ **Develop guidelines** for lower level facilitators as well as a lower level training guide

♦ **Continue training** of extension workers and community-based workers, for sustainability

♦ **Establish training teams**

♦ **Review pilot projects**

♦ **Continue to mobilise communities** so as not to lose momentum

♦ **Mobilise more commitment** and support for participatory hygiene and sanitation initiatives

♦ **Monitor and evaluate** existing programmes through reports on a quarterly basis, through meetings and follow-up visits

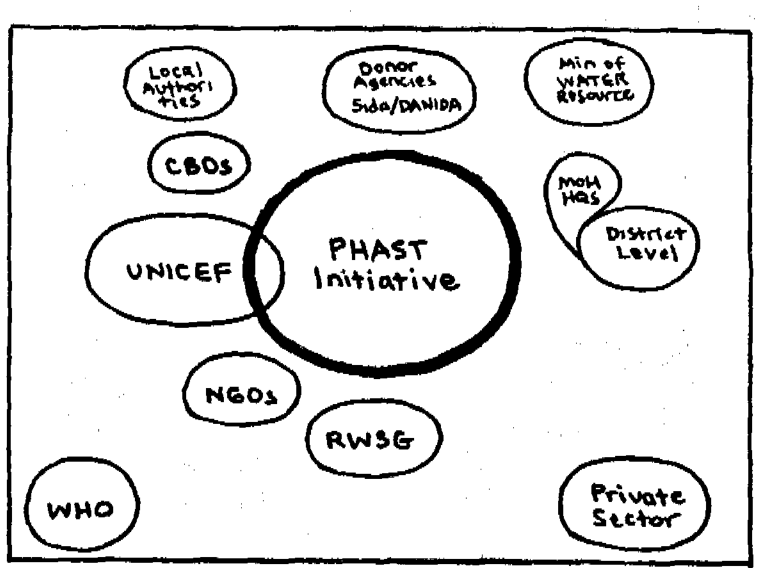
Botswana plans to mobilise more stakeholders, particularly the Red Cross to support more pilot projects.

They hope to decentralise participatory initiatives into day to day programmes at District level.

There are also plans to have school health clubs use the PHAST tools and possibly Ministry of Local Government for extension workers.

KENYA

A participatory tool, the Venn diagramme, is used to describe the relation of institutions to PHAST in Kenya, where PHAST is said to have been "seduced and married by other initiatives".



Where we are now in Kenya

PHAST in 20 Districts *with various donor's help*

- **Baringo** *UNICEF / Govt. of Kenya*
- **Garissa** (El Nino Refugee camps) *CARE / UNICEF* (a spin-off of work in the camps has been the spread of PHAST into other sectors)
- **Nyambene** *Govt. of Kenya / Sida*
- **Nandi, Uasingishu, Nakuru, Keiyo** *Govt. of Kenya / Sida*
- **Kisii, Naymira, Migoro, Bondo, Suba** *CARE, AN, UNICEF, RDWS, Govt. of Kenya*
- **Nairobi** *UNICEF, KWAHO, AANCAN (within urban slums, a Division of Ministry of Health; the focal person is in Environment and is charged with co-ordinating PHAST and donor support through the PALNET*
- **Kisumu, Siaya, Homa Bay, Rachuonyo** *KWAHO*
- **Tana River** *KWAHO*
- **Mombasa, Kwale** *UNICEF*

Opportunities

- Involve policy makers in government
- Develop tools for health programmes (there is heavy funding for malaria and STI control in Kenya, and it may be possible for them to use participatory approaches)
- Donor community acceptance of PHAST

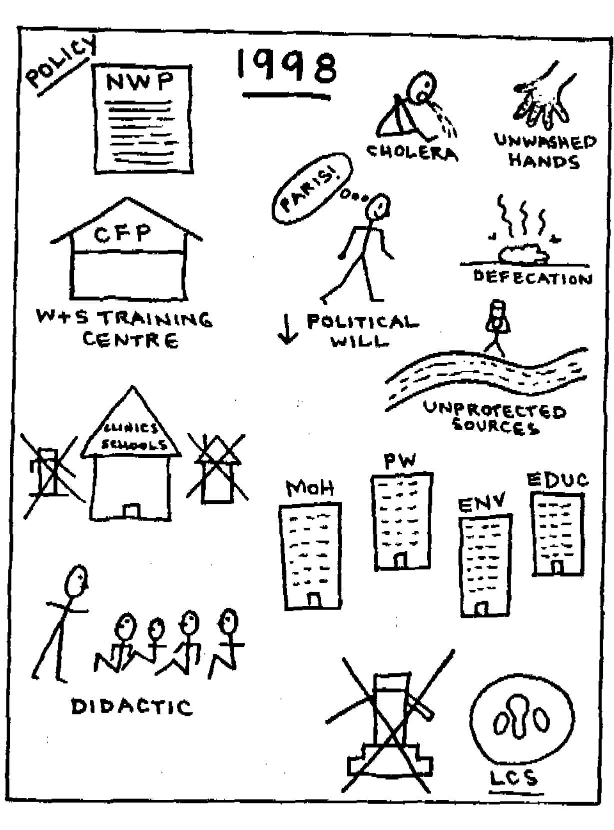
Constraints

- Uncertain future funding
- Poor attitude/ behaviour by some trained staff unwilling to use approaches
- Weak collaboration because no mandate for WES
- Lack of tool kits

Where Kenya would like to be

- Document case studies
- Undertake a baseline impact survey of PHAST
- Strengthen PALNET
- Expand PHAST in more rural and urban areas (slums)
- Expand the core training core
- Institute PHAST curricula in water, health and teacher training institutions
- Include PHAST in the Kenya National Sanitation Policy
- Strengthen partnership/co-ordination among key players (government and others)
- Set up fora to discuss hygiene, sanitation and PHAST at ministerial level
- Develop a cross-cultural toolkit for resource persons

MOZAMBIQUE



The chart at right illustrates the current situation in Mozambique:

♦ There is a water policy but none for sanitation.

