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WASH FIELD REPORT NO. 217

CARE/SIERRA LEONE COMMUNITY PARTICIPATION ASSESSMENT

Prepared for the USAID Mission to Sierra Leone
and CARE
under WASH Activity No. 352

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GLOSSARY OF ACRONYMS

ACE	Assistant Chief Engineer
CD	Country Director
CUSO	Canadian University Services Overseas
DO	District Officer
EHE	Environmental Health Education
ES	Environmental Sanitation
FAO	Food and Agriculture Organisation
FBC	Fouray Bay College
GOSL	Government of Sierra Leone
MAF	Ministry of Agriculture and Forestry
MEP	Ministry of Energy and Power
MIRDP	Moyamba Integrated Rural Development
MOH	Ministry of Health
MRDSSY	Ministry of Rural Development, Social Services, and Youths
MYP	Multiyear Plan
NGO	Nongovernmental Organization
NORAD	Norwegian Agency for International Development
NRWSSP	National Rural Water Supply and Sanitation Program
PC	Paramount Chief
PCV	Peace Corps Volunteer
PHC	Primary Health Care
PHI	Public Health Inspector
PN	Project Number
RTA	Regional Technical Advisor
RWSSU	Rural Water Supply and Sanitation Unit
SL	Sierra Leone
SOW	Scope of Work
TBA	Traditional Birth Attendant
TPM	Team Planning Meeting
VIP	Ventilated Improved Pit (Latrine)
WASH	Water and Sanitation for Health Project
WS&S	Water Supply and Sanitation

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CARE is the largest nonsectarian, nongovernmental, nonprofit development and relief organization in the world today. CARE's collaborative efforts in overseas projects are valued at almost $5 billion since its inception in 1945. During its 41-year history, CARE has worked in more than 75 countries and has supported efforts in every conceivable sector of development while effectively responding to emergencies.

CARE's programs are consistent with national development plans and involve to the fullest extent possible the partnership approach. They provide for timely and flexible inputs of relevant resources (human and financial) and skills. From project planning through implementation and evaluation, CARE is involved in a collaborative effort with active participation of local community groups and such institutions as host government agencies and multilateral and/or private sector organizations.

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EXECUTIVE SUMMARY

This report is a result of a request for technical assistance made by CARE/Sierra Leone to the Water and Sanitation for Health (WASH) Project. CARE asked that assistance be provided in revising its implementation strategy for the Moyamba Rural Water Supply and Community Health Project to more fully incorporate community participation.

Community participation, which CARE regards as being the most appropriate means of maximizing benefits of water supply and sanitation projects, is defined according to a framework presented in a draft paper by Paula Donnelly-Roark ("New Participatory Frameworks for the Design and Management of Sustainable Water Supply and Sanitation Projects," WASH Field Report No. 220, 1987). The process of community participation is described as being the means by which "... communities deal with changes in their midst and incorporate those changes into their existing ways of doing things."

Over the past six years, CARE's water supply and sanitation initiatives in Sierra Leone have focused primarily on the technicalities of establishing water supply and sanitation infrastructures in small rural communities. Once established, however, it was often found that the infrastructures quickly deteriorated and were subsequently abandoned.

During the 12 months preceding the preparation of this report, however, CARE, in collaboration with the Ministry of Energy and Power, made progress toward developing a revised implementation plan which features significant elements of community participation. The report must, therefore, be viewed as a continuation of what has already been achieved by project staff.

The three-week assignment, in August 1987, was a field-based exercise and employed a methodology developed in situ by the team in collaboration with the project health education and construction staff.

The findings and recommendations presented in the report are based upon consideration of issues which arose during the field work and interviews with other development agencies in Sierra Leone. These issues include project approach, community structure, technology, and personnel as they relate to the National Rural Water Supply and Sanitation Program.

The principal conclusions are as follows:

- The necessary changes and shifts in emphasis in implementation practices may come about only as a result of a commitment to community participation by project staff at all levels.

- Community participation implies recognition by the project staff of the validity and effectiveness of village-based organizations and the decision-making apparatus that is in place.

- Community participation implies a need to establish, at an early stage in the intervention, an exchange of information between project staff and community.

- Community participation implies a process whereby control of the project becomes a communal responsibility, rather than a situation in which project staff determine the agenda.

The report, which is organized to reflect the sequence of activities undertaken during the assignment, will be of interest to individuals engaged in other rural water supply and sanitation projects in Sierra Leone. It is also hoped, however, that the methods employed and processes developed for the Moyamba Project will be of interest and use to project managers and field workers facing similar challenges in water and sanitation projects in other parts of the developing world.

Chapter 1

INTRODUCTION

1.1 Scope of Work

On October 24, 1984, staff of USAID S&T/H and the Water and Sanitation for Health (WASH) Project staff met with CARE program staff to discuss the ways in which WASH could assist CARE in its water supply and sanitation (WS&S) activities. The meeting resulted in an agreement between WASH and CARE to conduct a workshop for CARE project managers in planning and implementing a training project for water supply and sanitation. The workshop, WASH Activity 133, was held in Freetown, Sierra Leone, on July 18, 1985. It focused on skills needed in community participation, technical applications, and project management for water projects. Under WASH Activity 162 (completed in November 1985), WASH consultants also prepared an evaluation plan for various components of CARE and the Government of Sierra Leone (GOSL) WS&S projects.

The current assignment is a result of discussions with CARE/Sierra Leone and WASH staff. CARE/Sierra Leone agreed that the CARE Regional Technical Advisor for Primary Health Care for West Africa and a WASH staff member would undertake this collaborative assignment. The two original team members were joined by two GOSL employees--the Assistant National Coordinator for the National Environmental Sanitation Secretariat and the Moyamba Project Manager--and the CARE Field Representative who oversees the project.

From August 17 through September 4, 1987, the team was asked to undertake the following activities:

1. Determine the need for the further development of the "preimplementation," community organization component of the strategy. Particular attention was to be given to the ways in which a community can participate in formulating a village health plan. What form should the plan take? How can this process best be designed to sensitize a community to health issues?

2. Regarding the proposed strategy, review project personnel capabilities. What level of ability exists? Identify the training needs of the staff. Who needs training? Who should train and when should training be implemented?

3. Based on the above, assess the need for further technical assistance.

1.2 Background to the Project

1.2.1 The Setting

Located in the south of the country, Moyamba District is for much of the year green and lush. This appearance may, however, belie the fact that the District, in common with the whole of Sierra Leone, is poor and undeveloped. Moyamba District is characterized by small agricultural settlements, each with a population of between 100 to 1,500. An estimated 470 such villages are located in the project area. Of these, approximately one-half are accessible by motor vehicle.

Moyamba District is dominated by the Mende tribe, whose traditional lands extend from Moyamba, eastward to the Eastern Province and beyond into Liberia. Also of importance are the Sherbro and Temne people who predominate in the coastal areas and west of the District, respectively. In the northeast of the District, bordering Bombali District, a few Susu and Loko communities are also found.

Agriculture is the most important economic activity in Moyamba District. Slash-and-burn cultivation is carried out on a shifting basis in upland areas, while inland valley swamps and those areas adjacent to rivers are farmed perennially. Agriculture is almost exclusively subsistence; few of the cash crops (for example, coffee and cocoa) found in the Eastern Province are cultivated. Small quantities of ginger are, however, exported from Moyamba, as is some palm oil, maize and, occasionally, rice.

1.2.2 Project Chronology

1.2.2.1 Introduction

CARE/Sierra Leone's involvement in rural water supply and sanitation efforts began in the late 1960s, through the funding of proposals for small village water systems in the Northern Province of the country. This involvement was gradually phased out during the mid-1970s as CARE started to develop a more systematic approach to its programming activities.

1.2.2.2 First Multiyear Plan Period

Activity in the sector was renewed in 1981 with the funding of the first CARE Multiyear Plan (MYP) proposal for the Moyamba Clean Water Project, as it was then called. The proposal, which was implemented in cooperation with the Moyamba Integrated Rural Development Project (MIRDP) and the Water Supply Division of the Ministry of Energy and Power (MEP), covered the three-year period 1981 through 1983 and featured hand-dug well construction, environmental health education (EHE), and sanitation components.

Well construction was the dominant activity during this first three-year period; a total of 41 units were installed in rural communities of between 250 and 1,000 people. The well design itself was adopted from standards established by the MEP and comprised two basic elements:

- A reinforced concrete lining down to the dry season water table
- A reinforced concrete cutting edge and culvert (caisson) cast inside the lining and sunk to a depth of between three and five meters into the water table.

A rope and bucket run on a simple pulley provided the means of drawing water from the well.

In association with well construction activities, the project also undertook a program of environmental health education (EHE) in participating communities. An important feature of this program was the provision of ventilated improved pit (VIP) latrines, of which 69 were constructed between 1981 and 1983.

In 1983 WASH was asked to assist in organizing and implementing a latrine construction workshop for technicians working on the Moyamba and similar projects in other parts of Sierra Leone. The workshop established the VIP latrine as the standard design for expanding the National Rural Water Supply Program.

1.2.2.3 Second Multiyear Plan Period

The second MYP proposal for the Moyamba Clean Water Project, (jointly funded by CARE/USA and NORAD, the Norwegian governmental development agency) covered the period 1984 to 1986 and was based largely upon the experiences gained during the previous three years' activity. Well construction again dominated project activities and objectives, while EHE and sanitation continued to be classified as follow-up to the main intervention. Nevertheless, during this period 77 well units and 195 VIP latrine slabs and vent stacks were constructed in more than 70 communities throughout Moyamba District.

Thus, for the first six years of the project, emphasis was placed on refining well-construction techniques and solving attendant logistical problems. A total of 120 wells were in place, providing total coverage of approximately 40,000 people. (The Moyamba District population is approximately 250,000.)

Health education, which had not received sufficient attention during the early stages of project development, became increasingly overshadowed until, it seemed, the construction of wells and installation of latrines became ends in themselves rather than just two means through which an improvement in health could be realized.

