WORLD HEALTH ORGANIZATION
Community Water Supply Unit (CWS)

UNDP/WORLD BANK WATER AND SANITATION PROGRAM
Regional Water and Sanitation Group-East Africa

KENYA PARTICIPATORY HYGIENE AND SANITATION TRANSFORMATION (PHAST)

WORKSHOP REPORT AND TOOL-KIT

NOVEMBER 2-6, 1994
BARINGO, KENYA

World Health Organization
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Hosted and Sponsored by UNICEF Kenya Country Office

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Executive Summary

The Regional Water and Sanitation Group-East Africa (RWSG-EA), in cooperation with the Community Water Supply (CWS) of WHO, initiated a program in 1993 to develop guidelines and participatory tools for hygiene promotion in water and sanitation projects. The aim was to develop field oriented guidelines/materials to assist extension staff, health educators and trainers to effectively enhance sustainable hygiene related behavioral practices.

In Kenya, a PHAST team of the various participatory organizations was formed as a basis for piloting and testing the PHAST tools and techniques. The PHAST team is made up of Ministry of Health, UNICEF, NETWAS, Care International and the World Bank's RWSG-EA. Several project level workshops have been organized to date by the MOH (GoK), UNICEF, CARE Kenya and PALNET to train (trainees and) field extension staff in participatory methods. PALNET is a Kenyan Network initiated as an outcome of a PROWWESS (Promotion of the Role of Women in Water and Environmental Sanitation Services) Participatory Regional Workshop held in 1990 which generated interest to establish a Network to share experiences and ideas through training in various participatory methods.

In collaboration with UNICEF and the MOH (GoK), the UNDP/World Bank RWSG-EA, organized a Kenya Workshop from 2-6 November, 1994 in Baringo to review the progress of PHAST pilot project activities. The Workshop objectives were to:

- review progress of PHAST activities in pilot projects through experience sharing, lessons learnt, successes and constraints;
- Assess the PHAST initiative in relation to capacity building at both grassroots and institutional level;
- Refine and adopt the monitoring and evaluation schedule developed in August, 1994 meeting and map out a country level Action Plan for continued implementation and sustainability of PHAST in Kenya.
- Develop country-level documentation to include country report and tool-kit for presentation at the 2nd Regional PHAST Workshop in Harare.

This workshop report starts with an overview of PHAST, followed by the workshop objectives. PHAST project progress reports make up the second part of the report with Nandi District highlighted as a typical progress report. Observations from the field visit and issues identified are presented before the tool-kit evaluations. The third part of the report continues with the application of PHAST project monitoring and evaluation schedules. This is followed by presentation of the country PHAST objectives and action plans. Annexes of the PHAST Pilot Projects are provided at the end of the report.

This workshop report, documents the major outcome of experiences and lessons learnt during the implementation of the Pilot Phase of PHAST in Kenya. Briefly the experiences reveal how communities are quite knowledgeable of hygiene practices and only lack the drive to change; the use of PHAST Participatory tools has enhanced the communities self esteem; the tools facilitate the exchange of information and experiences; women are more conversant with health problems at family levels and men appeared conservative in accepting certain roles; almost all communicable diseases could be prevented by improvement of general hygiene standards, AND retention of messages disseminated through visual aids/discussions is higher than in other methods, e.g lectures, meetings.

The participants expressed the need to strengthen the relationship between the Government of Kenya and Non-Governmental Organizations to foster the implementation of PHAST. This can best be achieved by enhancing the relationship between PHAST and other participatory methodologies. There

is also a potential for linking PHAST tools with participatory research networks, and it should be considered to relate PHAST with the Bamako Initiatives at community level.

Based on careful discussion on the various views expressed, the Kenyan project teams adopted the following objectives for the Kenya country-level:

- Enhance networking between national and regional agencies
- Develop monitoring tools and indicators for determining the progress of the application/use of PHAST
- Advocate PHAST in implementing agencies and encourage the adoption and use of PHAST methodologies
- Facilitate capacity building both at grassroots and institutional levels
- Develop an integrated approach to the design of appropriate participatory health learning materials in PHAST which are sensitive to women, men, youth and children
- Enhance demand-driven and community-centered interventions to foster sustainable PHAST program.

In an attempt to achieve the above objectives, the report has highlighted a number of identified PHAST priorities together with a plan of action developed with suggestions of possible time frame and organizations responsible for executing the various tasks. Participants agreed to sensitize policy makers in PHAST pilot projects, develop individual pilot project action plans and embark on training of extension staff by March 1995. As a priority, it was agreed that training curricula for Medical Training Centers (MTCs) and other institutions as well as communities, be developed to explore ways and means of tool-kit production by the Ministry of Health Materials and Production Unit.

Frequent country-level retreats to monitor and review progress of PHAST project experiences and practices are proposed. This will enhance networking among pilot projects and/or sector partners and will include information sharing through publication of journals and newsletters. It was suggested that research proposals be developed to experiment, evaluate and document the application and experiences of PHAST tools and other participatory methods. A PHAST regional workshop for Uganda, Ethiopia and Kenya was proposed to share experiences. Finally, it was unanimously agreed that there was a need to develop a PHAST Resource Center; NETWAS was identified as the suitable Center. At present NETWAS is the focal point for PHAST project partners and the ITN Center for Uganda, Kenya and Ethiopia.

List of Acronyms

ARUNET	African Research Utilization Network
CPO	Chief Public Health Officer
CWS	Community Water Supply Unit
IWSD	Institute of Water and Sanitation Development
GOK	Government of Kenya
KWAHO	Kenya Water for Health Organization
LBDA	Lake Basin Development Authority
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MTC	Medical Training Centre
NETWAS	Network for Water and Sanitation
NDHEWAS	Ndewas Health Education Water and Sanitation
NGOs	Non-Governmental Organizations
PALNET	Participatory Learning Network
PHO	Public Health Officer
PHTs	Public Health Technicians
PHAST	Participatory Hygiene and Sanitation Transformation
PHEW	Participatory Hygiene Education Workshop
PROWWESS	Promotion of the Role Of Women in Water and Environmental Sanitation Services
RWSG-EA	Regional Water and Sanitation Group-East Africa
SARAR	Self Esteem, Associative Strengths, Resourcefulness, Action Plan, Responsibility
SHEWAS	Siaya Water and Sanitation Project
UNICEF	United Nations Children's Fund
WAHAs	Water and Hygiene Assistants
WASE	Water and Sanitation Education
WHO	World Health Organization

Acknowledgement

The Regional Water and Sanitation Group-East Africa (RWSG-EA) and Community Water Supply Unit (CWS) of World Health Organization (WHO) would like to express their gratitude to the participating agencies for their collaborative effort in piloting the Participatory Hygiene and Sanitation Transformation (PHAST) initiative in various projects implemented by Ministry of Health (Nandi/Baringo), UNICEF/Baringo and Kisumu, KWAHO, CARE-Kenya and BKH, Lake Basin Development Authority (LBDA), in the country. Our sincere appreciation is extended to UNICEF Kenya Country Office for accepting to host and fund the Workshop and without whose support this workshop would not have been possible. We look forward to UNICEF's continued support for this important initiative.

Special recognition to the International Training Centre Network Centre (NETWAS) for proficient coordination of PHAST initiative in the country and within the East African region.

Our gratitude is also extended to the two consultants responsible for the preparation of this PHAST Baringo Workshop Report and Tool-kit.

We would also like to our acknowledge to the Kenya Participatory Learning Network (PALNET) for their significant role in providing the forum for sharing of field experiences and enhancing the testing/implementation of the various participatory approaches. We look forward to its continued facilitation of such forums.

OVERVIEW OF PARTICIPATORY HYGIENE AND SANITATION TRANSFORMATION (PHAST)

The Regional Water and Sanitation Group in Eastern Africa (RWSG-EA), in cooperation with the Community Water Supply and Sanitation Unit (CWS) of WHO, initiated a program last year to develop guidelines and participatory tools for hygiene promotion in water and sanitation projects. The aim was to develop field oriented guidelines/materials to assist extension staff, health educators and trainers to effectively enhance sustainable hygiene behavioral practices.

It was felt that SARAR methodology, pioneered by PROWWESS, could be adapted to hygiene education as an alternative to the conventional message-oriented, didactic approaches which have not generally produced significant results in terms of individual behavior change. A Participatory Hygiene Education Pre-Planning Workshop was organized in September 1993 at the Aberdares Country Club in Nyeri in Kenya for Botswana, Kenya, Uganda and Zimbabwe trainers. The criteria for selecting the respective countries was based on their previous experience in using the PROWWESS/SARAR participatory methodology since 1990. Based on this a one week Pre-Planning Workshop was convened to pre-test prototype tools and design the regional Participatory Hygiene Education Workshop (PHEW) held in Mukono, Uganda, in October 1993.

The PHEW, held in Mukono Uganda, in 1993 was convened to facilitate the development and testing of prototype materials in the four pilot countries. One of the main aims of this Workshop was to draw from existing hygiene education concepts and materials and produce a training of trainers' manual on participatory methods for hygiene education. In addition to training a core team of specialists from each of the pilot countries, the Mukono workshop also got the participants to draft plans for field testing the participatory hygiene promotion approach in each of the respective countries. The workshop also identified the need to produce a variety of communication materials and to form a pool of artists who would contribute to future workshops.

In Kenya a PHAST team of the various participating organizations was formed as a basis of piloting and testing the PHAST tools and techniques. The PHAST team is made up of the Ministry of Health (GOK), UNICEF, Network for Water and Sanitation (NETWAS), CARE International (Kenya) and the World Bank's RWSG-EA. Most of these organizations are members of Participatory Learning Network (PALNET). PALNET was initiated as an outcome of a PROWWESS Participatory Regional Workshop held in 1990 which generated interest to establish a Network to share experiences and ideas through training in various participatory methods. Several project level workshops have been organized to date by the MOH (GOK), UNICEF and CARE/Kenya to train trainers and extension staff in participatory methods. The tools are now being tested in six projects in different areas of the country. UNICEF in collaboration with the MOH is involved in two pilot projects in Baringo and Kisumu districts. The Ministry of Health (MOH) - with funding from WHO is involved in a pilot project in Nandi. CARE/Kenya is involved in two projects in Nyanza Province - SHEWAS and NDHEWAS. KWAHO and the Lake Basin Development Authority (LBDA) have recently initiated PHAST pilot projects in various parts of Kisumu district.

In March 1994 a Pre-PHAST meeting was held to review progress of the PHAST activities. As a follow-up to the Mukono recommendations, PALNET organized a five day Artists' Workshop in Maseno, Kenya in April 1994. The objectives of the Artists Workshop was to enrich the artists skills in designing, reproducing, adapting participatory hygiene promotion materials, to develop a field-oriented guide for artists and to design sequenced prototype kit of hygiene promotion.

Another regional follow-up meeting was held for both Kenya and Uganda in August this year to review the original objectives of PHAST Programme, where appropriate re-formulate them to suite country-level situations and to develop project monitoring schedules and a documentation strategy. One of the main outcomes of the August 1994 meeting was the development of country-level objectives and the monitoring and evaluation schedules for application in all the participating projects. The country-level objectives were set out as a basis of meeting the overall PHAST goals. A monitoring and evaluation schedule was designed and various activities outlined to determine ways and means of achieving the objectives. Indicators and means of verification were also designed to measure achievements. A time frame was also specified for each set of project activities.

A Kenyan PHAST Workshop, with financial support from the UNICEF Kenya Country Office, WHO, CARE/Kenya, MOH, NETWAS and RWSG-EA was held in Baringo in November 1994 to adopt the country level monitoring schedule developed during the August 1994 meeting. The outcome of the Baringo Workshop has formed the basis of documenting the Kenya Country experiences to be presented in the Second Regional PHAST meeting in Zimbabwe.

The Second Regional Workshop is scheduled to take place on 5-9 December 1994, in Harare Zimbabwe to bring together experiences of the four countries selected to participate in this pilot phase. The Regional Workshop is organized by the CWS Unit of the WHO and the RWSG-EA of the World Bank and will be locally hosted by the Institute of Water and Sanitation Development (IWSD).

WORKSHOP OBJECTIVES

In collaboration with UNICEF and the Ministry of Health, the UNDP/World Bank RWSG-EA, organized a Kenyan workshop from 2-6 November, 1994 in Baringo. The purpose of the workshop was to review the progress of the PHAST pilot projects' activities in relation to the monitoring and evaluation strategies formulated during the August 8 -9, 1994 meeting in Nairobi. The workshop objectives as identified and developed by the participating project representatives were to:

- Review progress of PHAST activities in pilot projects through experience sharing, lessons learnt, successes and constraints.
- Assess the PHAST initiative in relation to capacity building at both grassroots and institutional level.
- Refine and adopt the monitoring and evaluation schedule developed in the August meeting.
- Develop a country-level documentation - including the country report and tool-kit of the materials developed to be presented at the 2nd Regional Workshop in Harare, Zimbabwe.
- Work out a country-level Action Plan for PHAST experience in Kenya.

PHAST PROJECT PROGRESS REPORTS

Project progress reports were presented by representatives of the respective PHAST pilot projects from Baringo, Kisumu, Nandi, CARE/Kenya and KWAHO. In addition ARUNET Kenya made a brief presentation on how to link PHAST activities with current participatory research efforts.

Presentations of the progress reports were done along the lines of the draft outline sent out as a guide to drawing up PHAST Country Reports by the WHO. The presentations covered among others, comments on the various tools used, nature of response, any modifications done and effectiveness of the tools applied. It was essential to include a brief outline on the acceptance of the PHAST approaches at Institutional level and at community level. The participating projects also carried out tool-kit evaluation exercise to highlight the specific tool used, the area of domain modification of tools if any and how it applied in either hygiene promotion, water/sanitation or in community mobilization. A presentation of the toolkit evaluation for each project is presented in the report. A further exercise was also carried out as a follow up of the Toolkit Evaluation for each Project. In conclusion the presentations addressed the issue of sustainability of the PHAST process and materials development.

During the August 1994 review meeting, country level objectives were identified and a monitoring and evaluation schedule developed. During the course of this workshop, the respective projects reviewed how the monitoring and evaluation schedule was applied at specific project level. Application of the M&E schedules for the specific PHAST Pilot projects are incorporated in the final section of this report.

Lessons Learnt and Observations:

One major observation arising out of the presentations was that only a small number of tools were utilized in all the projects and the ones being used were modified to suit local situations. The tools used in the projects presented include:

TOOLS APPLIED	
•3-PileSorting	•Sanitation Ladder
•Mapping	•Pocket Chart
•Dr AKili Sana	•Barrier Matrix
•Flexis Flans	•Unserialised Posters
•Faecal Route	•Story with a Gap
•Gender Task Analysis	

Tools Modifications:

In most cases the in-between in the 3-Pile-Sorting was done away with. The name of a local doctor was used to substitute Dr Akili Sana. The Barrier Matrix, Planning posters and Flexis, and the mode of dressing was made to suit the local community. The size of the *Ugali* in Faecal Routes was reduced.

UNICEF/BARINGO	CARE/KENYA
Pocket Charts were made using locally available materials. - Two specific modifications were done by the UNICEF/Baringo Project where in using Unserialised Posters, mothers were depicted sitting on a mat. - In the Gender target analysis changes were made on the tool to omit the body of the people altogether and just show the hands only. - A major outcome of the UNICEF/Baringo Project is the development of a toolkit for application in all UNICEF supported projects. - This has also been translated into three local languages.	In CARE/Kenya, the SHEWAS experience has been extended to cover pre-testing of the toolkit for aids awareness project for the "under 18 teens" (CRUSH). - The tools have been adopted from Mukono Toolkit to suit the youth. For instance depicting a youth instead of a walking adult, a disco in place of a dance with drums. - The Barrier matrix modified in terms of "very difficult to lift", "difficult to lift" to "unable to lift" altogether.

The Nandi District Progress Report is included as part of the text to highlight the various issues addressed in each of the presentations. The other project progress reports are annexed to this report where a project summary is presented. The issues arising out of all the project progress presentations are summarised at the end of the Nandi District PHAST Report.

Nandi District PHAST Report

Nandi District is one of the smallest districts in the Rift Valley Province in Kenya with a total area of 2,745 square km and a total population of about 500,000 people. About 50% of the population is made up of the youth. It is a rich agricultural area with plenty of rainfall and the mainstay is farming especially maize growing, coffee, tea and animal husbandry.

Water and sanitation takes about 1/3 of the Primary Health Care (PHC) cost in the District. The major health problems are Malaria, Upper Respiratory and Diarrhoeal Diseases. Most of these are preventable through hygiene education.

Program Activities

In the district, hygiene promotion has been done by the Primary Health Technicians (PHTs) through Chiefs' meeting. As a Government Ministry, sources of funds have been a major constraint in adopting PHAST methods. However through the support of WHO, it has now been possible to conduct training and follow up the application of the PHAST tools. A training was conducted in Nandi for 16 participants (Chiefs, PHTs, and Community representatives) with facilitators from the team trained in Mukono Workshop. A workshop document has already been produced and circulated. The Chief Public Officer launched the programme. The major outcome of the training was the consultative process initiated with the Principal at the Medical Training Centre on how to integrate PHAST in the Medical Training Centre curriculum. A second training for the field staff was planned for Nov-December 1994.

Some Reaction from the Field

The tools are quite applicable to their local situation. Most training participants felt they were free and relaxed and all the information was provided through voluntary effort without the intervention of the Public Health Technician (PHT). The sanitation ladder and 3-pile sorting, and mapping were used for analyzing hygiene behavior.

Experience of Participatory Methodologies in Communities

1. In all areas visited, people were free and more relaxed. The deliberations were undertaken by them rather than by other authorities (health staff)

2. Most of the tools were simple enough to relate to what was actually happening in their villages.

3. They discovered that almost all communicable diseases could be prevented by improvement of general hygiene standards.

4. Taboos and beliefs are no longer strictly emphasized at family levels. Although though fear of being seen performing unusual tasks persists i.e. a man cleaning a baby's faecal matter or a woman thatching roofs.

5. Women are more conversant with health problems within family levels and men appeared conservative about it.

6. Retention of messages disseminated through pictures/discussion is higher than in other methods i.e. lectures, barazas.

Lessons Learnt

(i) They found that women and men have collective responsibility in improving hygiene standards in the family and community.

(ii) They found that they could easily measure their health standards and plan for their felt needs. e.g in giving priorities of breaking the transmission cycle as shown in faecal oral routes i.e. boiling water, covering food, personal hygiene, using dish-racks restraining animals from mingling amongst food utensils.

(iii) They found they could be responsible for their health standards and even devise methods of dealing with defaulters.

(iv) They realized that good health practices should be targeted and that practices such "in between" should not exist.

(iv) According to the tools applied they learnt that for the development/projects to succeed, they have to cooperate and participate together as a community (i.e. cup exercise, story with a gap, task analysis).

Acceptance of Participatory Approaches at Community Level

(a) Reactions of Community Members and Leaders

(i) They vowed to undertake house-to-house hygiene education in the villages.

(ii) They agreed on compilation of pit latrine defaulter lists in the village.

(iii) They requested for coloured tools for use in local schools and by local health workers selected from the community.

(iv) They approached the Public Health Officer (PHO) for the technical aspects of latrines, water source protection and housing.

(b) Changes/Community Recommendations

(i) Formation of village health committees and request that they be taught how to use various tools.

(ii) They agreed that the increased sightings of freshly dug up earth was an indicator of changes in their areas.

(iii) They agreed to institute local prosecution of defaulters by village elders.

Conclusion of Participatory Hygiene Education in Nandi District

- The PHAST methods are effective in disseminating relevant health information than other methods previously used.
- PHAST methods discourage intersectoral meetings as they take more time (e.g. of Siwo primary School where the chief had convened a meeting of school committee, parents, TAs, the public).
- While the method is effective, the tools are prone to weather interruptions, where meetings are held outside in the open. For instance rain, wind, dust etc
- Participants especially rural women may not have enough time from their domestic chores
- Some pictures are prone to misrepresentation due to differences in perceptions by the community.
- Language may be a barrier amongst health workers and the community.

<u>Areas Covered (8 Villages)</u>

Irimis, Undeerit, Kipsotoi, Kapkoibai, Kipkeibon, Choimin, Kapkeruge, Siwo (Kapnyasa)

Constraints: The community identified the following as their major constraints in the Nandi PHAST project.

1. Limited Resources for training and follow up
2. Sustainability of the tools.
3. Decision on what penalties to impose on the unwilling villages that fail to apply participatory tools.
4. Community expectation that the MOH should visit them frequently.

<u>Future Plans for Nandi District PHAST Project</u>

Meetings to review the field experiences were planned to take place in November and in December 1994.

Summary of Issues Identified from PHAST PILOT Progress Reports/Kenya

The issues identified from the Project Progress Reports are summarised here below as follows:

- The issue of how we can produce cost effective sustainable toolkit was raised in all the presentations.
- The need to de-mystify the tool-kit so that it becomes a common persons tool without it being labelled as a tool for the Public Health personnel.
- There is need to clearly identify at community level the link between PHAST and the BAMAKO Initiatives.
- The issue of the production and distribution of toolkit materials needs to be addressed as a follow up to the artists workshop recommendations in Maseno.
- The issue of interpretation of some of the tools e.g. the BIG fly so that whatever is depicted it should actually convey the intended message.
- There is the issue of dealing with resistance to change within rural communities and how the PHAST tools can address this constraint.
- The NGO/Government of Kenya relationship should be considered as a critical input in all the projects particularly when the NGOs pull out of an area once their project cycle is finalised and leave the communities to deal with the Government Ministries.
- The issue of potential linkages in application of the tools used in PHAST with other participatory research efforts and the role of such research Networks in the PHAST process.
- There is the issue of lack of relevant documentation on PHAST and the distribution of such materials It was proposed that NETWAS and GoK/MOH should facilitate this.
- The issue of the relationship between PHAST tools with other participatory methodologies.

Addressing the Issues/Concerns Identified from the Kenya PHAST Project Reports

Participants agreed on the following ways of addressing the issues/concerns identified from the Kenya PHAST project reports:

- For sustainability and cost effectiveness of the toolkit to be realised, it was agreed that there was need in all projects to do the following:

  (a) It was noted that since PHAST complements the primary school syllabus of Home Science, it would therefore be useful to involve artists based in local primary schools and school children.

  (b) It would be useful to share of toolkits developed (in the same area) among NGOs and other agencies working in the same area. For instance UNICEF/Baringo could share materials developed and pre-tested with WHO/NANDI projects.

(c) Link up with the Health Education Unit of the MOH where they have an artist on full-time employment.

(d) There is need for cataloguing/codifing of the toolkit. These materials could be numbered hence establishing a tracking system by coding the materials.

(e) Provide master copies of materials designed/developed for back up purposes. This can be done by photocopying on transparencies, or by use of polythene/celotape etc. and *Jua kali* artisans could used to reproduce the materials.

(f) There is need for a Kenyan Artists' workshop as a follow up of the Maseno workshop. In an attempt to develop relevant toolkits, and also to institute regular feedback for constant updating of the toolkit.

- Efforts in de-mystifying the Toolkit should be incorporated in PHAST projects.

  (a) By the way it is designed, packaged and make the actual tools appropriate to the community; and

  (b) Translate the toolkit in local languages e.g UNICEF/BARINGO project has already translated toolkit into three languages: Pokot, Tugen and Njempes

- Production and Distribution of Materials

  The question being addressed here is how do we enable the community to produce materials. Various strategies are suggested:

  (a) Community involvement in material production

  (b) Involve and make use of school teachers

  (c) Encourage simple tracing e.g consult the Production of Health Education Materials Section in the Health Education Unit of the Ministry of Health.

  (d) Be sensitive to cross-cultural habits.

- The 'BIG' Fly. There is need to pre-test and adapt toolkit material developed based on the community's responses e.g. the disproportionate size of the BIG fly looks like a bee or a Tsetse fly.

- Materials development in SARAR

  (a) Some of the pictures are left to give an ambiguous interpretation. However too much ambiguity may distract effective discussion.

  (b) Need for more artist training.

(c) Artists need to depict actual cases for purposes of what is intended e.g. a fly but not a Tsetse fly!

- To enhance NGO/GOK relationship, there is need to encourage collaboration with other agencies including the various GOK/Ministries so as to integrate government officers in the project activities. This is to ensure continuity and sustainability of the project once the NGO pulls out of the area as the case of CARE/SHEWAS.

- To enhance linkages with research and dissemination of PHAST methods and processes, PALNET/ARUNET Kenya and other regional research Networks should be encouraged to offer opportunities for encouraging activities which involve communities in identifying their problems and ways of overcoming them.

FIELD VISITS TO NG'AMBO, KAMAR AND LARUK

Purpose of the Field Visit

To test the application of some of the tools, field visits were made to three communities of Ng'ambo, Kamar and Laruk. The purpose of the field visits was to familiarizing the participants with the local community, but more significantly to have a field reality of the effect of the PHAST initiative. The participants divided themselves in three groups and each group was responsible in selecting the tools they would apply and test in the respective communities. The intention of the field visit was to encourage the participants to examine the successful aspects of their visits, try to analyze some of the weaknesses and make positive recommendations. The output would provide an information checklist of the tools utilised in the community during the pilot phase, the community's perception/familiarity with the tools and the lessons learnt.

Issues and Observations from the Field Presentations

The groups agreed that it was useful going out into the field projects and coming out with substantive observations. There was evidence of pit latrine construction in progress (both in Kamar and Ng'ambo), high level of awareness about hygiene practices and general willingness to acquire PHAST skills. In Laruk the community was well trained and two members of the community actually took over the training from the rest of the team and there was obvious acceptance of the tools by the community. Also in Laruk, the training team had to revise the gender awareness toolkit for their gender awareness was relatively higher. A general observation in all the three villages is that the fly used in the tool-kit was too big. Asked about the image of the village in future, the Laruk community replied that they want sanitation for all the villagers, latrines and durable dish racks not prone to termite attack. (See field visit reports in the annex).

Lessons Learnt From Field Visits/Presentations

1. The groups felt that using the PHAST tools had been a much more successful way of gathering information and encouraging maximum community participation.

2. The groups felt that there is a significant change in the respective communities where PHAST approach was applied.

3. Though they are time-consuming, PHAST techniques create impact if properly applied. It was vital to keep in mind that proper pre-planning prior to field work is essential, otherwise field results can turn out very differently.

4. The sanitation ladder and the F-diagram were effective in stimulating community response. The two tools seem to be playing a significant role in enabling the community to take/consider some action.

5. The fly depicted was a bit too big and this led to un-intended interpretations. Perhaps the obvious point is how to overcome this issue. Do we leave the tool as it is to give a wider view and cross-interpretations? Do we avoid ambiguity to limit unintended distractions?

6. Regarding gender task analysis, the tasks of the men need to be included so that men in the community are not just seen as idlers (for instance, they look after animals and keep them from destroying crops). We could look for ways of complementing gender relations in hygiene promotion. For instance where the woman puts up the latrine superstructure and the men dig the hole.

7. There was consensus that there is need to enhance women's participation in hygiene promotion.

8. Cultural inhibition and lack of knowledge on improved hygiene behavior. There is need to focus on real and not perceived or ethnocentric resistance to change factors.

9. The issue of coverage and application of the tools in terms of effecting change was discussed and participants agreed that PHAST tools if properly utilized can achieve this.

10. Though the communities agree it is in their own interest to promote hygiene amongst themselves and their neighbours, financial constraints to purchase materials for latrine construction still persist in addition to termites and animals knocking down their dish-racks.

Conclusion of the Field Visit

The visit was useful to the group members as well as to the community. Perhaps better pre-planning of field visits in future will bring out more results. The final comment after the field visit was a fear expressed that we do not push the PHAST process too fast on the communities. The issue of expecting change overa relatively short period should not be oversimplified. We should not expect miracles and there is need to avoid setting over ambitious goals too soon during the PHAST Pilot Phase.

INTRODUCTION TO TOOLKIT EVALUATION FOR THE KENYA PHAST PROJECTS

After the Mukono Workshop in 1993, the pilot projects were requested to try and adapt the Toolkit designed during the workshop to their respective project areas and determine how best the tools are applicable to their specific environment. Over the period various modifications have been made to some tools depending on specific projects' requirements. To determine the extent of such changes to the tools developed, a *Tool-kit Evaluation exercise* was conducted for each PHAST pilot project represented in the Workshop. Each project representative was required to identify the tool that was modified or re-designed and indicate in a table the type of modification carried out and the area of focus for the use of the tool. They were also required to indicate the domain for the use of the particular tool in terms of food hygiene, community mobilization, human waste disposal, water hygiene and latrine use/hand washing.

Analysis of the tools modified for the PHAST projects in BARINGO, SHEWAS/NDHEWAS, NANDI and KWAHO as shown in the following charts indicate that: *Sanitation Ladder* was modified to depict local situation, the *Gender Task Analysis Matrix* designed to integrate the triple roles of women (see Caroline Moser), *Unserialised Posters* adapted to fit local dress styles, mothers sitting on a mat, *Task Target Analysis* changed from depicting the whole body to just "hands only" performing the various tasks, *Three Pile Sorting Cards* had the "in-between" removed the " and *Doctor Akili Sana* changed to a local doctor's name in place of Dr Akili Sana.