♦ There is a water and sanitation institution but cholera outbreaks are frequent and unwashed hands remain a problem.

♦ Political will for hygiene is low: politicians have little knowledge of community participation and think more about the man in Paris than at home.

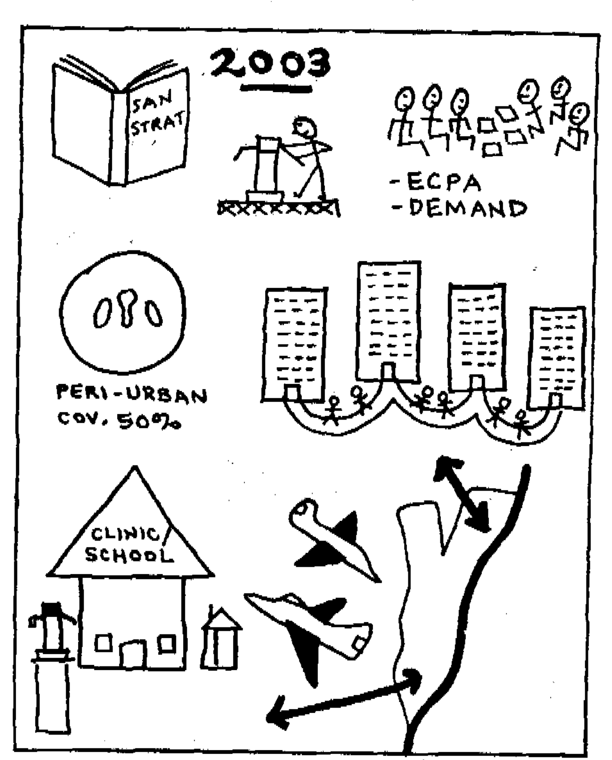
♦ There is open defecation and unprotected water.

♦ There is no co-ordination between various Ministries.

♦ Newly constructed clinics and schools are without protected water sources or latrines.

♦ There is no leader for participatory hygiene and sanitation education methods so training is for the most part still didactic and the number of trainees are few.

♦ There are few pumps or piped systems in the rural areas, and many handpumps are broken down. There is little in the way of LCS (low cost sanitation).



Mozambique wants to make improvements over the next five years as shown at left.

♦ Though without an immediate strategy, it is hoped by 2003 to develop a strategy and establish a sanitation policy;

♦ increase PHAST and community demand;

♦ cover 50% peri-urban areas with sanitation;

♦ get Ministries to work together;

♦ provide clinics and schools with water and sanitation; and

♦ remain open to other countries to exchange views on W&S.

In Mozambique, participatory hygiene education is little used. Workshops have been held but there is little support or understanding of participatory approaches. Ministry of Health is not involved although responsible for a low cost sanitation programme. There are only 82 rural extension workers to cover millions of people. Some communities lack cohesiveness as a result of recently being displaced by war and isolation and language constrain network development.
And monitoring and evaluation systems, weak in general, are more so for
participatory systems.

Mozambique: Tasks and Strategies

♦ **Advocate and begin the consultative process** (for sanitation strategy, integration of hygiene, sanitation and water promotion, roles and responsibilities)

♦ **Conduct materials development training** (for training institutions, to adapt existing tool kit,

♦ **Secure technical assistance** (*for workshops*)

♦ **Use school-based approach** (because low density populations)

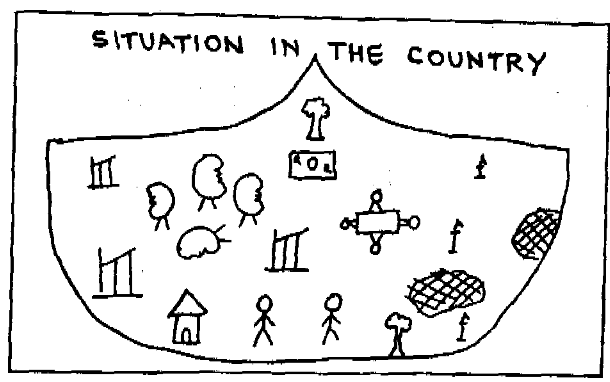
♦ **Encourage private sector role** (and build on existing consultative groups)

♦ **Integrate agriculture/health/water** (as a core package for sanitation extension services and in provincial master plans for hygiene, sanitation and water promotion to reinforce co-ordination and an integrated approach

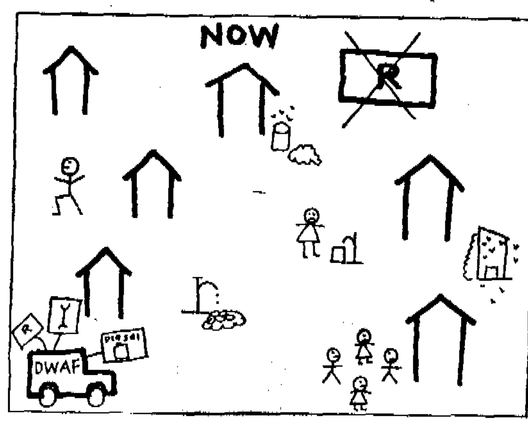
Mozambique – Opportunities

Sanitation strategy to be developed by Ministry of Health and UNICEF to put sanitation on the national agenda
Integrate WSHP at central / provincial levels
NWP / TP to decentralise, generate a demand approach at community level
Existing training centres for water and sanitation and agriculture teach PRA and existing workers can be used to spread PHE
Definition of a core package which can be used by sanitation /water/agriculture/health with hygiene behaviour change at the centre

