



***Progress in the Development
of the Participatory Hygiene
and Sanitation Transformation
(PHAST) Initiative in Africa***

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Participatory Hygiene and Sanitation Transformation

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List of abbreviations

AWARD	Association for Water and Rural Development
CREPA	Centre Regional pour l'eau potable et l'Assainissement
DANIDA	Danish International Development Agency
FINNIDA	Finnish Development Agency
GTZ	German Technical Cooperation
HEATT	Health Education Awareness Task Team
ISD-DWAF	Institute for Social Development - Department of Water Affairs and Forestry
IWSD	Institute of Water and Sanitation Development
KWAHO	Kenya Water and Health Organization
NASCO	National Sanitation Coordination Unit
NETWAS	Network for Water and Sanitation
NGO	Nongovernmental Organization
NORAD	Norwegian Agency for Development
PALNET	Participatory Learning Network
PHAST	Participatory Hygiene and Sanitation Transformation
PROWWESS	Promotion of the Role of Women in Water and Environmental Sanitation Services
RUWASA	Rural Water and Sanitation
RWSG/ESA	Regional Water and Sanitation Group/ Eastern and Southern Africa
SARAR	Self-esteem, Associative Strength, Resourcefulness, Action Planning and Responsibility
Sida	Swedish International Development Agency
TREND	Training Research and Networking for Development
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Participatory Hygiene and Sanitation Transformation

1. Background

HAST stands for Participatory Hygiene and Sanitation Transformation. It is an innovative approach using participatory techniques to promote good hygiene behaviours, sanitation improvements and community management of water supply and sanitation facilities. It builds on people's innate ability to address and resolve their own problems. By promoting health awareness and understanding, it helps to empower communities to manage their water resources and to control water and sanitation-related diseases.

PHAST is adapted from the SARAR methodology of participatory development, which was developed in the 1970s and the 1980s in order to enable people to identify their problems, plan for change and then implement and monitor that change. SARAR stands for Self-esteem, Associative strengths, Resourcefulness, Action-planning and Responsibility. Its two main principles are that people solve their own problems best in a participatory group process and that the group collectively has enough information and experience to begin to address its own problems. SARAR is applicable to a wide range of development concerns.

PHAST takes the principles and techniques of SARAR and applies them to problems of water supply, sanitation and hygiene behaviours at the community level. Its basic purpose is to help communities to develop the capacity to take charge of their water supply and environmental sanitation needs, to control water and sanitation-related diseases, and to promote health awareness and understanding. As the process moves forward, PHAST leads to environmental improvements and positive behavioural changes.

The PHAST initiative is a joint project of WHO and the UNDP/World Bank Water and Sanitation Programme initiated in 1993 to promote hygiene behaviour change. It was developed in collaboration with the health, water and sanitation ministries of the Governments of Botswana, Kenya, Uganda and Zimbabwe. Other collaborating institutions include the UNICEF country offices in Botswana, Kenya, Uganda and Zimbabwe, the Swedish International Development Cooperation Agency, the Danish International Development Agency (DANIDA), and a number of national and international NGOs.

This report is the result of a recent review of the use of participatory methods in seven African countries: Botswana, Kenya, Mozambique, South Africa, Uganda, United Republic of Tanzania and Zimbabwe. It was prepared on the basis of replies to questionnaires distributed to institutions for training in PHAST methods.

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2. The central principles of PHAST

It is a basic premise of the PHAST initiative that no lasting change in people's behaviour will occur without health awareness and understanding. People must believe that better hygiene and sanitation will lead to better health and better living.

The main underlying health-related community development principles of PHAST are as follows:

- Communities can and should determine their own priorities for disease prevention.
- People within a community collectively possess a great deal of health-related experience and knowledge.
- Communities are capable of arriving at a consensus regarding the hygiene behaviours and sanitation systems most appropriate to their needs.
- When people understand why improved sanitation is to their advantage, they will act.
- All people, regardless of their education, are capable of understanding that faeces carry disease and can be harmful, and can learn to trace faecal-oral routes of disease transmission within their communities.
- Communities can identify manageable barriers to block this disease transmission, based on their own assessments and available resources.

In addition, PHAST promotes a new awareness of the complex interaction between technological and behavioural elements. It does not promise rapid change, but rather leads to sustainable benefits through a series of incremental improvements.

To sum up, PHAST seeks to help communities to improve hygiene behaviours and prevent water- and sanitation-related diseases, and to encourage community management of water and sanitation facilities. It does this by demonstrating the relationship between sanitation and health status, increasing the self-esteem of community members, and empowering the community to plan environmental improvements and to own and operate water and sanitation facilities.

3. Methods of applying a participatory approach

Participatory methods encourage the participation of individuals in a group process, no matter what their age, sex, social class or educational background. They are especially useful for encouraging the participation of women who in some cultures are reluctant to express their views or unable to read and /or write.