NDHEWAS TOOLKIT EVALUATION

Tool	Design/ Procedure Modification	Area of Focus	Domain Hygiene/Sanitation/Community Mobilization	Any Other Comments
1. Dr. Akili Sana	1.0 Name changed to local doctor's name - 1.1 Pictures modified to suit local community	1.0 Diarrhoeal disease identification		1.0 Other tools have been developed eg.poster of a child, places for RX
2. Faecal Routes	2.0 More posters added 2.1 Posters modified eg. Ugali plate reduced in size	2.0 Causes/Transmission of DD	2.0 - Food hygiene 2,1 - Personal hygiene 2.2 - Water hygiene 2.3- Human waste Disposal	
3. Barrier Matrix	3.0 More posters added 3.1 Posters modified to suit local community	3.0 Prevention of DD	3.0 As above	
4. Flexis	4.0 Modification of posters eg. dressing	4.0 For creativity and climate setting	4.0 Community participation enhancement	
5. Planning Posters	5.0 More posters added 5.1 Posters modified to suit local situation eg. planning posters of latrine construction; tank construction etc.	5.0 To enhance community participation	5.0 Community participation	
6.0 3 Pile Sorting	6.0 More posters added 6.1 Removed in-between	6.0 To investigate knowledge on hygiene behavior	6.0 - Human waste disposal 6.1 - Food hygiene 6.2 - Water hygiene 6.3 - Hand washing	

KWAHO TOOLKIT EVALUATION

Tool	Design/Procedure Modification	Area of Focus	Domain in Hygiene/Sanitation, Community Participation	Any Other Comment
1 Faecal oral routes	1.0 Nil	1.0 Causes mode of transmission of D. diseases	1.0 Food hygiene 1.1 Water hygiene 1.2 Faecal disposal	1.0 The tools have been adopted by the community
2 Faecal route barrier matrix	2.0 Nil	2.0 Control and prevention methods of diarrhoeal diseases	2.0 Hand washing, 2.1 Boiling of water 2.2 Covering of food 2.3 Proper faecal disposal methods	"
3 Three pile sorting	3.0 Removed the in-between	3.0 To investigate knowledge on hygiene behavior	3.0 As above	"
4 Sanitation	4.0 Nil	4.0 Level of faecal matter disposal	4.0 Social economic status of the community	

NANDI DISTRICT TOOLKIT EVALUATION

Tool	Design/Modification of	Area of Focus	Domain	Other Comments
1 3-Pile Sorting	1.0 Background and pictures and dressing changed	1.0 Disease prevention 2.1 Hygiene promotion	1.0 Wash hands 1.1 Good personal hygiene 1.2 Proper food handling	1.0 Pre-testing and adapting of tools on-going
2 Story with a Gap	2.0 No modification	2.0 O&M of water and sanitation activities 3.1 Disease prevention (centre)	2.0 Good personal hygiene 2.1 Safe water supply 2.2 Good excreta disposal	2.0 -Do
3 Mapping	3.0 -Do	3.0 Community situation analysis in terms of existing water and sanitation facilities 3.1 Determine community felt needs and priorities	3.0 Do	3.0 -Do
4 Sanitation Ladder		4.0 Disease control eg. DD, worm infestation 4.1 Understanding/assessing available options of toilet construction	4.0 Safe water supply 4.1 Good food hygiene practices and excreta disposal	4.0 -Do
5 Pocket Chart	5.0 Used the easily available materials to make pocket chart eg. manila paper, news print and glue	5.0 Disease control 5.1 Situation analyses and self evaluation on water and sanitation	5.0 -Do	5.0 -Do
6 Question Box	6.0 No modification	6.0 Assess the innovative skills and resourcefulness of the community towards health 6.1 Assess level of understanding of health in broad perspective	5.0 Disease control 5.1 Good handling 5.2 Proper excreta disposal 5.3 Safe water and domestic hygiene	6.0 -Do

BARINGO DISTRICT TOOLKIT EVALUATION

Tool	Design Modification	Area of Focus	Domain Hygiene Practice/Sanitation	Any Other Comments
1 Faecal routes	-	1.0 Disease prevention eg. diarrhoea	1.0 Hand washing 1.1 Boiling of water boiling of milk 1.2 Covering of food	1.0 Well understood by community and to be pre-postered
2 Understand posters	2.0 Mothers sitting on a mat	2.0 Guidance to good hygiene practices	2.0 Leads you to good health behavior	
3 Attributes of good community participation	-	3.0 Projects	3.0 Self esteem 3.1 Associative strength 3.2 Resourcefulness 3.3 Action planning 3.4 Responsibility	
4 Sanitation ladder	-	4.0 Level of faecal water disposal	4.0 Socio-economic status of an individual	
5 Task target analysis	5.0 Changed from body to just only the hands	5.0 Task sharing	5.0 Reduce work load	

SHEWAS TOOLKIT EVALUATION

Tool	Design/Modification	Area of Focus	Domain Hygiene Practice/Sanitation	Any Other Comments
1 Unserialised Posters	1.0 Designed and developed for school-children 1.1 Adapted to fit local dress situation	1.0 Open-up discussion 1.1 Ice-break Domain	1.0 Pre-testing going	
2 Planning Poster	2.0 Included roof tanks, springs 2.1 Designing one hygiene promotion starting from selection of WASEs to M & E of community levels	2.0 Construction of W & S tank 2.1 Hygiene promotion	-	
3 Gender Task Analysis	3.0 Gender analysis matrix integrating the triple roles of women (by Caroline Moser)	3.0 Gender	-	
4 Sanitation Ladder	4.0 Latrines to reflect local situation 4.1 The goals made realistic	4.0 Safe excreta disposal	4.0 Latrine use	

INTRODUCTION OF KENYA PHAST COUNTRY LEVEL OBJECTIVES

A major outcome of the PHAST Meeting held in August 1994 was the development of country level PHAST objectives and a Monitoring and Evaluation Schedule (M&E). Participants in the Workshop resolved that for the country objectives to be meaningful and have impact on the pilot projects a meeting of all PHAST Pilot Projects in Kenya was essential to adopt the objectives developed and the M&E schedule. Partcipants were given the country level objectives and divided into working groups to discuss the objectives and comment on how the objectives could fit into their current project objectives. After a plenary discussion on the various views expressed from the project teams the following objectives were agreed upon as the Kenya Country level objectives of PHAST:

- To enhance networking between national and regional agencies
- To develop monitoring tools and indicators for determining the progress of the application/use of PHAST
- To advocate PHAST in implementing agencies and encourage the adoption and use of PHAST methodologies
- To facilitate capacity building both at grassroots and institutional levels
- To develop an integrated approach in the design and development of appropriate participatory health learning materials in PHAST which are sensitive to women, men, youth and children.
- To enhance demand-driven/community-centred interventions to foster sustainable PHAST programmes.

The country level objectives are shown in the following chart. In addition to specifying the objectives the *Monitoring and Evaluation Schedule* was developed to be used as a basis for monitoring PHAST. Against each objective all the activities related to the objective were identified and the indicators to be used to assess the activity and the means of verification developed. A time frame was also assigned to each activity and the person responsible to undertake the activity also specified.

COUNTRY LEVEL OBJECTIVES (KENYA)

Objectives	Activities	Indicators	Means of Verification	Person Responsible	Time Frame
1. To enhance networking between national and regional agencies	1.0 Documentation of PHAST 1.1 Exchange v[illegible] 1.2 Structured cross visits 1.3 Workshops 1.4 Exchange of newsletters 1.5 Consultative meetings 1.6 Establishing resource centres feasible and achievable	1.0 Quality of documents and documentation 1.1 Lessons learnt and documented recommendations 1.2 Number of meetings and quality of workplans 1.3 Availability of resource centres/data	1.0 Records 1.1 Review meetings 1.2 Visits 1.3 Achievable GoK commitment through MoH	1.0 RWSG-EA 1.1 NETWAS 1.2 Palnet 1.3 UNICEF	1.0 Continuous Dec'95
2. Develop monitoring tools and indicators for determining the progress of use of PHAST	2.0 Sensitize policy makers and policy implementors 2.1 Identify and develop indicators 2.2 Develop pictorial evaluation tool 2.3 Hold regional workshop (U/K) on participatory evaluation 2.4 Evaluation visits by PHAST team	2.0 Quality of indicators 2.1 Simple pictorial tool 2.2 Documentation arising out of the workshop 2.3 Lessons learnt out of visits	2.0 As in objective one GoK/MoH	2.0 As above	2.0 Dec'95
3. To advocate PHAST in implementing agencies adaptation and use of phast methodologies	3.0 One-to-one meeting with management/policy makers 3.1 Distribution of documented applications 3.2 Organise visits to communities participating in PHAST 3.3 2-3 day workshop to include mgt/policy makers 3.4 Sensitise managers and policy makers	3.0 Acceptance and support for implementation of PHAST 3.1 Resources allocated to PHAST 3.2 Management initiatives in support of PHAST 3.3 Number of managers sensitised 3.4 Willingness to support e.g budget line for materials dev. training	3.0 Document review 3.1 Meetings 3.2 Progress reports on PHAST GoK/MoH commitment 3.3 Availability of funds GoH/ MoH commitments	3.0 Individual member agencies PALNET team 3.1 UNICEF (As above)	3.0 Dec'1995

4. To facilitate capacity building both at grassroots and institutional levels	4.0 Develop a work plan for PHAST/PHEM activities 4.1 Awareness creation and mobilisation 4.2 Problem identification/Baseline	4.0 Availability of workplan	4.0 Document review GoK/MoH	4.0 PALNET team 4.1 Individual agencies (projects)	4.0 March' 1995
5. -do-	5.0 Developing training curriculum and participatory learning materials	5.0 Curriculum designed 5.1 Gender focused materials developed	5.0 GoK/MoH commitment and allocation of funds for PHAST activities	5.0 MoH 5.1 UNICEF 5.2 PHAST team	5.0 1 year Dec'95
6 -do-	6.0 Train extension staff 6.1 On-job training of extension staff	6.0 Application of PHAST methodology and activities of extension	6.0 Direct observation 6.1 GoK/MoH commitments	6.0 Individual agencies	6.0 Oct.'95
7	7.0 Train communities on PHAST Pretest materials with communities 7.1 Review of materials 7.2 Adoption of materials 7.3 Training of village trainers 7.4 Monitoring and follow up	7.0 Show of progress on community map 7.1 Increased number of latrines 7.2 Use of facilities 7.3 Washing of hands 7.4 Maintenance of facilities 7.5 Request for tool kit 7.6 Adaptation of hygiene practices	7.0 Direct observation 7.1 Focus groups discussions 7.2 Survey Participatory Evaluation method 7.3 GoK/MoH commitment	7.0 Training officers 7.1 Extension workers 7.2 Local community leaders PALNET	7.0 June - Oct'95
8. Develop an integrated approach in the design and development of appropriate participatory health learning materials in PHAST which are sensitive to women, men, youth and children	8.0 Develop materials	8.0 No. of tools produced 8.1 Materials sensitivity/acceptability 8.2 No. of extension staff trained 8.3 No. of community member trained and can confidently apply materials (Confidently apply)	8.0 Records 8.1 Reports from field visits	8.0 Individual agencies	8.0 Dec'.95

9. Enhance demand driven/community centred interventions to foster sustainable programmes	9.0 Design strategies for community mobilisation 9.1 Problem identification 9.2 Participatory planning 9.3 Implementation and participatory evaluation 9.4 Hold regional workshop (U,K,E) on PHAST	9.0 Nature of villagers/nature of commitment 9.1 Demand for services 9.2 Clear delineation of roles: community, leaders, institution/govt. 9.3 Enhance women participation in decision making 9.4 Effective use and replicability of PHAST tools and sustainability	9.0 Applications and proposals 9.1 Villagers own resource contribution 9.2 Project/agency meet term reports and review	9.0 Individual agencies 9.1 NETWAS	9.0 Dec'95

Issues on the Application of Monitoring and Evaluation Schedules at the Kenya PHAST Project Levels

The M&E Schedules were distributed to the project representatives from CARE/Kenya, Baringo, Nandi and KWAHO. They were asked to use the M&E Schedule given to indicate against the identified objectives what activities had been carried out to achieve the objective at project level. The outcome of the exercise revealed that a number of project level activities had been put in place in the two CARE/Kenya Projects, UNICEF/Baringo and MOH/Nandi pilot projects. The project M&E's are shown in the following tables under the specific project where they were used to get feedback on the current state of each of the projects. The acceptance of the M&E Schedule was identified as a good entry point to get feedback on the PHAST projects.

KWAHO Kadibo Water and Sanitation Project

Objectives	Activities	Indicators	Means of Verification	Person Responsible	Time Frame
1. To enhance networking between national and regional agencies	1.0 None	1.0 Number of meetings 1.1 Lessons learnt 1.2 Availability of resources	1.0 Records	1.0 N/A	1.0 N/A
2. Develop monitoring tools and indicators for determining the progress of use of PHAST	2.0 None	2.0 Not yet done	2.0 None	2.0 KWAHO	
3. To advocate PHAST in implementing agencies adoption and use of PHAST methodologies	3.0 Not yet		3.0 Learnt about PHAST through UNICEF		
4. To facilitate capacity building both at grassroots and institutional levels	4.0 Develop work plan	4.0 Work plan available	4.0 Work plan available		
5. -do-	5.0 Not yet using mukono toolkit	5.0 Outright adoption			
6.		6.0 Have trained village volunteer			
7.	7.0 Train staff	7.0 Education staff trained			

8. Develop an integrated approach in the design and development of appropriate participatory health learning materials in PHAST which are sensitive to women, men, youth and children		8.0 Baseline study was carried out 8.1 Report available			
9. Enhance demand driven/community centred interventions to foster sustainable programmes		9.0 Mobilization of community has been done but no evaluation			

Application of M&E Schedule at Project Level

NANDI DISTRICT

Objectives	Activities	Indicators	Means of Verification	Person Responsible	Time Frame
1. To enhance networking between national and regional agencies	1.0 Achievement/Accomplishment 1.1 Regional: 2 meetings, March and August 1.2 National: projects consultation meetings L. Bogoria 1.3 Not much done in exchange of PHAST materials.	1.0 Number of meetings 1.1 Lessons learnt 1.2 Availability of resources	1.0 Records	1.0 N/A	N/A
2. Develop monitoring tools and indicators for determining the progress of use of PHAST	2.0 Not done	2.0 Not yet done	2.0 None	2.0 KWAHO	
3. To advocate PHAST in implementing agencies adoption and use of PHAST methodologies	3.0 Chief P.H.O has been briefed and has endorsed the PHAST approach. 3.1 MoH involved in pilot area selection/approach. 3.2 Budget/ allocation of funds has been done		3.0 Learnt about PHAST through UNICEF		

Objectives	Activities	Indicators	Means of Verification	Person Responsible	Time Frame
4. To facilitate capacity building both at grassroots and institutional levels	4.0 Plan for PHAST activities done 4.1 One extension staff train workshop of 16 participants done. 4.2 Workshop report available 4.3 Field experiences/less on learnt report available (draft) 4.4 Pre-testing of tools & adapting on-going 4.5 Training curriculum not done 4.6 Train communities on PHAST not done	4.0 Work plan available	4.0 Work plan available		
5. -do-	5.0 Pre-testing and adoption of materials is on-going	5.0 Outright adoption			
6.	6.0 Participatory training has been used in water and sanitation projects.	6.0 Have trained village volunteer			

Objectives	Activities	Indicators	Means of Verification	Person Responsible	Time Frame
7.	7.0 Train staff	7.0 Education staff trained			
8. Develop an integrated approach in the design and development of appropriate participatory health learning materials in PHAST which are sensitive to women, men, youth and children		8.0 Baseline study was carried out 8.1 Report available			
9. Enhance demand driven/community centred interventions to foster sustainable programmes		9.0 Mobilization of community has been done but no evaluation			

Application of M&E Schedule at Project Level
CARE-Kenya

Objectives	Activities	Indicators	Means of Verification	Person Responsible	Time Frame
1. Documentation Exchange visits to enhance networking between national and regional agencies	1.0 Documentation - on-going 1.1 Exchange visits - Ruto visited NDHEWAS/SHEWAS ROH Sawyer/Robertta to review PHAST activities. 1.2 Facilitating in Workshop - NDHEWAS to RWD 1.3 SHEWAS F.O - CMW - workshop 1.4 CARE's representation	1.0 Number of meetings 1.1 Lessons learnt 1.2 Availability of resources	1.0 Records	N/A	N/A
2. Develop monitoring tools and indicators for determining the progress of use of PHAST	2.0 Develop monitoring tools- in the process of developing pictoria follow-up format	2.0 Not yet done	2.0 None	KWAHO	
3. To advocate PHAST in implementing agencies adoption and use of PHAST methodologies	3.0 Advocacy - sharing PHAST values and approaches with MoH personnel at Dist/Divisional level 3.1 Sharing with counterpart in the area		3.0 Learnt about PHAST through UNICEF		

4. To facilitate capacity building both at grassroots and institutional levels	4.0 Workplan - quarterly w/plans for H/E upto June 95. 4.1 Availability of flow charts for hygiene promotion. 4.2 Training curriculum - for WASE training available 4.3 Child to child guidance 4.4 Learning material for health education (SARAR tools) 4.5 Training of extension staff - 4.6 5 workshops - held since Dec 93 - SHEWAS/NDHE WAS. 4.7 On going coaching and monitoring 4.8 Training of village level trainers 4.9 about 350 WASES trained by SHWAS and NDHEWAS projects	4.0 Work plan available	4.0 Work plan available		
5. -do-	5.0 Pretesting- on going Adoption 5.1 On-going - Ref. toolkit evaluation	5.0 Outright adoption			
6.	6.0 Community mobilization 6.1 PRA at Sub-locational and village levels 6.2 PRA review meeting 2 per Sub-locational per month (8 Sub-locations). 6.3 SHEWAS programme evaluation report focuses on the above. 6.4 Participatory planning - during PRAs	6.0 Have trained village volunteer			
7.	7.0 Train staff	7.0 Education staff trained			

8. Develop an integrated approach in the design and development of appropriate participatory health learning materials in PHAST which are sensitive to women, men, youth and children		8.0 Baseline study was carried out 8.1 Report available			
9. Enhance demand driven/community centred interventions to foster sustainable programmes		9.0 Mobilization of community has been done but no evaluation			

Application of M & E Schedule at Project Level
BARINGO

Objectives	Activities	Indicators	Means of Verification	Person Responsible	Time Frame
1. To enhance networking between national and regional agencies	1.0 Training plan for PHOs, PHTs, other extension workers	1.0 Three training sessions have been conducted	1.0 First to be accepted by the DWSC	1.0 D.P.H.O, DWSC	
2. Develop monitoring tools and indicators for determining the progress of use of PHAST	2.0 Adaptation and modification of Mukono tools	2.0 Toolkit development		2.0 D.P.H.O. DWSC UNICEF	
3. To advocate PHAST in implementing agencies adoption and use of PHAST methodol ogies	3.0 training of committee was done at the village level	4.0 Changes in health behavior eg. construction of pit latrines	3.0 Direct observation group discussion	3.0 - Do -	
4. To facilitate capacity building both at grassroots and institutional levels	4.0 Does not apply in Baringo				
5. -do-		5.0 Outright adoption		5.0 UNICEF	

Objectives	Activities	Indicators	Means of Verification	Person Responsible	Time Frame
6.	6.0 All	6.0 Trained 75 extension workers producing more tools	6.0 Records and reports from the field compile	6.0 D.P.H.O trained personnel	6.0 March 95
7. Develop an integrated approach in the design and development of appropriate participatory health learning materials in PHAST which are sensitive to women, men, youth and children					
9. Enhance demand driven/community centred interventions to foster sustainable programmes					

The Kenya Country-Level Action Plan

Identification of the Kenya PHAST Priorities

The participants embarked on the process of developing a Kenya country level action plan by first identifying the overall PHAST activities for Kenya. This was based on the outcome of the project profiles presented in the workshop in which issues of concern were highlighted. The subsequent toolkit evaluation adopted for each of the participating projects in the PHAST initiative in Kenya was reviewed once again together with the country level objectives developed in the August 1994 workshop. The participants were requested to apply the country level objectives to their own specific projects and insert against each objective the specific project activities undertaken, the mode of indicators used including the means of verification and the persons responsible to execute the activity within a specified period.

From the above analysis it was now possible to clearly see and identify overall PHAST activities for Kenya. The following activities were identified as the overall PHAST activities for Kenya:

- To develop a PHAST Curricula for Primary schools, MTCs and Teachers Training Colleges
- To design, develop and distribute PHAST learning materials
- To document country and agency experiences in the application of the PHAST tools
- To exchange information between PHAST pilot projects
- To develop a PHAST resource centre at the country level
- To design and enhance the application of PHAST tools and methods
- To advocate PHAST to agencies, managers and policy makers in the NGOs, public and private sectors
- To initiate community capacity building programmes within the PHAST pilot projects
- To undertake PHAST Project Planning at all levels
- To prepare PHAST Project reports for Project operation and management
- To introduce PHAST Project Monitoring and Evaluation

In determining the above activities, the participants were requested further to look at all the identified activities and propose a viable action plan for the undertaking of the activities and a suitable time frame within which these activities can be achieved with reasonable success. In determining the priorities, it was agreed that responsibility should be assigned to specific project personnel and organizations to undertake the various tasks.

The workshop identified the following as the PHAST priorities for Kenya:

PHAST Priorities

- To sensitize policy makers in all PHAST Pilot Projects by December 1995
- To develop individual pilot project plans by March 1995
- To embark on training of extension staff by March 1995
- To develop training curricula for MTCs and other institutions and grassroots level communities specifically for PHTs, WASEs and WAHAs
- To explore ways and means of production of toolkit by the MOH materials production unit immediately
- To organise Country Level Monitoring and participant retreats frequently to review PHAST project progress and exchange of good practices
- To encourage information sharing and networking in all projects e.g PHAST project articles for publication and inclusion in the NETWAS Newsletter
- To develop research proposals to experiment and document the process of the use of participatory tools in relevant research projects
- To conduct a Regional workshop for Uganda, Ethiopia and Kenya PHAST projects to share experiences and assess progress of the PHAST experiment within the three countries
- To develop a PHAST resource centre at NETWAS as at the moment NETWAS is the major link between partners of PHAST and part of ITN centre. The main activities of NETWAS include support and enhancement of training in community-based approaches, promotion of information exchange and dissemination.

Workshop Evaluation and Conclusion

The evaluation was summed up into these three questions:

- Write down one or two things found useful in this workshop
- What would you like to see done better?
- Any other comments

Responses for what was found useful in the workshop were as follows:

- Field visit
- Sharing experience at grassroots level
- Use of Participatory approaches
- Exchange of ideas with the participating projects/agencies
- Establishing a Monitoring and Evaluation schedule for Kenya was tremendous
- The visit to UNICEF/BARINGO projects
- Developing a country level action plan
- Cooperation among the participants
- Working together
- Different ways (methods) of field testing
- Documentation of PHAST country experiences
- Refining and adapting the country monitoring schedule

Participant responses to what they would like to see done better were as indicated:

- Easy exchange of ideas and toolkit etc.
- RWSG-EA's own commitment in terms of support to country program by not focussing just on regional activities *per se*.
- Monitoring and evaluation of PHAST
- Continued collaboration and willingness to share tools
- Participants should have been given adequate time to prepare as the Workshop was convened within a very short notice
- Everything was alright
- More emphasis on water provision to community to enable practical hygiene to be practised
- Better time management
- Quick circulation of project reports to other PHAST pilot projects
- Include ice-breakers between the sessions
- Put up a showroom or a display board showing Project materials
- Review PHAST tools
- More time for the workshop
- More field visits
- More free time

The participants expressed a number of suggestions which if adopted will definitely enhance the PHAST initiative in the country. Some of these comments were:

- Timely Workshop Invitations to all participants
- PHAST workshops should rotate in all regions
- There should be enhanced partnership in the development of PHAST tools
- Organise similar workshops frequently
- Encourage more networking
- Immediate distribution of outstanding PHAST Workshop reports
- PHAST tools are applicable in the field
- Good workshop
- Each PHAST Workshop to seek financial support from one source
- Pleasant Workshop venue
- PHAST initiative is good

- Establish a structured and sponsored visit by participants to other projects to assess/monitor application of PHAST tools
- Learn from others
- Document application of various methods used in PHAST

Conclusion

The overall conclusion from the workshop evaluation is that the workshop objectives were achieved fairly well and that the PHAST initiative is good and has been easily acceptable by the communities. A need to expand the PHAST pilot projects and document the various methods and tools for future replicability in other projects within the country was also expressed all throughout the project progress reports.

ANNEXES

ANNEX I

PHAST Workshop held at Lake Bolgoria Lodge in Baringo Workshop Programme
2-6 November 1994

Wednesday November 2, 1994

4.00 pm — Arrival/Registration of participants

5.00 pm — PHAST Overview
Workshop Objectives/Purpose
Logistics/Time Table/program

Thursday November 3, 1994

8.30 am — Project profiles (Overview based on experiences/findings/lessons learnt
Baringo Project profile

Lunch

2.30pm — FIELD VISIT to Ng'ambo, Kamar and Laruk

Friday November 4, 1994

8.30 am — Filed visit presentations/comments
Other Project profiles
CARE/Kenya (Kisumu/NDHEWAS/SHEWAS)
MOH/Nandi District
BKH/LBDA
KWAHO
MOH/Kisumu District

Lunch

2.00 pm — Overviews of Projects Contined

Tea Break

4.30 pm — Synthesis of Experiences/what are the key issues/outcomes
Toolkit Evaluation

Saturday November 5, 1994

8.30 am — Plenary reports on Toolkit Evaluation
Monitoring and Evaluation Strategy/Schedule (Working Groups)

Lunch

2.00 pm — Developing Country level Report/Documentation in terms of:

- Designed/Developed Monitoring tools/techniques
- Findings/Outcomes/experiences/lessons learnt
- Organized Training Programs of Extension Staff, Capacity Building, Field visits, Sensitizing Managers/Policy makers
- Action Plans prior to the 2nd Regional Workshop (Harare Zimbabwe).

Tea Break

4.00 pm — Workshop Evaluation
5.00 pm — Closure of the Workshop

Sunday November 6, 1994

Departure after Breakfast

ANNEX II

List of Participants

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ANNEX III

Field Work Presentations

NG'AMBO COMMUNITY

* There was evidence of latrine construction in progress

* High level of awareness about hygiene practices and how they can suffer as a result of poor hygiene

* Community initiative was evident as witnessed by the community members willingness to construct latrines

* Desire to acquire skills and knowledge and expressed need to

* The tools have contributed to the people's transformation

Faecal Oral Routes

The interpretation of the fly (a bee? The male fly?). In fact they were associating the big fly with latrines and the small fly with milk

- they believe that in the absence of latrines even if a cow eats faeces, that very evening they will fall sick

- the tools bring out the levels of awareness - e.g once the tools are applied the community is able to express what they know and do not know.

- lack of pre-planning can have a direct bearing on the application of the tools. e.g the Facilitator and the team did not have a plan for facilitating the session and he needed procedures

PHAST techniques create impact if applied correctly though they are time-consuming. If the tools are appropriately applied, they can have positive results.

- Given the harsh environment at the community level, it is amazing that they can have the time and be willing to utilize the tools

- Gender roles should be respected e.g the women do the roofing of pit latrines (the superstructure) as the men do the digging. The tools should respect gender sensitivities.

Resolutions: the community members present resolved that it is in their own interest to promote hygiene among the neighbouring communities but identified their problems as:

- Clean dish-racks were windswept
- termites
- financial constraints to purchase materials for latrine construction

- animals - knock down dish-racks quite frequently

KAMAR COMMUNITY

Composed of 53 homesteads about 316 persons. The vegetation is mainly shrubs. The area is semi-arid and the inhabitants mainly pastoralists, with mostly mud-walled houses.

Objectives

- To assess the level of understanding of the community after the application of PHAST tools
- To assess the reaction/acceptance by the community members during and after application of the PHAST tools

Observations

Some members of the community including the assistant chief were waiting for the participants. There were " eight men armed with tools". After a short discussion with the participants, the team was led into the village by the assistant chief and other 6 members. Three homes were visited and in the first homestead, a discussion was held with the household head.

Discussions with the Household Head

A dish-rack was in use and the head of household was fairly knowledgeable. For instance he was able to explain why he had decided to dig the pit latrine, which was already in progress (5ft already dug).

2nd Home - a pit under construction. Composit pit also available.

3rd Home - a pit being dug on a rocky soil 10 ft already dug at 150/- per metre. Presence a dish rack.

Faecal oral routes tried out with 2 women.

They identified the routes. They came out on their own with the barriers though no barrier poster was used they were able to discuss the barriers.

Comments

- The fly depicted was rather too big.
- Chicken can still fly on to the dish-rack and enquired about what to do to address the problem.

3-Pile Sorting

- Next stop: 17 men and 2 womens. Presented for further discussions. Most of the posters fell under bad. They were able to cite constraints that hinder them from improving their hygiene practices.
- Equally they lack the tools which are used by 15 other families.

- Lack of building materials
- Nature of the soils
- Within about 1 month they are working on 15 latrines after the PHAST initiative.

Recommendations
- Community health workers in the Bamako initiative should also be trained on PHAST.
- Find ways of protecting the tools from rain and other damages

LARUK COMMUNITY

The community had their own system of communication and they assembled within a very short time. Elderly men indicated to the group the route of water pipe from lake Baringo covering the two tribes of Tugen and Pokot each deriving water from the irrigation pipes.

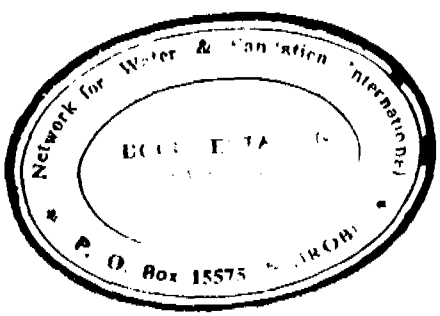
Village Health Committee (VHC)

There were two village health committees and the community was already trained in using the tools. The PHT was well trained as well as two committee members who were quite articulate. They took over the show and the team could see the level of acceptance of the tools by the committee.

Also the level of gender awareness was very high. The group had to revise the gender tool kit to reflect this. The community was well versed with the faecal routing and other PHAST techniques.

When the group was asked how they would like to see their village in four years' time was their responses were:

- Sanitation for all households in totality i.e., Latrines, Dish-racks, Garbage pits
- They would be able to conduct training by themselves and for themselves.
- Household water supply.
- Look forward for domestic water supply
- Need to replicate the success of the village to other areas.



Constraints

- Ignorance within the community (pretenders)
- Lack of knowledge
- Lack of capital
- Traditional belief conflict
- Unclear objectives at times

<u>How the Community intends to Address the Issues</u>:

- Conduct a baseline survey
- Hold *baraza* to apply PHAST tools
- Show people without latrines the importance of a latrine

Questioned on the use of the tools, they replied that they were useful. For example, they were repeating some tools and were not bored. In faecal route, the men said that they were responsible as the routes used were in their activities.