1.2.2.4 WASH Evaluation

CARE/Sierra Leone recognized that the EHE component was being neglected and in 1985 invited a WASH consultant to evaluate the Moyamba Project. The results included recommendations which, while wide ranging, focused mainly on the project's failure to address the central issue of poor health in many of the participating communities. Too often, wells were not being used, latrines were simply not being constructed beyond slab installation, and behavior and attitudes toward health and sanitation remained unchanged. The consultants recommended that health education should be given higher priority by the project managers and that project staff should become better informed regarding the needs, complexities, and time requirements of effective health education programs.

The WASH evaluation marked the beginning of a process of rethinking project content and approach which was continued into 1986 with assessments being made by both CARE/Sierra Leone staff and visitors from CARE/New York. Opinions invariably concurred with the WASH findings, and, consequently, the decision was made to undertake a revision of the intervention.

1.2.2.5 Project Redesign

A first step in the process of revision came in September 1986 at the inception of the third MYP period (1987 to 1989), when the CARE/West Africa Regional Technical Advisor responsible for primary health care visited the project. The visit coincided with the emergence of a number of new ideas being developed by both the Project Manager and the EHE Coordinator. These ideas, which were aimed at redefining levels of participation expected both in villages and among project personnel in the project development process, concentrated on strengthening both the sanitation and EHE project components. As such, they served as the basis for revision and experimentation over the past year.

The revisions made thus far in the project implementation plan were initially facilitated by a 50 percent reduction (from 40 to 20) in the number of wells targeted for completion during 1986-87. In this way, project resources were concentrated in a smaller number of communities, thereby creating more time in which to pursue new themes.

Thus far, it does appear that the revisions included in the implementation plan have produced encouraging results. Significant progress has been made in developing a latrine and associated sanitation EHE project component; a considerable increase in the number of latrines being completed and used has been reported. In this instance, the improvements are interpreted as resulting from a combination of improved scheduling, more appropriate EHE techniques, and a greater level of involvement by participating communities in the choice of latrine materials.

Equally significant is the way in which project personnel have, over the past year, been increasingly involved in shaping the revision of the implementation plan. For example, project personnel (health workers and technicians) were instrumental in formulating the 1987-88 implementation plan upon which the sequence of activities recommended in this report is based.

It became apparent that while worthwhile revisions were under way, further input was required to develop the EHE strategy to a level which embodied the principle of community participation at all stages of project planning and implementation. Of particular concern were issues relating to the involvement of communities in project decision-making processes (for example, identification of health issues), participation of women in project development and implementation, and project sustainability. Thus, in January 1987 CARE/Sierra Leone requested technical assistance, and in April, WASH responded with a visit from its Deputy Director, who helped to prepare the scope of work upon which this report is based.

1.3 Methodology

This section outlines the process used to achieve the objectives of the assignment. In keeping with the primary objective, that is, the development of a strategy for a more participatory process in the project area, team members felt compelled to put into practice what they were advising others to do.

The major constraint to reaching implementation of this process was the lack of time. Assignments such as this consultancy are assumed to be somewhat directive in nature with, at best, a substantial amount of information sharing between project staff and consultants. Such an approach assumes that the "experts" have the answers, they relay them to project staff, some discussions occur, and a strategy is handed to project staff for implementation. The consultants realized that this approach is no different from nonparticipatory "directive" water projects where project staff "tell" communities what to do. It is the hope of the team members that this section will assist others in adopting a more participatory process to meet their needs.

Implementation of this process was helped by three factors. First was the collaborative nature of the team's composition, that is, project staff, NGO staff, and national government representatives. The second was the multidisciplinary composition of social scientists, technicians, health educators, and communications specialists. Third, all concerned, that is, the donor, the project staff, and those representing the government, were convinced that this refocusing was necessary.

1.3.1 Review of National and District-level Experience in Community Participation

The objective of this step was to identify those projects that have included community participation. At this point, it was not detailed evaluative information that was being sought, but rather a general idea of the scope of earlier projects and the identification of key people involved in their design and implementation. (Appendix D contains the interview guide used in this process.) Three teams devoted one and a half days to this activity.

The major outcome of this step showed that PVOs and governmental agencies are experimenting with similar issues of community participation. Among them, the Canadian University Services Overseas (CUSO), through its adult literacy programs, developed the Rural Rapid Planning method whereby communities develop their own health and development plans: outlining the activities, how they are to be implemented, who is responsible to carry out each part, and a tentative time schedule.

Plan International trains its field workers at the Delta Pastoral Center at Kenema. The Ministry of Social Welfare is developing curricula in community participation at the Training Center (NTC) and Bunumbu through the National Dissemination Program. The Community Health Department at Fourah Bay College has students interested in conducting research on community participation in health related fields.

The Moyamba Integrated Rural Development Project at Moyamba has successfully organized farmers' groups and has field and extension agents implementing community development activities. FAO has a similar program. In addition, the Bo-Pujehun Project has a handpumps water component with a community participation approach and staff training capability (See Appendix E.)

1.3.2 Team Orientation and Design of Field Work

The team spent 15 hours in a team planning meeting, the objectives of which were to arrive at a consensus and working definition of participation and to develop field instruments. During the course of one and a half days spent in developing tentative end products, all team members read the WASH/UNDP draft concept paper, "New Participatory Frameworks for the Design and Management of Sustainable Water Supply and Sanitation Projects" by Paula Donnelly-Roark.

Team members found the paper provided clear explanations regarding why things were not working. It also provided the much needed framework around which a refocusing effort can take place. CARE and GOSL staff became aware that their approach to participation has tended to be more "initiation" based and thus did not focus on creating a sense of "responsibility."

The field instruments developed attempted to elicit information on

- Community-based traditional institutions, that is, management systems for water and for other development activities
- The decision-making process
- Key influential people and institutions in the community
- Perceptions regarding water, latrine uses, and health
- Why and how the CARE water project either worked or did not work in their community.

Four small groups composed of team members and project personnel conducted the interviews in 12 villages over a three-day period. Because of the farming schedule during the rainy season, interviews were held during early mornings and late evenings. Each team visited one village from each of the following categories:

- Villages where sustained community participation is evident
- Villages where the well has water but is not being used and/or where latrines, if installed, are not used
- Villages in which initial contact has been made but no construction activities have been undertaken.

1.3.3 Moyamba Staff Input

A one-and-a-half day meeting in the form of a workshop involved CARE/MEP project staff. The objectives of the meeting were (1) for the members of the team to understand how staff currently go about preparing communities and what the staff ideas about participation are, and (2) to review the field instruments and to make changes and allowances for contextual and linguistic nuances.

Usually, there is a significant distinction between what people actually do and what they say they do. A structured interview of field workers, therefore, was deemed inappropriate. Instead, all staff (that is, management, construction, and health workers) made up two teams: one group enacted how things go in a participatory situation, while the second group enacted a situation where "things were not going well." Then teams reported on the reasons for each situation. During the process of enacting these situations, the attitude of the health worker toward communities became clear, as did the attitude of the communities toward the project staff.

In the course of dramatizing their experiences, as opposed to formal presentation or interviews with the team, subjective perceptions and attitudes of staff members emerged. Because staff are proud to be affiliated with the project and CARE, they view their mission as one of converting people to the effort, doing it with missionary zeal. Where communities did participate in the project, staff felt that community members were "cooperating" with the project or that the community leaders were forceful in mobilizing the community to participate. Among the project staff, there was no clear sense of shared decision-making in the well activity. It was evident that critical factors which can influence how a community participates in a project include the quality of its leadership, actions and attitudes of the health educator, and degree of unity and cohesiveness in the village.

In addition, it was pointed out in the dramatized presentation that the communities do not always view the well and/or the latrines as something necessary. The Mende saying, "water never kills," is cited. The convenience of using the stream where people can wash and collect water and "do everything at the same time" is not possible with a well. Only one person at a time can use the well.

The role plays were followed by small group discussions in which the health educators and technicians defined community participation and proposed indicators for measuring it. The final activity was a plenary session in which the group brainstormed to develop criteria for evaluating whether a project has been successful in a particular community.

In reviewing this one-and-a-half day exercise with team members and project managers, it was agreed that while the staff was brought into the process, with a few more days it would have been possible to also develop the field instruments with them.

1.3.4 Field Visit

The interviewers spent three days in the field, a full day in each village. After the first day and a half, the questionnaire developed during the team planning was reviewed and certain questions were slightly modified.

Given time and personal constraints, it was infeasible to attempt to do systematic sampling. However, it was considered important to interview formal and informal leaders as well as a number of other men and women in each community. Because the communities varied in size from 200 to 500 people, no fixed number of interviews was set.

Although the interviews cannot be strictly interpreted as representative of a particular village or of the project zone, the field work proved to be quite useful, as indicated in the following chapter regarding findings. The information gathered did show clear differences between villages where community participation continues and villages where the project had not been as successful.

Personnel participating in the exercise saw new possibilities for information collection and gained additional insight into the communities with which they work. With some revision and expansion, it is clear that the questionnaire used could become an integral part of the initial community survey which the health educators conduct in new villages.

1.3.5 Analysis of Field Data and Formulation of Findings and Recommendations

The analysis of findings and preparation of a list of recommendations were completed in two stages:

(1) Following the field work, an all-day session brought together the team and the project staff. The first task was to prepare an exhaustive list of what the health educators and technicians had learned from the field work and/or what the exercise had confirmed for them. Once the list was complete, they proposed a series of recommendations based on the question: "What can you as project staff do to strengthen the project, especially the community participation aspects?"

(2) The six-member team also met for two and a half days to discuss findings, to draft recommendations, and to begin to refine the sequence of activities to follow when working with communities.

Again, the findings and recommendations were developed with continuous input from GOSL technical personnel. In many ways, the recommendations are the program's objectives and priorities. The sequencing of events is essentially a process for all the components to fit together for specifically the Moyamba/CARE Water Project.