Implementation of the PHAST approach requires the development of personnel knowledgeable in PHAST techniques and capable of passing on this information to others. The initiation of PHAST country programmes usually involves an initial workshop in which the core of a country team of PHAST trainers and artists is trained. The members of this core team then act as trainers in community-level workshops where community facilitators learn about the PHAST process and how to apply it in their own communities. The community facilitators should be drawn from the communities in which participatory hygiene and sanitation development is planned. Members of the communities then learn how to take charge of their water- and sanitation-related health problems in an informal process led by the community facilitators.

Generally, participatory methods are used with small groups (15-40 people) who want to improve their community in some way. In selecting the group, facilitators have to use their own judgement. Ideally, big groups will be divided into small groups of 5-8 persons for some of the activities, since they provide greater stimulus and opportunity for participation.

PHAST employs a variety of techniques, tools and materials depending on the problems to be addressed in the community environment, e.g., improving hygiene behaviours, combatting specific health problems in the community or improving the operation and maintenance of water and sanitation facilities. Specific tools are developed to assist the participatory learning process according to the activities planned. Among the tools successfully used in Africa are :

- *Contamination routes*: Posters to illustrate the transmission routes of diseases from excreta.
- *Barriers matrix*: Pictures to illustrate common barriers (both technological and behavioural) that can be used to block disease transmission routes.
- *Sanitation ladder*: Posters to help communities to identify their own sanitation situation.
- *Three-pile sorting*: Photographs of hygiene- and sanitation-related situations used in identifying "good" and "bad" practices.

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- *Pocket chart*: An investigative tool to tabulate changes in defecation practices.
- *Dr. Akili Sana*: An activity illustrating the differences between curative attention and a preventive strategy.
- *Community mapping*: Locally- drawn pictures of the community showing water sources and sanitation facilities.

4. Review of PHAST activities in seven African countries

In March 1998 the Water, Sanitation and Health unit of WHO in Geneva and the UNDP/ World Bank Regional Water and Sanitation Group-East and Southern Africa (RWSG-ESA) undertook a prospective review of participatory approaches in the promotion of sustainable hygiene and sanitation. Six countries Botswana, Kenya, Mozambique, Uganda, the United Republic of Tanzania and Zimbabwe participated in this exercise. The main findings of the review are summarized below country by country.

Botswana

Botswana was one of the five countries that piloted the use of PHAST in 1994. Although some 100 people were trained in participatory methods, it proved difficult to follow up where they are now located because of job changes. Thus it appears that the scaling-up process did not take off as envisaged.

Some projects are still utilizing participatory methods, for example the UNICEF-supported sanitation programme and activities supported by other agencies such as the Netherlands Development Organization (SNV). The methods have not been confined to hygiene but have been found useful in addressing health issues in general. The SNV programme, for instance, is using participatory methods for home-based care patients to identify where diseases are concentrated, create awareness of causes and effects, and promote the sharing of responsibility for patient care.

Tools have been adapted to suit local conditions and problems and to depict community reality. The Ministry of Health is working on adapting and developing toolkits. Participatory methods have been used to promote the construction of latrines with hand-washing facilities. National competitions are held every year to choose villages with high standards of environmental cleanliness. Participatory methods have to some extent brought about collaboration among different agencies through multi-sector training.

At the moment the major issues that need attention to achieve effective use of participatory methods are:

- Identification of a coordinating unit to take charge of PHAST activities and to promote their development.
- Sensitization of policy-makers so that they provide support.
- Training and application at different levels.

After the Regional Workshop held in Harare in 1997, Botswana set up an interministerial committee that developed a plan of action for the application of participatory methods.

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Kenya

The Kenya PHAST programme continues to be a collaborative activity of the Kenyan Ministry of Health, CARE-Kenya, the Network for Water and Sanitation (NETWAS), Kenya Water and Health Organization (KWAHO) and UNICEF. Funding for the pilot phases was provided by the Government of Kenya, CARE-Kenya, UNICEF, WHO and Sida.

Pilot testing took place in six districts. In order to sustain the momentum of the initiative and to develop tools and indicators for monitoring the experience, several consultations were organized between the PHAST programmes in Kenya and Uganda. Several NGOs in the water supply and sanitation sector have played a significant role in the application of participatory hygiene and sanitation methodologies. Most of these organizations are members of the Participatory Learning Network (PALNET) in Kenya. The PHAST tools and approach have generated great interest within other sectors. CARE-Kenya, in particular, has used the approach to develop materials and methods for the prevention of AIDS, for youth employment generation, and in the field of agro-industry.

Institutional arrangements in support of PHAST in government organizations are weak and it is proposed that sector agencies review the options for placing the promotion of PHAST in the Ministry of Health as the focal point, with support from PALNET.

Changes observed in Kenyan communities as a result of the application of PHAST tools and techniques are impressive. For example, community leaders have approached public health officers for information on the technical aspects of latrine building, protection of water sources and healthful housing. Health committees have created a system of community monitoring of water supply and sanitation.

The future of PHAST in Kenya is focused on capacity-building in the methodology at both grassroots and institutional levels, by including PHAST methods in standard training curricula for extension agents, monitoring the quality and application of materials developed for PHAST tools and techniques at the extension and community level, and expanding the application of PHAST country-wide.