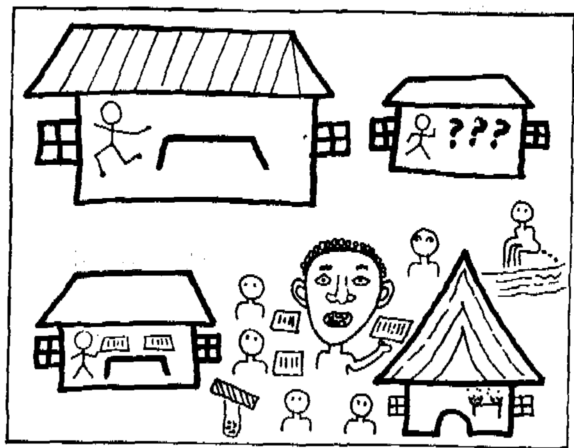
SOUTH AFRICA



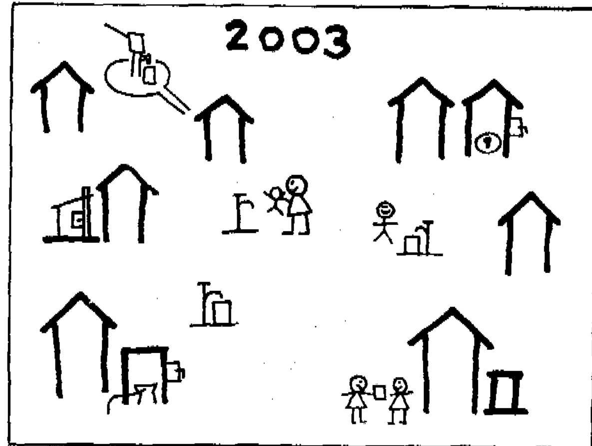
The illustration at right shows the pre-1994 situation in South Africa when the government was not involved with rural communities and NGOs did not work in the areas. The darkened areas are unsustainable areas (former homelands) which had little water and no services. There were scattered services and few people to help.



The situation **now** is that during election campaigns, politicians have been promising free services (water, housing, etc.) and raise expectations. This situation won't last as the money is drying up. Participatory ideas will need to come in to sustain services.

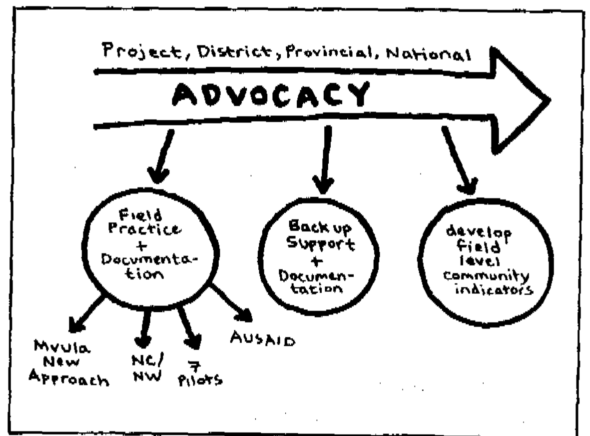


People came from Zimbabwe to explain participatory approaches in South Africa. Now a few in government have made Participatory Hygiene Education a priority. There is a "mixed masala" of capacity in terms of experience and support.

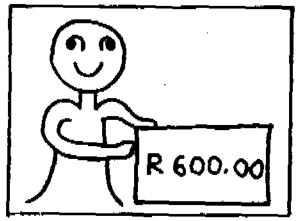


Where South Africa wants to be in the future is shown here: every home has a latrine (sanplat, diverting or VIPP) and water source (pump or tap).

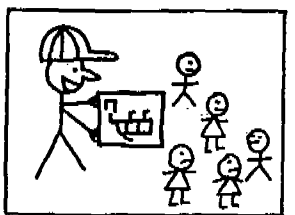
To get there, an advocacy strategy is needed. ADVOCACY needs to move forward at Project, District, Provincial and National levels. Field practice and documentation will be undertaken with the Mvula new approach in the NC/NW in seven 7 pilots with the help of AusAID.
Advocacy will lead to back up support and documentation and field level community indicators will be developed.



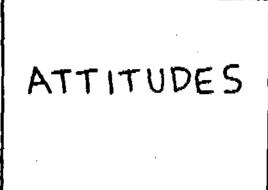
South Africa's constraints:



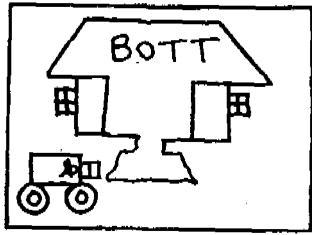
Government's policy to subsidise each latrine with R600 is impeding progress and becoming a source of corruption.



Engineers have still not "bought in" to the concept of participation and are reluctant to involve the community in their work.



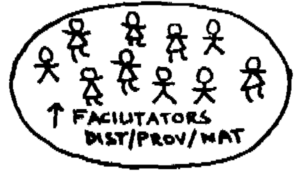
Even people who have been trained miss the point of participation because of **poor attitudes**.



In an attempt to privatise and implement cost-recovery, the Department of Water Affairs has contracted with a consortium of consultants to manage water projects on their behalf for speedy delivery of services but with no community participation.

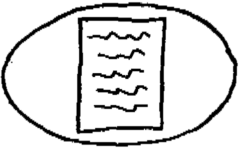
There has been a major evaluation of BOTT already and preliminary findings show that the government is going down the wrong road. Their promises can't be fulfilled and over time people will realise that BOTT is unsustainable.