In planning the sequencing of activities, the major emphasis was placed on attention to issues such as timing and content. Each step was structured to enable both project staff and communities to have an opportunity to change their minds.

Chapter 2

FINDINGS

Most of the findings listed in this chapter are a result of information collected during field work. Others were a result of conversations and work sessions with the project staff during the ten days that the team spent in Moyamba.

2.1 Project Design and Approach

The project's reorientation process, which was initiated a year ago, focuses on enhancing community participation and ensuring sustainability of the intervention. The project has not, however, made sufficient use of existing village-based groups which initiate communal activities. Villages where such organizations had previously undertaken "self-help" initiatives (e.g., mosque construction) are more participatory.

The project has not exploited some notable successes in which communities have participated fully in the project implementation process. In these villages, community members expressed a willingness to travel to other villages to describe and promote their experiences. They also indicated an interest in inviting villagers to their own community for the same purpose.

Applications for a well do not always represent what the community wants. This is due partially to the fact that the initial approach to the community has usually been through the formal district- and chiefdom-level structures. Not enough allowance was made for variations between villages or for nonformal structures and decision-makers already in place.

The frequency and duration of contact with the community by project staff may be a factor in the success of the intervention. When more time and thought are applied to a thorough community investigation so that a number of opinions and views from a wide range of individuals are solicited, a much clearer understanding of the workings of the community is obtained. As a result of insufficient time being spent in the villages, the health workers have not been effective in helping the communities to develop a health improvement plan based on WS&S activities.

Because insufficient time is being spent on community investigation and the process of participation, the responsibilities of the community and its expectations of the project are not always clearly defined. For example, in some instances, communities expected greater numbers of wells and latrines; other communities believe that it is CARE's responsibility to maintain and/or replace the rope and bucket for the well.

Communities greatly value well-opening ceremonies and formal recognition of their participation in the project, including certificates for members of the water committee. In communities which had previously been involved with the project, the water committee members requested either refresher courses or additional messages in EHE.

2.2 Community-based Information Networks and Structure

There are many local organizations and nonformal leaders that need to be involved in the decision-making process; youth groups, osusu (Women's Savings Association), and farming groups, for example, are important channels for information dissemination. If these organizations and recognized leaders are not consulted, any structure for managing the WS&S intervention will not be representative of the community.

The mosque or church is frequently a focus of activity in the village. Imams and other community-based religious leaders, therefore, could play an important role in communicating project messages. Having respected and effective community leaders seems to be a factor in the success of participatory processes.

In each community's standard decision-making process, women are consulted on all decisions which affect the entire community, especially water-related issues. Women are always the first-level authorities on water use, locations of sources, and resolutions of disputes about water. Not surprisingly, women generally gave more complete and informative answers than men regarding water and health issues.

Communities have internal mechanisms for organizing themselves. In this respect, each village has a recognized division of labor by age, sex, and other criteria.

Smaller communities (less than 300) tend to be more unified, with fewer factions, than larger villages. This often results in a greater willingness to participate in village development activities. For example, such communities were viewed as better able to maintain the well and to organize the purchase of replacement ropes and buckets.

2.3 Perceptions Regarding Water and Its Use

Perceptions about "good water" and "bad water" for drinking vary from one community to another. For example, some considered running water as being "good" while others thought the opposite. Temperature seemed to be an important variable (coolness is desired) as were odor, color, and taste. The taste of chlorine in well water was considered to be medicinal and, therefore, good.

Convenience and availability of water during the dry season were cited as the main reasons for wanting a well. Health was rarely mentioned. Similarly, convenience, status, and esthetics (rather than health) were cited as the main arguments in favor of latrines. In general, the connection between health improvement and water and sanitation interventions was not made. Some communities do not see the necessity for having a well because they have a convenient, year-round water supply.

2.4 Technology

Well-construction technology has reached a high standard in this project. Villages have definite preferences in terms of what type of water to use for different purposes, for example, bathing, drinking, and so forth. In many cases it is apparent that the well may not meet all the water needs of the community. In a number of communities traditional sources continued to be used alongside the new well.

While the demand for latrines is high, insufficient attention has been paid to local beliefs, practices, and preferences regarding sanitation. Examples include the following:

- People want to have washing water near or in the latrine. This is especially true for Muslims who use water for cleansing after going to the toilet.
- In Muslim households, men and women do not want to use the same latrine.
- The VIP latrine requires an absence of light in order to work effectively. Most people interviewed objected to this lack of light as it is difficult to see inside. The absence of light also inhibits children from using the latrine.
- People prefer a door on their latrine to keep animals out.
- Some people would prefer a latrine with a seat.

Replacement ropes and buckets for the well are not widely available on the open market. Consequently CARE/MEP have been obliged to supply these items to the communities at cost.

2.5 Personnel

It was observed that the health educators have been moderately successful in communicating basic health messages to many community members, particularly to influential individuals. A need exists, however, to develop a secondary level of EHE messages (for example hand-washing and soap making) to complement the first set.

Staff tend to define project success in terms of the community's willingness to "cooperate" with them rather than in terms of creating a sense of responsibility for change through participation. Women health workers tend to have better access to women in the community.

2.6 Policy Issues

During a given season, it may be more efficient and more effective for the project to work in a smaller geographical area. The project is associated throughout the District with the installation of free wells and latrines, thereby making it difficult to start at any other point than talking about water when working in new villages. This situation has implications for project staff's desire for health issues to be the starting point for discussion, not the well itself. Finally, the GOSL approach places more emphasis on the number of systems in place than the community participation process.

Chapter 3

RECOMMENDATIONS

To continue to refocus the project so that emphasis is on participatory process rather than on actual numbers of systems, the following recommendations (highlighted in bold print) need to be implemented.

3.1 Revise the Village Selection Process

In a given construction season, concentrate project activities in a narrower geographic area. This approach will facilitate logistics, permit more frequent contact, and enhance visibility. Within this geographic zone, work in several villages in a cluster. This approach will maximize the multiplier effect of successful experiences on surrounding clusters and will have higher visibility than working in only one village within a cluster. To the extent possible, include in these clusters villages which were previously in the project but whose systems need to be rehabilitated.

For the immediate future, concentrate activities on smaller villages (those having 200 to 400 people) where the revised strategy can be further developed before undertaking larger communities which are often more problematic to work with. Previously excluded communities with even smaller populations (less than 200) should be considered for inclusion. Consider giving priority to villages which do not have a nearby year-round water source, as motivation is generally high in such communities.

Because previous self-help initiatives are often a key to successful intervention, **consider giving priority to those villages which have demonstrated prior commitment to and motivation for community improvement activities.** If the project staff decide to work in larger communities in the future, explore the possibility of working in one section (neighborhood) at a time, thereby reducing the likelihood that ethnic and other rivalries will hinder activities.

3.2 Expand the Technological Options

Within the villages selected, the options available for water supply need to be expanded as it is clear that an improved well alone does not always meet a community's needs. In a similar vein, the villagers' suggestions for adjustments in the VIP latrine design need to be investigated and, where possible, acted upon.

Where communities are interested, **improve traditional water sources as a complement to the new well,** thereby encouraging the use of the well especially for drinking water.

In communities which seem motivated, **consider rehabilitating systems which are not being used.** This approach will require developing a methodology that will enable staff to conduct a thorough investigation of why the system is not being used and an appraisal of the community's potential for maintaining the system when project personnel withdraw.

The foregoing recommendation does not preclude the fact that the MEP standard-design well is the safest alternative to traditional water sources. It must be acknowledged that there are average or poor traditional sources that will require an investment much larger than the construction of a new well. MEP's recommendation is that the project should endeavor to meet all village water needs through the new well (and additional wells if required).

In each village, **conduct a study to determine the community's attitudes, practices, and preferences concerning latrines.** It will be especially important to explore the special needs of Muslims and small children. Every effort should be made to consider the feasibility of altering the current VIP latrine design to meet people's requests for the following:

- More light
- Doors
- Seats
- A place to wash
- Separate facilities for men and women.

3.3 Strengthen Community Participation Processes

Selecting villages and deciding upon the range of technologies to offer are preliminary steps which set the stage for collaboration between project staff and the community. To ensure that this collaboration is successful, all parties must implement a number of recommendations which will strengthen the participatory process.

Continue to improve the two-way flow of information between project staff and the community. The following methods are suggested:

1. Revise the instrument used to carry out the initial village survey. Include a modified version of the questionnaire used for the field work in this assignment.

2. Ensure that health educators spend more time in the village, involving themselves in the daily activities of the community and building rapport.

3. Involve villagers in the baseline survey, especially in mapping the community to show preproject water and sanitation facilities.

4. Further develop the EHE strategy to include more creative and varied communication techniques and materials.

5. Develop a second level of EHE messages (for example, hand-washing and soap-making) and train staff accordingly.

Involve a wider, more representative range of people in the project, especially women who are the principal decision-makers and managers where water systems are concerned. Some possible activities would be the following:

1. Direct EHE through existing village-based women's organizations and formal and informal leaders, such as mammy queens and traditional birth attendants (TBAs).

2. Increase the number of female health educators to facilitate contact with village women.

3. Ensure that women are represented on whatever management body the community designates for its water supply and sanitation system.

4. Ensure that health educators see that:

    - the community's major ethnic groups are represented on the management body.

    - The application for the WS&S improvements is representative of the majority of the village.

5. Use Imams and other religious leaders as channels of communication. (Mosques and churches are focal points for communities. Older women, often the caretakers for young children, may stay in the village during the day, attending the mosque for prayers several times each day.)

6. Promote exchanges between leaders in participating and nonparticipating villages.

7. Reinstitute activities which motivate and reward individuals and communities which have participated in the project. Examples include:

    - Formal well-opening ceremonies to which neighboring villages are invited.

    - Certificates of achievement for the village as a whole and/or for individuals who complete special EHE training.