Mozambique

The Low-Cost Sanitation Programme that is implementing sanitation activities among rural and peri-urban low-income groups has adopted the use of participatory methods and trained personnel at national, provincial, and district levels in participatory methodologies. A few agencies are also utilizing participatory methods for hygiene and sanitation promotion such as Care International and Finnish Development Agency (FINNIDA).

The Ministry of Health, which has a mandate to promote hygiene and sanitation, has not been trained in participatory methods and is therefore not using them. The different organizations that are trying to introduce the PHAST approach need the support of the Ministry.

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The Low Cost Sanitation Programme first piloted the application of the methods in peri-urban areas, and since 1997 has expanded their use to three rural provinces. Participatory methods have largely been used for training extension workers, and for development and field application of materials.

The Low-Cost Sanitation Programme has observed the following changes in the pilot areas after using participatory methods:

- The construction of improved pit latrines has risen. Normally it is difficult for households with a traditional latrine to invest in an improved pit latrine, and they have to wait until the existing structure is full.
- There is increased confidence and a sense of purpose on the part of the extension workers. In particular, there has been increased interest in hygiene promotion.
- Trust and communications between communities and extension workers have increased. This has led to addressing real but unrecognized problems.
- Increased numbers of rubbish disposal sites have been dug at household level.
- General cleanliness around the households has improved.
- Among professionals, there has been a change in attitude from perceiving communities as ignorant to appreciating of their ideas.

Specific problems and issues in relation to the application of participatory methods for hygiene and sanitation in Mozambique are as follows:

- *Systematic application:* At the moment there is no systematic application of participatory methods in the water and sanitation sector. The fact that different organizations are using different methods is an advantage, as it leads to enrichment of the process. However, the problem lies in the differing application of participatory methods, and sometimes even the transmission of conflicting messages.
- *Development or adaptation of materials:* The development or adaptation of materials to suit the local conditions and environment and to reflect local reality is expensive. Artists charge about US\$ 10 per picture. Projects are currently relying on external support for this component.
- *Lack of materials:* Although toolkits have been distributed to the animators, activities at the community level have no materials for field application.

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- *Capacity for adapting:* Training workshops often equip participants with skills for the application of participatory methods but do not give them experience on how to adapt to reality. The problem is that, when faced with different situations, extension workers find themselves unable to adapt.
- *Mistrust and suspicion:* Communities in Mozambique are still traumatized by the civil war, so that when a meeting is called they are sometimes distrustful, perceiving it to be a political meeting.
- *Group process:* Participatory methods often promote group problem identification and group initiatives. The problem is that it is not always possible to get households to come together in groups. In Mozambique's rural community it is not always possible to find a nuclear village as households are spaced. In urban areas problems arise from people's economic activities, since household members go to work in either the formal or informal sector. The informal sector has no rest days and so meetings cannot be scheduled, even during weekends.
- *Commitment on the part of volunteer workers:* Rural sanitation projects use volunteers at the community level for promotional work. This approach is used by NGOs and the National Low-Cost Sanitation Programme. However, it is difficult to get enough staff to adopt and apply the methodology with strong commitment.
- *Methodological dependency on extension workers for application:* Participatory methods are labour-intensive in that there has to be a facilitator in the form of an extension worker/volunteer to facilitate the participatory process. The process requires the initial communication to be followed up from problem identification and analysis to identification and analysis of solutions, planning for interventions and actual implementation. In the case of Mozambique, where the ratio of extension workers to members of the community is about 1: 34000, it is difficult to achieve the desired contact with the communities.
- *Follow-up after needs identification:* Through the use of participatory approaches, communities are asked to identify their problems, analyse them and find solutions. After this process, which raises expectations, there is often no direct government support to communities in providing the necessary hygiene-enabling facilities. There is often no follow-up and the process is left unfinished. The methods therefore create awareness and raise expectations which may not be fulfilled.

The future application and success of participatory methods in Mozambique lies in the proposed integration of hygiene education, water supply and sanitation under one umbrella ministry. There is still a need for capacity-building through training and development of materials.

The Ministry of Health should be exposed to and involved in the development of a strategy for the expanded use of participatory methods. Local training institutions should be identified in order to train personnel in participatory methods and the adaptation of materials for schools .

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Uganda

In 1993 the Rural Water and Sanitation Project (RUWASA) of the Government of Uganda hosted the Regional Participatory Hygiene Education Workshop in Mukono, Uganda. In February 1994, the RUWASA Project, in collaboration with SARAR/PROWESS training experts from the UNDP/World Bank Regional Water and Sanitation Group in Nairobi, carried out PHAST training for its central staff and a core team of social mobilizers. The PHAST approach was piloted in Mukono district. On the strength of its success there, the methodology was extended to cover the other five districts where RUWASA is active. The training was not limited to hygiene education and sanitation, but included other areas of rural development dealt with by social mobilizers.