Baringo PHAST Progress Report by UNICEF Kenya Country Office

Goals and Objectives

The goals and objective of UNICEF are:

- To increase water supply and sanitation so as to narrow the gap between 1990 levels of universal access to water supply and sanitation and the end of the decade. The expected coverage target for water supply by 1/4 and sanitation by 1/10.
- To ensure political commitment by the Government of Kenya.
- Community involvement and project control right from the inception to the commissioning stages
- More efficient management of supplies and financial management
- Regular and reliable monitoring and feedback
- Broadening the concept of sanitation beyond the conventional notion of pit latrine construction
- To establish new and renewed commitment to accelerated sanitation development in each district according the specific project plan of action
- To impart effective advocacy technics and social mobilization strategies in order to put sanitation in the forefront of the country's political and social development agenda
- Identify donors, NGOs, individuals and other private sector enterprises willing and able to support new initiatives in water and sanitation

The other project activities involved the following:

* Initiation of UNICEF/Baringo project after Mukono meeting
* Involvement of Baringo team in the UNICEF/Baringo projects
* Integration of Phast pilot projects with on-going water and sanitation in Baringo especially projects drawn along the Bamako Initiative
* Phast training undertaken in pilot project and impact
* Development of toolkit constraints identified
* Joint collaboration with other agencies eg. Ministry of Education through school sanitation and use of toolkit

Baringo Project Progress by Ministry of Health

Training was conducted in November 1993 and also facilitated in other workshops for Chiefs and PHTs in Kabarnet Division. Malaria, intestinal worms and upper respiratory tract infections were the main diseases identified. Tools used during barazas and women group meetings include:

* The use of sanitation ladder has had an impact on these communities especially taking into account the sanitation practices in the community.
* The second tool used was the story with a gap. Quite useful in enabling planning.
* Gender task analysis reveals that men are more overworked. For instance hunting antelopes and then coming back with logs of trees for cooking.
* The workload has been less taxing with the training of the Assistant Chief who has been really helpful in supporting the initiative.
* The interpretation at the schools is even more interesting and the community health workers in the Bamako initiative expressed desire to learn PHAST tools.
* The utilization of socio-drama is also commendable and well received by the community.

Kisumu PHAST Progress Report by UNICEF

The objective of this UNICEF sponsored project is:

- to promote sustainable hygiene behavioural change based on community participation in handwashing after visiting latrines, children and adult faecal disposal, safe drinking water, water protection and safe food preparation and storage.

Project Activities

- Hold workshop for PHTS including chiefs, assistant chiefs, nurse and teachers
- Develop new methods for hygiene promotion based on community participation
- To explore concepts and ways of promoting sustainable hygiene
- supervision and monitoring and production of hygiene education tools.

In Kisumu there is mandatory District Water and Sanitation committee an arm of the DDC. The purpose of the committee is to adequately address the issue of water in the district. The committee also synthesizes proposals for water supply and sanitation. The committee also took over the roles of the District Water Boards. All NGOs working in the area also work with the DPHO. UNICEF has been channelling funds through the Catholic Diocese of Kisumu mainly for sanitation and hygiene. Since June 1994, the project has been involved with participatory hygiene education methods. Three workshops for PHTs have been held and the project focus has been on those areas with the lowest water and sanitation coverage.

Success with Participatory Tools: The Kisumu PHAST project has successfully initiated sustainable hygiene promotion at village levels.

For the success of the PHAST approach all the staff in the field need to be trained: Further PHAST training is planned for next year with a focus on schools' sanitation in low coverage areas.

NDHEWAS

This is a young project, one year old, based in Homa-Bay District. At the moment it is only covering 8 sub-locations. The project uses participatory approaches in hygiene promotion.

The Project Approach to the Use of Tools

Dr. Akili Sana used to enable the community members to identify the major diseases. Through discussions they agree on the prevalent diseases. So far diarrhoeal disease has come out as the most prevalent disease with children.

The tool depicting the picture of a child has been used to identify the signs and symptoms of Diarhoea Disease (DD). Discussions are then generated to devise an action plan to address the problem. Villagers have good knowledge about diarrhoeal disease.

Where do they take children in case of diarrhoea. Participants list the signs and symptoms of diarrhoeal disease. From the exercises, most people try to treat diarrhoeal disease at home.

Two-pile sorting is used to discuss how the community manages diarrhoeal disease at home. The in-between posters were not included. Participants come out with an action plan for managing diarrhoeal disease. Villagers recommended home remedies for managing diarrhoeal disease.

Lessons Learnt

1. Tools become more meaningful if they participate in the pre-testing and development
2. Villagers are quite knowledgeable about hygiene practices and only lack the drive to change
3. Use of participatory tools has opened the villagers self-esteem
4. The WASEs need more training in the application of tools
5. Tools enable the exchange of information and experience

WASEs are graduating into income generation activities.

Constraints

- Training over 1000 WASEs is a major challenge especially providing toolkit to each and everyone of them.
- Sustainability of the tools really prohibitive

SHEWAS PHAST Project Progress Report

Highlights of the presentation of the report of CARE SHEWAS project is the evident success of the project in health sector, agro-forestry and extension of the pre-testing of the toolkit for aids awareness project for the under 18 teens (CRUSH). The CARE approach should be replicated in other sectors of the development process. An initial success in this direction has been in pre-testing the toolkit for aids awareness targeted to the youth in Kisumu. Tools adopted from the Mukono toolkit to suit the youth in the form of:

- unserialised posters
- adoption of a youth walking as opposed to an adult
- a disco instead of dance with drums
- Barrier matrix modified in terms of 'very-difficult to-lift' all through to 'unable to-lift'
- Taking all the preventive measures in AIDS and placing them in the matrix and modify to suit the AIDS/CRUSH Programme.

SHEWAS has been applying and adopting the toolkit developed in Mukono and a report will be issued by mid-November. The project is down sizing for it is now on its final quarter but there are possibilities of exploring extension of the project. The project is in the process of handing over to the community where the training will now be done by the WASE's.

In terms of material development, the project has been using an artist from Kenya Finland Western Water Supply Project (KFWWSP) to develop and pre-test some of the toolkit materials.

Since CARE has been involved for over 4 1/2 years in the SHEWAS project, it has been possible to develop a process of showing where the project has been heading since inception. This has been done by applying a variety of participatory tools and methods. SARAR methods/tools have been utilized fully depending on identified needs.

Issues Arising

Collaboration with other agencies including the various Government ministries so as to integrate government officers in the project activities to ensure continuity and sustainability of the project once CARE pulls out of the area.

Issues of the relationship between NGOs and GOK

Development of hygiene promotion flow chart

CARE International in Kenya through the SHEWAS project has developed several charts showing the experience gathered in construction of village water and sanitation facilities using Participatory Rural Appraisal approach (PRA) and the sub-locational site selection using PRA.

KWAHO PHAST Project Report

KWAHO Kadibo Water and Sanitation Project

Project Name:	**Kadibo WatSan Project**
Location:	Kawino and Bwanda locations in Kadibo division, Kisumu District, Nyanza Province
Implementing Agency:	KWAHO
Donor Agency:	UNICEF
Collaborating Agency:	MOH, MOWD, MOCSS and relevant agencies
Population:	90,000 people
Area Coverage:	Approx. 200 sq.m

Project Objectives

- Provide safe drinking water at managable distance
- Reduce infant mortality and morbidity rates
- Promote hygiene education and increase latrine coverage
- Reduce incidences of diarrhoeal diseases

Project Activities

- Drilling tube wells and equipping them with Afridev Handpump
- Hygiene training and promotion
- Construction of VIP latrines
- Training in hand pump operation and maintenance
- Community mobilization
- Promotion of income generating activities (IGAS)

The project started in January 1994 with a target of drilling 60 tube wells by December 1994 and conducting 60 sessions of hygiene education.

Interim Results So Far

To date the following Tasks have been accomplished:

- 50 wells have been drilled and equipped with handpumps
- 6 sessions of training on hygiene education using participatory tools developed at the Mukono workshop have been conducted.

African Research Utilization Network Kenya (ARUNET Kenya)

The dual purposes of ARUNET Kenya are:

- To encourage dialogue and collaboration between members of the Kenyan Research community and representatives of potential users of development research results in Kenya, and

- To identify appropriate research and communication strategies which encourage and facilitate the adoption and/or use of relevant results of development research.

The main focus of ARUNET Kenya is on training and experiential learning in participatory methods and processes. ARUNET Kenya is a methods and processes network. It focuses on encouraging activities which involve communities in identifying their problems and ways of overcoming them, and on strengthening researchers' abilities to listen to communities' articulated needs.

The Question Being Addressed by ARUNET Kenya is:

> How can researchers and those who can benefit from research results form a better interface than that which exists at present in Kenya?"

Several facilitating strategies are suggested in the ARUNET Kenya focus:

- Better training in the use of participatory methods and processes

- Provision of grant monies to allow experimentation in the use and application of participatory methods to demonstrate whether they actually work;

- Publication and dissemination of outcomes of the grant awards.

Rural Domestic Water Supply and Sanitation Programme II - RSWSSP II/PAT/LBDA

The Programme Advisory team advises the Lake Basin Development Authority LBDA/RDWSSP II on the implementation of the water, sanitation and health programme in the Nyanza Province in Western Kenya. RDWSSP II has continued in the use of participatory methods in trying to achieve hygiene promotion. However, this has not been done through the use of PROWWESS/SARAR methods, rather other methods, have been used e.g. participatory appraisals, role plays, illustrations, demonstration, re-demonstration and theatre through drama, songs, poems, and mime. All these have been documented as written documents, photographs and video tapes. The main focus has been on 10 messages (5 for water and 5 for sanitation).

Challenges

The main project challenges are the:

- Need for hygiene behavior change in some communities
- Need to re-examine the project targets

The above challenges should be seen in the context of the whole programme which covers 6 districts and which in the final analysis has a target set out of 1000 water points covering 1000 communities and 25000 latrines.

Possible Solutions:

- Equip the extention staff with a basket of participatory techniques which can be used according to specific target group's and progress achieved. It is here that a few tools may be borrowed from SARAR methodology after discussion to identify which tools would be most useful. Anticipated changes may however, be minimal.

- Continued collaboration between RDWSSP II and other agencies working in the area e.g. CARE-Kenya

- Start on the hygiene promotion process early even before hardware is complete if substantial hygiene behavioural change is to be achieved and sustainability attained in the long run.

- A comprehensive training workshop is planned for field extention staff later in the year in October/November 1994.

- In conclusion, RDWSSP II has continued to collaborate with CARE-Kenya (SHEWAS and NDHEWAS projects) in the exchange of ideas and views on the promotion of improved hygiene behavior.

CARE-Kenya Case Example: Application of Participatory Hygiene Methods in CRUSH

The communication resources for under eighteens on STD and HIV (CRUSH) works with out-of-school youth in Kisumu district to prevent and control the transmission of AIDS/STDs. The project uses a influential peer (IP) communication strategy which involves the identification and selection by the youth 6-10 influential peers who participate in a seven week training programme. The objective is to enhance the interactive skills of the IPs on STDs and HIV. The project also reaches out to adults in communities to enable them understand and support the project activities.

Over the past three months, CRUSH has adapted and pre-tested a few SARAR tools developed at Mukono. These, to name a few, include:-

* Unserialized posters (these have been adapted largely for the youth audience and posters and situations of adults in majority, replaced by those of the youth.

* Story-with a gap (depicting a seduction, dating, 'rooming' sequence with three different endings/preventive behaviours: use of condom, abstinence and unprotected sex)

* The F-diagram (which has been re-named 'H-diagram and applies the same procedure except instead of the MOUTH, we have separate pictures of a girl and a boy. Two groups place the transmission around each of these)

* Barrier Matrix (which includes all the possible preventive behaviours of controlling the transmission of HIV and STDs and rated high risk, in between and low risk against easy, in-between and difficult)

* Dr Akili Sana (with largely youth patients queuing to see the Doctor)

* Sortiing posters for three pile sorting (in terms of myths', behavior and practices which transmit, do not spread HIV/STDs)

The project is currently in the process of pre-testing these materials.

Field User-friendly Guide?

In an endeavour to develop, the project has developed discussion-centred facilitator guide for applying these materials. One copy of the guide for community leaders training is attached. We hope that the field extension staff and counterparts will find it easy reading and adaptable.

Objective	Discussion Points	Particiapnts' Activities
1.0 Identify issues and concerns of the youth in the area Unserialized posters	* Issues, experiences and problems and events that preoccupy the youth * The role of adults in influencing the behavior of the youth	1. Provide the adults with 10-12 cards 2. Ask them to select any four and make a story that best represents what happens in the area 3. Based on the presentation, enable the participants to freely discuss the problems, challenges and opportunities faced by the youth. 4. Discuss what they as adults do to respond to the bahaviours and events cited.
2.0 Understand and appreciate HIV/AIDS as a problem facing the youth **TOOLS** Obongo's Story Sorting Cards	* Is HIV/AIDS a problem in the community? * Reasons given for AIDS * Who is at risk? * Why are the youth particularly at risk?	1. Participants make a story usiing Obongo's story cards (refer to the procedures in the EC package) 2. Discuss whether HIV/AIDS is a problem in the community and among the youth 3. Team brainstorming on reasons the community give for AIDS 4. Sorting cards on how HIV is and NOT transmitted.
3.0 Adults identify opportunities for preventing the spread of STDs and AIDS among the youth **TOOLS** Team brainstorming	* The value of adult support * The need for youth-to-youth communication * Behaviours/preventive measures for preventing STDs and HIV * Need for village networks and meetings	1. In small groups, participants brainstorm on the opportunities for preventing the spread of STDs and HIV among the youth 2. Small groups present to the plenary 3. Discussions and consensus building 4. Participants define the role of the community leaders in supporting youth action against the spread of AIDS/STDs
4.0 Enable the adults to appreciate the value of free and open communication with the youth **TOOL** Johari's Window	* Maintain open communication with the youth on matters relating to sex * Understanding the feelings and viewpoints of the youth * Encourage the youth to participate in project activities	1. Ask the participants to interpret each of the windows of Johari 2. Presentation by sub-groups 3. Reflections on how each of the windows relate to their communication patters with the youth 4. Open discussion on how the adults can improve their communications with the youth

5.0	CRUSH project objectives and activities	* The AIDS 'emergency': key facts * CRUSH project objectives * The influential peer (IP) * The behavior change process * The need for adult support * Next steps: Village meetings and the identification and training of IPs Influential peers	1. Make a brief and concise presentation of the CRUSH project objectives and proposed activities 2. Allow comments, suggestions and ideas for improving on the projects' activities in the area 3. In terms of the next step the village meeting - the adults in three groups agree on convenient place, date and time for a joint meeting for the three villages 4. Presentation and analysing of the strategies 5. Selection of facilitators for the village meeting.

CARE-Kenya
NDHIWA HEALTH EDUCATION WATER AND SANITATION (NDHEWAS) PROJECT - HYGIENE PROMOTION

INTRODUCTION

NDHEWAS Project Hygiene Promotion is centered around water and sanitation related hygiene education. Diarrhoeal Disease (DD) is the main focus in hygiene promotion activities with strong emphasis on its prevention and management. In addition to DD promotion, activities also encourages water and sanitation hygiene. The Project uses participatory approaches and tools in all its promotion activities.

DEVELOPMENT OF TOOLS

Tools used in NDHEWAS are developed with the community using local artists. The development of the tools is based on the PROWWESS approach especially the Participatory Hygiene Education tool kit. The development process starts with the generation of ideas by project staff. Generated ideas are then put on paper in form of drawings by local artist. Once this is done the developed tools are tested in the community for ratification on their suitability in conveying the intended messages. Comments and inputs from the community are incorporated in the production of the final tools.

To date the Project has developed tools with the community for:

- disease identification
- causes and symptoms of DD
- home management of DD
- when to refer cases of DD to health centre (clinic)

USE OF TOOLS

Tools are used for:

1. Training of Project staff. Once trained the staff become facilitators in training of village volunteer Hygiene Promoters commonly known WASEs (Water and Sanitation Educators).

2. Training of WASEs who in turn use the tools for carrying out hygiene promotion campaigns in their villages.

Tools	Objective	Procedure	Remarks
1. Dr Akili Sana	To enable the participants identify community problem disease.	In groups participants identify the diseases that affect them and through discussions agree on the most prevalent disease and the people most affected.	In all sessions conducted by the project DD has come out as the most prevalent disease with children as those at the greatest risk.
2. Picture of a young child	Identification of signs of DD and key sings that lead to hospital referral.	Through discussions participants identify all signs of dehydration and stick leaves on the poster to mark the signs on the child. Discussions are then generated to agree on action to take against the signs.	Villagers have good knowledge on the signs of DD
3. Posters of hospital, home, herbalist and witch doctor	Identification on where they need to take a child with DD for treatment.	through brainstorming participants come up with where they take children with DD for treatment. By use of the posters, participants list signs that lead them to seek treatment at the various places. Through discussions the participants list the signs of DD under the places they are treated using the poster.	Treatment of DD in the villages starts with home management.
4. Several pictures depicting various ways of home management of DD.	Identify various ways the community manage DD at home and have them understand the right ways of home management of DD.	In groups participants arrange the posters into good and bad ways of managing DD at home. Through discussion they agree on the right ways to manage DD at home.	Villagers recommend the use of local porridge and fluids for home management of DD.

5. Unserialized posters of the causes and modes of prevention of DD.	To enable participants identify causes and prevention of DD.	Working in groups the participants sort out the posters: causes of DD and prevention mode. Through discussions participants agree on the routes of transmissions. Once they have serialized the posters through discussions, place poster identified as prevention modes against causes to break the cycle.	Villagers have good knowledge on prevention of DD but lack the drive to practice.

RECENT ACTIVITIES

1. Pretesting of Tools

The project carried out a pretest of the tools in two villages. Objective of the pretest was to determine the relevance of the tools in terms of interpretation and suitability to the villagers. A total of 100 villagers participated in the exercise. The findings of the pretest were incorporated in the production of the final tools.

2. Training of Volunteer Hygiene Promoters (WASEs)

The project has conducted training to 114 WASEs on Participatory Hygiene Promotion techniques. The training covered the use of participatory tools in:

- identification of community problem disease DD
- signs of DD and key signs for health facility referral
- causes and prevention of DD
- management of DD at home and consequences of DD to child, mother and the entire family

Our approach is promotion of good hygiene practices which are intended to encourage adoption by householders. Training are therefore to cover as few topics as practicable. Upon training the WASEs will go on outreach campaigns in their villages. One session will be done for a period of about one month.

A review meeting will be held at the end of this period to determine whether to move to the next session or continue with the same session. Review meetings will be important forums for experience sharing among WASEs and project staff. Outcomes of such meetings will be instrumental in the improvement of promotion activities.

PARTICIPATORY HYGIENE AND SANITATION TOOL-KIT

Introduction

The attached learning materials Tool Kit was compiled at a Participatory Hygiene and Sanitation Transformation (PHAST) Workshop held in Baringo, Kenya from 2-6 November 1994. The Workshop was organized in collaboration with UNICEF/Kenya, the Ministry of Health, (GOK) and the UNDP/World Bank Regional Water and Sanitation Group-East Africa (RWSG-EA). The PHAST materials were initially developed during the first Regional PHAST Workshop held in Mukono, Uganda in October 1993. The Mukono Workshop was a collaborative effort between WHO/PROWWESS RWSG-EA with joint organization with the RUWASA Project in Mukono, Uganda. As part of the regional effort the Kenyan PHAST team made up of Ministry of Health, UNICEF, Network For Water and Sanitation (NETWAS), CARE International and Kenya Water For Health Organization (KWAHO), have continued to apply, test the tools and techniques, as a basis of piloting in their respective projects.

In the PHAST, initiative the emphasis has been on enhancing sustainable hygiene behavior within the sector. The sequenced tools in this Kit are therefore based on the SARAR learning "methods" which together describe a dynamic process for effectively engaging a community in identifying, analyzing and planning solutions to their water and sanitation problems. The SARAR methods are:

- creative-expressive
- investigative
- analytical
- planning
- theoretical

The materials in this Kit having been developed with the community in mind have been field tested in local situations in the various participating projects (Baringo, Nandi, Kisumu, SHEWAS Siaya, and NDEWAS Homa Bay) in Kenya. Experience drawn from the field is shared in this Kit.

While many of the materials found in the Kit might be suited for use in a broader range of areas in Kenya and East Africa, community level facilitators must be sensitive to physical and cultural variations between different countries and regions and be prepared to adapt the materials where necessary. Since most of the materials are prototypes, it will be up to the extension teams themselves to design additional participatory materials that are appropriate to the programs and areas within which they work. For these reasons we strongly encourage development institutions and funding agencies to give the necessary support for local artists to be included as integral members of community-based water and sanitation program extension staff.

This Kit is not meant to stand entirely on its own. Rather the appropriate or effective use of the participatory techniques will require some understanding of the purpose for which they have been designed. Participants should therefore refer to the (attached) Kenya Participatory Hygiene and Sanitation Transformation (PHAST) Workshop Report and to the PROWWESS *Tools for Community Participation: A Manual for Training Trainers in Participatory Techniques*, which also includes a detailed explanation of some of the exercises. In this, will be required for users of this tool kit who did not participate in the Mukono Workshop. Currently, NETWAS is offering this training.

Finally, we strongly encourage the users of these participatory methods to document and share their experiences with other participants of the workshop and broader the WHO/PROWWESS network.

Rose Lidonde, PROWWESS/RWSG-EA
Mayling Simpson-Herbert, CWS/WHO, Geneva

PARTICIPATORY HYGIENE AND SANITATION TOOL-KIT

Table Of Contents

LIST OF PROJECTS

KWAHO	Kenya Water for Health Organization
MOH	Ministry of Health/Nandi District
CARE/Kenya, Kisumu	NDEWAS Project
CARE/Kenya, Kisumu	SHEWAS Project
UNICEF	Baringo District
UNICEF	Kisumu District

LIST OF TOOLS

- ◊ Attributes of Good Community Participation
- ◊ Attributes of Sustainable Hygiene Behavior
- ◊ Faecal Oral Routes
- ◊ Faecal Barriers
- ◊ Barriers Matrix (Hand Washing Methods)
- ◊ Flexi-Flans
- ◊ Three Pile Sorting Cards
- ◊ Dr Akili Sana (Three Posters on Management of Diarrhoeal Diseases)
- ◊ Gender Target Task Analysis)
- ◊ Mapping
- ◊ Story With A Gap
- ◊ Planning Posters
- ◊ Joharis Window
- ◊ Unserialized Posters

TOOLS MODIFICATIONS

CARE/Kenya (NDEWAS Project)

Dr Akili Sana - Posters on Management of Diarrhoeal Diseases

Modifications were made on three posters, namely:

- Poster of Child
- Poster of Witch Doctor/Health Centre/Hospital
- Poster of Mother and home treatment of Diarrhoeal diseases

The name of the local Doctor was also used to substitute Doctor Akili Sana

Three Pile Sorting Cards (Good, Bad and In-Between)

In most cases the "In-Between" in the Three Pile Sorting Cards was done away with. In this way the community was able to identify for themselves what is "Good" and "Bad" hygiene behavior. Modifications was also made on the pictures to depict the local environment. For instance the maize plantations, coffee, dairy farming

CARE/Kenya (SHEWAS Project)

Most of the tools were adopted to the CARE CRUSH AIDS AWARENESS PROGRAM. For instance the *Unserialised Posters* were modified to create AIDS awareness to the school children.

UNICEF Baringo

Pocket Chart:	This were made using local available materials
Unserialized Posters:	Mothers were depicted sitting on mats
Gender Task Target Analysis:	To avoid depicting women performing the tasks, this tool was modified to simply show the hands involved in the task performance.
Johari's Window:	The community had difficulties in understanding the purpose of thiss tool. The trainers in this case did not understand that the tool is meant for trainers and not application at the community level. The tool helps in establishing at what level the extension workers should approach the community and what factors they need to take into consideration, while approaching the community.

Nandi District and KWAHO

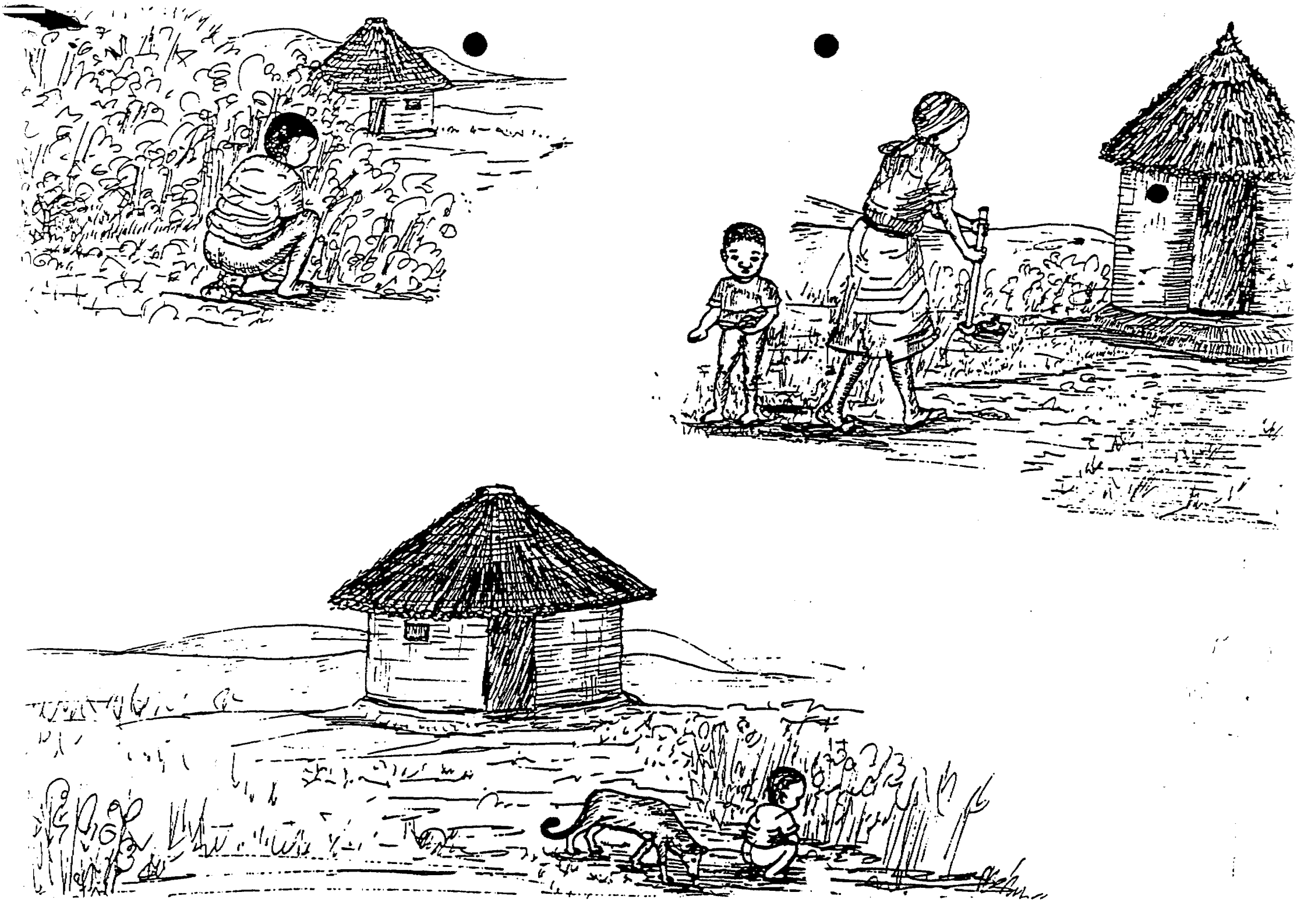
The only tools modification was on the three pile sorting cards, where the pictures and dressing were modified to suite local situations. In Nandi District the Tools were modified to determine disease prevention e.g. Malaria, Diarrhoeal diseases (DD) and Upper Respiratory Infections etc.