3.4 Strengthen Staff Capabilities

Project staff are the key to improving community participation. No matter how well the project is designed and how carefully the communities are selected, it is the health educators and technical staff who, in the final analysis, have to carry out the daily activities that will culminate in a refocusing. There are a number of ways in which their capabilities can be strengthened, including providing both technical and moral support.

Use advertising and enlarge the recruiting pool to increase the number of female health educators. Candidates could be drawn from:

- State-enrolled community health nurses
- Graduates of NTC
- The National Dissemination Program which trains primary school teachers in community development
- The Community Health Department at Fouray Bay College (FBC).
- Schoolteachers
- The Institute of Adult Education at FBC
- Public health inspectors.

Focus in-service training for staff on the following content areas:

- Topics they propose during a training needs assessment
- Participatory processes through which the community can take greater responsibility for implementing, sustaining, and evaluating a project
- Diversifying health education methods, including the use of drama in the community
- Improving the documentation and record-keeping process within the project.

Design a long-range training plan to include topics and identify resources to carry it out:

- Short- and medium-term: use of drama, documentation process, interviewing techniques
- Long-term: community participation techniques. (On-the-job action training may be the best method for doing this type of training.)

- Possible resources in Sierra Leone: the National Environmental Sanitation Secretariat; Dele Charley, playwright; the Delta Program; the Community Health Department at FBC; Bunumbu Teachers' College; and resources used by other NGOs.

Consider hiring a full-time employee with strong training, health education, and communications skills to ensure that the long-term training is carried out.

Strengthen communication and team work within the project by continuing to

- Integrate the previously disparate interests of the construction and EHE personnel
- Schedule regular all-staff meetings to discuss technical issues and health/welfare/support concerns
- Include the entire staff in the planning and reorientation activities

Improve the quality of contact between health educators and communities by

- Ensuring continuity of personnel within a given community (that is, keeping the health educator in a village throughout the project's activities)
- Using language facility (both Mende and Temne) as a criterion when hiring additional staff.

Design a more complete health education strategy, with particular attention to using a variety of communication techniques and developing appropriate visual aids.

3.5 Policy Considerations

Embodied in the preceding recommendations are a number of policy questions which need to be resolved before certain activities are undertaken. These include the following:

> How can the project's focus on the importance of participation be reconciled with the national policy which emphasizes numbers of systems installed over the participatory process?

Is the proposal to rehabilitate old systems and improve traditional sources acceptable to villagers? acceptable to MEP? technically feasible and appropriate? logistically possible?

What is the possibility for incorporating some cost-recovery mechanisms into the project (for example having households pay for latrine materials) to further develop project sustainability? Are villagers willing and able to pay?

Chapter 4

PROPOSED SEQUENCE OF ACTIVITIES

4.1 Introduction

The foregoing chapters have described the process by which an investigation into the Moyamba Project's experience of community participation was carried out. On the basis of an important redefinition of community participation and its implied need for a major refocus of the project strategy, the team undertook a period of field work from which a range of findings concerning both the project itself and the communities making up the project area were presented. The findings, in turn, when combined with considerations of "nonfield-related" factors bearing on the project, were the basis upon which the recommendations were proposed.

The recommendations, therefore, were developed by the team in cooperation with project staff, to help solve the problem of incorporating community participation, as the only effective and appropriate means of achieving behavioral change within the context of the existing water supply and sanitation projects.

It is important at this stage to stress that the recommendations, and the resultant proposed sequence of activities which flow from them, have been developed for the unique set of circumstances surrounding the Moyamba Project. Those working in other projects can pick and choose from this process. Please note three important points: (1) The process does not focus on formation of water and health committees. The process developed here places emphasis on the community forming its own interest group or groups which will evolve in the course of the year. (2) There are concrete end products for each sequence to allow for monitoring. (3) At the end of each phase, the community and the project staff have the option of stopping further activities in that community.

4.2 Applying the Recommendations

The sequence of activities to emerge from the recommendations needs to take account of three important factors, as follows:

1. Existing implementation plans: as previously described, the decision to revise the Moyamba Project was first taken during 1986, and over the past year a number of changes and innovations have been implemented by project staff. Clearly, any further changes to the project strategy must recognize this fact.

   The revisions made in the Moyamba Project and progress achieved during 1986-87 culminated in July 1987 of this year with a workshop which was designed to focus on lessons learned and to formulate an implementation plan for the coming 12 months. The workshop was the third in a series of similar activities in

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which project staff (health workers and construction supervisors) participated in what had previously been considered "project management" activities involving only project management staff.

Implemented over a period of three days, the workshop had as its final product a Project Implementation Plan which described a 12-month strategy in terms of field-based activities. This plan (see Appendix I, page 79) will, therefore, form the basis of the sequence of activities. The recommendations proposed as a result of the field investigation are superimposed upon, and developed within, the framework of the plan. Significant changes have been proposed only where necessary.

2. The National Rural Water Supply Program: in developing the current plan (see attached Flow Chart of Implementation Plan), the project staff clearly took into account the nature of and constraints imposed by the National Rural Water Supply Program (NRWSP). The Moyamba Project is an important and integral part of the NRWSP and as such it must abide by the guidelines established by the Ministry of Energy and Power (MEP), the executing agency.

   Any additional revisions to the project recommended herein must treat the same guidelines with equal respect. For example:

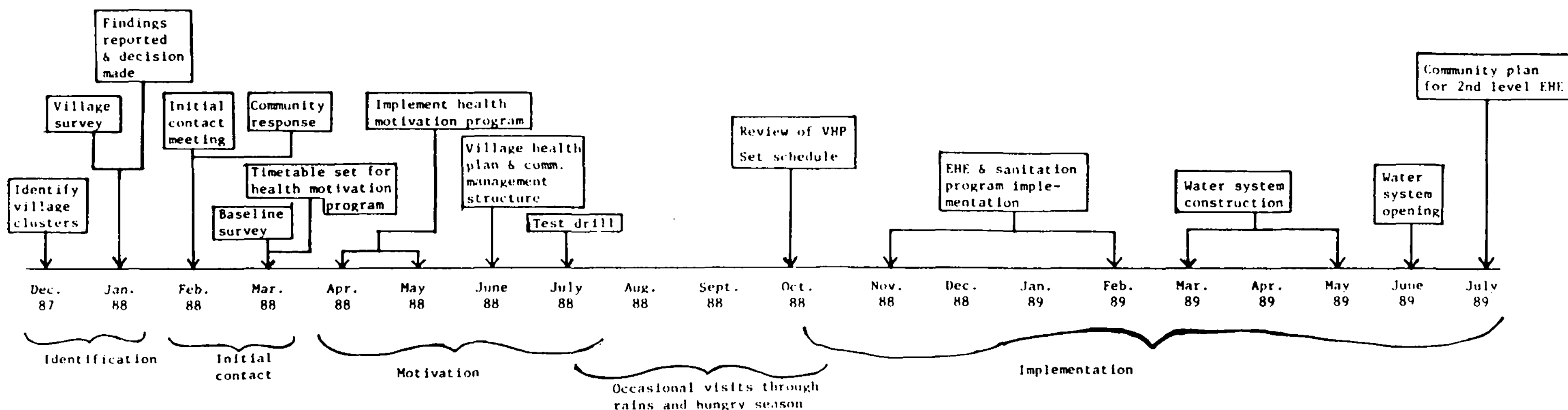
   - As long as MEP continues to be CARE's counterpart agency--and here it should be noted that CARE maintains an excellent working relationship with MEP--the Project will continue to include well and latrine construction as a major component of its health initiatives. In other words, the project, within the context of the NRWSP, is unable to develop other health-related interventions which exclude water supply and sanitation.

   - Equally, CARE, in its relationship to MEP, accepts the technical standards and specifications adopted by the NRWSP.

3. A third factor bearing upon recommendations to be made regarding strategy and activity sequence concerns the way in which the communities perceive the project. In this respect two points need to be made.

   - Communities in the Moyamba District associate CARE with well and latrine construction. This association becomes significant when the issues of village health needs and health agendas are raised. Community members will not be able to dissociate, in their minds, CARE project staff and the installation of free wells and latrines.

NEW VILLAGES



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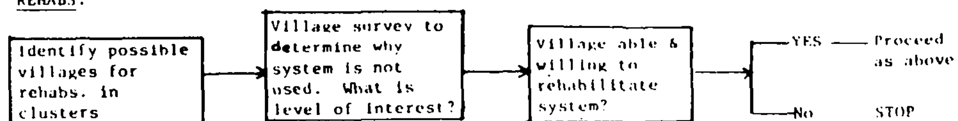

Figure 1. Flow Chart of Implementation Plan

- For similar reasons, a proposal for incorporating a cost-recovery mechanism in the strategy as a means of developing the sustainability of latrines, for instance, will face resistance from the communities. Clearly, such resistance would be a function of the project's policy to date of providing, free of charge, locally unavailable materials for VIP latrines and wells.

4.3 Implementation Plan (see attached flowchart)

On the basis of the recommendations described earlier and upon consideration of the foregoing factors, an implementation plan comprising a sequence of activities is proposed.

Identification of village clusters is based on applications received by way of the District Office from the Paramount Section and Village Chiefs, and other approaches from nonformal groups or organizations. Clusters of new villages located near a previously successful project intervention are identified. Given the project's current resource availability, there should be no more than 30 villages included in the program in a given year.

The village survey is the point of entry and preliminary information gathering. The project health worker implements a community survey to obtain information concerning levels of community organization, experience of participation, community decision-making, motivation, and village needs. The survey may be based on a more developed version of the field instrument used in this consultancy. (See Appendix F, page 63.)

During the survey, which should be implemented over a three to four day period, a range of village residents would be interviewed. It is important to stress at this point that care must be taken to ensure that channels of communication are established with the "nonformal" community leaders rather than with just the visible hierarchy of village chief, mammy queen, and so forth. Religious leaders, organizers of farming and savings groups, TBAs or "grannies," and youth leaders are usually central characters in a community's life but are not always immediately known to the outsider.