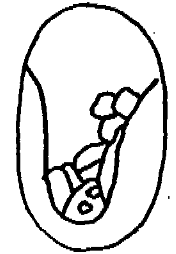
South Africa's strengths:



There are already trained facilitators at district/province/national levels. SA wants to demonstrate participatory method strengths: PHAST is being used in the University of the North for training just now and promoted at the bi-monthly Provincial Sanitation Task Team (PSTT). NGOs, Mvula, Local District Councils and others have been sensitised and PHAST is being allowed to spread on its own

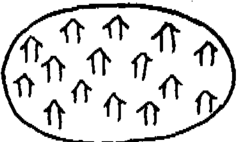
There is some documentation and materials, although only in English.





SA is surrounded by friends (shown on the map at left) who can help them network the participatory process.

There is a lot of strength in communities in South Africa.



PHAST AS "THE SOLUTION"

For South Africa, PHAST is an initiative and a methodology. They see it as "the Solution".

The home for PHAST remains with NGOs with lead institutions in different provinces.

SWAZILAND

Swaziland has already formed a core team for participatory hygiene to undertake:

- Advocacy
- Sensitisation
- Policy level
- Baseline studies (ongoing now: ARI, EPI, CDD studies)
- Water & Sanitation in schools for the first time

Swaziland: Where we are

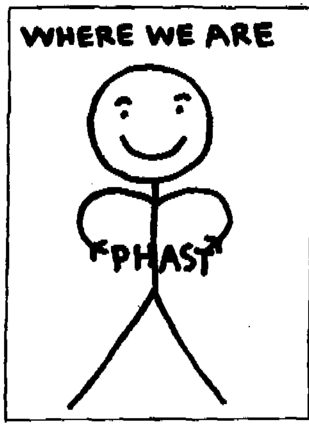
School programmes (PHAST is used in hygiene promotion in schools)

Proposal development (funding: official launching; production of tools, training at national, regional, community levels)
Advocacy meetings (sectoral co-ordination committee; govt. and NGO senior officials)

Sensitisation (16 extension workers in schools; rural health motivators; 4 pilot committees; water supply/sanitation committees in funded programmes; school teachers/committees/community leaders)

Policy (PHAST incorporated as initiative for hygiene education in sector policy)

Baseline studies (ARI, EPI, CDD surveys; survey of water supply and sanitation at schools)



We are "embracing" PHAST:
In future we want to use it as a "tool" for water, agriculture, sanitation, HIV/AIDS prevention.

Swaziland: Constraints

- ♦ Lack of policy level support
- ♦ Inadequate institutional support
- ♦ Emergency projects (drought relief and diarrhoeal outbreaks --- only enough funding to cover two Regions because of drought situation)
- ♦ Lack of donor funding (to assist in setting principles, time frames and funding)
- ♦ Not enough trained personnel

Resources needed

- ♦ Technical expertise on PHAST (to launch pilots, train trainers, review existing methods)
- ♦ Personnel (more coverage, more levels trained in PHAST)
- ♦ Funding (for tool production, training, baseline surveys)

Where we want *to be*

- ♦ Sector policy recognising and implementing PHAST.
- ♦ PHAST in school curricula.
- ♦ Strengthened linkages among all stakeholders.
- ♦ WATSAN community and other sectors using PHAST.
- ♦ Funding and commitment from all stakeholders.
- ♦ A higher percentage of facilitators trained.
- ♦ Hygiene high on Swaziland's national agenda.

"If Swaziland takes PHAST into the agriculture sector, what will they rename it?"
"Grow PHAST!"

TANZANIA

Assessment of current situation

♦ GAPS
♦ Limited behaviour change
♦ Inadequate data and information on hygiene and sanitation
♦ Resource mobilisation for hygiene and sanitation
♦ Inadequate trained facilitators *(30 million people and only 25 trained staff to cover 34 Districts!)*
♦ Limited capacity at district level

Strengths & Opportunities

♦ Water & sanitation programmes exist in most regions
♦ There are supportive policies for health and water
♦ Demand exists *(evidence of this is that trained staff are already being poached by other projects!)*
♦ There is some political will
♦ A draft translated PHAST manual is available
♦ Some existing programmes are using participatory methodologies
♦ There is a draft manual and tool kit for cholera prevention
♦ There is an enabling environment through NGOs, CBOs and private sector

Analysis: why are there gaps? Why haven't participatory methods taken off in Tanzania?

♦ There are deep rooted cultural values and practices
♦ There is low motivation
♦ Women have limited participation in decision making for WES
♦ Some dominating leadership hinders approach to communities
♦ Undecided as to whether to have community or household focus?
♦ Poor quality of installed sanitation and water structures
♦ Limited exposure to alternative participatory methodologies

1999 – 2004 Tanzania's Objectives

STRATEGIES:

Capacity Building

♦ Strengthen the capacity of sector ministries
♦ Support the promotion of inter-ministerial co-ordination at national level
♦ Ensure needs assessment for identifying priorities, actions taken and gaps
♦ Promote the revival of the national participatory team of core trainers
♦ Ensure consolidation of participatory methods in partnership organisations

Service Delivery

♦ Ensure timely delivery
♦ Ensure learning through provision of an appropriate national PHAST materials and guide

Information Management System

♦ Develop monitoring system for participatory hygiene and sanitation transformation

Advocacy and Social Mobilisation for Rights

♦ Promote sensitisation in government for funds allocation to participatory hygiene and sanitation transformation

♦ Nation wide advocacy with NGOs, private sector, communities

Tanzania Priority Activities

STRATEGIES:

Capacity Building

♦ Develop project proposal

♦ Appoint focal person at Ministry of Health

♦ Identify technical and financial assistance

♦ Strengthen inter-ministerial co-ordination

♦ Mobilise Resources

♦ Conduct training

♦ Conduct needs assessment

♦ Identify resources

♦ Establish a network

♦ Hold workshops on materials development: curriculum, field guides, training strategy