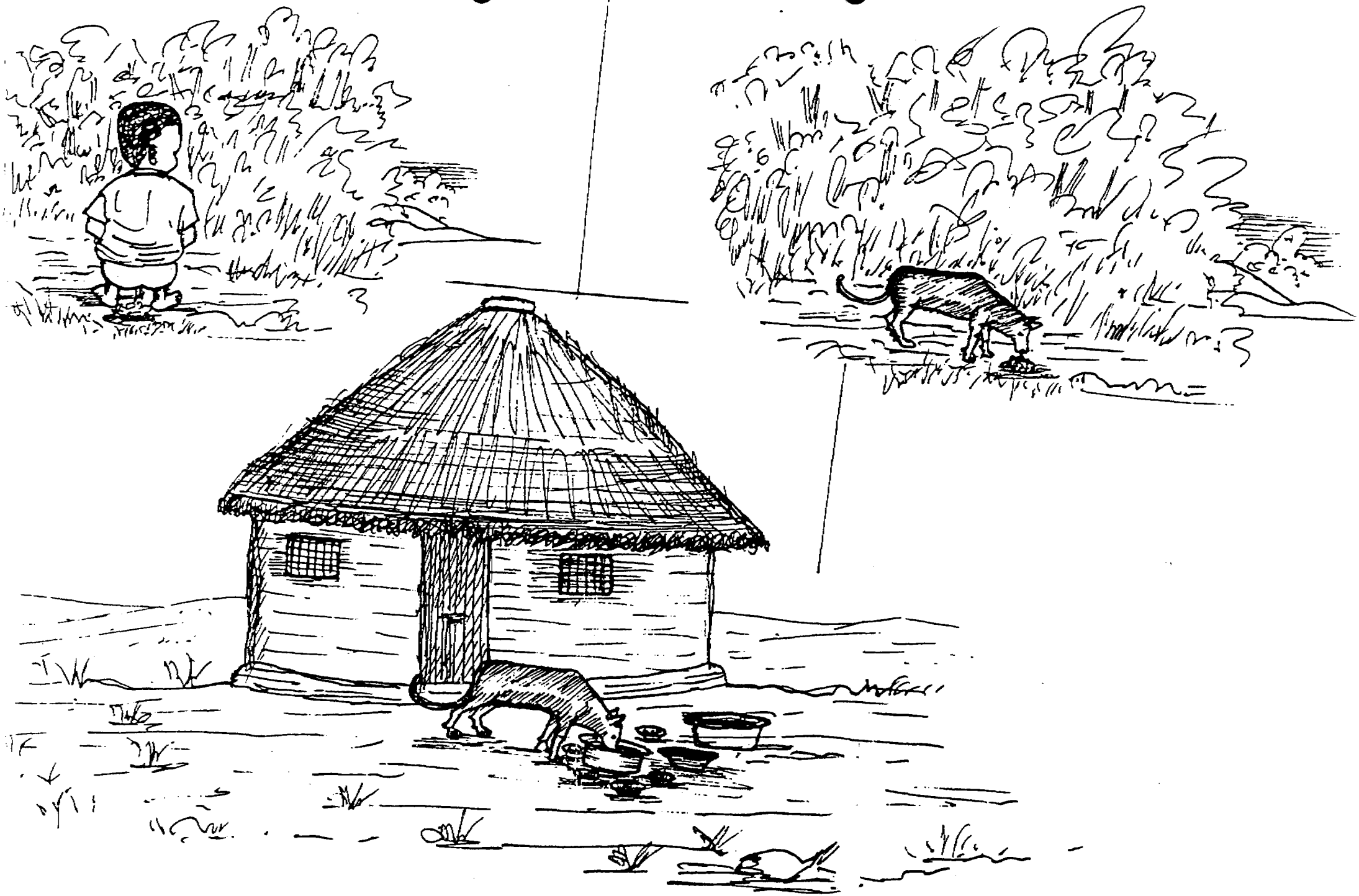
LESSONS LEARNT

- Most of the PHAST Tools did not require a lot of modification, as they were understood by the communities
- The process followed was that originally designed in Mukono (Uganda) and Voi (Kenya) workshops. The modifications listed are incorporated.
- In relation to the *Three Pile Sorting Cards Tool (Good/Bad In-between)* communities felt that hygiene behaviours were either "good" or "bad" with no room for "in-between".
- When the *Faecal Oral Routes Tool* was applied, it helped the community to determine at what levels, their health standards were. The tool facilitates the provision of health information from the community in a more participatory way as opposed to the conventional styles. For instance "big boring meetings"
- In most cases Tools were found to be simple and easy to relate to
- It was observed that the coloring of tools would enhance clearer/better understanding of the tool
- It was noted that the use of PHAST Tools *generates discussions and exchange of ideas* amongst community members and the extension staff.
- As the PHAST Tools are not message focused, they open up villagers attitudes, towards hygiene promotion
- The PHAST Tools measure the community domestic hygiene standards.
- The application of the Tools can be time consuming both to the community and the facilitator in terms of preparation

PARTICIPATORY HYGIENE AND SANITATION TOOL-KIT

FAECAL ORAL ROUTES





SARAR METHODOLOGY

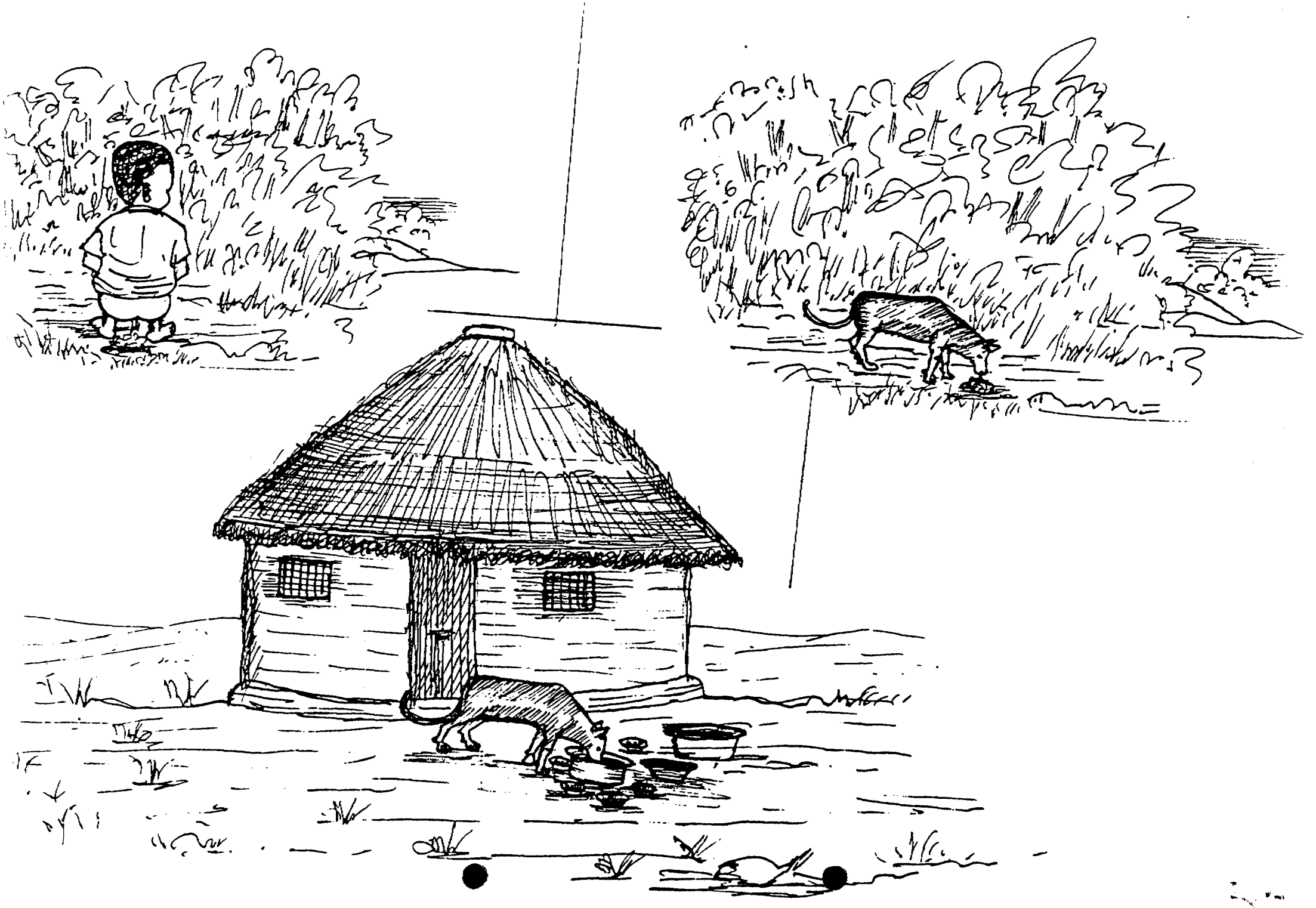
PHAST TOOL-KIT, BARINGO, KENYA 1994

SARAR METHODOLOGY

The acronym **SARAR** is derived from the following five characteristics:-

- **SELF ESTEEM** - The self-esteem of individuals and groups is acknowledged and enhanced by recognising that they have the creative an analytical capacity to identify and solve their own problems.
- **ASSOCIATIVE STRENGTHS** - The methodology recognises that when people form groups, they become stronger and develop the capacity to act together.
- **RESOURCEFULNESS** - The methodology recognises that each individual is a potential resource to the community. It seeks to develop the resourcefulness and creativity of individuals and groups in seeking the solutions to problems.
- **ACTION PLANNING** - The methodology recognises that planning for action to solve problems is central to the method. Change can only be achieved if groups plan and implement appropriate actions.
- **RESPONSIBILITY** - The methodology recognises that responsibility for follow through is taken over by the group. Actions which are planned must be followed through. Only through such responsible participation do results become meaningful.

FAECAL ORAL ROUTES



ATTRIBUTES OF SUSTAINABLE HYGIENE BEHAVIOUR

PHAST TOOL-KIT, BARINGO, KENYA 1994

Sense of responsibility

Sense of humour

Capability to generate new ideas

Initiative

Resourcefulness

Ability to sort out priorities

Willingness to take risks

Political connections

Capability to make rational decisions

Savings habit

Land ownership

Ability to follow directions well

Willingness to deviate from tradition

Willingness to accept advice without questioning

Optimism

Obedience

Acceptance of women's roles in community decision-making

Ability to work well in a group

Ability to participate in constructive group discussions

Ability to understand hygiene concepts

Self-confidence

Self-esteem

Managerial skills

Willingness to provide free labour or materials

Confidence

Openness to change

Skill in planning

Ability to work well on committees

Patience

Enthusiasm

Willingness to deviate from community values, beliefs and customs

---

Skill in maintenance of hardware

Technical know-how

Skill in problem-solving

Creativity

Confidence in articulating ideas

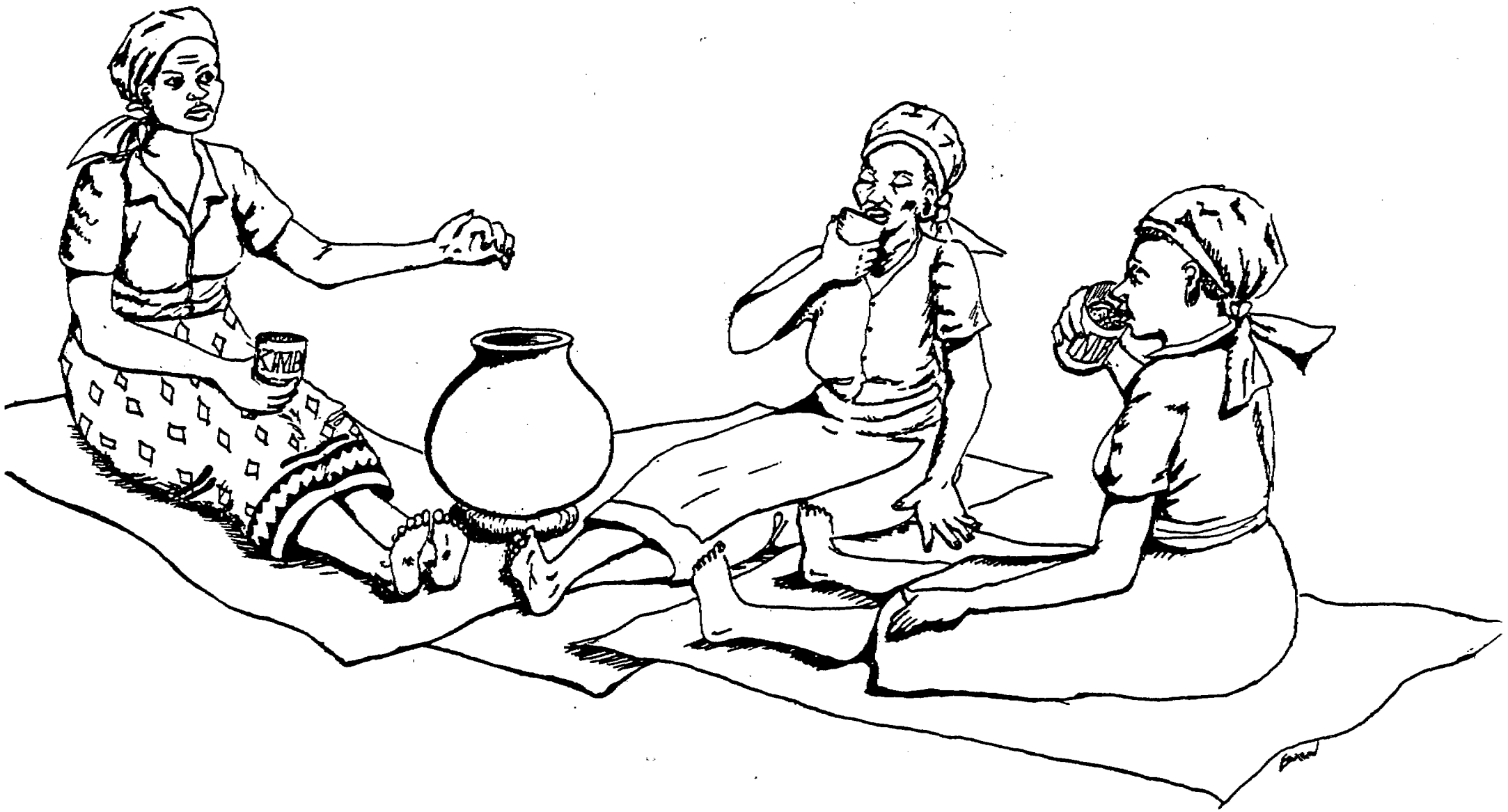
Confidence in relating to authority figures