The health worker reports findings to the project staff upon which a provisional decision is made to proceed with the intervention. Once the decision is made, the health worker will arrange a time for what has been termed the initial contact meeting.

The initial contact meeting is an opportunity for the Project Manager and/or EHE Coordinator to meet with the community to discuss the broad scope of the intervention.

The meeting should aim to produce an understanding between the community and project that the wells and latrines, seen in other villages and which the community wishes to have itself, are but two components of a larger effort aimed at helping the village improve health through water supply and sanitation. Emphasis will be given to the fact that the intervention can succeed only if the village obtains consensus. (At this point, it is helpful to point out that, in some communities, decisions about project implementation appeared to have community support but were actually decisions of a few political figures; they did not represent a true consensus of the community. In such cases, project sustainability was not achieved.) Accordingly, the community will be asked to decide upon a way by which it can demonstrate that its commitment to village health improvement is an expression of the majority. It is also important at this stage to ask the community to consider the length of time necessary to develop and implement a plan for health improvement. Community members will be made clearly aware of the costs and benefits to them of such interventions. The meeting will close with an arrangement for the health worker to return (within two weeks) to obtain the community's response to the issues raised.

The community's response to the initial contact meeting, for example, in the form of a letter to the project signed by 80 percent of household heads, will enable the project to proceed with the baseline survey. (The form that the show of majority takes will vary from one village to the next.)

The baseline survey enables the project to assess relevant health-related knowledge, attitudes, and practices.

During the survey period, the community will be asked to prepare, with the assistance of the health worker, a map or schematic plan of the village. Upon completion of the baseline survey and map, a time and date will be arranged for a meeting at which the community will be asked to discuss the health status of the village. The meeting will aim to share with the community issues and ideas about health, with particular regard to water and sanitation, which arose from the interviews conducted during the village and baseline surveys.

A timetable for health motivation is then drawn up. Following the baseline survey, the community will be invited to participate in a program of health motivation. The program, which will be implemented over a two month period according to the community's own timetable, will attempt to bring to the fore issues relating water and sanitation to health.

Implementation of the health motivation program follows. It is suggested that the program be based upon materials developed by the nearby Bo-Pujehun Project. These materials, which highlight water and sanitation issues rather than dealing with specific solutions, were field tested by project staff and found to be appropriate in terms of directness of approach and levels of participation required for their implementation.

In addition, it is suggested that project staff also consider traditional storytelling, using village-based dramatic techniques, as a means of highlighting the health issues arising from the baseline survey. Of course, such methods cannot be simply applied without the health education staff first acquiring the necessary skills through training. It is, therefore, assumed that training will be given to health workers before any initiatives are undertaken in this field. (See Appendix A for an example of village-based drama.)

A suggested approach might be to organize a formal or informal meeting of users, where pictures or flip charts are shown, questions asked about the text, and community members come up with their own answers and examples. Materials, used to stimulate discussion, might focus on

- how dirty water brings illness,
- how safe water is good for everyone's health,
- differences and uses of well water and old water points, and
- safe collection and storage of drinking water.

Such materials need to be developed and integrated into the activities schedule.

Through these meetings and discussions, the community will be able to develop for itself a range of water- and sanitation-related issues which it believes can be addressed through a village health improvement plan.

The village health plan and community management structure are drawn up by the community to form a program of health education focused on water supply and sanitation. The community, having recognized the range of issues which it believes can be addressed, will be asked to formulate a timetable of activities. The activities will be implemented according to the agreed timetable in conjunction with a program of activity-specific EHE. During this period, the EHE project staff worker will assist the community in either identifying a management committee based on his/her village survey findings, or suggest one that is already functioning in the community.

The test drill is an important activity and is placed early in the implementation phase because of two important constraints. First, the well must be located in advance of any latrine construction to avoid the possibility of fecal contamination; and second, the test drill itself requires a considerable amount of water which, in the majority of villages, is available only during the rainy season.

In addition to its primary function, the test drill is a useful indicator of the community's motivation and organizational ability. Large quantities of water are required which the community will be asked to provide. In addition, the community is asked to provide food and lodging for construction workers for two to four days. The response to the request, given past experiences on the project, is often indicative of the community's commitment and organizational capability.

Review of the village health plan (VHP) by the EHE coordinator occurs next. The needed skills of the EHE community worker are identified, and training/review are provided for him or her to implement the plan. This step needs to be further developed in terms of training EHE workers in the delivery and the content of the plan they must implement.

EHE and sanitation program implementation follow. Health lessons will need to be designed according to the issues raised by the community, although it is likely that the range will be within fairly predictable limits. For example, a list of water supply and sanitation issues is likely to include:

- Different uses of different water sources
- Latrines and human waste disposal
- Making and using clothes lines
- Making and using plate racks
- Clean transport and storage of drinking water

- Food hygiene
- Improving traditional water sources
- The use of compost fences
- Evacuating used water from the compound.

A word on the nature of the health lessons: while it is beyond the scope of this report to review and propose amendments to existing EHE methods and materials, it is worth making a number of observations.

- The approach of health workers needs refinement. Both the substance or messages and the way in which they are transmitted need to be evaluated and strengthened. More training is needed for health workers.
- Dr. Paz Lutz's EHE community development strategy, developed specifically for Sierra Leone's RWSSP, can provide the basis or general ideas of a program, but it should be adapted to the specific needs of the Moyamba District CARE project.
- New techniques such as drama, storytelling, and singing should be investigated.
- EHE curriculum from the Bo-Pujehun project has proved to be useful but additional materials and refinement will be needed.
- Specific materials for use by Imams and TBAs resulting in critical messages are needed.

Other "end products" for monitoring health worker activities in the community could also include the following information:

- The number of hours spent at each activity
- Where the health worker stayed
- Who provided his or her food
- How many people attended each meeting (specifying numbers of men and women).
- Questions asked by the villagers during each meeting.

Well construction is the final stage in the village health improvement plan. Given that communities in Moyamba District perceive the project in terms of well construction, it would be naive to assume that a well would not be gratefully accepted if it could be obtained without undue effort. Such being the case, the project must have in place sufficient criteria to screen out, at an early stage in the intervention, those villages unwilling to put forth effort or resources.

The problem has been stated: too often wells and latrines were put in place and subsequently abandoned. The solution, albeit limited by a number of factors, is to allow the community to participate in the process and to take responsibility for the decision to improve its water supply and sanitation infrastructure. In order for this to happen, the community must be able to reach its own conclusions on the value of the intervention. At each step outlined in this process the community may say "no" to the project. Through the agenda of EHE, the decision to construct a well will reflect the views of the majority, having reached their own conclusions. Hopefully, the process used will also provide the impetus for other development activities the community wants to undertake.

Water system opening ceremonies are held. Many communities expressed the importance of this event. Sometimes certificates may be issued. Most importantly, village members can invite neighboring villages who are to become the next cluster.

A community plan for the second level EHE is developed. Here, again, communities will set a timetable. The committee members may be trained in delivery of health lessons. ORT may be taught, along with the importance of immunization and a plan to get the completed series and, where it is unavailable, making and using soap.

Chapter 5

LESSONS LEARNED

5.1 Introduction

This final chapter attempts to place CARE/Sierra Leone's project approach within the context of project design and implementation challenges confronting Water Decade plans. The chapter also proposes a number of what may be described as generic guidelines drawn from the experiences gained during the assignment.

As indicated earlier, the first six years of the Moyamba Project efforts focused primarily on establishing water supply and sanitation infrastructures in small rural communities. Once established, however, it was often found that the infrastructures quickly deteriorated and were abandoned. For this reason and with an understanding that benefit can result from water supply and sanitation interventions only if the communities participate fully in all stages of planning and implementation, CARE/Sierra Leone decided to revise the project. The revision process began some 12 months prior to the assignment described in this report and, as mentioned, has resulted in a number of steps being taken which aim to enhance the sanitation and health education project components. At the same time, well construction, which is implemented to a high technical standard, has been slowed down and placed more within the framework of other health and sanitation activities. This shift is in marked contrast to previous years when well construction was the single point of reference for the entire project. The current assignment should be recognized as one in a series of steps being taken by the project in an effort to enhance its effectiveness regarding project goals.

5.2 The Issues

The Moyamba Project is clearly not a unique case in terms of its recognition of the need to reassess its purpose and implementation practices. Throughout the developing world in the 1980s, there has been a proliferation of rural water supply and sanitation programs which have consumed millions of dollars and been the inspiration for countless workers. Yet, the news is not encouraging: too often a water system is put into place only to fall into disrepair; the community, unable or unwilling to use the system, reverts to its traditional sources; health behavior and practices remain unchanged; and mortality and morbidity resulting from unclean water and inadequate sanitation continue to be as much a problem as before the intervention.

While the foregoing scenario gives rise to concern, there are indications that an increasing number of projects and agencies are starting to recognize the need to address the problem and look for ways of making water supply and sanitation interventions more effective.

Given the fact, therefore, that the challenge facing the Moyamba Project is being shared by similar projects elsewhere, it may be useful at this point to identify processes and methods gained from this particular experience which can be applied to water supply and sanitation projects in general.

5.3 Obtaining a Consensus

The assignment described in this report is based upon the assumption that community participation is the most appropriate and effective means of maximizing benefits from water supply and sanitation interventions. In order for the principle of participation to be applied, however, a working definition needs to be derived. As presented in the recent WASH/UNDP study mentioned earlier in the Executive Summary, the process of community participation is described as being the means by which "communities deal with changes in their midst and incorporate those changes into their existing ways of doing things."

Having redefined community participation in terms of "responsibility" rather than "project initiation," it becomes apparent that in order to incorporate the principle into a project's implementation plan, a fundamental and parallel shift in the focus of the project-holder's own attitudes is required. This shift in emphasis is, in fact, quite profound and demands a high level of commitment from all project personnel, whether field-based or responsible for policy and planning.