Service Delivery

♦ Conduct TOT and other refresher courses

♦ Conduct workshop to deliver national tool kit

♦ Pre-test tool kit

♦ Reproduce and distribute tool kit

Information Management System

♦ Develop and adopt participatory M& E indicators in collaboration with relevant ministries and facilitators

Advocacy and Social Mobilisation for Rights

♦ Conduct advocacy meetings

♦ Undertake data collection and surveys

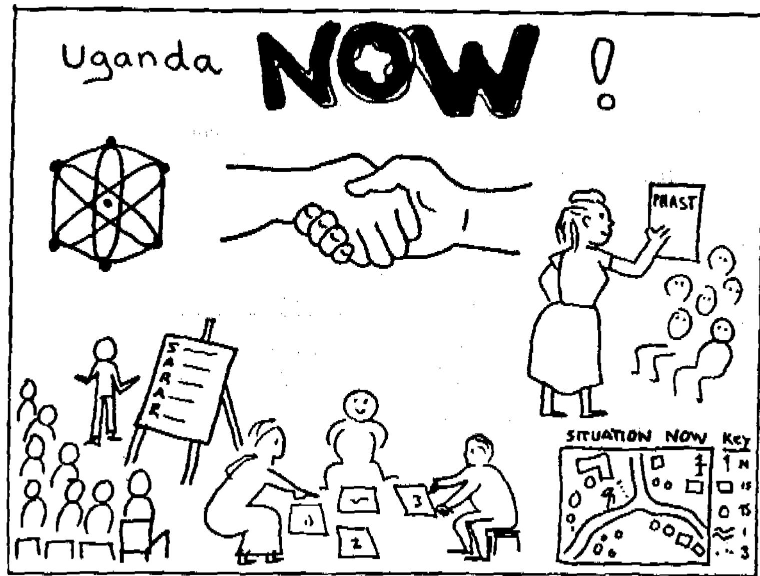
♦ Evaluate progress

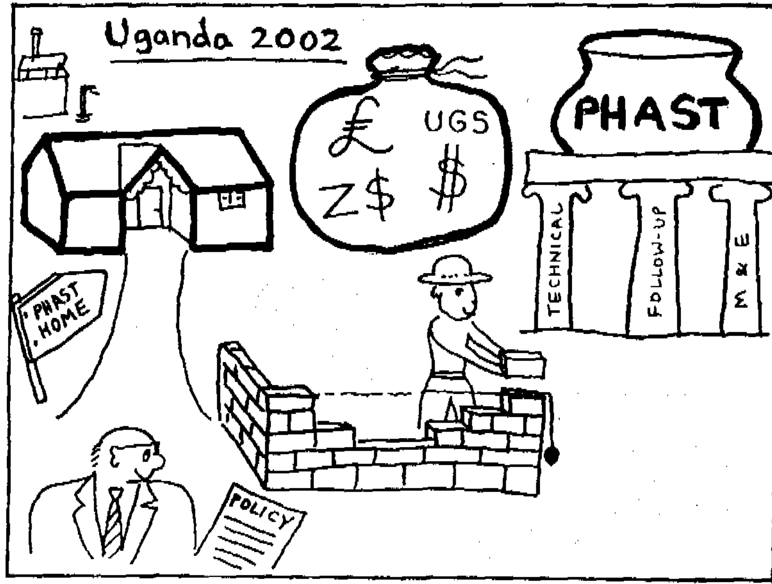
For Tanzania, PHAST is an initiative, not an approach.

UGANDA

This illustration shows the current situation of participatory hygiene and sanitation in Uganda which:

- ♦ has a network of other partners
- ♦ has been advocating, training (building capacity for participatory training)
- ♦ has begun to implement PHE
- ♦ has done some monitoring and evaluation.

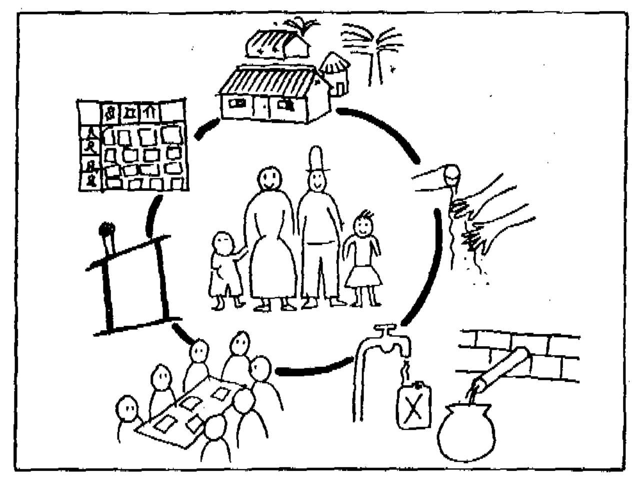




This illustration shows the desired future:

- ♦ a "home' will be established for PHAST (it currently "resides" in the Environmental Division, Ministry of Health but may change to NETWAS)
- ♦ more resources and support for PHAST research will be sought
- ♦ policies will be developed
- ♦ stakeholders will build on what has already been started.

In Uganda, participatory approaches are being used to strengthen community empowerment. The family is at the centre of the community. This illustration shows that PHAST tools, improved homesteads, improved sanitation and water and community participation are meant to help protect the family.