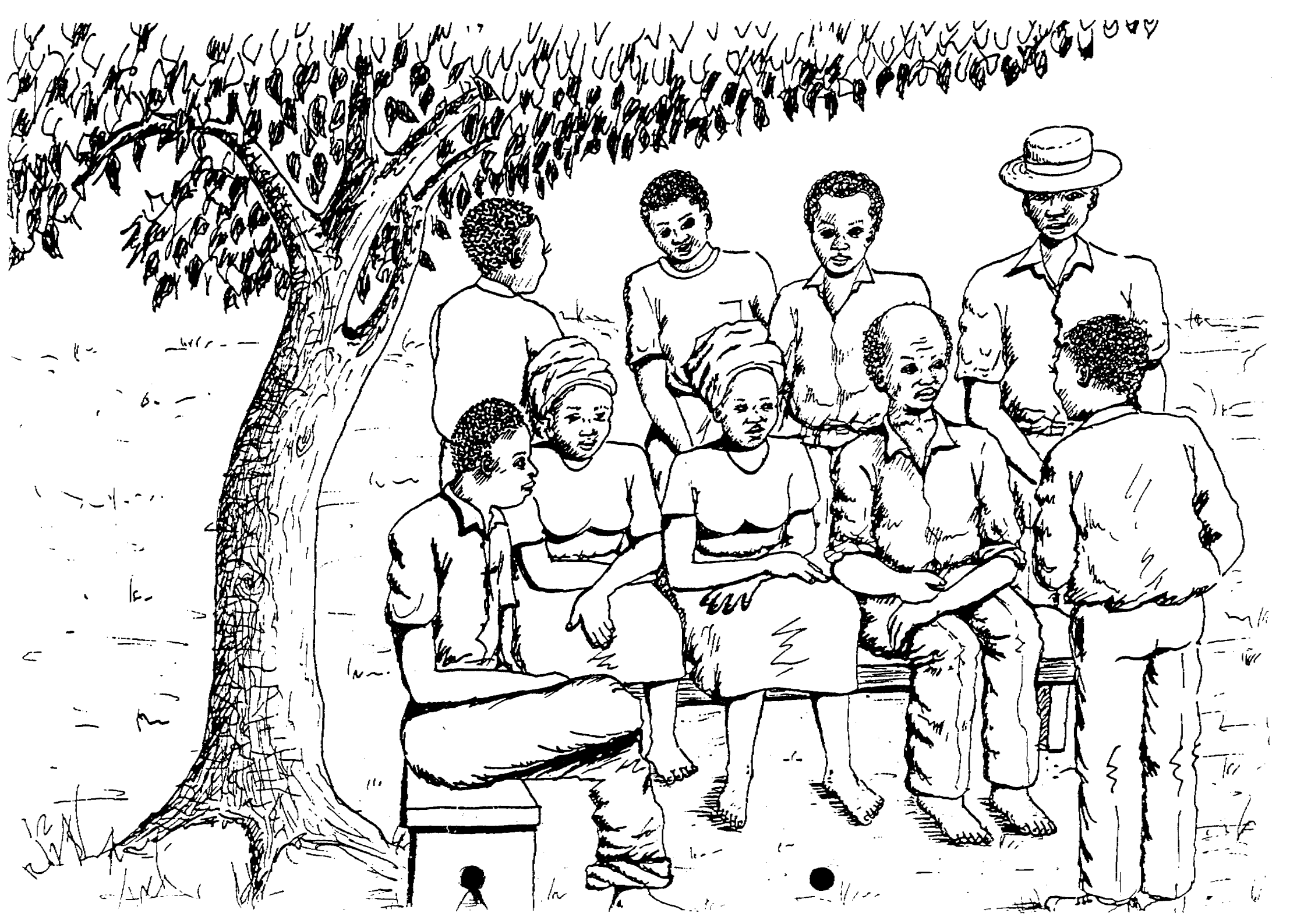
Leadership

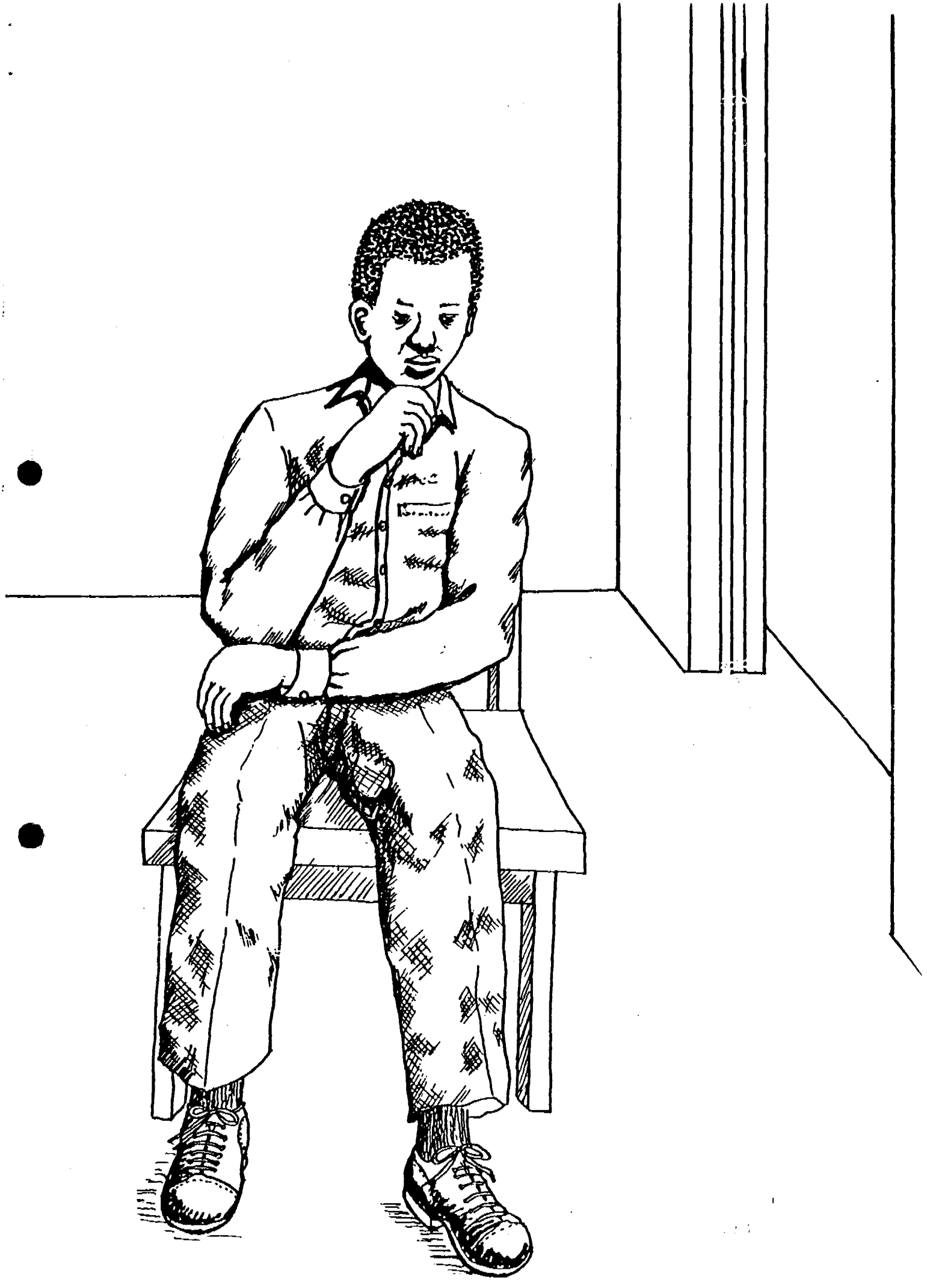
Willingness to pay for basic services

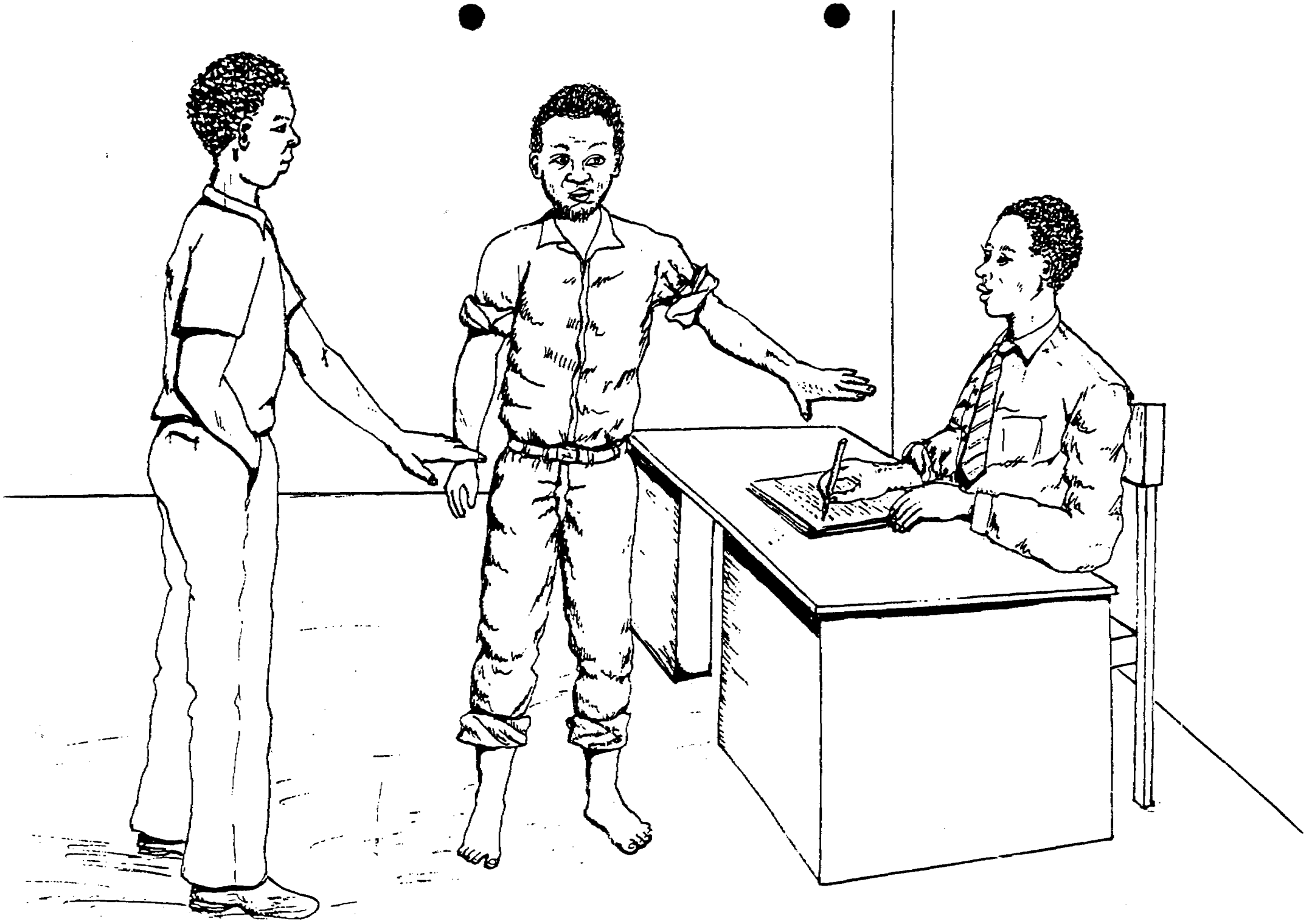
Humility

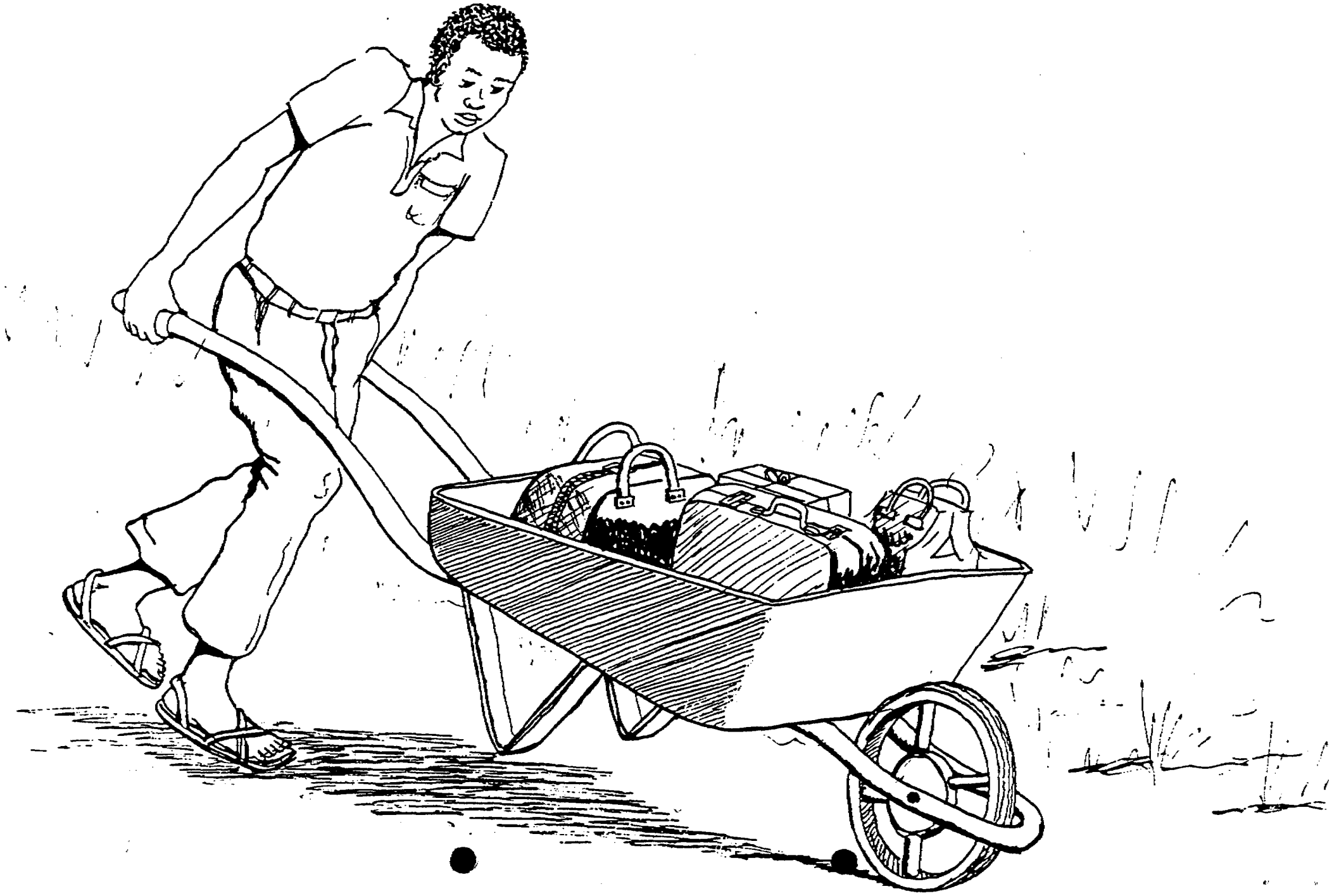
UNSERIALISED POSTERS

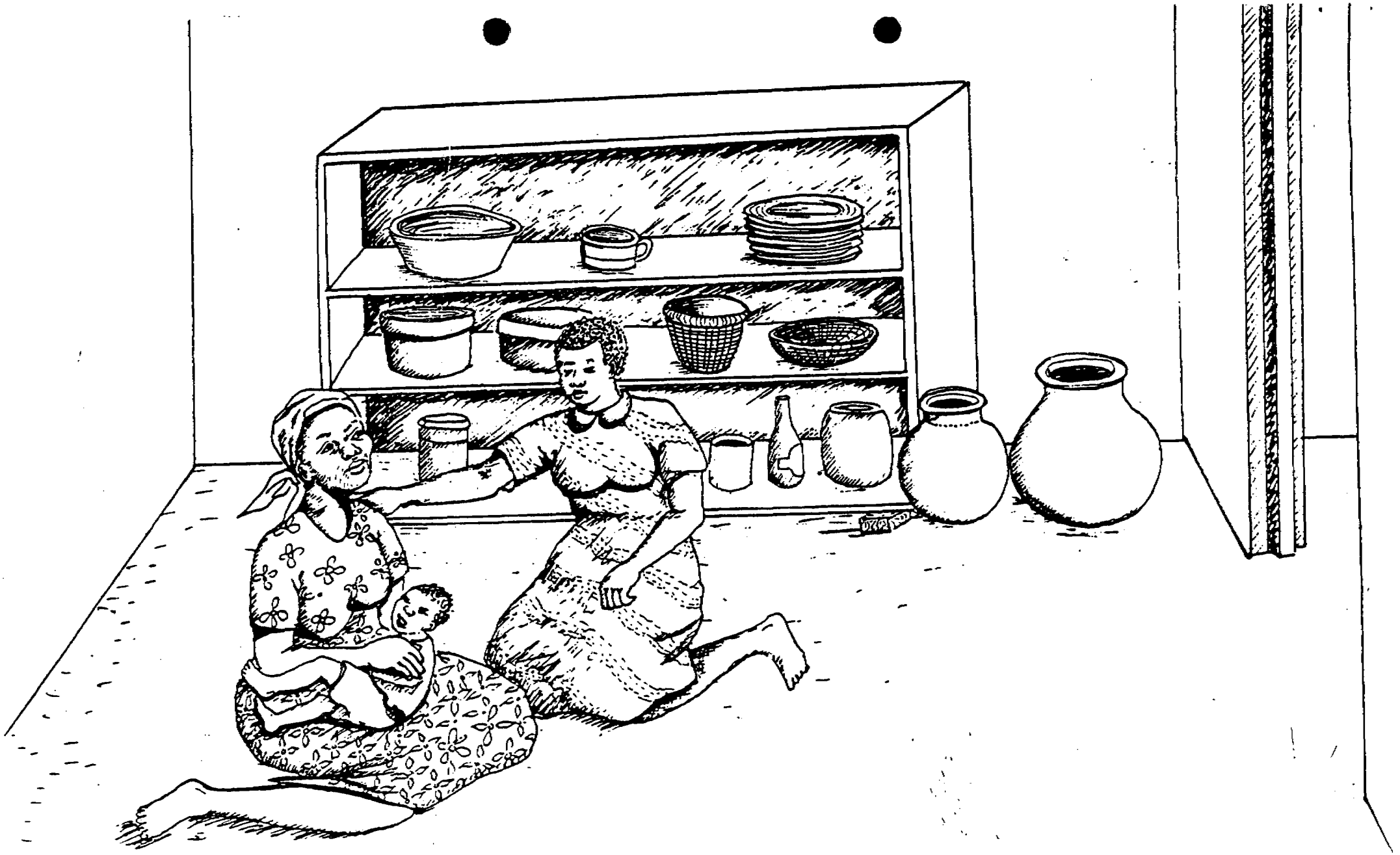


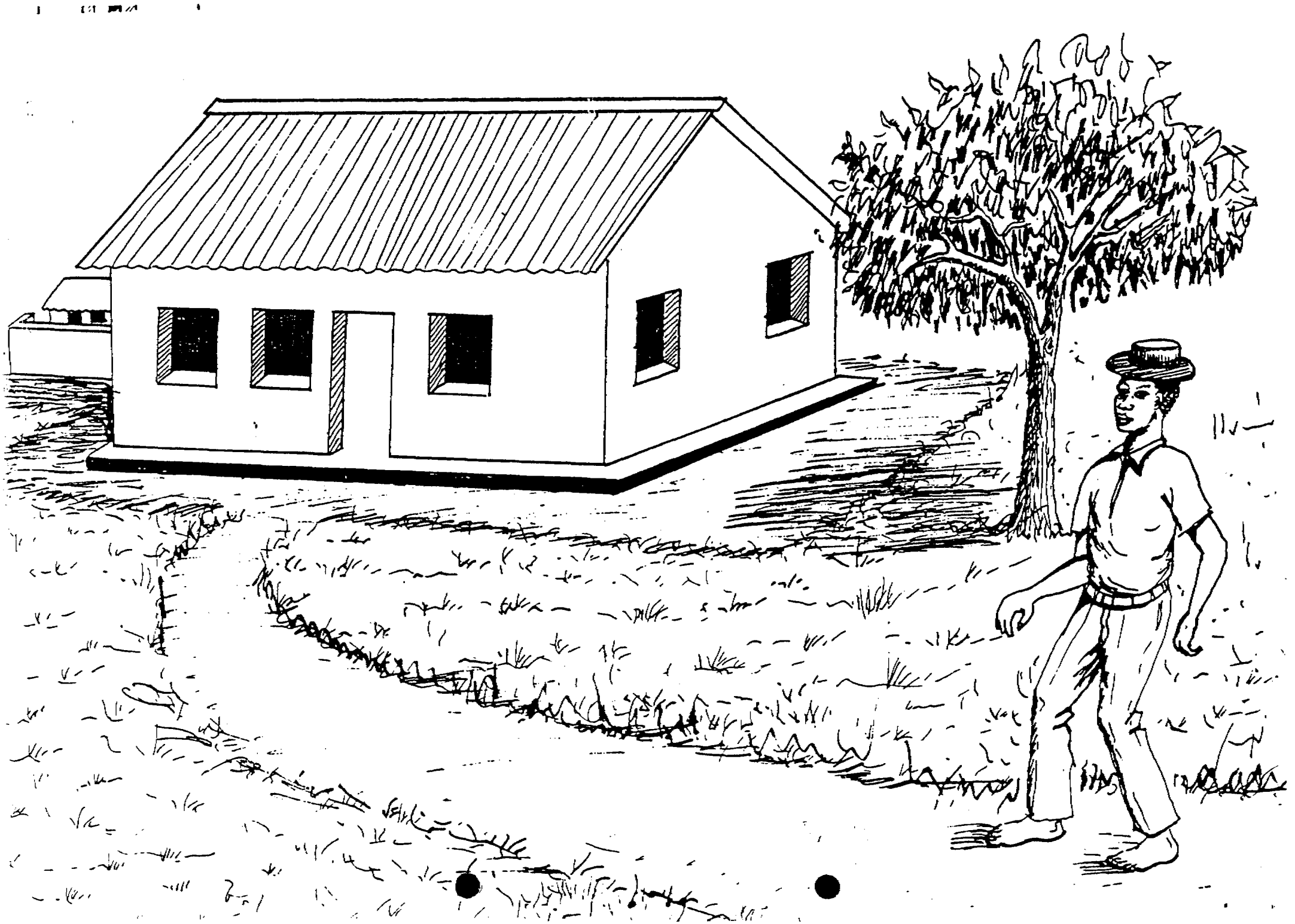


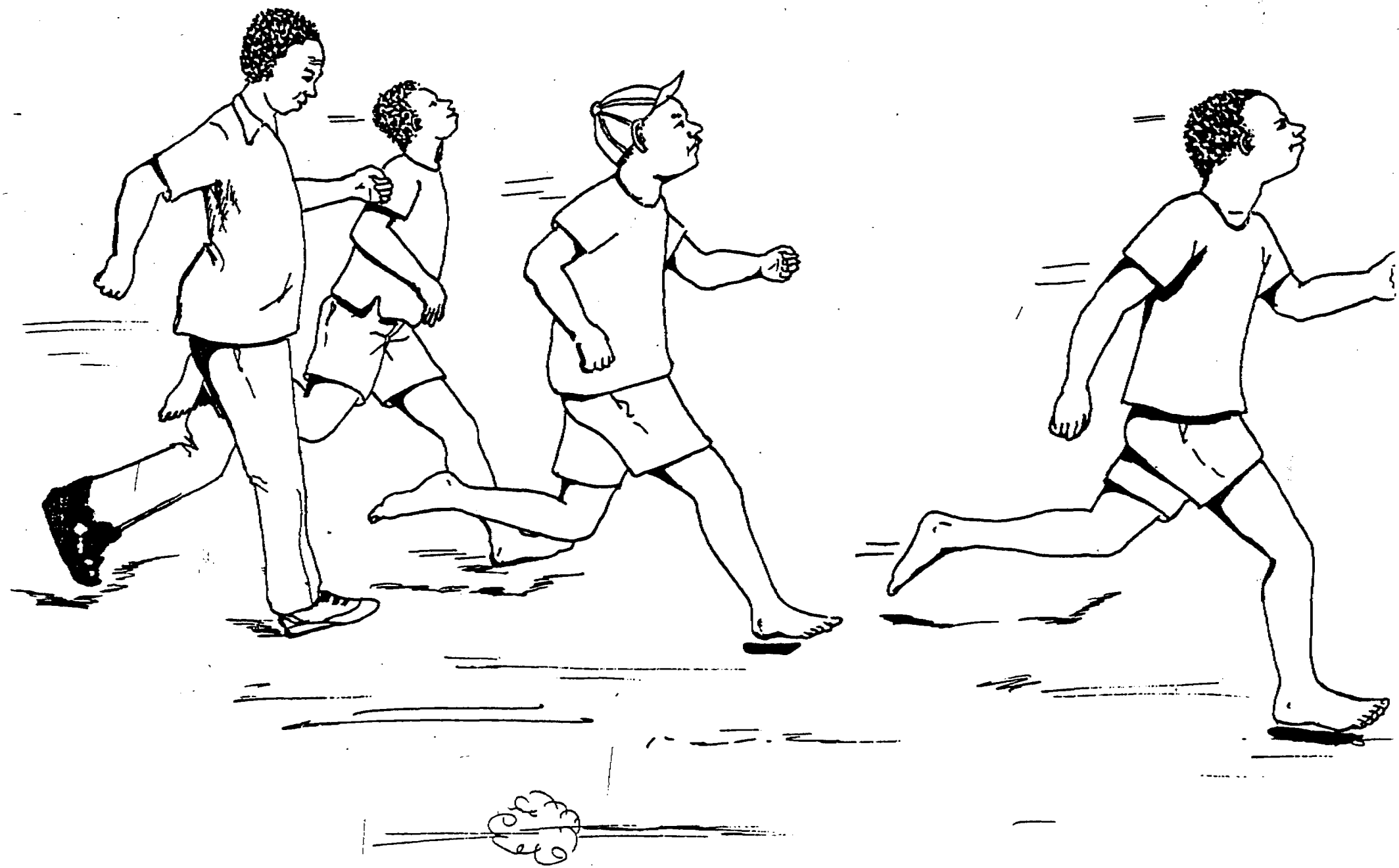






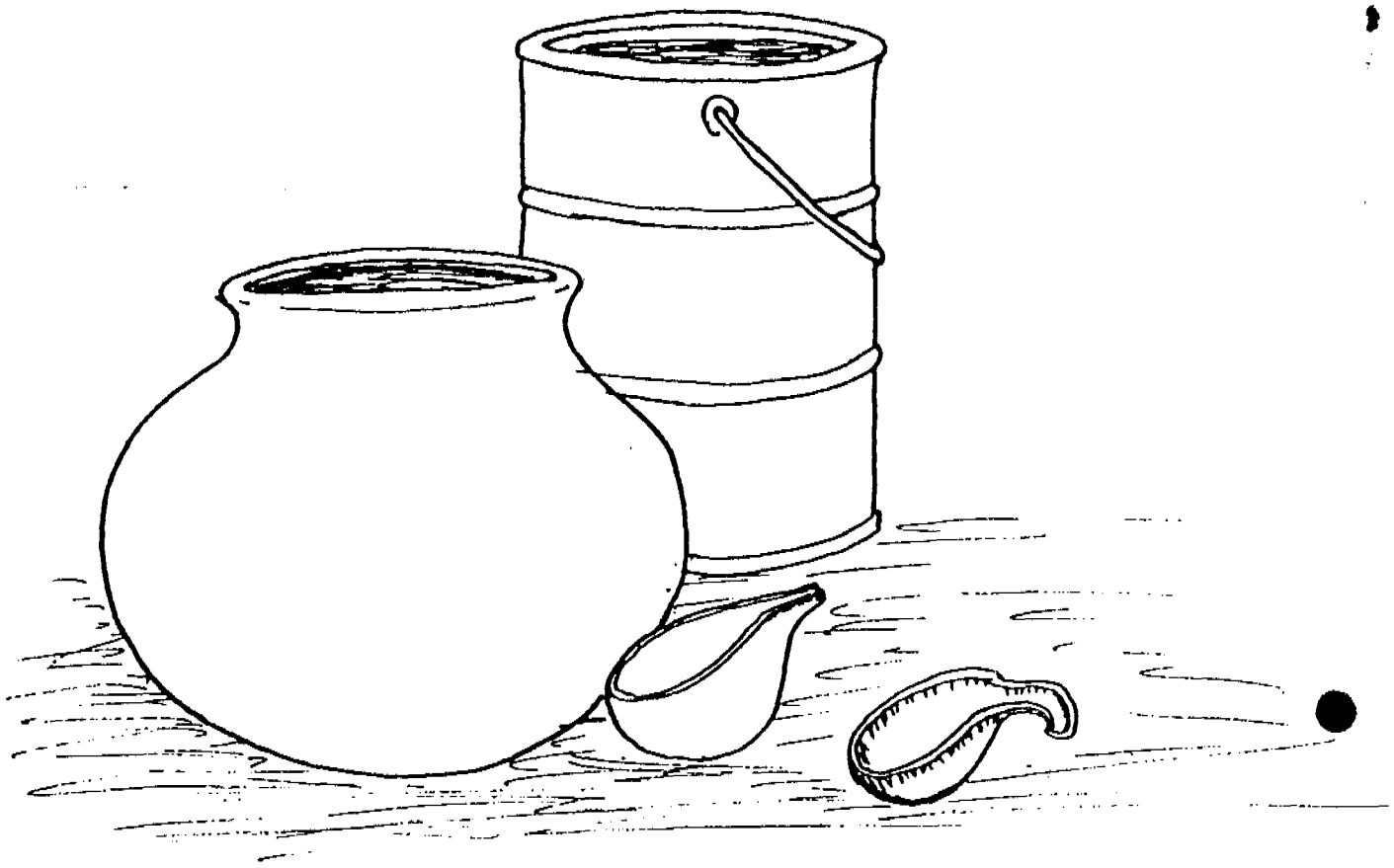


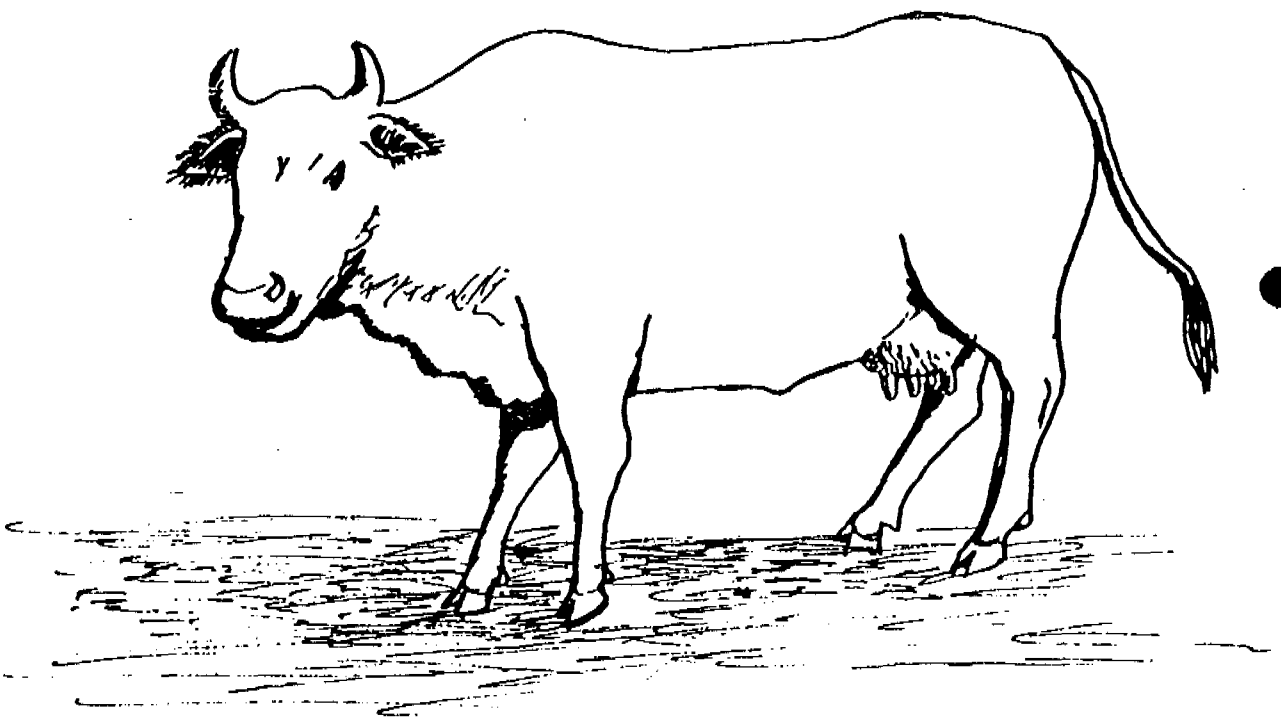


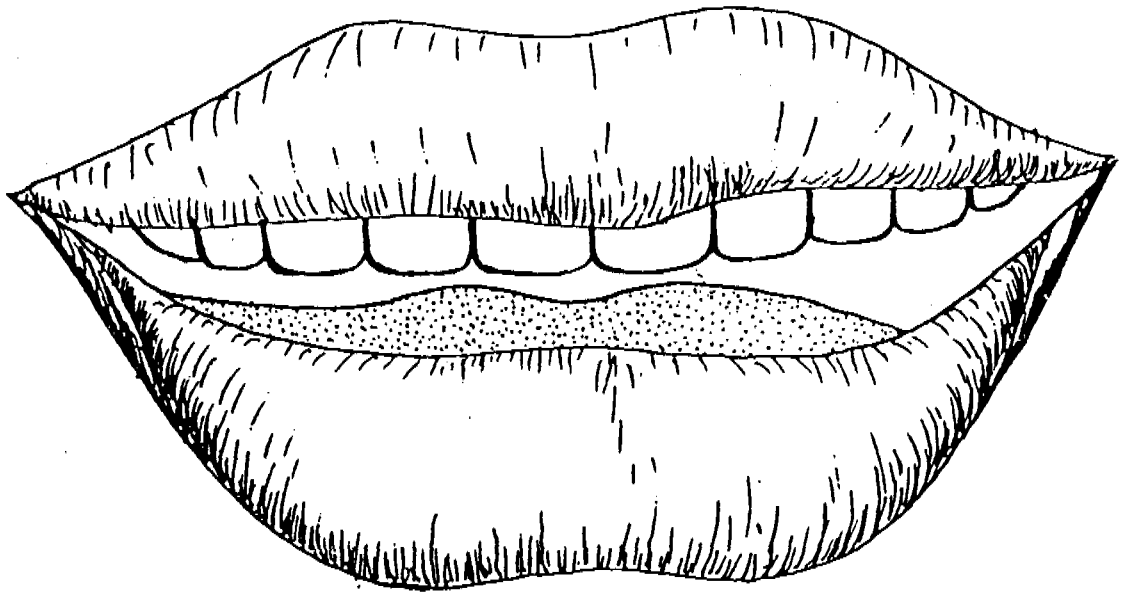


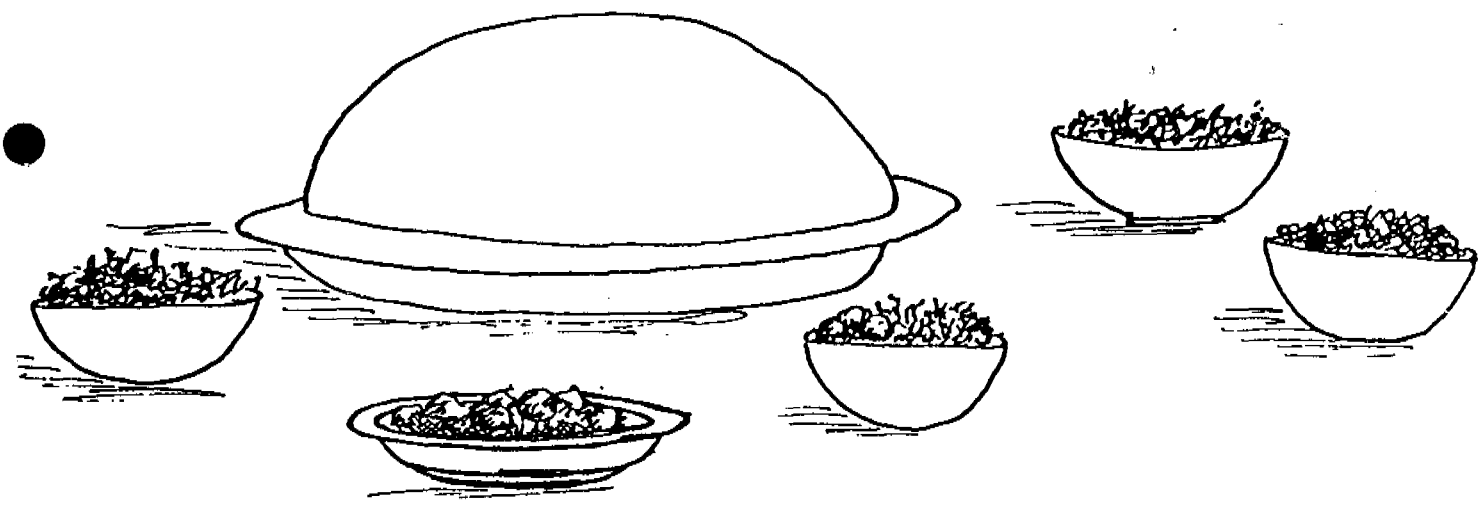