Indeed, it is likely that the level of commitment needed by the project to facilitate the refocusing process is the most critical element of all. Change will not occur spontaneously, but only as a result of a consensus among project personnel concerning the objectives of a water supply and sanitation intervention and how those aims can be achieved.

Not surprisingly, participation in decision-making processes by all principal project personnel is probably the most effective means of obtaining the required consensus. This assertion is supported by the experience of the Moyamba Project where, over the past year, health workers and construction supervisors have participated in two workshops aimed at developing an implementation strategy for the coming 12 months. Through these workshops, the strategy has become the product of the project staff and, as such, is far more likely to be faithfully implemented than one handed down "from on high." Similarly, a strategy derived by consensus and participation will encourage field-based staff to adopt a similar approach while working with the community, rather than dictating messages in the same way as messages have been dictated to them.

5.4 Implications for Project Implementation

The process and recommendations described in the preceding sections are based on a recognition of the validity of community participation and of the associated shift in emphasis required in the project's implementation policy. Certain themes underlie this emphasis on community participation and chart the course for a change in implementation strategy.

5.4.1 Community Organizational Structures

A vital aspect of the implementation strategy proposed for the Moyamba Project is a recognition of the existence and suitability of community organizational and decision-making structures. The field work undertaken during the assignment clearly demonstrated the capacity within small rural communities to organize themselves and make decisions on issues of importance.

In the past, field-based staff have tended to focus on the more visible "formal" leadership structure, usually the village chief and his advisers, when discussing important project issues. Insufficient attention has been given to equally important "informal" leadership based upon interest groups. For example, many villages organize farming activity on a communal basis; savings or mutual assistance groups are also a common feature of small villages, as are youth groups. These groups are an essential feature of a village and each has a recognized leader and decision-making apparatus, respected and used by the community.

The Moyamba Project has in previous years bypassed these groups, establishing instead a project-specific decision-making committee which may or may not be representative. Certainly, a committee which failed to include the principal leaders of any village interest groups would be limited in its access to the community as a whole.

5.4.2 Establishing a Dialogue

An analysis of past experiences and the field work conducted during the assignment suggest the need to establish during the early stages of the intervention a two-way flow of information between the community and project. The process by which the community learns about health and health-related issues is the very essence of behavior change. Yet, too often field-based staff will not take time to find out important details concerning how a community is organized.

The process used in developing the revised implementation strategy focused on identifying how existing water sources are managed and who manages their use. In addition, by understanding how the community carries out its decision-making processes, the team was able to identify principal community residents and where they are located in this structure.

It was felt that, in this respect, the field instrument developed during the assignment was useful in establishing a dialogue between project staff and community. Further, the fact that the health workers themselves were instrumental in developing and implementing the questionnaire was in itself a training experience in learning to establish information exchange with the community.

5.4.3 Local Control and Responsibility

The process by which a community makes decisions for itself, and thereby determines its own agenda, is an important feature of the proposed strategy. The process, as developed, identifies local systems and focuses on giving both communities and project planners the opportunity to say no at every stage of the implementation plan.

The strategy emphasizes the importance of the learning process leading to development and implementation of an overall health plan. Local control of the intervention and the resultant strengthening of a sense of responsibility for the changes taking place are maximized.

In previous years, the project defined its "success" in terms of the village using the well for all of its water needs. Here, the strategy will allow for the well to become one component of an incremental process stemming from the upgrading, or rehabilitation, of the community's traditional water source. This in turn will facilitate an incremental approach to the way in which a community learns, and the community's control of and responsibility for the intervention will be strengthened.

5.5 Conclusions

Overall, the team realized that there is no one set of actors who, because of their formal title, will provide the needed linkages to the community. Time and patience are required to identify community decision-makers, to strengthen the local organizations, and to establish a continuing dialogue with them.

The strategy developed and the process used here shows that this shift in emphasis or project refocus is not simple. It is complex, technically difficult, and politically sensitive. This assignment is by no means a final step in the process. It is only one additional step in the continuing refinement of a sensitive issue--community participation.

The approach developed here will show that sustainable and effective rural water projects are based on the community's own knowledge, resources, and preferences.

APPENDIX A

Health Education and Community Participation through Drama and Theater

by Dele Charley

APPENDIX A

Health Education and Community Participation through Drama and Theater

by Dele Charley

OBJECTIVES

I. To initiate Health Workers and Community Volunteer Participants in the principles and practice of Community Theater and to encourage them to discover its potential for community education and mobilization.

II. To explore the potential of drama (improvisation, role-play) as a method of reinforcing community hygiene learnings.

III. To conduct participatory investigation to identify the community's problems and health issues.

IV. To present these issues in creative dramatizations so as to involve the community in planning and action to solve their identified problems.

METHOD OF APPROACH

I. A Four-Day Orientation Workshop

It is essential to help Health Workers (future users of this approach) rediscover basic elements of community life and artistic expression such as simplicity, spontaneity, flexibility, cooperation, and informality. In short, it is important to recreate the rural storytelling situation since experiences with formal theater in our formal education system may have obscured our awareness of the importance of these elements.

The following elements should be explored:

A. Integration of performers, performance and spectators achieved through:

1. Themes (issues and ideas) familiar to the community

2. Familiar language and language idioms

3. Audience participation through familiar songs; use of songs that are easily learned; verbal exchange between performances and spectators

4. Mime, dance and familiar movement idioms.

B. Spontaneous audience (community) participation generated by all of the above plus:

1. Informal setting, usually outdoors with provision for basic lighting such as a fire kept going with dry palm fronds or simple lamps made by lighting a piece of rag stuck into a half-bottle of kerosene or any other fuel.

2. No strict division between acting space and audience space. Performances in-the-round or a half-moon setting with the flat side simply covered with mats, lapas or bedsheets evoke more natural responses.

Without a reorientation of this type, Health Workers will continue to see the familiar, less formal rural presentation as a 'poor' substitute for the more formal, urban parallel with its scripted piece; formal learning of lines and rehearsals (implying the ability to read); a hall with a stage (and curtains); backstage space; special lighting and seats arranged in neat rows facing the stage with usually a 'forbidden' space between the edge of the stage and the front row seats.

Theater games, community games, (especially those of children), music, movement and dance, and improvisation should be used to explore and experience the following during the proposed four-day workshop.

DAY ONE - Introduction and Overview

a) Games with strong elements of:

- freeing oneself from inhibitions
- relaxation and concentration; observation
- integration and communication (non-verbal)

b) Improvisation using the above as sub-themes and health education topics as main themes.

DAY II - MODES OF COMMUNICATION

a) More improvisation; with an emphasis on group work

b) Non-verbal communication to "assemble a vocabulary" of gestures and movements, thereby reducing the need for wordy dialogues and a dependence on words for communication.

DAY III - DRAMA AS A METHOD OF TEACHING

- Invention of games; song-writing (health messages); improvisation and role play; micro teaching on health education themes, using drama as a method.

DAY IV - ELEMENTS OF COMMUNITY THEATER (REVIEW)

- Discussion based on experiences over the past three days; interviewing techniques; story lines from problems and health issues; improvisation. Emphasis on listening to each other and on community ethics.

As future facilitators, Health Workers need to sharpen their responsiveness and skills of observation as they search for the strands of thread to tie rich, spontaneous and committed contributions to the storyline without assuming the role of "director," unconsciously slipping back into it, or letting an overenthusiastic village volunteer do this.

The workshop should help them discover that all they may have to do is simply to weave a health message onto a backcloth of a rich, simple and expressive form that already exists.

Thus, the workshop would serve also to help Health Workers unlearn attitudes, tastes and forms alien to the rural community and that limit the villager's potential to participate fully in improving her or his community.

II. THE COMMUNITY DRAMA

After the orientation, Health Workers and a facilitator/group leader (total not to exceed 3) go into the community.

PHASE 1 (One Day)

Identify counterparts (volunteers) from among youth groups, community leaders and community development members. This can be done after a preliminary session of games, dance and improvisation. This session is also ideal to discover versatile performers.

PHASE 2 (One Day)

Conduct a baseline survey of the community's health issues. The survey is carried out by the entire group of Health Workers and village volunteers working in pairs or groups of three.

PHASE 3 (Two Days)

Analyze the findings of the survey. Lead an improvisation with the group to tie identified issues into a storyline; emphasize the process of preparation and show respect for everyone's contribution through a non-directive role for facilitators. Hold rehearsals in public to ingrain the concept of outdoor space and engender community participation in shaping the drama.

PHASE 4

Put on performance, followed by discussion: "We have just examined our problems. WHAT NEXT?"

SAMPLE LIST OF THEMES FOR IMPROVISATION

- Unity is strength
- Health is wealth
- Every villager should be healthy
- The deadly effects of diarrhea, malaria, bilharzia, and other water-related diseases
- The advantages of pure water
- Sanitation practices for health
- The proper use, maintenance, and management of wells and latrines.
- The advantages of wells and latrines

(Some of these themes can be used during the orientation workshop, as themes for microteaching, and during drama and health education classes in the village.)

To sustain and increase the interest and awareness generated by this workshop, the following possibilities can be considered, though they could evolve gradually if the experiment is exciting and intense enough:

I. Village/community theater company dealing with other themes as well as those related to water and sanitation.

II. Exchange performances among communities to share experiences and success stories.

III. Performances at agricultural fairs and other gatherings.

IV. Mini-festival of community theater featuring participating communities for non-participating communities.

The method also takes cognizance of the potential of simple songs to transmit messages and this element must be amply used to ensure that the message of the performance is not forgotten immediately afterwards. An active circuit/network/repertory of performances with recurring themes will also enhance awareness and sensitization.