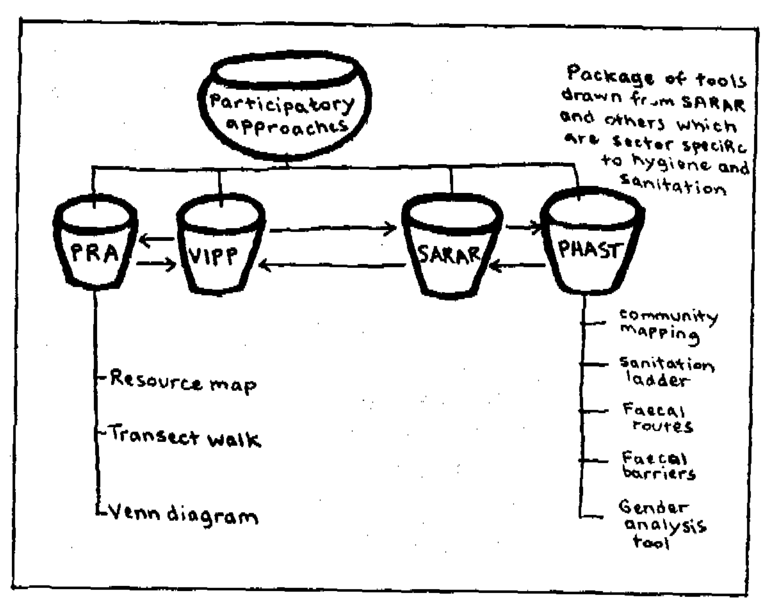
Uganda:
Constraints *(or "action points")*

- ♦ lack of tools
- ♦ poor management information and reporting system
- ♦ inadequate documentation of process and experiences
- ♦ not all partners on board,
- ♦ M&E still wanting
- ♦ inadequate support supervision,
- ♦ lack of monitoring indicators
- ♦ no link between service delivery staff and household
- ♦ inadequate service delivery staff

Opportunities

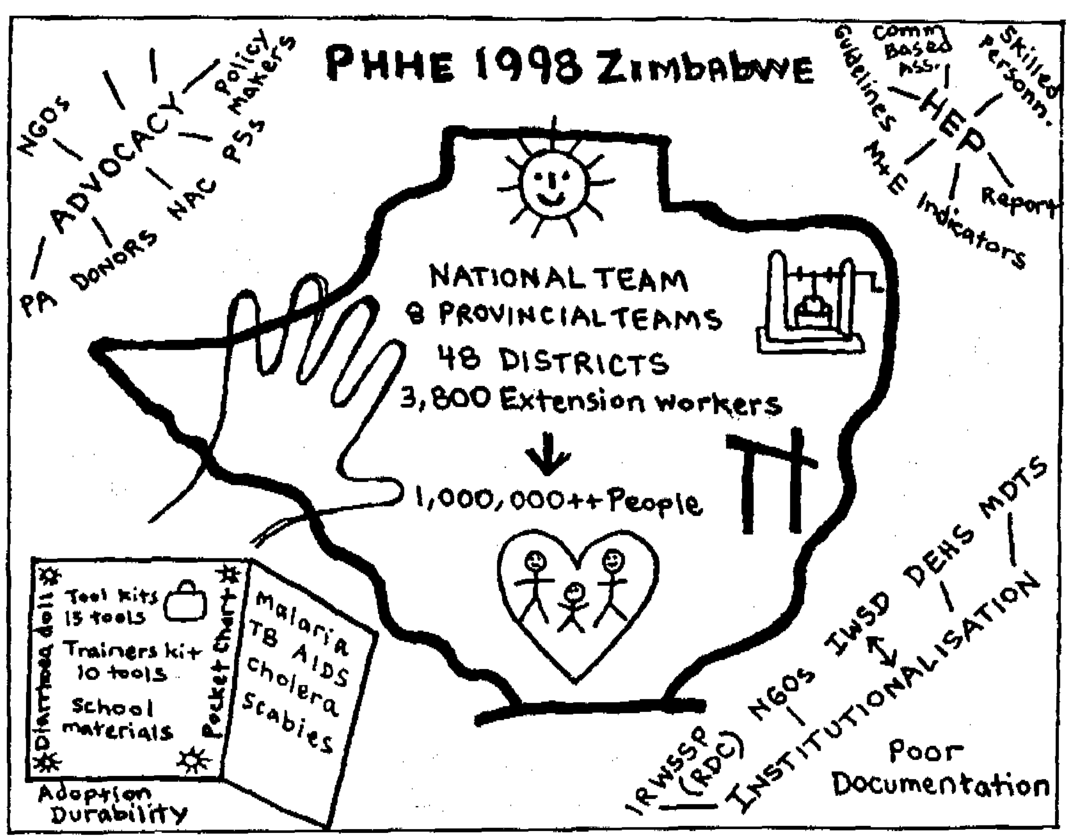
- ♦ existing PHAST experiences and skills in programmes
- ♦ well-established local councils, supportive gender and water policies
- ♦ training institution for service providers (e.g. schools of hygiene, social development work, etc.)
- ♦ committed national core team
- ♦ support from donor agencies
- ♦ collaboration with NGOs, IMSC policy-making body for WESS
- ♦ school sanitation promotion prioritised

What is PHAST?
Out of the "pot" of "participatory approaches" come PRA, VIPP SARAR and PHAST which each share some elements and also have their own tools, as shown in this illustration.



Zimbabwe

Zimbabwe is represented in this illustration as a country of "plenty of sunshine and lots of smiles". PHAST per se is not used but its philosophy and the methodologies behind it are. Participatory methods are used to promote anti-TB and other areas and referred to as Participatory Hygiene and Health Education (PHHE) in Zimbabwe.



PHHE is integrated and many institutions are sensitised to it. Zimbabwe has:

♦ a strong National Training Team ♦ 8 Provincial Training Teams
♦ 48 District Teams (48 out of 57 Districts covered)
♦ Ministry of Health & Child Welfare is "home" to PHHE
♦ 1,612 Government Extension Workers ♦ 3800 Community Extension Workers
♦ 953 VCWs ♦ 849 FHWs ♦ 644 Teachers ♦ 727 Leaders ♦ 120 VHPs
♦ 129+ NGO Personnel ♦ Approximately 1 million + community members reached
♦ All tutors at training colleges trained
♦ PHHE a component of the training curriculum for students
♦ Communities at the heart of PHHE programmes
♦ Advocacy to NGOs, PA, donors, NAC, Permanent Secretaries.
♦ Zimbabwe is becoming a resource centre for its neighbours.