PHAST was tested in one urban site, the Katwe Urban Pilot Project in the city of Kampala, with a great deal of success. The Katwe Project seeks to improve environmental conditions in a largely artisan peri-urban community. The field workers used the PHAST methods to stimulate community involvement, to raise awareness about health risks, and to set in motion some planning and action. This resulted in the formation of four community - organized groups, trained in participatory tools and with the task of mobilizing the community and raising awareness of proper hygiene, sanitation, waste disposal and drainage. Within a few months latrines had been built, drainage improved and garbage collection instituted. The group also embarked on income-generating activities.

Major achievements of the PHAST initiative in rural areas were as follows:

- Communities became willing to pay for operation and maintenance of their water points.
- Communities became increasingly committed to the concept of community management.
- Communities requested extension workers to visit more often and, when they came, attendance at meetings increased.
- Communities had an increased appreciation and understanding of the value of water supply and sanitation facilities. This resulted in increased numbers of latrines and the installation of more hand-washing facilities.
- Communities wanted to monitor and evaluate their progress and designed billboards to monitor the hygiene practices and sanitation status of their communities.
- Communities asked to be given copies of the tools to use for the mobilization of other community members.

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Although the effects of applying PHAST methods in terms of behavioural changes at community level have been well demonstrated, the scale is still small, considering RUWASA's limited coverage by (eight districts) and the size of the remainder of the country. There is therefore a need to expand the application of PHAST and strengthen its institutionalization within a sector programme framework.

A National Sanitation Forum held in 1997, endorsed the use of participatory methods, and efforts are being made to link them to the activities of the National Sanitation Task Force. The Environmental Health Unit of the Ministry of Health is required to take a lead role in promoting the use of PHAST. Other existing structures such as the Interministerial Committee, the Project Coordination Unit in the Directorate of Water Development, and other ministries concerned with the sector will also be utilized.

Proposed action for the development of PHAST in Uganda is outlined below:

- Institutionalizing participatory methods in the Ministry of Health, Ministry of Local Government, and Ministry of Water;
- Identifying a focal person within the Ministry of Health;
- Enhancing the capacity of the Ministry of Health;
- Providing coordination among sector partners;
- Sensitizing the government line ministries so that they vote funds for participatory training;
- Developing skills in the use of participatory methods;
- Introducing quality control mechanisms in implementation and training;
- Providing incentives for the use of participatory materials.

United Republic of Tanzania

The United Republic of Tanzania has pioneered the implementation of PHAST by building on the PROWWESS/SARAR approach. PHAST has been applied in some rural water supply and sanitation programmes. Training workshops have been held in refugee-affected districts of Kigoma and in seven cholera-affected districts. There is strong advocacy for the use of the PHAST approach in promoting market-place sanitation, school health and food hygiene through the healthy city project in Dar es Salaam. Water committees have also been established in rural areas to manage water supplies through the use of participatory methods.

In spite of the limited data available on the use of participatory methods in Tanzania, there is considered to be scope for expansion of PHAST through the Ministry of Health, which works closely with the Ministry of Water and the already existing National Interministerial Coordination Committee.

Proposed action for the expansion of PHAST in Tanzania is outlined below:

- Creating awareness and sensitizing policy-makers to the need to incorporate participatory methods in national policy;
- Strengthening the capacity of the Ministry of Health and collaborating ministries;
- Promoting coordination among sector agencies;
- Selecting an area to pilot the use of participatory methods for hygiene and sanitation;
- Developing skills in the preparation of materials;
- Developing monitoring systems;
- Assessing what has been realized in health education and promotion through the use of participatory methods;
- Developing participatory methodologies for use in schools and training institutions;
- Conducting a baseline survey to identify problems and monitor impacts.

Zimbabwe

The Zimbabwe PHAST pilot programme was initiated following a national PHAST training workshop conducted at Meteoric, Masvingo, in March 1994. Initially, three pilot districts were selected for their ethnic and geographical diversity to test the approach. These were two Ministry of Health programme districts supported by Sida, Goromonzi and Mutasa, and the UNICEF project area of Beitbridge. A special focus of the Goromonzi programme was the use of PHAST training in tandem with the Mvuramanzi Trust's programme to upgrade family wells. The Health and Hygiene Education in Schools project has also used a number of PHAST tools.

Within very little time - less than a year - use of the methodology increased outside the pilot districts, spreading to four more districts. The approach was also highlighted at the UNICEF regional sanitation workshop held in Harare in October 1994.

As from mid-1995, the PHAST approach has been institutionalized in Zimbabwe and is now an official Ministry of Health programme. Within the Ministry of Health participatory approaches have been found useful not only in hygiene education but also for the control of diseases such as malaria, TB and scabies. Participatory methods are also widely used by other agencies and NGOs as a standard approach in promotion, training and awareness creation for several development activities. Specifically, they have been used for mobilizing communities, land use planning, wild life and environmental management, poverty alleviation, food security programmes, and community-based management.

Although the bulk of the funding has been provided by the Government of Zimbabwe and UNICEF, support for the initiative has also come from a number of other institutions and external funding agencies such as NORAD, DANIDA, DFID, and the European Union (EU). NGOs also play an important role in hygiene promotion and the construction of hygiene-enabling facilities. So far, the financing of participatory hygiene education has totalled some US\$ 2 million, excluding staff time.