APPENDIX B

Schedule of Activities

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Schedule of Activities

Sunday, August 16 (Freetown)

* Arrival of May Yacoob, WASH Associate Director for Health

    * Informal orientation with Howard Bell, CARE/Sierra Leone

Monday, August 17 (Freetown)

* Team meeting: Introductions, discussion of schedule, preparation for meetings with GOSL services and NGO's

* Meetings with

    -Rural Water Supply and Sanitation Unit/MEP

    -CUSO

    -Health Education Unit/MOH

    -Communications Unit/MAF

    -Ministry of Rural Development, Social Services and Youths

* Arrival of Kathy Tilford, CARE Regional Technical Advisor for Health

Tuesday, August 18 (Freetown)

* Meetings with:

    -Plan International

    -UNICEF

    -National Secretariat/MOH

    -Christian Children's Fund

    -Department of Community Health/FBC

    -Institute of Education/Ministry of Education

Wednesday, August 19 (Bo)

* Team Planning Meeting (TPM)

* Draft survey instrument

Thursday, August 20 (Bo/Moyamba)

* Discussion of meetings with Government services and NGO's

* Meeting with staff of Bo/Pujehun Water Supply and Sanitation Programme.

* Travel to Moyamba

    * Orientation/Planning with Moyamba Project Manager

Friday, August 21 (Moyamba)

* All-day meeting with Health Education and Construction Staff for the Moyamba Project.

Saturday, August 22 (Moyamba)

* Preparation of interview teams, including oral translation of the survey instrument

Sunday, August 23 (Moyamba)

* Field work in Mokelay, Nyandehun, Sigi and Sembehun

Monday, August 24 (Moyamba)

* Field work in Mokende, Nguala, Yoyeima, and Levuma.

Tuesday, August 25 (Moyamba)

* Field work in Rokump, Motonko, Rotawa and Sosowo.

Wednesday, August 26 (Moyamba)

* Revision of MYP Logical Framework

* Review of findings from field work

Thursday, August 27 (Moyamba)

* Review of findings, formulation of recommendations with entire project staff

Friday, August 28 (Moyamba)

* Presentation by Dele Charley for the use of drama in Moyamba Project

* Continued formulation of recommendations, including a proposed sequence of activities for working with communities

Saturday, August 29 (Moyamba/Freetown)

* Continued formulation of recommendations

* Travel to Freetown

Sunday, August 30 (Freetown)

* Worked on individual writing assignments

* Team meeting to review schedule plan for coming week

Monday, August 31 (Freetown)

* Drafting report and reviewing

Tuesday, September 1 (Freetown)

* Meeting with USAID

* Continued formulation of recommendations

* Drafting (cont.)

Wednesday, September 2 (Freetown)

* Review and revision of draft

* Revision of Logical Framework

Thursday, September 3 (Freetown)

* Review and revision of draft

Friday, September 4 (Freetown)

* Final draft written, typed and proofed

Saturday, September 5 (Freetown)

* Debriefing with newly-arrived CARE Director

* Debriefing with Rural Water Supply and Sanitation Unit/MEP

Sunday, September 6 (Freetown)

*Departure

APPENDIX C

Organizations and Persons Contacted

APPENDIX C

Organizations and Persons Contacted

1. Ministry of Energy and Power:

   Mr. Alex Harleston
   Assistant Chief Engineer
   Rural Water Supply and Sanitation Unit
   3rd Floor, Leone House
   Siaka Stevens Street, Freetown

2. UNDP:

   Mr. Gianni Bicego
   Chief Technical Advisor to Rural Water Supply and Sanitation Unit MEP/MEP

3. CUSO:

   Mr. Franklyn McEwen
   Project Officer
   4A Siaka Stevens Street
   P.O. Box 750
   Freetown

4. Plan International:

   Kevin O'Brian - Co-Director
   Sean Harrington - Director

5. UNICEF:

   Dr. RogerWright
   7th Floor
   Youyi Building
   Brookfields
   Freetown

6. National Environmental Sanitation Secretariat of WSS Unit

   Mr. J.A. Lansana
   National E.S. Coordinator
   6th Floor W 606
   Ministry of National Development and Economic Planning
   Youyi Building
   Freetown

7. Health Education Unit of Ministry of Health

Mr. T.E.A. Macauley
Senior Health Education Officer
3 Wilberforce Street
Freetown

8. Christian Children Fund

Dr. Joseph Conteh
Spiritus House, 8 Howe Street
P.M. Bag No. 910
Freetown

9. Department of Community Health

Professor George N. Gage
Head of Department
Department of Community Health
Fourah Bay College
University of Sierra Leone
Freetown

10. Ministry of Rural Development, Social Services and Youths

Mrs. Posseh Njie
Chief Social Development Officer
MRD, SS&Y
New England
Freetown

11. Institute of Adult Education and Extra-Mural Studies

Mr. David Henry Malamah Thomas
Fourah Bay College
University of Sierra Leone
Freetown

12. Bo/Pujehun Rural Development Project

Mr. Vandi Dauda
Campaign Manager
Water & Sanitation Motivation Campaign
B/P RDP
Bo

13. Institute of Education

    Dr. Jack Lutz
    National Dissemination Project
    Institute of Education
    Ministry of Education

14. Dr. Paz Lutz
    MEP/UNDP
    Rural Water Supply Unit
    Freetown

15. Communication Unit of Ministry of Agriculture and Forestry

    Mr. Unisa Sesay
    Acting Senior Publicity Officer
    M.A.F.
    3rd Floor
    Youyi Building
    Brookfields
    Freetown

APPENDIX D

Guide for Interviewing Organizations with Community Participation Programs

APPENDIX D

Guide for Interviewing Organizations with Community Participation Programs

1. What programs do you have on community participation?
2. How long have you had these programs?
3. What do you do in these programs?
4. Who are the key people implementing the programs?
5. What bottle necks have you encountered?
6. How have you overcome them?
7. Have evaluations been done?
8. What did you find out?
9. Do you do training?
10. Have other agencies collaborated with you? How? Do you see any scope for possible collaboration with CARE?

APPENDIX E

Bo-Pujenun Community Participation Process

APPENDIX E

Bo-Pujenun Community Participation Process

Present: Mr.Vandi Dauda - Senior Health Superintendent

Mr. Kailey - District Supervisor

Mr. Gambai - Field Supervisor

A. Pre-Motivation Phase:

1. Information sheets sent to villages outlining responsibilities.

2. Decide on village.

3. Appoint people (health motivator) to village. (Is preferably from village, has knowledge of it and its people).

4. Project is outlined by health motivator.

5. Villagers decide when and where sessions will take place.

6. Need for Village Committee suggested.

7. Four days spent by Motivator collecting baseline data whose end product is a village map.

8. Decide on community committment of 3 days per week for a period of one month.

9. Carry out lessons 1-8 in that one month. In that time, committment of the Community made by undertaking plans and community health actions e.g. cleaning village etc.

B. Pre-Construction Phase

1. Lessons 9, 10, 11, 12, 13. (9 for women, 10 for men, 11-13 both).

2. Motivator evaluates base-line, shows a sample model of latrine.

3. Assess if communities are ready:

-Collects applications.

-Are materials ready? sand etc. in place.

-Is maintenance fund in place? (Le1000 per population of 300: 38 out of 50 villages had the money ready, 9 were collecting it and 3 had done nothing to date.)

-Operations and maintenance schedule laid out.

- End of initial visit; communities write an application to give to motivator.

- Village development committee.

  Motivators identify influential people; always include women. (13 out of 50 communities had their own committees.

- Give people time to "hang heads."

- Project is considering using diarrhea prevelence for evaluation twice a year.

- KAP message retention.

- Beginning recruitment among Social workers (PHI 1 choice) for the selection of larger pool of women.

- Currently have trained 15 Motivators (1 month training, 1 month on the job training.

APPENDIX F

Field Instrument Used for Data Collection

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Field Instrument Used for Data Collection

A. Background Information (This section for town chief and elders only)

A1. What is the population of the village?

A2. How many households are in the village?

A3. Which ethnic groups live in the village?

A4. Indicate approximate proportions for each group.

A5. Are there recognized leaders for each group?

A6. Which religions are practiced?

A7. Are there recognized leaders for each group?

A8. Do some villagers work outside the community?

A9. Approximately how many?

A10. What seasons are they usually away?

A11. What are the important economic activities in the village?

A12. How often does transport come to the village - if none, how far (in time) is it to the nearest public transport?

B. Health

B1. Is the village visited regularly by a health inspector?

a. when did he come last?

b. when before that?

c. what did he do?

B2. If you get seriously sick where do you go?

B3. Which diseases occur in the village?

B4. Where do you think they come from?

C. Decision-Making

C1. Who makes decisions which affect the community?

C2. How is the decision made when it affects the whole community - use specific examples.

C3. Are women involved in the decision making process?

If yes,

a. which women?

b. which decisions? how?

D. Village Organizations and Communal Activities

D1. Has the community done any specific communal activities (for example, construction of mosque, schools, roads etc.)?

a. what were they?

b. who was involved?

c. how was it organized?

D2. Does the community do regular communal activity such as road maintenance, road brushing?

a. what are they?

b. who is involved?

c. how is it organized?

D.3 a. What organizations exist in your community - (Youth clubs, farmer's associations, cooperatives, savings groups, women's groups).

b. How long have they existed?

E. Village Needs

E1. If the village is able to do something without outside assistance to improve its situation, what would they most like to do?

E2. What do you think the community needs most?

F. Traditional Water Sources

F1. What water sources are being used at present? (include all dry and wet season sources).

F2. For how long has each source been used?

F3. For which season is each source used?

F4. Who decides on issues concerning these sources?

F5. Who owns each water source?

F6. Are the water sources divided according to functions?

a. How are they divided?

b. How are these decisions made?

c. Who makes the decision?

F7. Which sources do you like for drinking - Why?

F8. Do you think you can get sick from drinking water?

F9. What do you think is bad water?

F10. Why is that kind of water bad?

F11. Why do you not use the well for all your water needs?

G. The CARE/MEP Intervention.

G1. Who requested the well?

G2. How was the request made?

G3. Did you know about the request?

G4. Who did you first meet from the project and what did he do?

G5. What were the first activities of the project?

G6. How were decisions made for such issues as well location, community contributions, activity schedules etc?

G7. Were you involved in this decision process?