FEACAL ORAL ROUTES

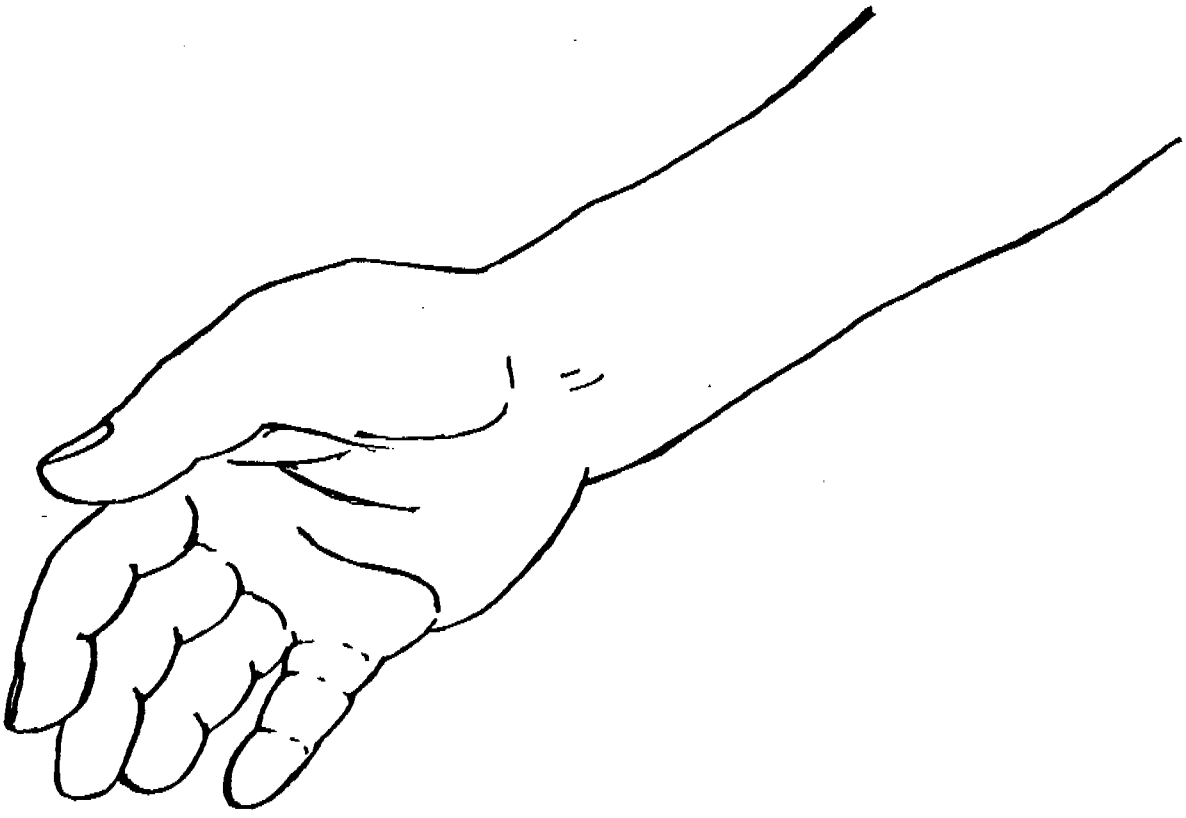
PHAST TOOL-KIT, BARINGO, KENYA 1994

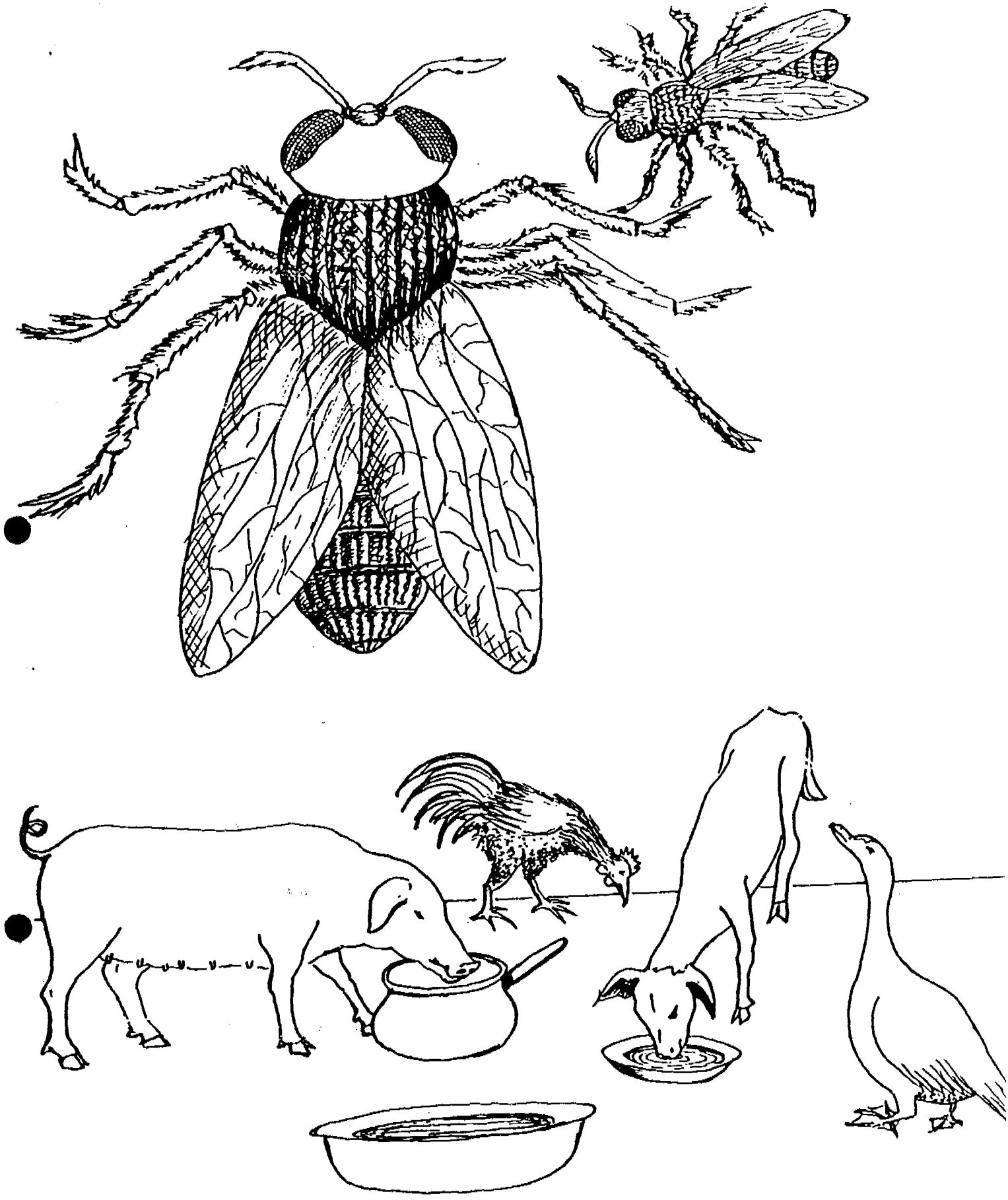


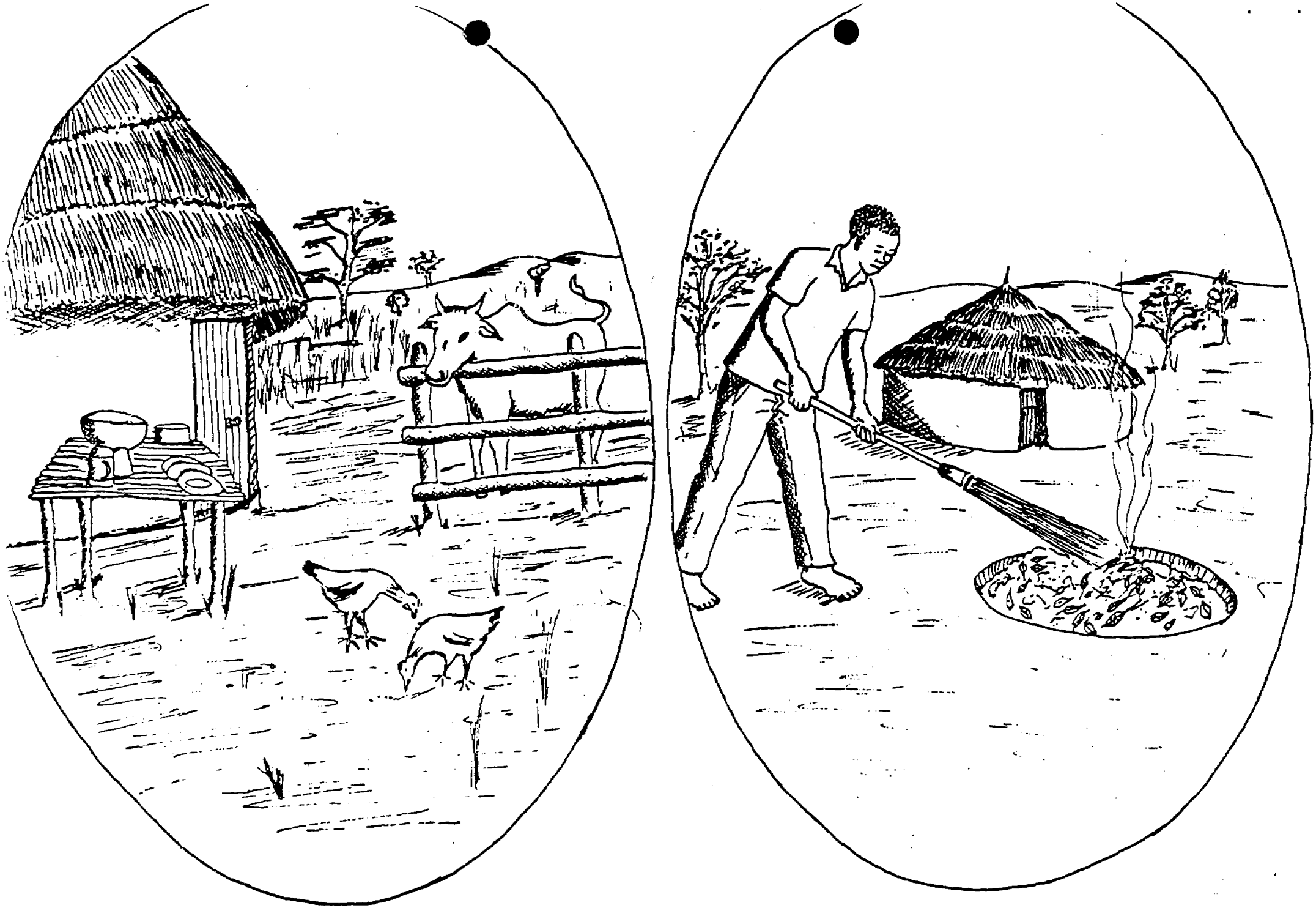


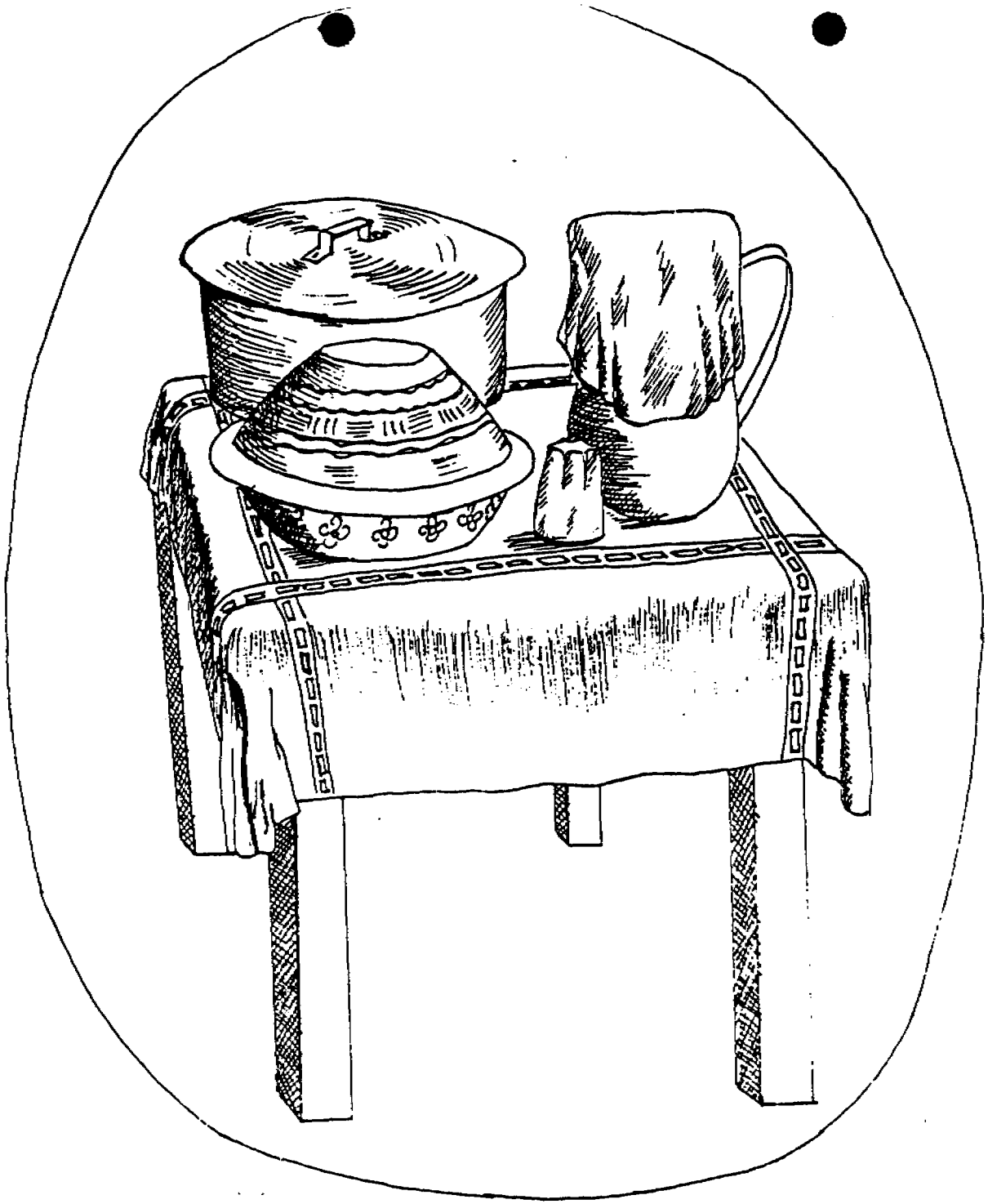


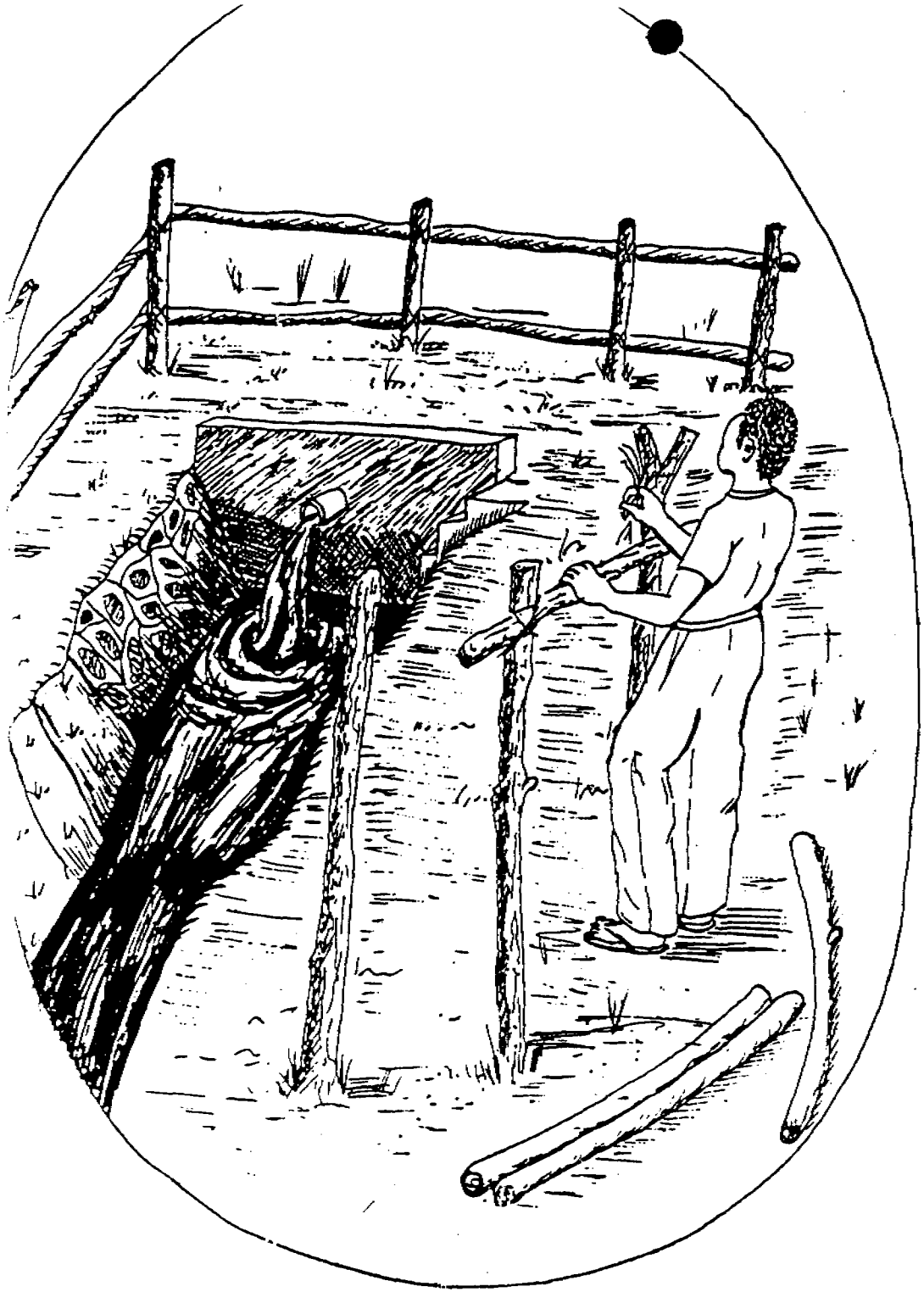


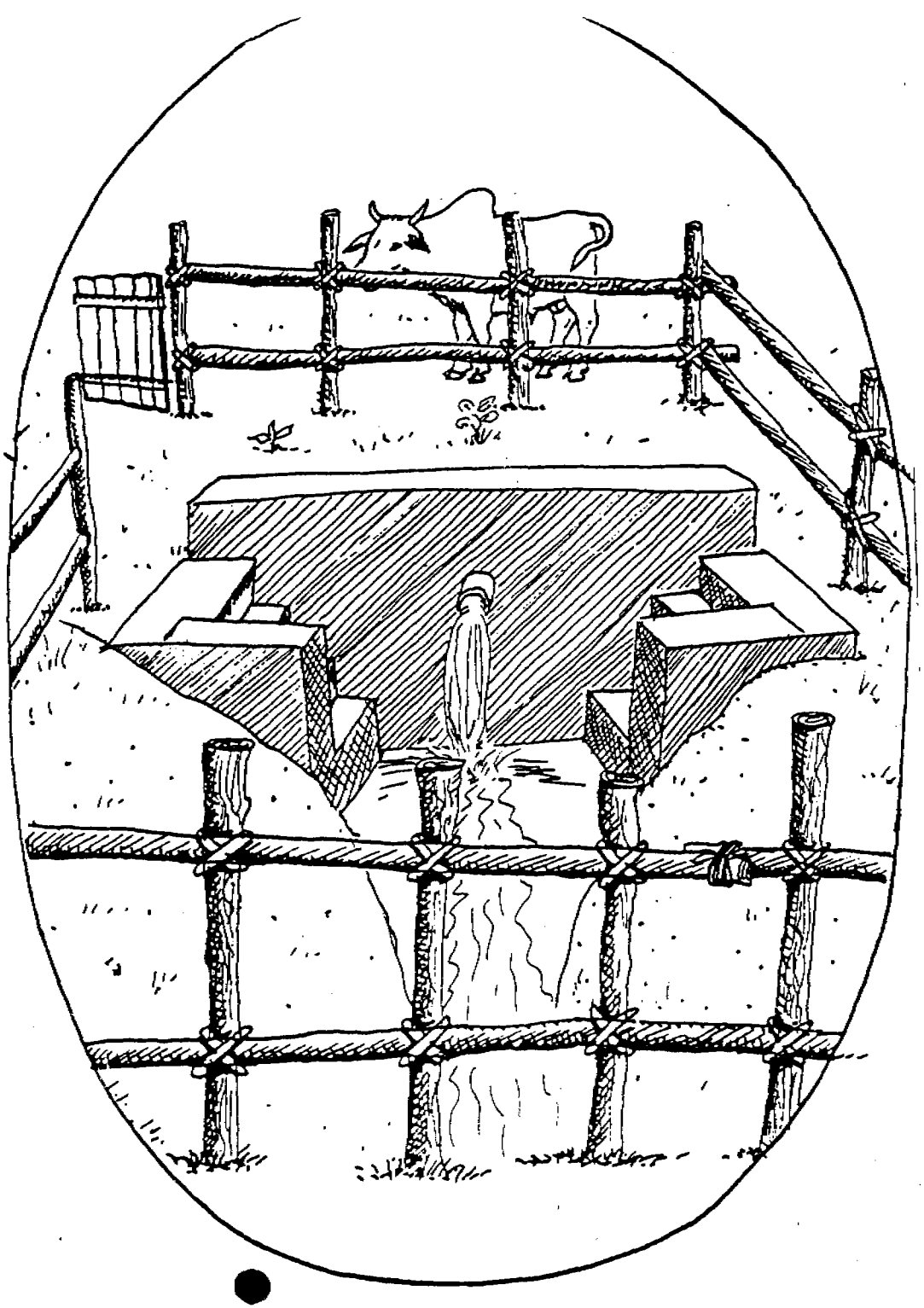


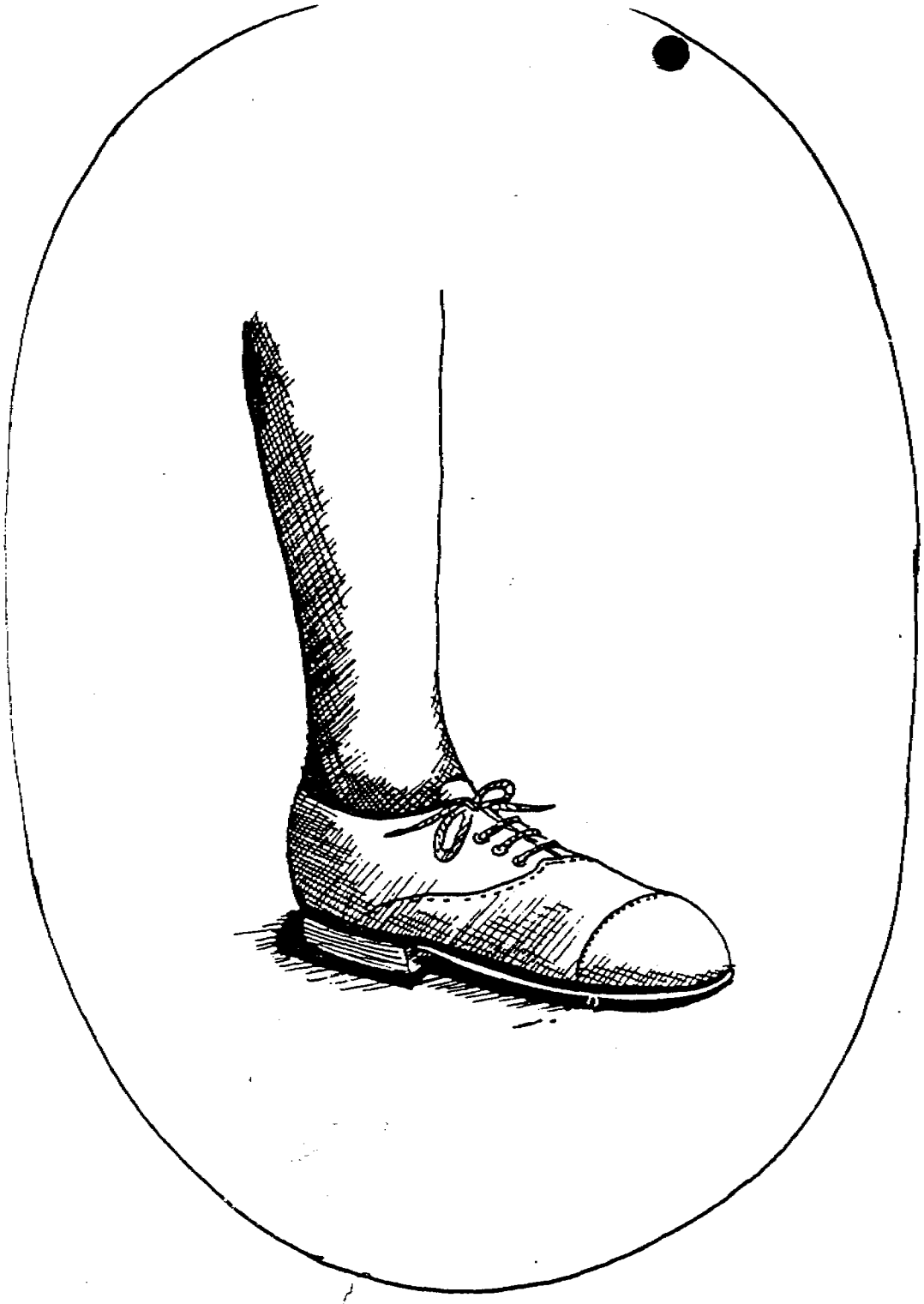


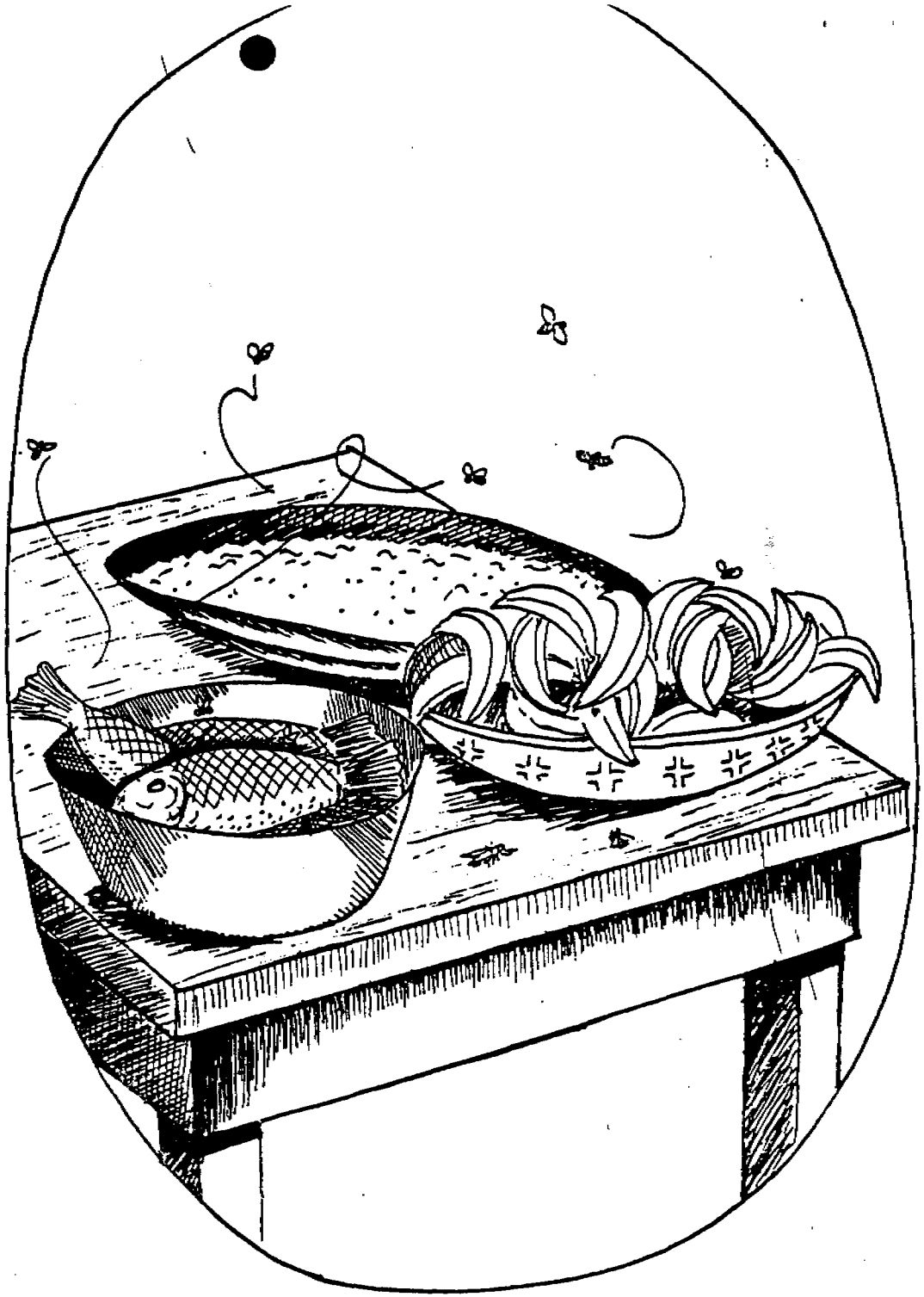


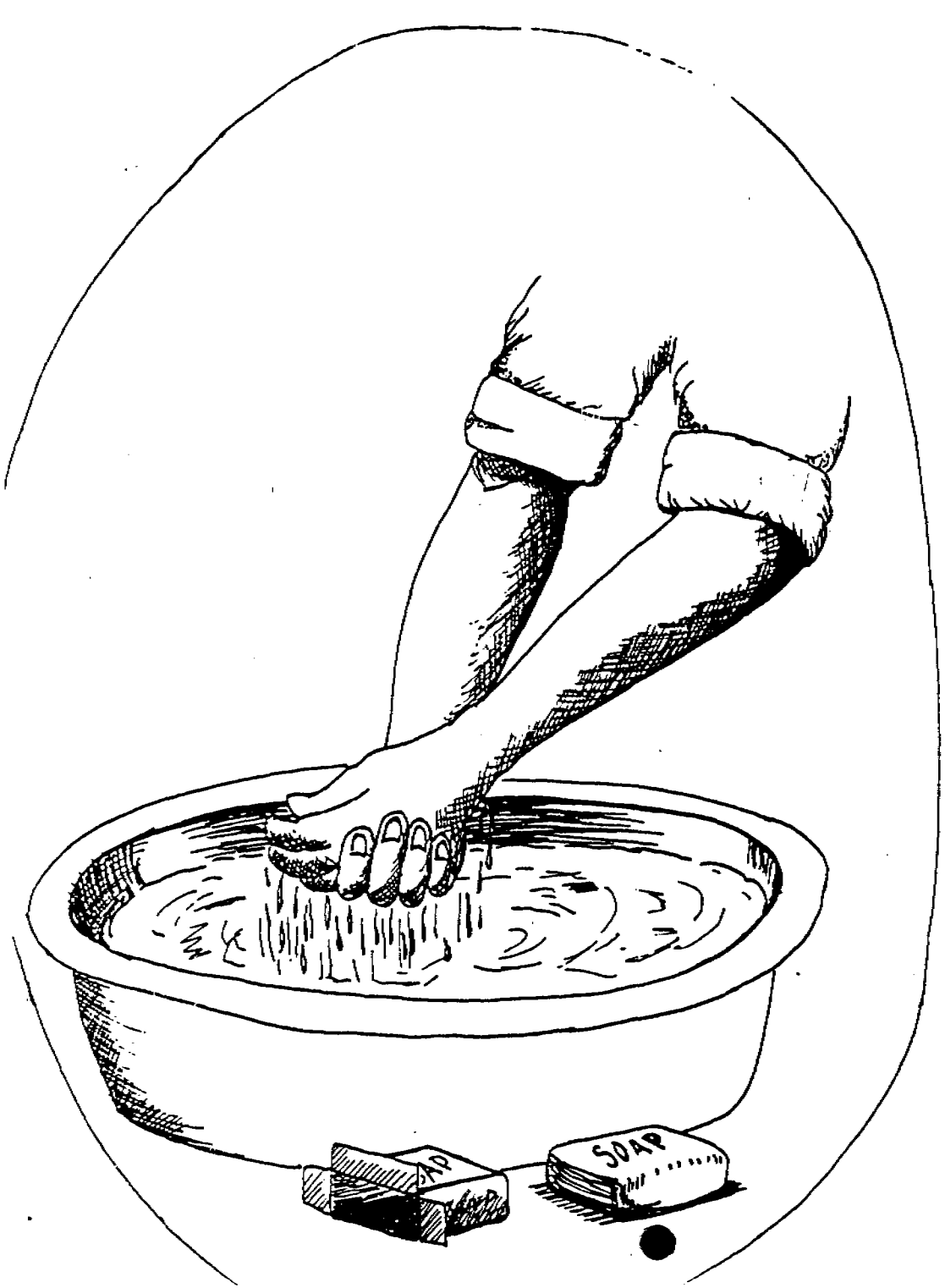








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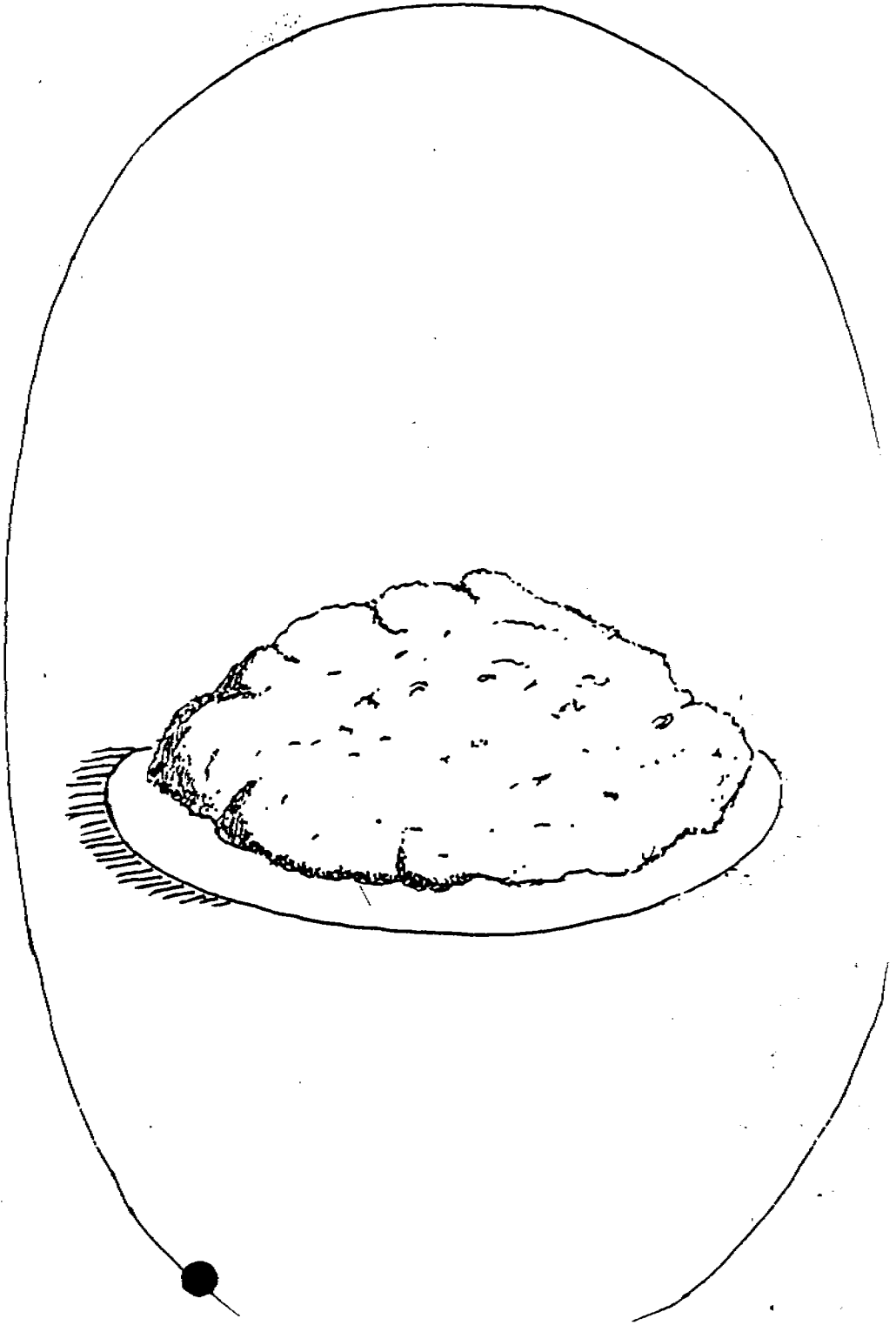