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While there has been no impact assessment of participatory methods, some of the changes that have occurred at both the institutional and community levels are outlined below:

- Institutionalization of the use of participatory methods;
- Expanded use of participatory methods;
- Visibility of hygiene education in the sector;
- Sense of purpose and attitude change of the communities;
- Greater community involvement in planning;
- Provision of demand-responsive services;
- Improved targeting of interventions;
- Self-reliance and evolution of health clubs.

In addition, some notable changes have been observed in the following areas as a result of participatory hygiene education approaches:

- Hand-washing after defecation;
- Construction of hygiene-enabling facilities;
- Initiation of community-level monitoring;
- Improved water transportation and storage through the use of covered water containers;
- Improved kitchen hygiene;
- Improved environmental hygiene.

Problems in the application of participatory methods have included the following:

- Training period too short, and thus not adequate for attitude change and skills development;
- Demand for training outstripping supply;
- Lack of capacity for follow-up;
- Ownership of process (this is notable at donor level since support agencies want to own the process);
- Weak conceptual understanding of participatory methods, leading to inability to apply the concept without tools;
- Lack of focus, so that tools are utilized as an end in themselves;
- Reactive use of participatory methods without a defined operational strategy;
- Participatory methods proving labour-intensive, hence time-consuming.

The use of participatory methods has been institutionalized within the Ministry of Health and Child Welfare. The Ministry is expanding and consolidating activities, focusing on schools. The activities planned are outlined below:

- Organizing refresher workshops on participatory hygiene education to further build the skills and confidence of the extension workers and to keep abreast with new developments;
- Organizing workshops on materials development;

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- Organizing training in participatory hygiene education for some districts and extension workers;
- Development of a field guide for different levels of extension workers;
- Adaptation of participatory materials for schools;
- Development of monitoring indicators to assess the use and effects or impact of participatory hygiene education.
- Strengthening the PHE teams through networking among participatory users.

South Africa

In September 1996, the Health Education Awareness Task Team (HEATT) hosted a strategic workshop to assess ways in which health could be meaningfully linked to future water supply, sanitation, education, local government and housing policies and programmes.

In August 1997, the Mvula Trust developed a PHAST training programme for South Africa (PHAST-SA). The initiative is designed to:

- Develop a core team of South African PHAST facilitators at National and Provincial levels;
- Develop a South African PHAST toolkit;
- Identify lead institutions to house PHAST at provincial levels;
- Host a national training workshop to develop province-based PHAST training teams;
- Host six provincial workshops to strengthen the capacity of project implementers to integrate PHAST into their field-based programmes;
- Identify and support the implementation of PHAST in a series of pilot projects throughout the country;
- Provide ongoing field-based support and retraining in PHAST to ensure that the skills transferred to project implementers are applied in the field;
- Evaluate its activities in late 1999.

PHAST-SA is a joint initiative of the National Sanitation Coordination Office (NASCO), the Mvula Trust, SARAR Transformacion, the Institute for Social Development (ISD-Department of Water Affairs and Forestry), HEATT and the World Health Organization. Financial support has been generously provided by Irish Aid, Australian Aid, the EU/ Mvula NGO programme, and provincial rural development and sanitation programmes.

Lead provincial PHAST institutions are Rural Support Services (Eastern Cape), Association for Water and Rural Development (AWARD) (Mpumalanga), Copad Engineering (North-West), Operation Hunger (Northern Cape), the Mvula Trust (Northern Province).

Additional funding has recently been secured to support the development of artists in the country through a PHAST-SA Artists Workshop. This initiative could provide a critical foundation for emerging community-based artists throughout the country, and would assist provinces in developing province-specific toolkits.

5. Regional training institutions on SARAR/PHAST methods

Centre Régional pour l'Eau Potable et l'Assainissement (CREPA), Burkina Faso

CREPA is a WHO collaborating centre for low-cost water supply and sanitation in peri-urban and rural areas. In 1993 participatory approaches were introduced in CREPA's strategies for developing and implementing projects in rural and peri-urban areas when the Regional Director of PROWESS trained 12 staff.

In 1996 CREPA and WHO headquarters decided to work together to promote SARAR methodology in eight French-speaking countries in West and Central Africa. Two workshops have been organized by CREPA. The first workshop, which reviewed SARAR methodology, was organized for seven experts from Mali, Côte d'Ivoire, Burkina Faso, Ghana and Uganda. The second workshop trained 24 trainers, (Benin 4, Burkina Faso 4, Guinea, Mali 4, Côte d'Ivoire 2, Congo 2, Senegal 2, and Togo 2). In the first year (1996), these trainers had to train 35 animators (extension workers and planners of water supply and sanitation projects) in each of four countries: (Benin, Burkina Faso, Guinea and Mali) and 15 animators in three (Congo, Senegal and Togo).

A programme for training in and promoting the SARAR methodology called FOSAR, like the PHAST initiative in East and Southern Africa, was created for West and Central Africa. An assessment was carried out at a workshop organized in Benin in May 1998 where a subregional strategy for promoting the SARAR methodology in West and Central Africa was established. More than 300 persons have been trained in the SARAR methodology up to now.