A problem is poor documentation: though a reporting format has been developed (HEP incorporates monitoring & evaluation, indicators, reports, skilled personnel, community-based assessments and guidelines), it is not being used.

Tool kits

A PHHE tool kit with 15 tools and 270 pictures has been developed. The kits are being modified and expanded beyond hygiene education (e.g. cholera information pack, materials for diarrhoea, malaria, AIDS, scabies) all contained in a bag for graduates of the PHHE course

Changes in Zimbabwe with the advent of participatory approaches in hygiene and health education

- Hand washing behaviour in many areas has been changed from the basin to the run-to-waste method
- Where you find toilets in rural areas, it is also common to find hand-washing facilities with them
- Water point hygiene is improving
- Toilets are increasing in numbers

By 2003 Zimbabwe hopes to:

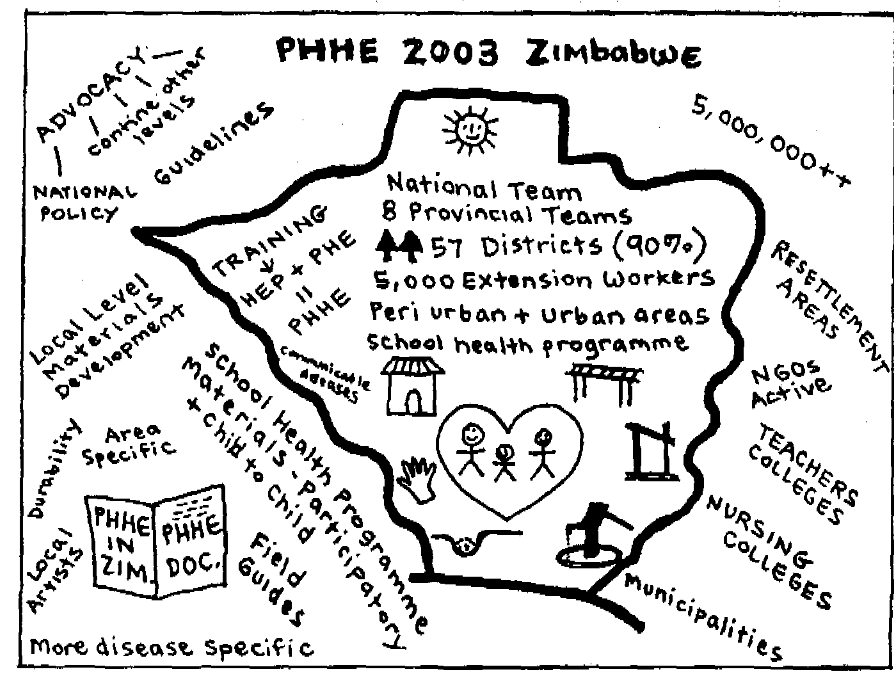
♦ cover 57 Districts (90% coverage) ♦ have 5,000 extension workers trained ♦ have peri-urban and urban areas covered ♦ have school health programmes ♦ be serving 5 million people ♦ continue advocacy ♦ develop guidelines/policy ♦ strengthen materials production (solve the problem of durability, get more local artists trained, develop more disease/area specific tools, develop field guides, make school health materials more participatory and incorporate CHILD-to-child activities) ♦ target resettlement areas ♦ institutionalise participatory methods in NGOs, teacher and nursing colleges and in municipalities

Constraints

- Some resistance to change
- Difficult to reproduce

Opportunities

- Zimbabwe has the trained personnel



ANNEX V:
Workshop Evaluation

Participant rating

33 participants rated the workshop on a scale of 1 to 5 (1 = negative, 5 = positive):

1) Were the objectives of the workshop met? *8 participants gave a 3; 24 participants gave a 4; and 1 participant gave a 5 rating.*
Participants therefore felt the objectives had almost entirely been met.
2) Was the workshop participatory? *7 participants gave a 2; 19 participants gave a 3; 4 participants gave a 6; and 1 participant gave a 5 rating.*
Participants therefore felt the workshop was participatory, but not highly so.
3) Were the recommendations and outcomes of the workshop accurately articulated? *9 participants gave a 3; 22 participants gave a 4; and 2 participants gave a 5 rating.*
Participants therefore felt that the recommendations and outcomes of the workshop were well articulated.

Facilitation team rating

9 Facilitators rated the overall success of the workshop at a debriefing meeting:

1) Were OBJECTIVES of the workshop achieved?
Yes. The "way forward" for participatory hygiene and sanitation in Eastern & Southern Africa was mapped out. Outcomes from the prospective review were shared. Strategy for the way forward was mapped out at both country and regional level. Mechanisms for support for future activities were identified. Strategies for partnership among collaborating agencies were identified.

2) Were OUTPUTS of the workshop achieved?
Yes (see main report)

3) Was a WAY FORWARD from the workshop established?
Yes (see main report)

4) Was COLLABORATION and PARTNERSHIP established?
Yes, for the most part. This needs to be further strengthened but the process has been started. Other agencies necessary to a Regional network for promotion of participatory hygiene to be contacted, given workshop feedback and asked to endorse Regional Task Force.