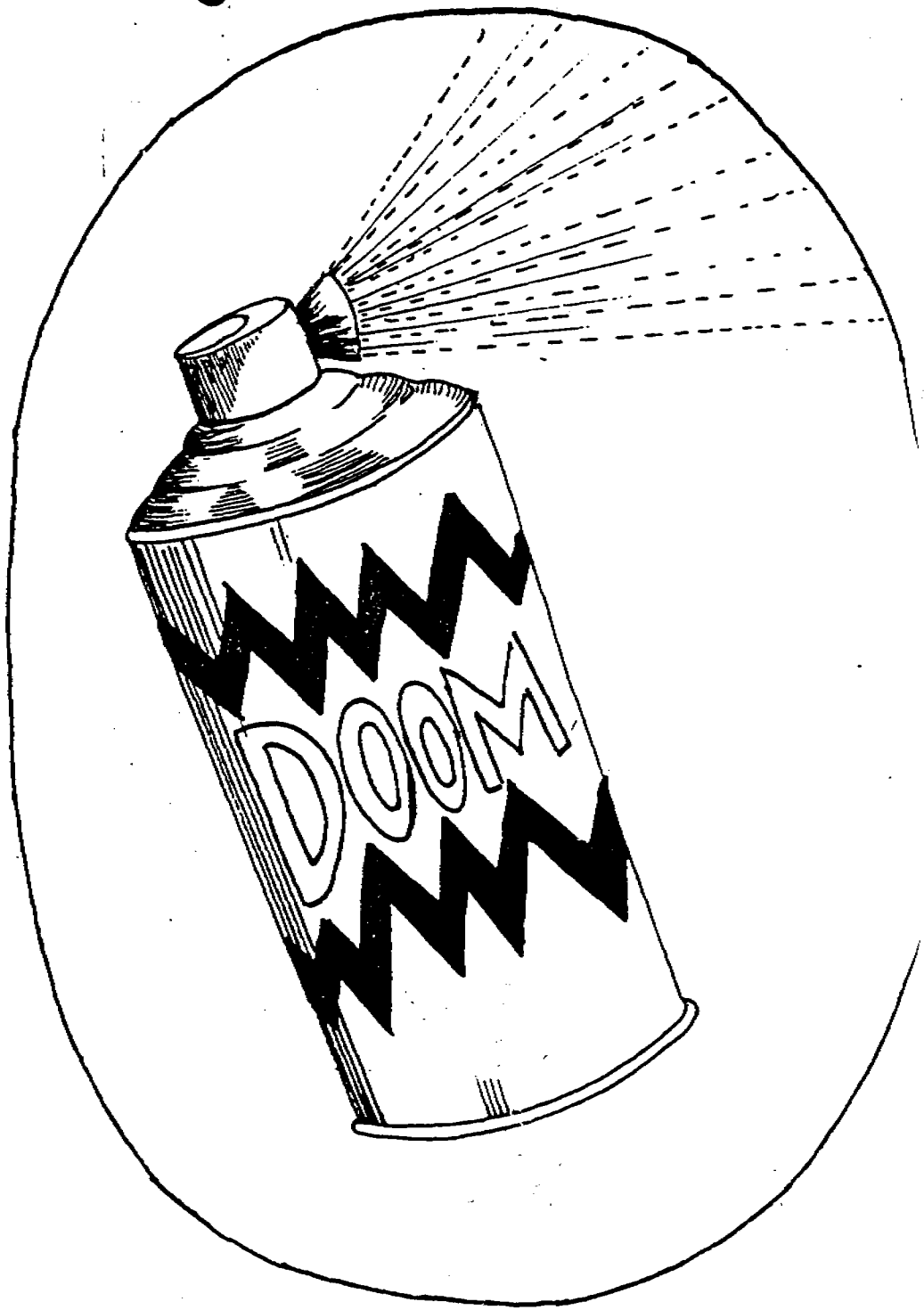
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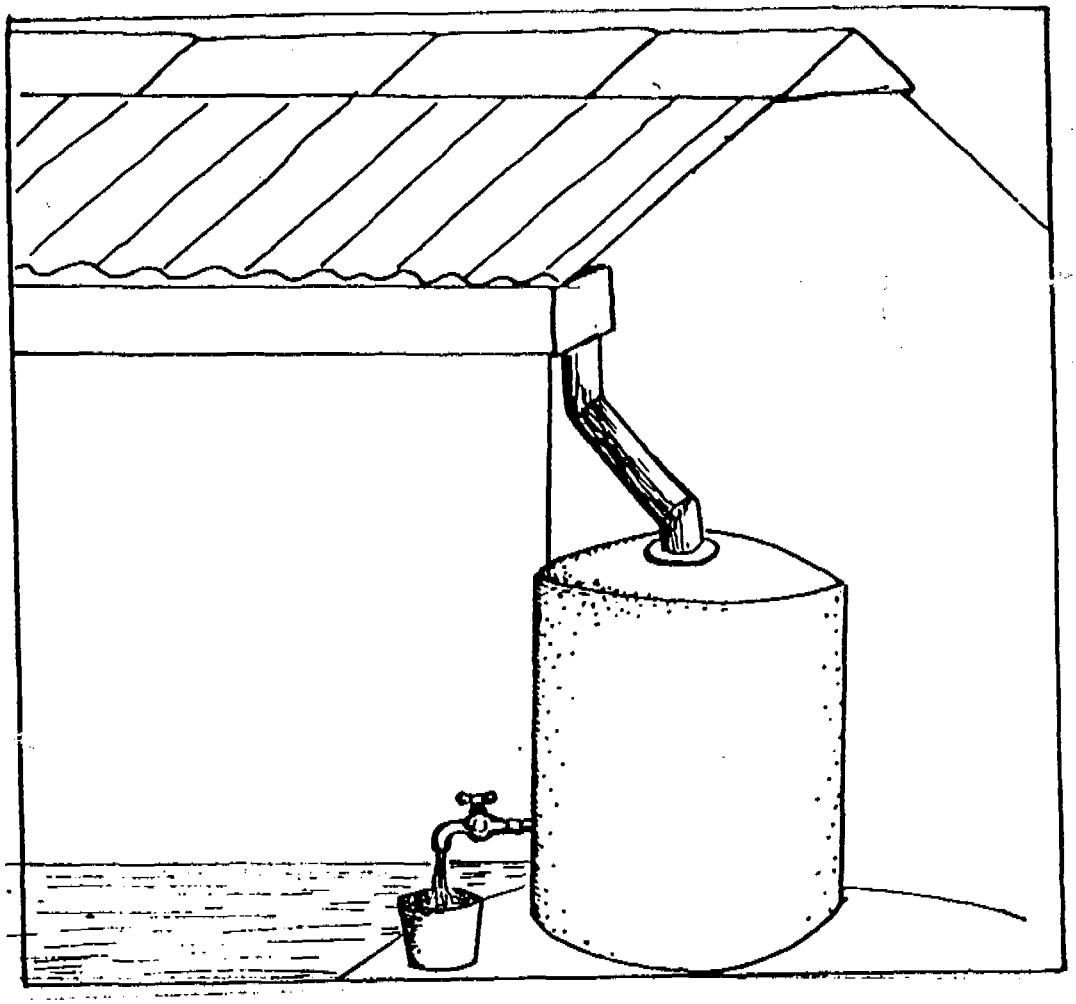
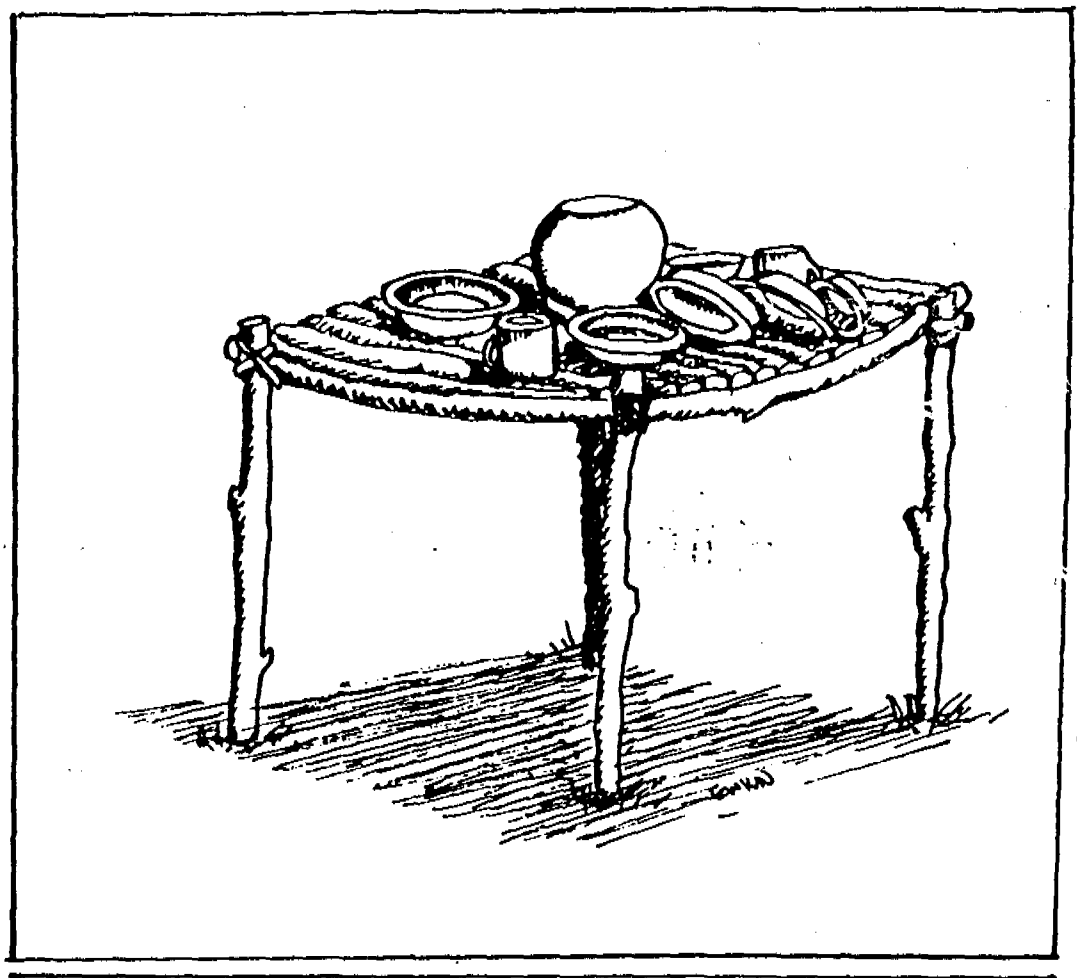
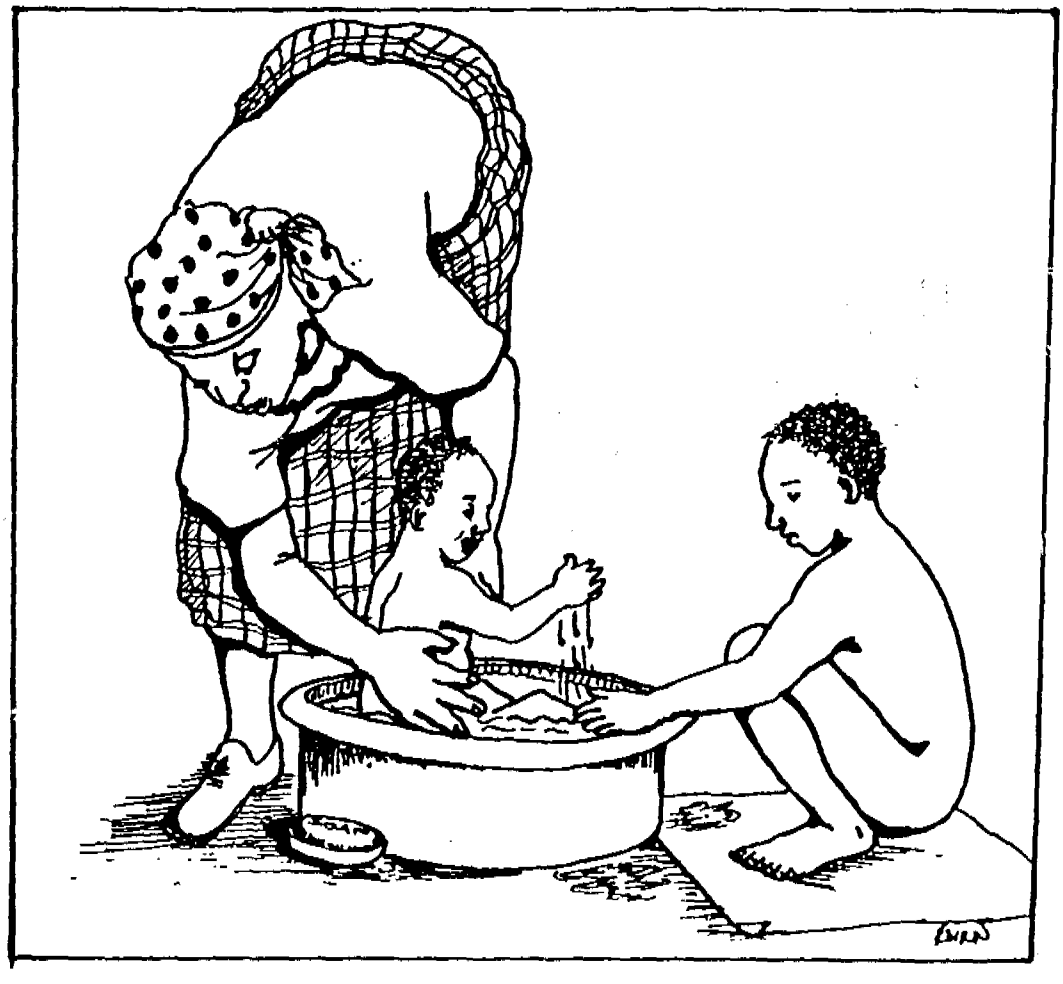
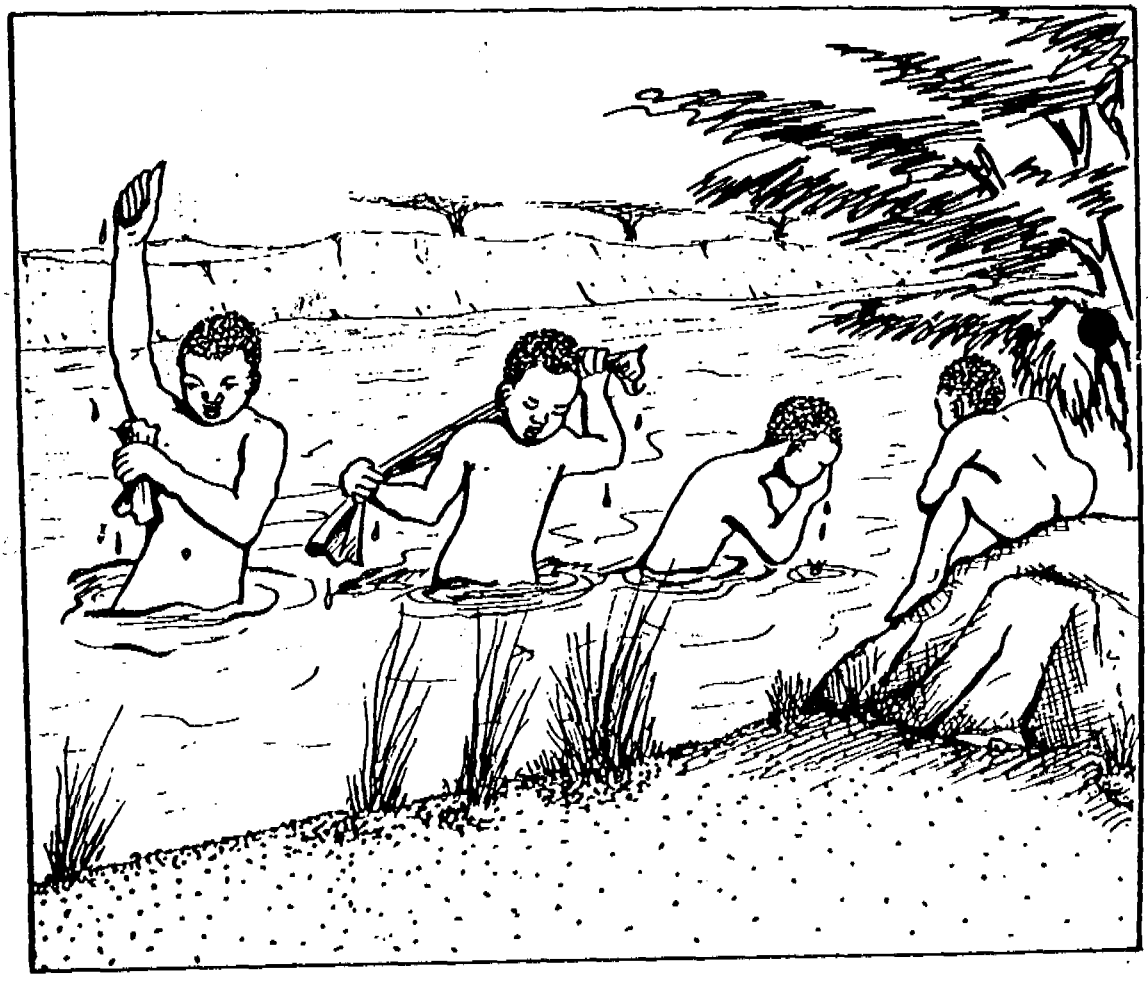
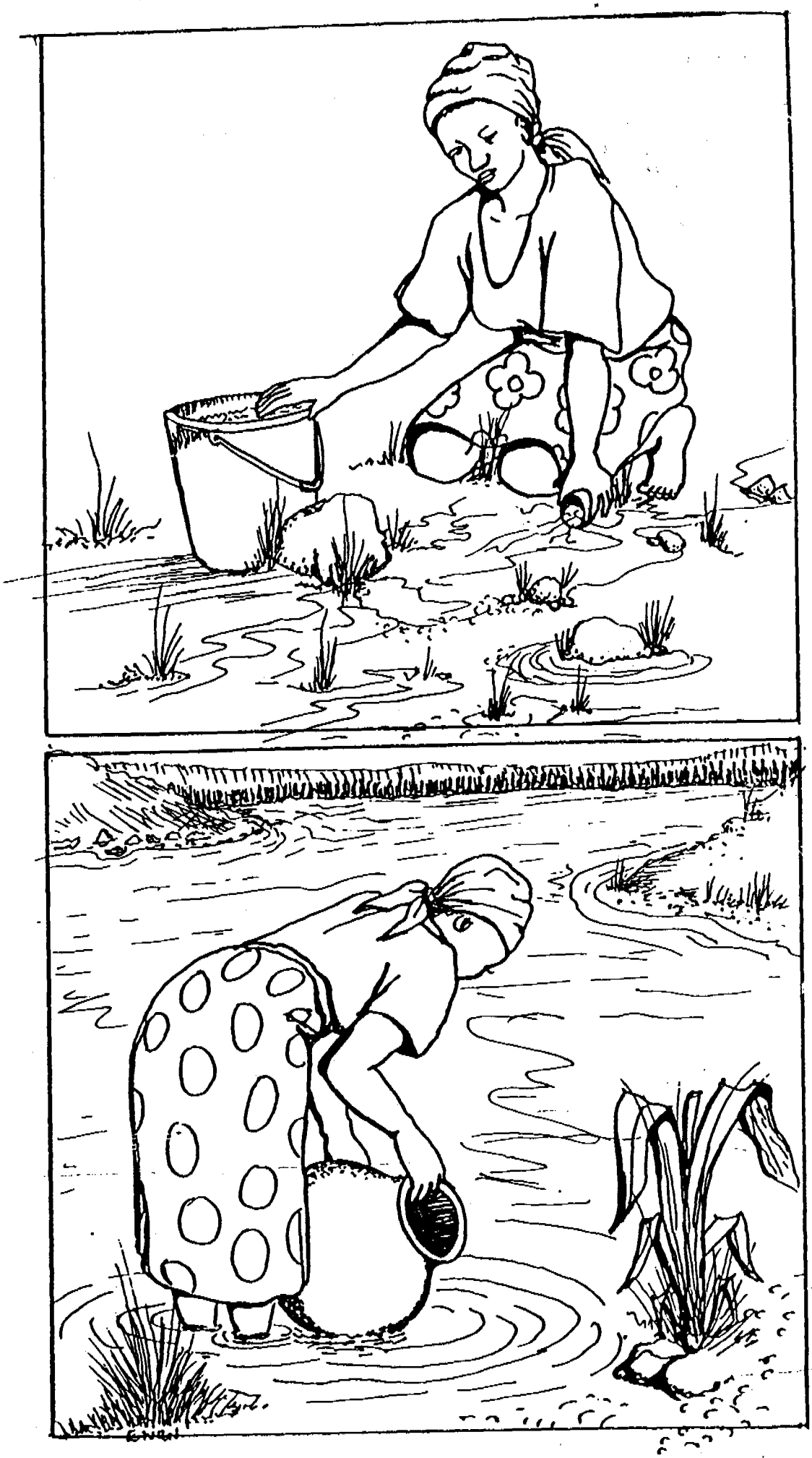
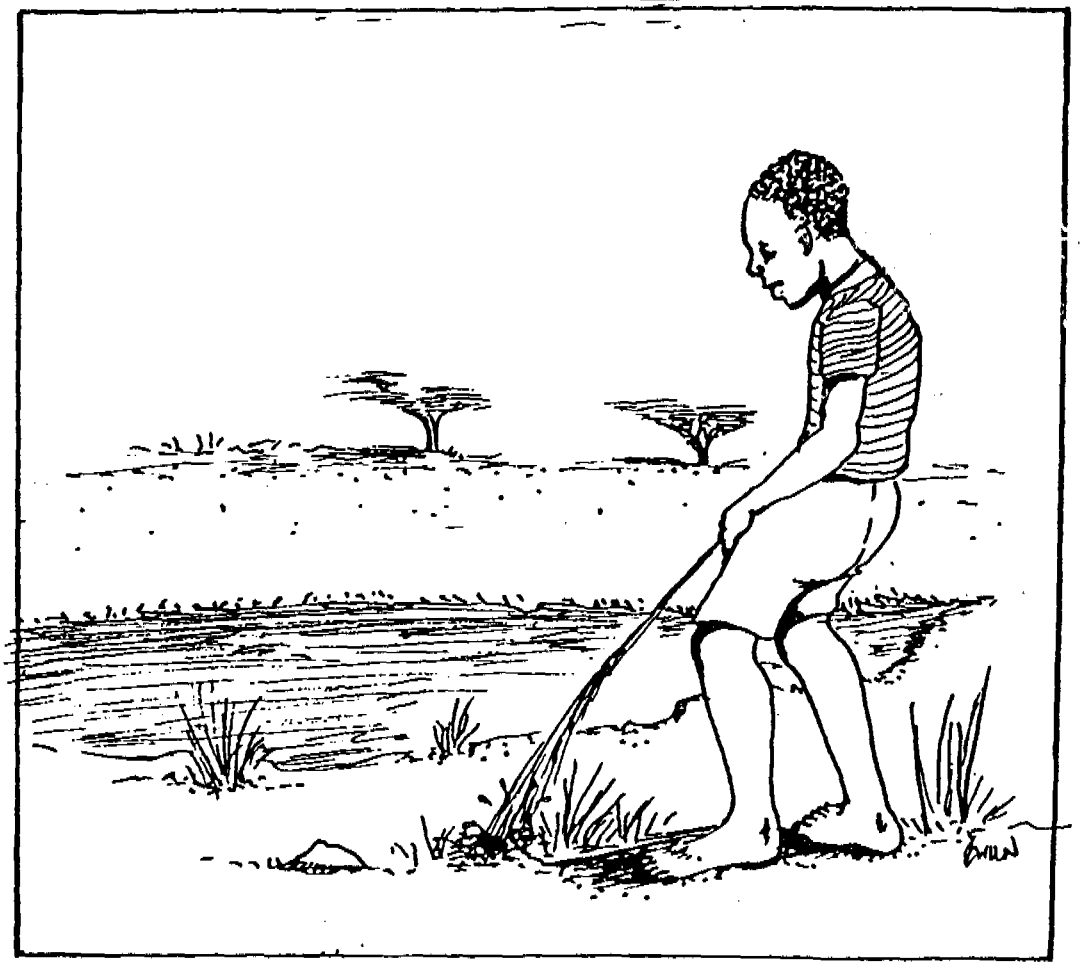