Although the SARAR methodology has not been institutionalized in any of the eight countries that have benefited from CREPA's training, some bilateral agencies, international organizations and NGOs such as DANIDA, GTZ, UNICEF, WHO, Save the Children and PLAN International are applying the method to motivate water supply and sanitation project implementers. CREPA plans to expand training in the SARAR methodology to Cameroon, Chad, Guinea-Bissau, Mauritania and Niger in 1998 and 1999. It also plans to train engineers, technicians, sociologists and planners in the methodology.

The main obstacles to implementing participatory methods in French-speaking West and Central African countries are financial, institutional and methodological. The following action has been recommended in order to remove the obstacles:

- Identify opportunities to include the SARAR methodology in national programmes in the water supply and sanitation sector;
- Implicate WHO representatives in the programme in every country;
- Market the SARAR methodology (demonstrate toolkits, organize meetings, etc.)
- Organize national workshops to train field workers;

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- Review workshops and carry out follow-up on the effectiveness of field workers and the tools used.

Institute of Water and Sanitation Development (IWSD), Zimbabwe

The Institute of Water and Sanitation Development in Zimbabwe has carried out training in participatory methods by running two types of courses: courses scheduled by the Institute and courses tailor-made at the request of the client. One of the modular courses that includes a large component of participatory methods is "Community management of water supplies and sanitation". Participants in this course have come from Ghana, Lesotho, Malawi, Namibia, Nigeria, Uganda, Zambia and Zimbabwe. IWSD has been invited to design courses on participatory methods in Botswana, Mozambique, Namibia, Zambia and Zimbabwe.

As the Institute operates on a demand-responsive basis, its plans depend on what its clients would like it to do. One of the services that it offers is support through information-sharing. It has continued to send new information both to the countries whose staff it has trained and to other countries. In summary, the major activities carried out by the IWSD are as follows:

- Support to countries through information-sharing;
- Responding to identified needs and requests;
- Development and adaptation of materials;
- Production of toolkits;
- Training-of-trainers workshops;
- Training of extension field workers.

Network for Water and Sanitation International (NETWAS)

NETWAS Uganda and NETWAS International, Nairobi, have trained trainers in participatory methods in Kenya, Uganda and the United Republic of Tanzania. However, there has not been follow-up because of lack of funds. A reasonable number of organizations in East Africa are using PHAST tools developed by NETWAS. The priority countries identified by NETWAS for the consolidation and expansion of PHAST in 1998 and 1999 are Eritrea, Ethiopia, Kenya, Sudan, Uganda, and the United Republic of Tanzania, depending on the availability of funds.

The approach of NETWAS to introducing PHAST in each country is as follows:

- Offer of two weeks of training for trainers;
- Preparation of action plans;
- Follow-up of action plans to check on their implementation.

The funding required to introduce PHAST in a country by training 30 trainers at one workshop for two weeks, according to NETWAS's experience, is US\$ 16 000.

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The Mvula Trust

The Mvula Trust is primarily responsible for SARAR/PHAST training in South Africa. It has designed, and is managing and implementing the PHAST-SA National Capacity Building Programme, which includes a national training workshop and six follow-up provincial training workshops during 1977 and 1998. The Trust also trained some 150 South African government sector personnel and artists in PHAST over the previous three years and implemented SARAR/ PHAST in a number of project sites throughout the country. It has modified PHAST for the HIV/AIDS sector, and run a training course on this for health sector personnel in KwaZulu-Natal. The Mvula Trust staff have been included in a sanitation tender for Uzbekistan, where the Trust would help to develop and implement PHAST and train counterparts as part of a United States Government-supported initiative. It has received a request to support a similar initiative in India.

The Mvula Trust-supported South African initiative is designed to decentralize and institutionalize PHAST in an effective and sustainable manner. To accomplish this the following has been achieved:

- At national level, it has received strong support from the Department of Water Affairs and Forestry, which has endorsed PHAST as a joint programme. It is expected that the Department of Health will soon join, with the assistance of the WHO Office in South Africa.
- At provincial level, it has developed provincial lead institutions - primarily NGOs where PHAST will be housed. These lead institutions then work in collaboration partnership with provincial sanitation task teams (interdepartmental sanitation forums coordinating the provincial sanitation programme) and the Mvula Trust provincial office to spread/implement PHAST in the Province. This model has proved to be effective, as it allows all role players to be involved but avoids the problems associated with PHAST becoming part of a large government bureaucracy.
- At local level, a range of pilot projects have been identified to field-test PHAST. The interventions will be well documented so that the strengths and weaknesses of PHAST can become clearer to field-based and programme role players.

The Mvula Trust has offered the following training courses in 1998:

- PHAST-SA provincial workshops in six Provinces (beginning in June and ending in August), including considerable follow-up support and retraining. Some 120 participants were expected, including at least 12 from other countries in Southern Africa.
- An artists workshop (6-10 July 1998), to introduce young artists to PHAST/SARAR so that they can support provincial PHAST programmes. The opportunity was provided for 21 artists and 6 core provincial facilitators to demonstrate how artists and facilitators can work together.