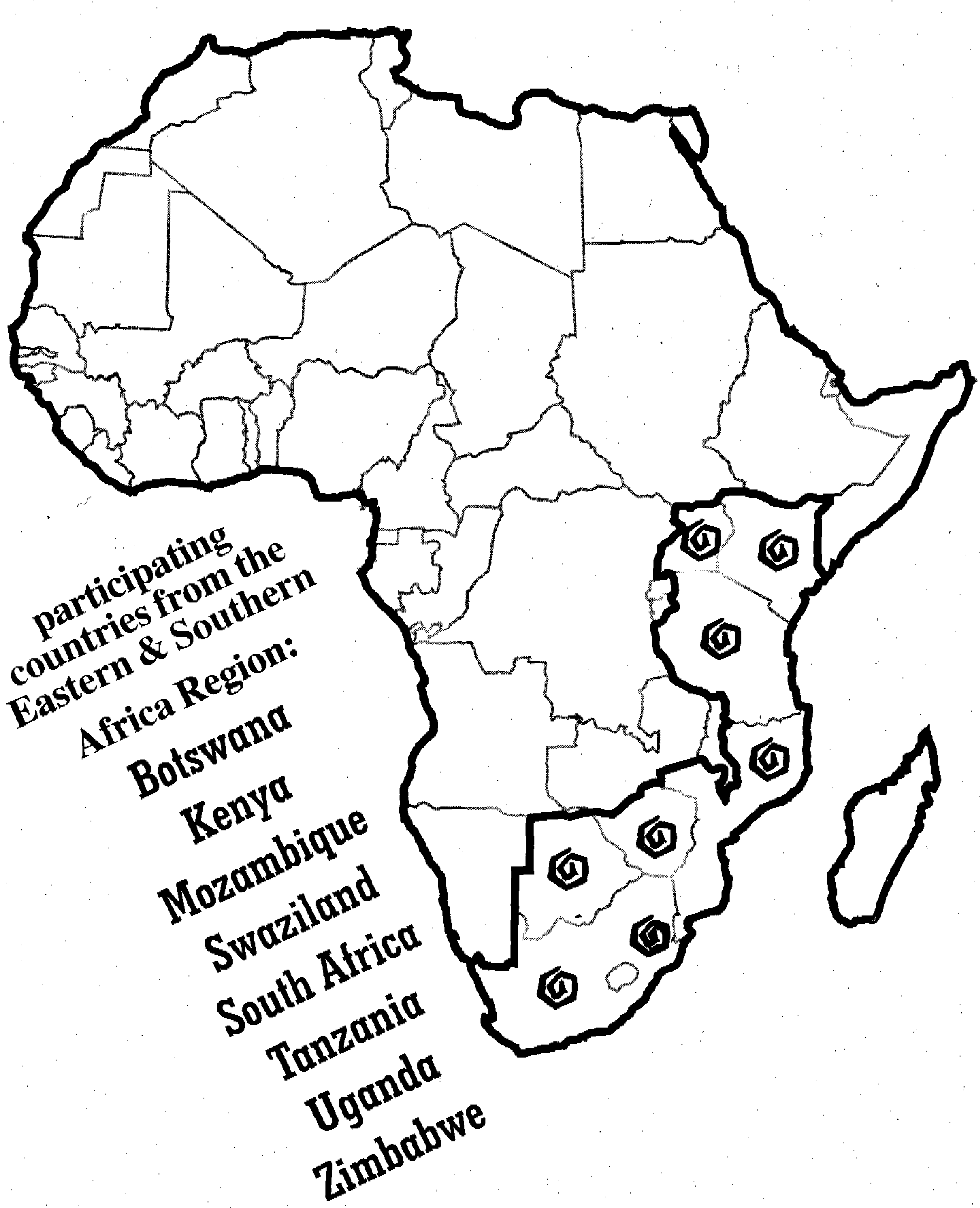
5. Were KEY RECOMMENDATIONS made?
Yes (see main report)

6. Was LOGISTICAL SUPPORT to the workshop satisfactory?
Yes, for the most part. The venue was adequate except for plenary session seating arrangement, which should have been made more open. Secretariat was so-so: support staff needed more space and there were unforeseen problems with the photocopier and computer. However participants were satisfied with services provided. Travel to and from the hotel and venue were well-planned, participants being particularly pleased with the low rate negotiated by organisers. Adequate preparations were made in anticipation of the midweek work stayaway in Harare.

Acronyms Used in this Report

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
AWG	Africa Working Group of the Water Supply & Sanitation Collaborative Council
CBO	Community Based Organisation
CDD	Control of Diarrhoeal Diseases
DANIDA	Danish International Development Agency
DELTA	Development Education for Leadership Teams in Action
DFID	Department for International Development
EADC	East Africa Development Community
EPI	Expanded Programme on Immunisation
HEP	Hygiene Evaluation Procedures
HIV	Human Immune Virus
ITN	International Training Network
M&E	Monitoring and Evaluation
NETWAS	Network for Water & Sanitation International
NORAD	Norwegian Agency for International Development
IWSD	Institute for Water & Sanitation Development
LPSA	Learner-centered, Problem-posing, Self-discovery and Action-oriented
NGA	Non-governmental actor (private sector)
NGO	Non-governmental organisation
PALNET	Participatory Learning Network
PHAST	Participatory Hygiene and Sanitation Transformation
PHE	Participatory Hygiene Education
PRA	Participatory Rural Appraisal
RRA	Rapid Rural Appraisal
RUWASA	Rural Water and Sanitation Project, Government of Uganda
SADC	Southern Africa Development Community
SARAR	Self-esteem, Associative Strength, Resourcefulness, Action-planning and Responsibility
Sida	Swedish International Development Agency
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOT	Training of Trainers
UNDP/WB	United Nations Development Programme/World Bank
UNICEF	United Nations Children's Fund
VIPP	Visualization in Participatory Processes
WHO	World Health Organization
WSP-ESA	Water & Sanitation Program for East and Southern Africa (UNDP/World Bank)

Participatory Approaches in Hygiene & Sanitation/PHAST Regional Workshop



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