G8. What are you using this well for?

G9. Are you satisfied with this kind of well or do you like the old source better? Why?

G10. Do you have a water committee?

a. How was the committee formed?

b. Was this an appropriate process?

c. If not, what would have been a better process?

d. What did the committee do after the well was finished?

e. Were are you involved?

G11. a. Was the entire village involved with project activities such as well construction, health education, etc. and lodging of project staff.

b. If not, why not?

G12. What do you remember of the H.E. Sessions?

G13. Did anyone from CARE come to the village after the well was finished -

a When?
b What did they do?

G14. How should CARE and the village do this project differently so that

a. the whole community is involved?

b. the well continues to be used?

G15. If the well is not being used, ask why.

H. Latrines

H1. Do some people in the village have latrines?

If yes:

a. Why do they have them and others do not?

b. Does the community use latrines?

If no:

c. What do people say is wrong with latrines?

H2. Do you think it is good to have a latrine?

a. Why/Why not?

H3. (In villages with CARE latrines not in use) Why is the community not using them?

APPENDIX G

Background on Villages Visited

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Background on Villages Visited

Mokelay: has a population of 260 with the two major tribes of Sierra Leone, Mende and Temne. Considered a "successful" project village. The village has constructed a four mile road, a mosque, a well with 8 VIP latrines. Community participation is high. The people are Moslems. Major economic activity is farming.

Yoyeima: population of 2,000 to 3,000. Predominately Mende village but other tribes include Temne, Mandigo, Soso, Koranko and Fula. Religion: Moslems and Christains. Has a primary school and is four miles from Moyamba. First project well constructed here. The community has neglected the well. The well is considered CARE well.

Rotawa: population of 500-1000. Tribes: Loko, Mende Religion: Christians, Moslems. Farming is their occupation. Unsuccessful test drill in Rotawa but the community is interested in latrines. The village is situated on a of rocks and they rely on a spring for water supply.

Sigi: population 200-250. Tribes: Mende and Sherbro, but predominately Mende. Religion: Moslem. Occupation: Farming. Sigi is one of the successful villages with a well and 5 VIP latrines, all in use. Highly motivated village.

Mokende: population: 200-300. Tribes: Mende and Temne, with more Temne than Mende. Religion: Moslems and Christians. Occupation: farming. Mokende is one of the villages where participation is poor. The community has neglected the 5 project/community VIP latrines. Mendes own this village and they do not involve Temnes in community decision making.

Rokun: population: 400. Tribes: Temne, Sherbro, Loko, mainly Temne. Religion: Moslems. Occupation. A few Temne government workers and traders. A new village being considered for wells and latrines and health education.

Sembehun: population: 2,500. Tribes: Mende, Sherbro, Fula, Susu, Madingo, Temne. Religion: Moslems and Christians. Chiefdom headquarters of Bagruwa chiefdom. Occupation: Farming, fishing. There is a primary and a secondary school.

Levuma: population: 180. Tribes: Predominately Mende, Temne, Susu. Religion: Moslems and Christians. The people have undertaken projects like building barrie. Participation is low. There is a well where individual buckets are used. The well is considered a CARE well.

Motonkor: population: 500. Tribe: Temne. Religion: Moslems. Community participation is very encouraging. The community has a well, 5 complete VIP latrines. Occupation: Farming.

Nyandehun: population: 200-500. Tribe: Mende. Religion Moslems. Occupation: Farming. Community participation has not been encouraging. There is a well but no latrines. The community feels CARE did not do a good job. Project workers seldom visit them.

Nguala: population: 200-500. Tribes: Mende and Limba. Religion: Christian and Moslem. Occupation: Farming, palm wine trading. The community has requested a well and latrines. The community is influenced by Moyamba Town about 2 miles away. The village itself is on the Moyamba/Freetown highway.

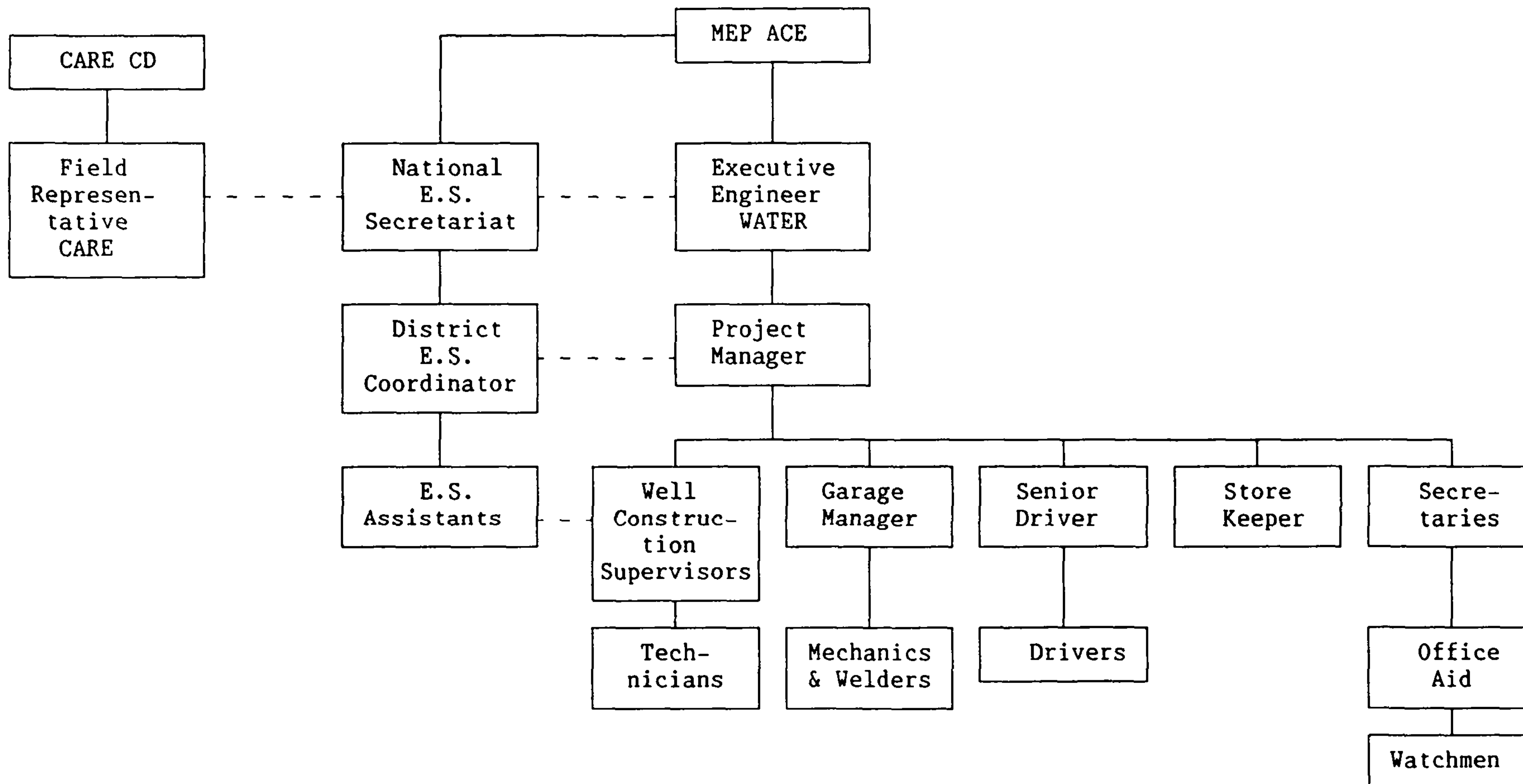
Sosowo: population: 150-200. Tribes: Temne and Susu. Occupation: Farming. Religion: Islam. The village is 20 minutes walk from the highway. Community participation is high. The villagers have completed 6 VIP Latrines and are about to finish their well.

APPENDIX H

Organigram for Moyamba Clean Water and Sanitation Project

APPENDIX H

Organigram for Moyamba Clean Water and Sanitation Project



APPENDIX I

Previous Project Implementation Plan

APPENDIX I

Previous Project Implementation Plan

	COMMUNITY ORGANIZATION	WATER AND SANITATION	WOMEN'S GROUPS
JULY	Initial contact, sign agreement, test drill		
AUGUST	Initial contact, sign agreement, test drill		
SEPTEMBER	Test drill, household survey, identify health problems, identify committee	Environmental sanitation - traditional water source protection, Bo/Pujehun #3 & 4 latrine workshop	Contact Chief, meet Mammy Queen set up first meeting
OCTOBER	Household survey, identify health problems, identify committee, train committee, formulate Health Plan	Application for latrines, site location, digging of pits	First meeting, set up meeting protocol, discuss goals, continue meetings
NOVEMBER	Train Health Committee, formulate Health Plan	Site location, digging of pits, latrine construction	Women's Group - E.S. meetings communal & domestic hygiene
DECEMBER	Train Health Committee, formulate Health Plan	Digging of pits, latrine construction, dry digging of wells	Women's Group - E.S. meetings latrine use & maintenance, child care
JANUARY	Implement Health Plan	Latrine construction, dry digging of wells, E.S. use and maintenance of latrines, Bo/Pujehun #5 workshop	Women's Group E.S. meetings identify two village health workers
FEBRUARY	Implement Health Plan	Dry digging of wells, E.S. Bo/Pujehun #5 domestic and communal hygiene	Continue Women's Group E.S. meetings, well use & maintenance, hygiene, child care
MARCH	Implement Health Plan	Dry digging of wells, concreting, E.S. domestic & communal hygiene	Continue women's activities
APRIL	Implement Health Plan	Dry digging of wells, concreting, E.S. hygiene & use & maintenance of wells	Women's Group activities health volunteer training
MAY	Implement Health Plan	Concreting, sinking & completing wells, E.S. use & maintenance of wells	Women's Group E.S. meetings health volunteer training
JUNE	Implement Health Plan	Sinking and completing of wells, well openings	Women's Group activities health volunteer training