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- Water quality testing/PHAST workshop-South Africa, planned for Mvula Trust engineers, consulting engineers and project agents. Some 20 participants were expected.
- Child-to-child workshop for environmental health officers, community health workers and institutions that support NGOs (KwaZulu-Natal). Some 15 participants were expected to take part.
- PHAST-BOTT workshops for project and training agents in the South African Department of Water Affairs and Forestry as part of the, "Build, Operate, Train and Transfer" Initiative. A total of about 40 participants from at least two provinces are expected.

During 1999, the Mvula Trust would like to host an evaluation of PHAST-SA, using participants from the Zimbabwe PHAST review workshop (November 1997) as evaluators, with a view to strengthening intercountry cooperation.

6. Other potential providers of training in PHAST

- RENDA (Training Research and Networking for Development) based in Ghana, has recently indicated its willingness to act as a focal point for the training of trainers in participatory methods.

In Zambia the training facility at Mwachisompola, Chibombo District, is being designated as a PHAST training centre in support of the integrated cholera control programme. Similarly, many countries in the Region are in the process of identifying suitable institutions to become focal points for training in the PHAST methodology.

7. Assessment of achievements of the PHAST Initiative

The progress that has been made in the past four years in developing, field-testing, sustaining, consolidating and expanding the PHAST Initiative in Africa is encouraging. Different types of training manuals and tools have been developed, improved and tested to ensure that they are country-, culture- and location-specific. This is the most challenging part of the Initiative at field level, as maximum local adaptation and innovation needs to be encouraged. The application of an adaptable learning process requires creative thinking. Those implementing the Initiative are therefore hard at work on creating sets of locally appropriate graphic tools for PHAST activities. This has enhanced the participation of young local artists in the implementation of PHAST. South Africa, for example, organized a workshop for 21 artists in July 1998 to introduce them to the PHAST/SARAR methodology.

Zimbabwe and South Africa demonstrate that institutional arrangements in government organizations, advocacy and sensitization of policy-makers, and collaboration with training institutions are vital for the success of PHAST programmes. PHAST means Participatory Hygiene and Sanitation Transformation; thus the approach is designed to promote good hygiene behaviours, sanitation improvements and community management of water and sanitation facilities. Therefore the Ministry of Health appears to be the appropriate government organization to house the PHAST initiative as in the case of Zimbabwe. Botswana, Kenya, Mozambique, Uganda and the United Republic of Tanzania are making efforts to institutionalize PHAST within the Ministry of Health.

The effects of the application of PHAST techniques have been well demonstrated at community level in all the countries where the methodology has been tested. The use of the participatory method has promoted the construction of latrines with hand-washing facilities, improved hygiene behaviours and empowered communities to own and operate their water and sanitation facilities. However, because of the lack of baseline data and systematic monitoring and evaluation it has not been possible to assess the magnitude of the impact. Although PHAST does not promise rapid change, its impact needs to be assessed over a specified period to refine the methodology and enhance its benefits.

The PHAST tools and approach have generated great interest within other sectors such as rural development, agriculture and the prevention of specific diseases such as malaria and HIV/AIDS. However, specific toolkits and training materials should be developed when the methodology is applied to other sectors. The fact that different organizations are using different methods is an advantage as it leads to the enrichment of the process. Some NGOs and bilateral and multilateral agencies have started using the PHAST approach as an integral part of their rural water supply and sanitation projects. In Zimbabwe, for example, support for the initiative has come from UNICEF, WHO, DANIDA, EU, NORAD and ODA. The opportunity to initiate and expand PHAST is limited without external support. There is therefore a need for intensified "marketing" of the methodology in every African country by organizing meetings of donors in the water supply and sanitation sector and by exhibiting the tools and training materials developed.

8. Main obstacles identified in implementing PHAST

Lack of institutional support: Zimbabwe's and South Africa's success in the expansion of PHAST is attributed to institutional support and commitment. In Botswana, Kenya, Uganda and the United Republic of Tanzania there has been insufficient government support, and hence a failure to expand.

Lack of funding: The application of participatory methods using the present approach requires substantial funds for the training of trainers, training of extension field workers, production of toolkits for field workers, refresher courses, monitoring and evaluation. In Mozambique artists charge about US\$ 10 per picture. The development and adaptation of materials for country-specific conditions, problems and realities is also expensive. Zimbabwe has indicated that it has spent US\$ 2 million on participatory methods since their introduction in 1994. Hygiene education and the use of participatory methods do not receive a meaningful budgetary allocation from government and therefore need to be financed by external aid agencies. This has been the case for both Zimbabwe and South Africa, with consequent concerns over the sustainability of such arrangements.

Lack of trained manpower: The implementation of participatory methods largely depends on human resources - the people who have to facilitate the process at the community level. Scaling up poses problems in countries where there are not enough extension workers. Volunteer workers who receive no recompense for facilitating participatory methods at community level often do not have the commitment to follow the process through. There is also a lack of skills for the development of materials and the training of trainers.

Lack of focus: The focus of PHAST is on improving hygiene behaviours, preventing water- and sanitation-related diseases, and encouraging the community management of water and sanitation facilities. The tools have been developed for clearly defined objectives. However, there is sometimes a tendency to use participatory tools as an end in themselves and not as a means to an end.

Time constraints: The introduction of participatory methods starts with the training of trainers, followed by training of extension workers at community level, pilot testing to draw country lessons, scaling up of training activities and the application of PHAST. The development of materials is a process which depends on specific local conditions, culture and practices that take some time to learn. Much time is therefore required to apply the process. In the absence of full-time personnel assigned to the programme, implementation by personnel with other duties suffers from severe time constraints. Follow-up support to extension workers is limited when activities overlap and institutional capacity is low.

Raised expectations: Following the training of extension field workers there is growing awareness in communities, and consequently their expectations that assistance will be provided for construction of hygiene-enabling facilities such as latrines and safe, protected water supply sources are raised. The communities become disillusioned if participatory methods are not accompanied by water supply and sanitation projects.

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Misconceptions about PHAST: There is a great fear that the concept of PHAST will be eroded by viewing it as a special programme for hygiene and sanitation without linking it with field-based implementation. Trainees who are not really interested will simply acquire the toolkit and fail to facilitate PHAST effectively in the field. As a result, there may be a tendency to go back to using didactic approaches in hygiene promotion. The problem is aggravated by inadequate follow-up and slow adaptation to change.

Ownership of process: Some organizations have a tendency to want to own the PHAST Initiative and process, thus undermining the efforts and contributions of different agencies that provide funds for the programme. PHAST is a methodology for transforming hygiene and sanitation behaviours through a participatory approach. Other participatory and nonparticipatory methodologies are used in implementing specific sector projects and programmes.

The challenge is the development of toolkits that will enable communities to identify their problems, plan solutions, select options, and implement, monitor and evaluate the interventions.

The tools and guidelines developed by WHO and the UNDP/World Bank Water and Sanitation Programme for PHAST can be adopted for country use by any interested organization provided that there is no commercial interest.

9. Future development of PHAST

In the light of the obstacles that have impeded the expansion and consolidation of the PHAST Initiative in countries where it has been introduced in the past few years, it is imperative that future development should address the issues discussed below.

Institutionalization: There is a need for institutionalization of PHAST at a national level to achieve the objectives set within the overall country hygiene and sanitation programme. While local institutions such as NGOs may facilitate and promote the process, experience shows that the right location for PHAST in the government is the Ministry of Health as it deals with hygiene, sanitation and health. Participatory methods will not win support for expansion unless they are placed in the right government department. At the same time, a broader coalition should be maintained so that PHAST does not become the "property" of one government department or sector.

Use of local training institutions: Training institutions that can facilitate and promote participatory methods should be identified in each country. This includes local NGOs, training institutions for hygiene, sanitation and health, and government departments. Training should include the development of materials and tools, training of trainers, and scaling up of training activities.

Top-down, bottom-up planning approach: A combination of the two types of planning should be pursued in order to gain financial support from the government in the form of a budgetary allocation for PHAST activities in the annual fiscal plan. At the same time, communities should put forward their requests for government support on the basis of identified needs and priorities.

Cost-effective approach to introducing PHAST: The present approach to introducing PHAST is very expensive as it involves the training of trainers, training of extension field workers, development and adaptation of materials, and production of tools. Other related costs may involve advocacy workshops at the political and decision-making level. These activities are not cost-recoverable and should always be subsidized. There are concerns over the sustainability of the present approach because of limited funding. The present approach therefore, needs to be reviewed in order to reduce the cost during the initial stages of the introduction of PHAST.

Monitoring and evaluation: Participatory methods should not be viewed as an end in themselves but as a means of achieving certain objectives within the overall country hygiene and sanitation programme. There is a need for efficient monitoring and evaluation of the programme to assess its impact at community level using specific indicators.

Information sharing and networking: Documenting activities and experiences relating to PHAST in all the countries where it has been introduced and field-tested provides information on its strengths and weaknesses. Intercountry and interregional cooperation can be strengthened by sharing such information and experiences and by establishing effective networking.

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Linking training workshops with ongoing projects: Experience indicates that participatory methods often raise expectations and should therefore be linked to projects that enable communities to improve their environmental sanitation and water supply sources. Commitment to follow the process through is likely to diminish, thereby limiting the potential use of the methodology after trainers and extension field workers have been trained, unless such an arrangement is made.

Public and private sector support: So far PHAST has been applied in a supply-driven rather than a demand-driven context. There is a need to give people in the public and private sector the necessary opportunity to become familiar with the PHAST Initiative so that they can advocate and provide support for a broader application of the methodology. This can be achieved by inviting senior government officials and NGO staff to actual project sites and training workshops and by demonstrating through discussions how PHAST has been used successfully in the field to promote hygiene, sanitation and community management of water and sanitation facilities.

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