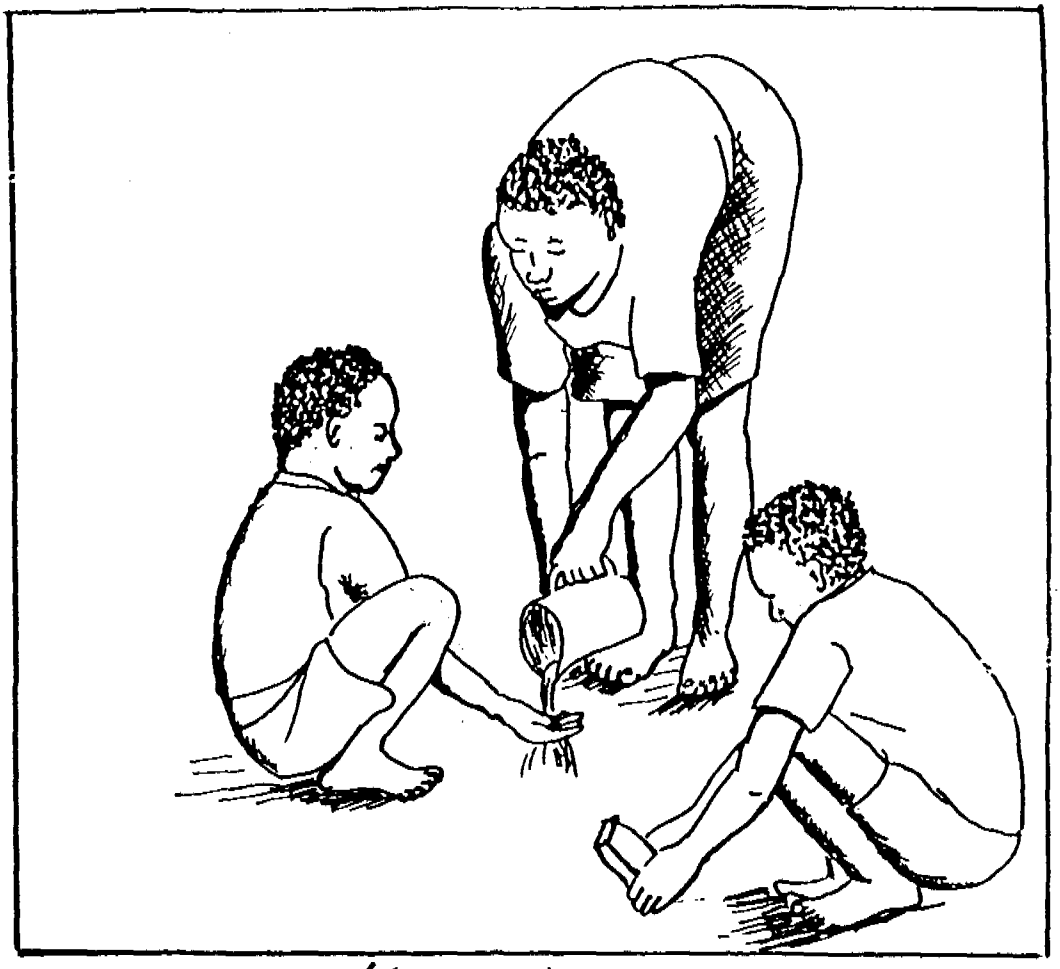


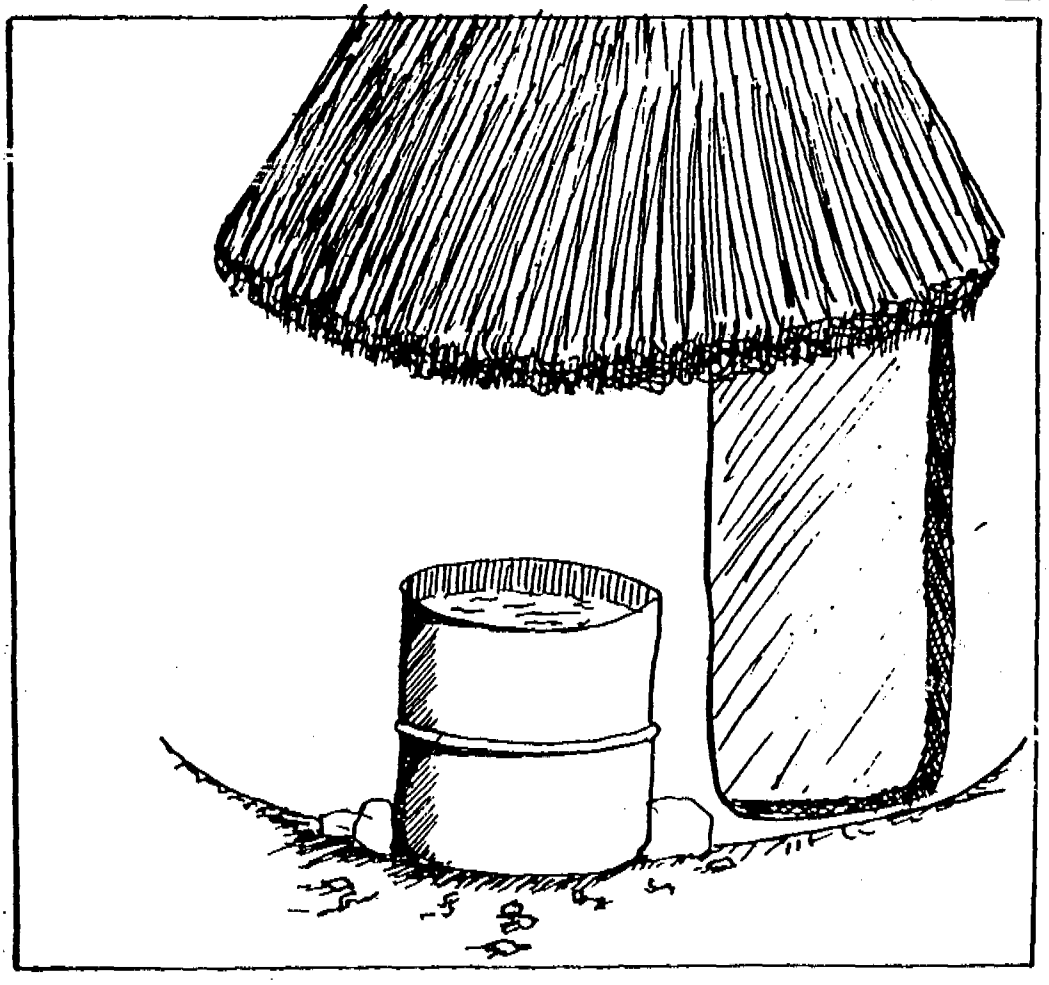








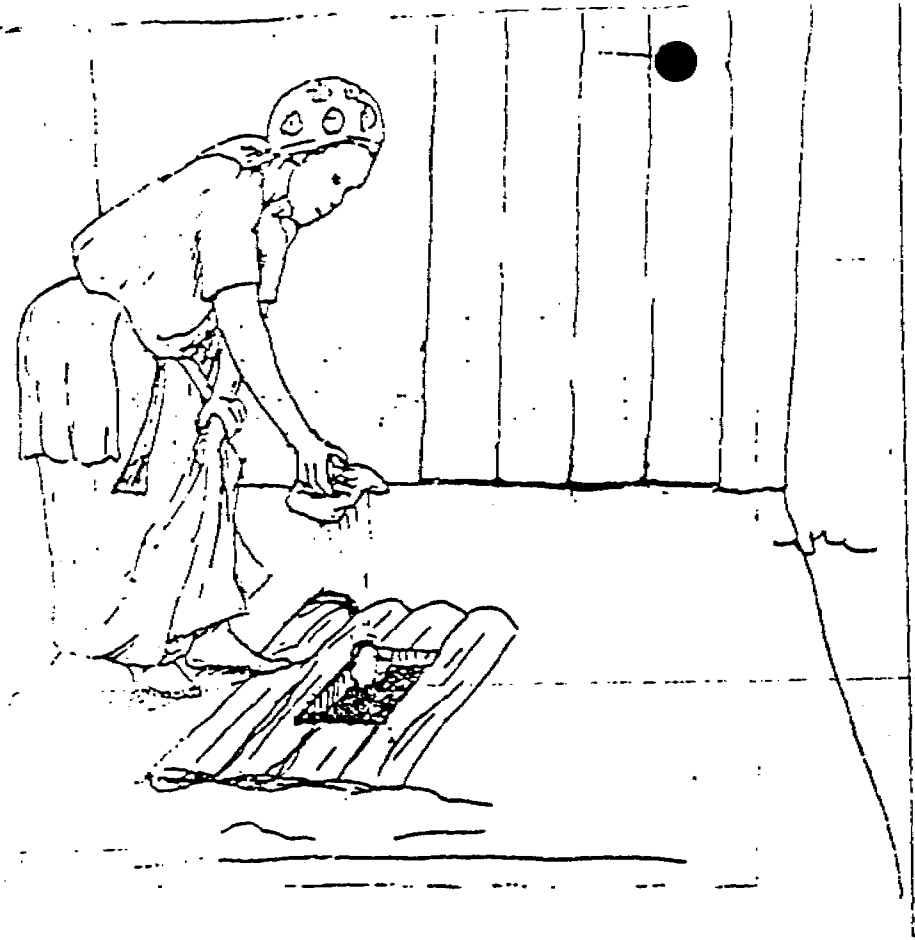


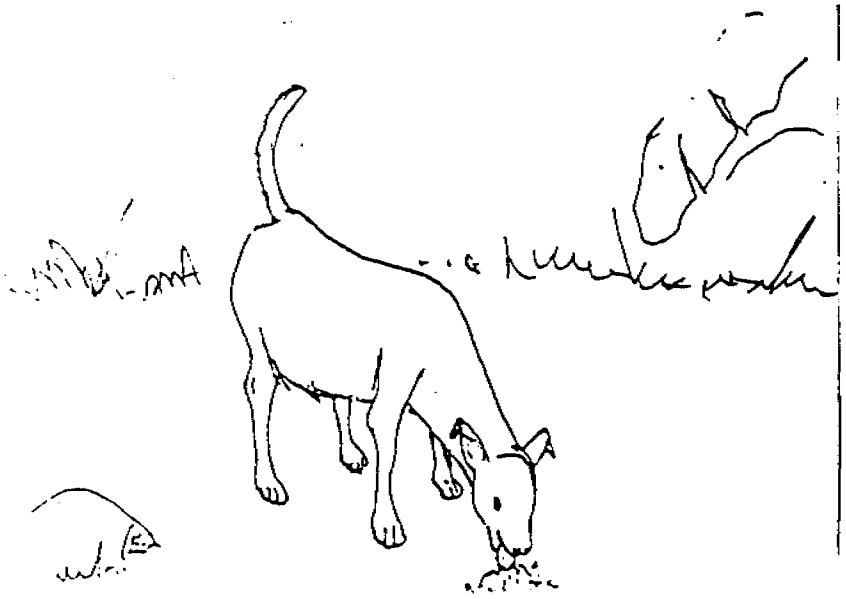


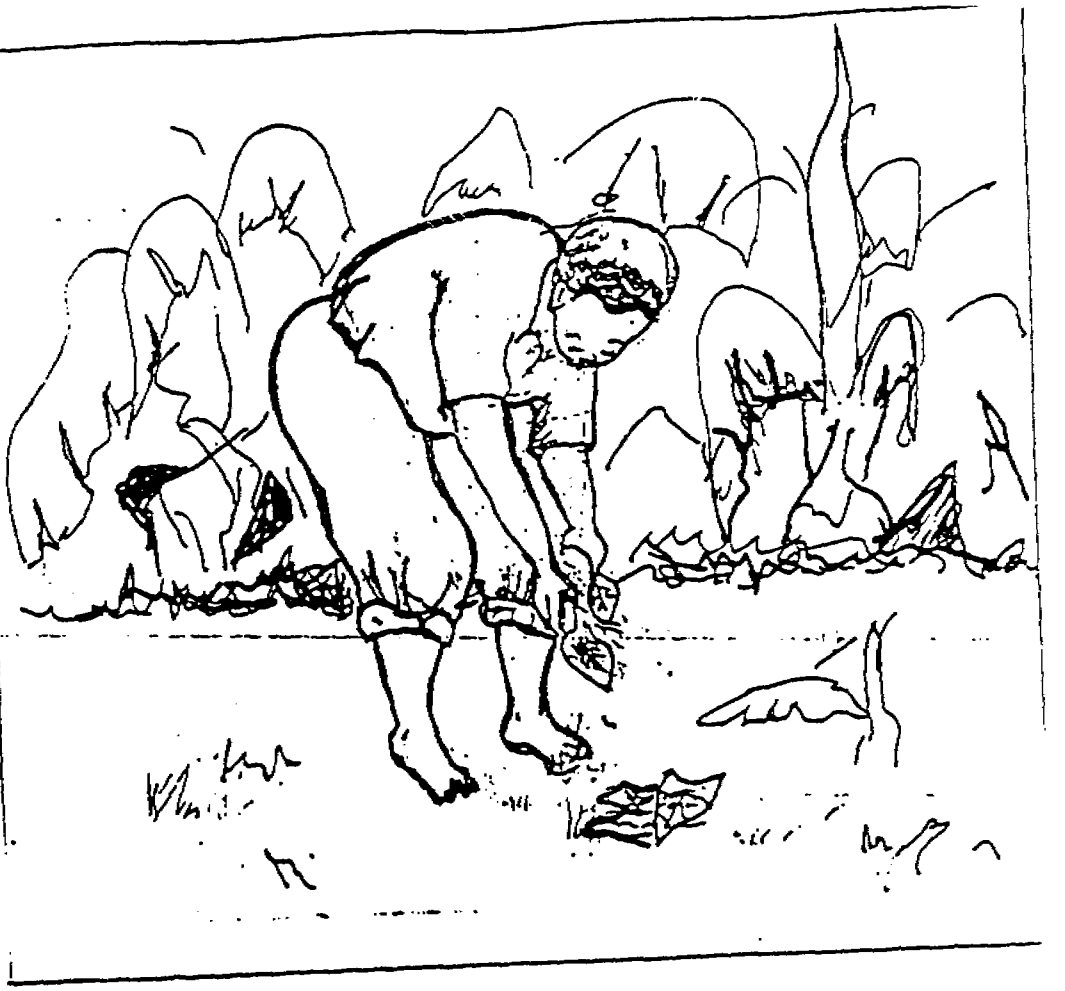
FEACAL BARRIERS

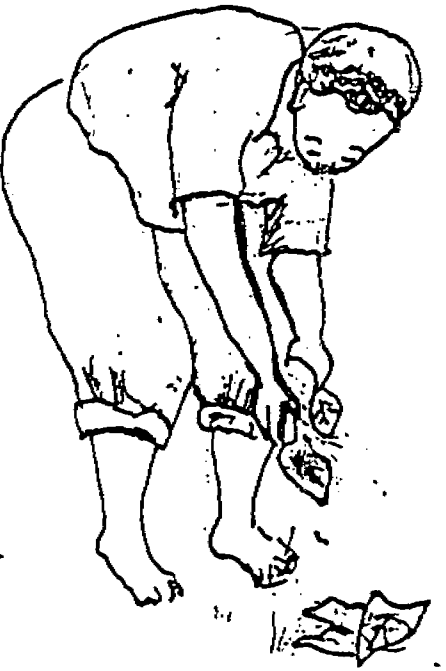
PHAST TOOL-KIT, BARINGO, KENYA 1994

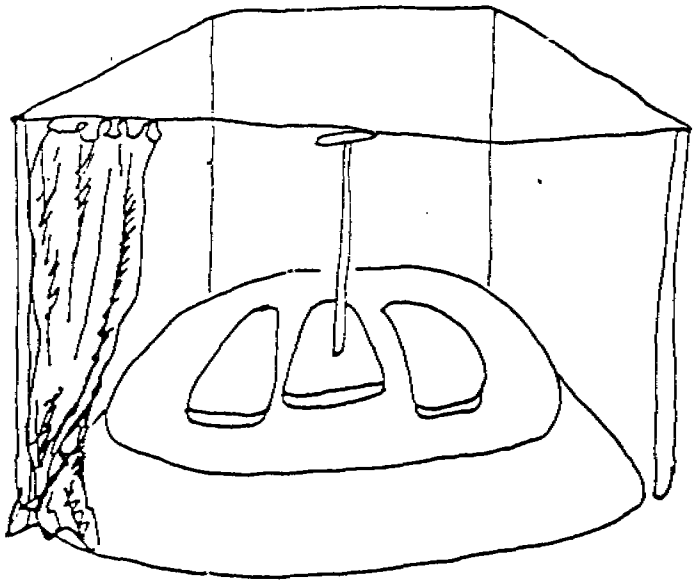
UNICEF, BARINGO

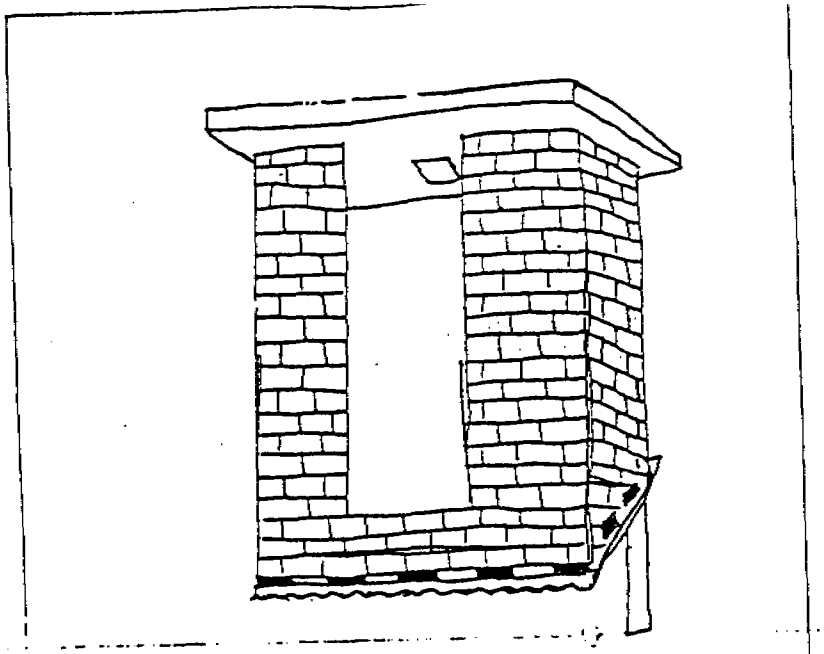


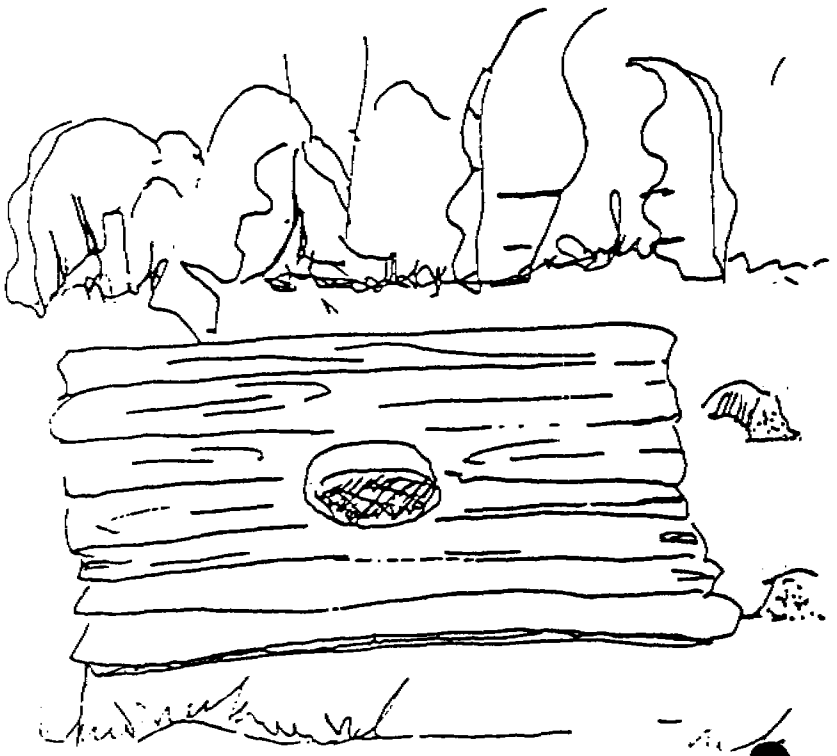


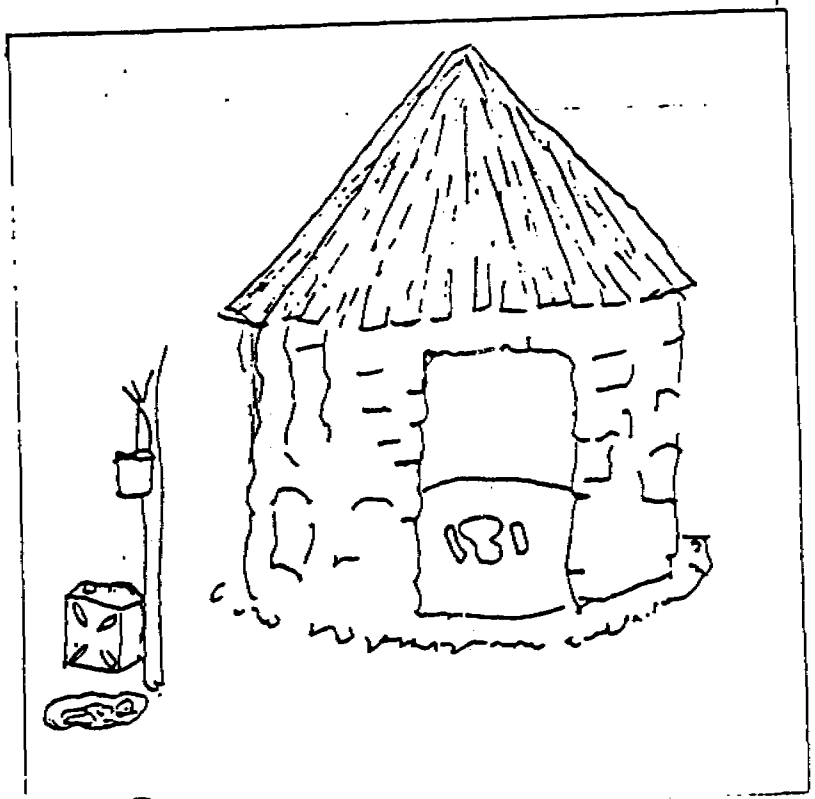


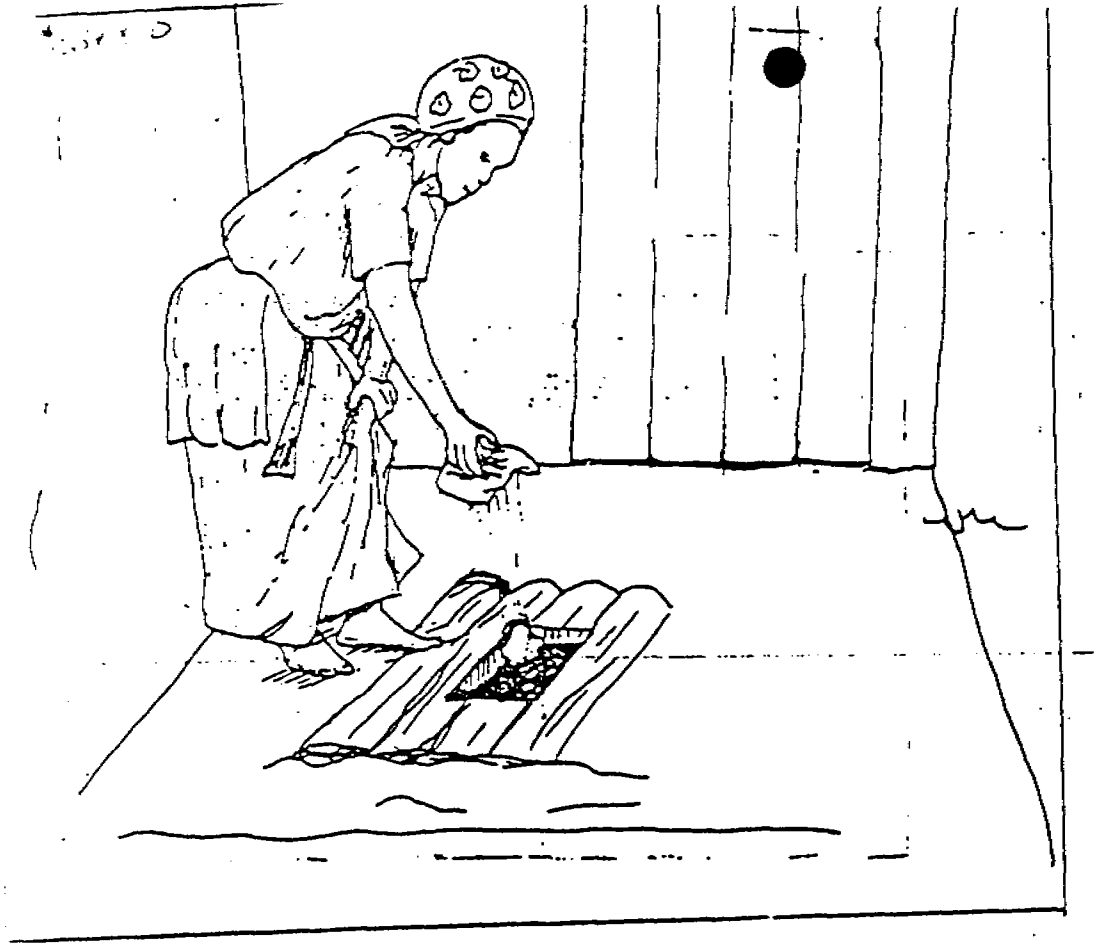


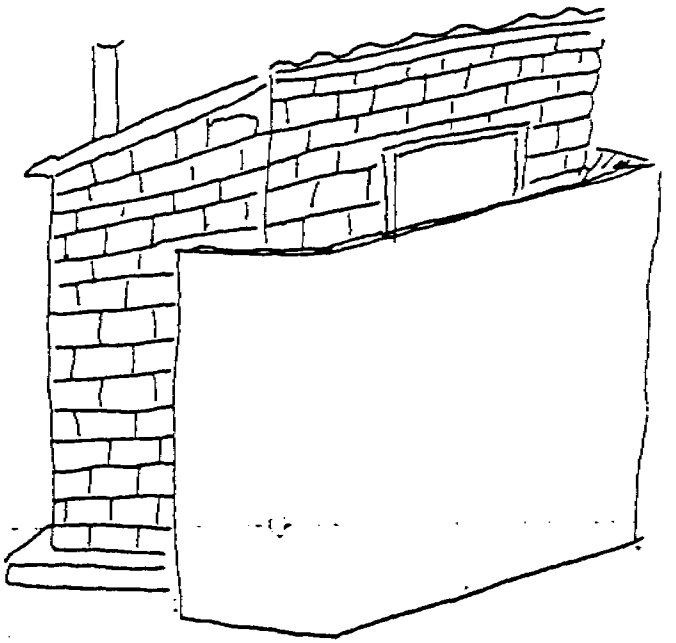


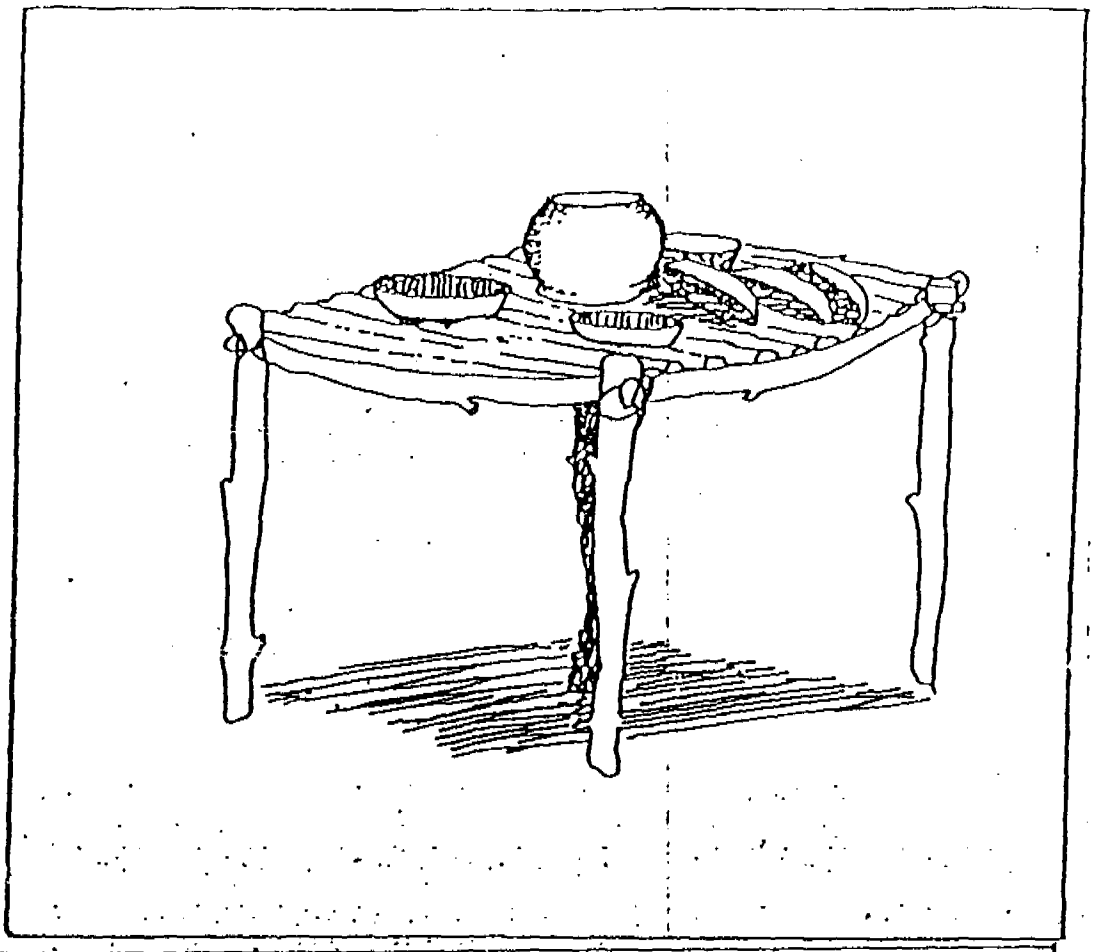


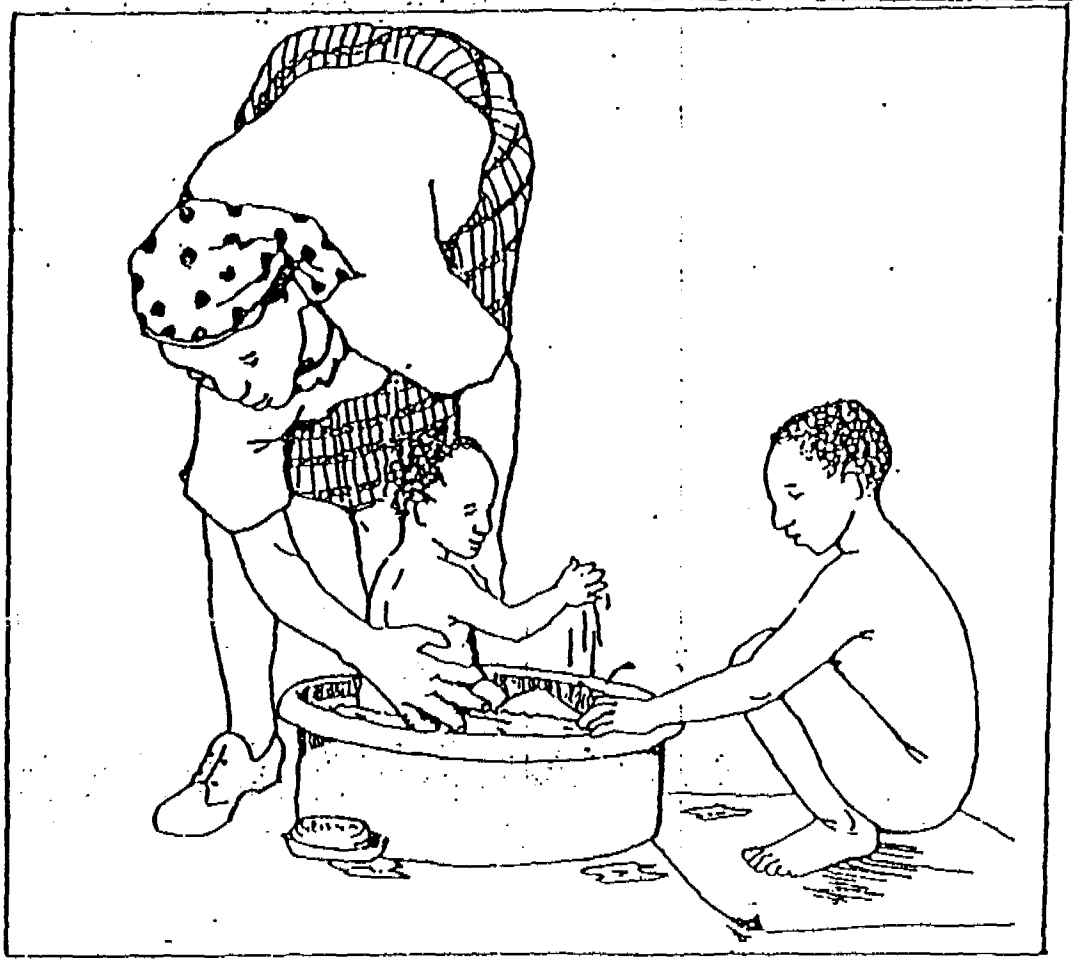


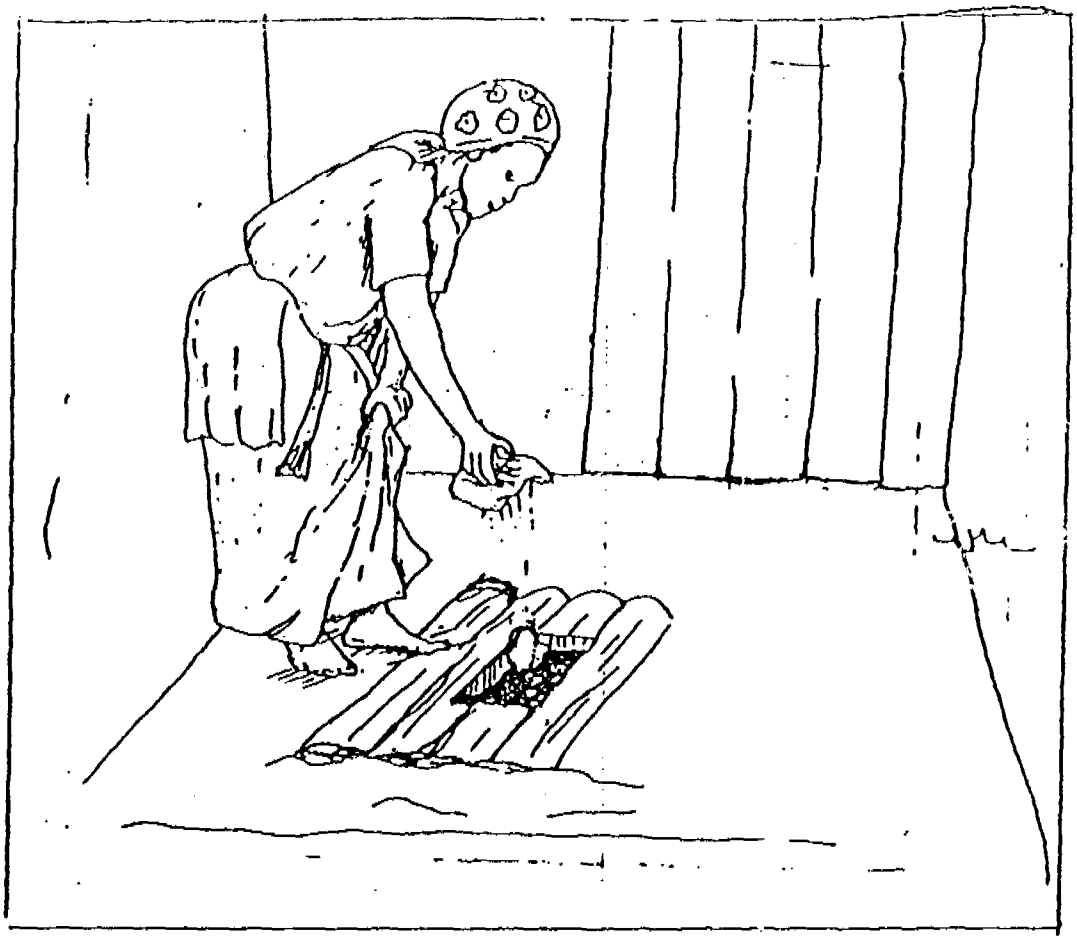


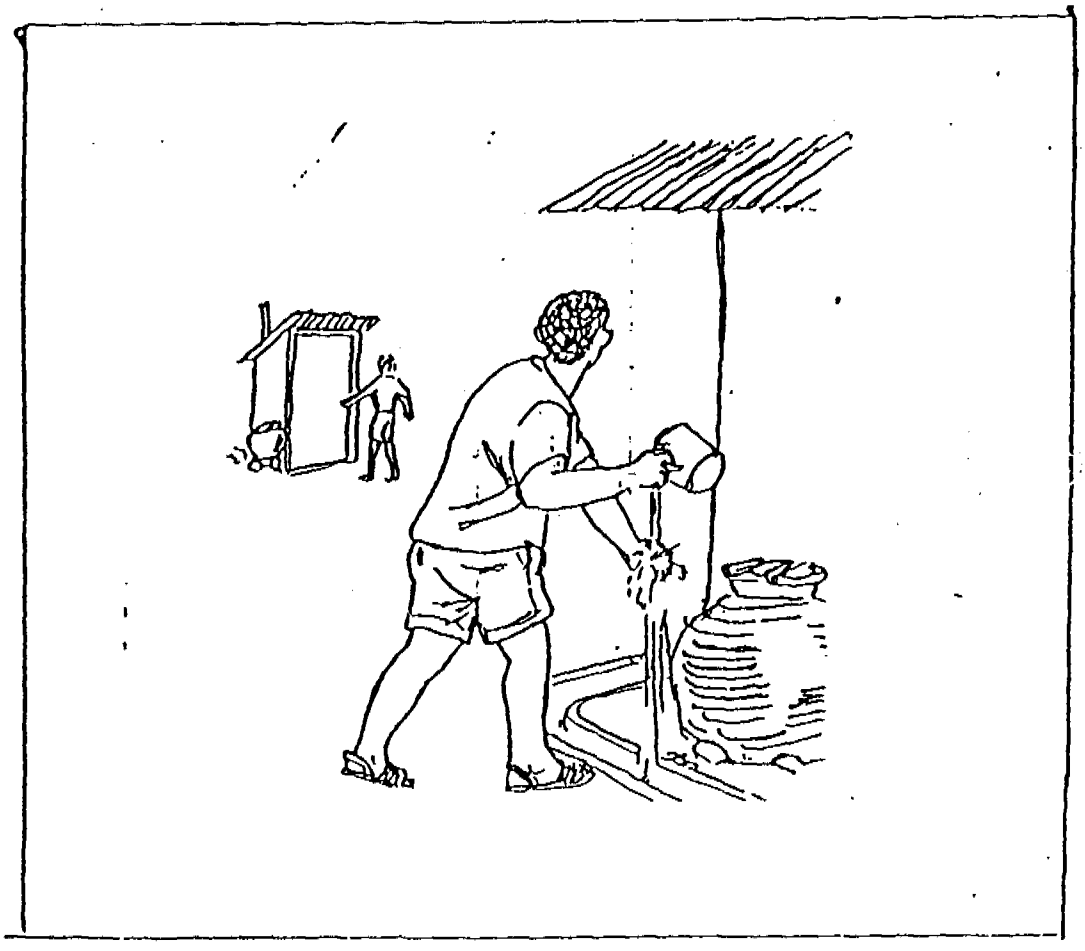


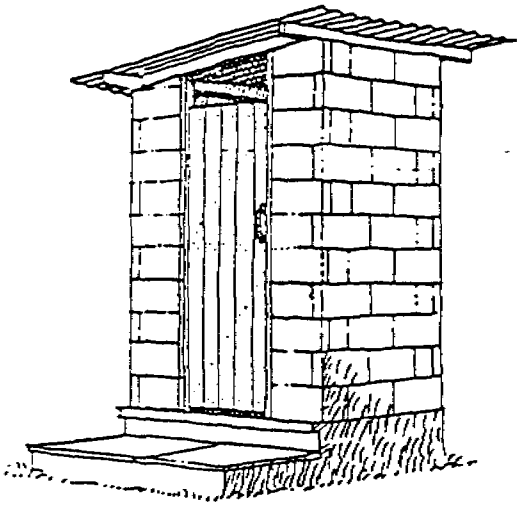












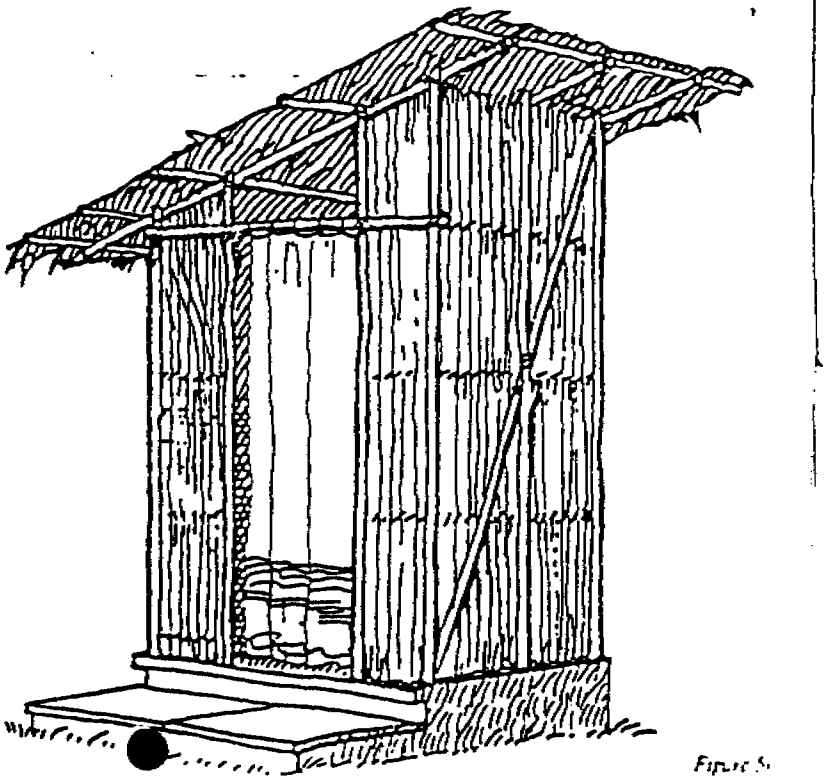
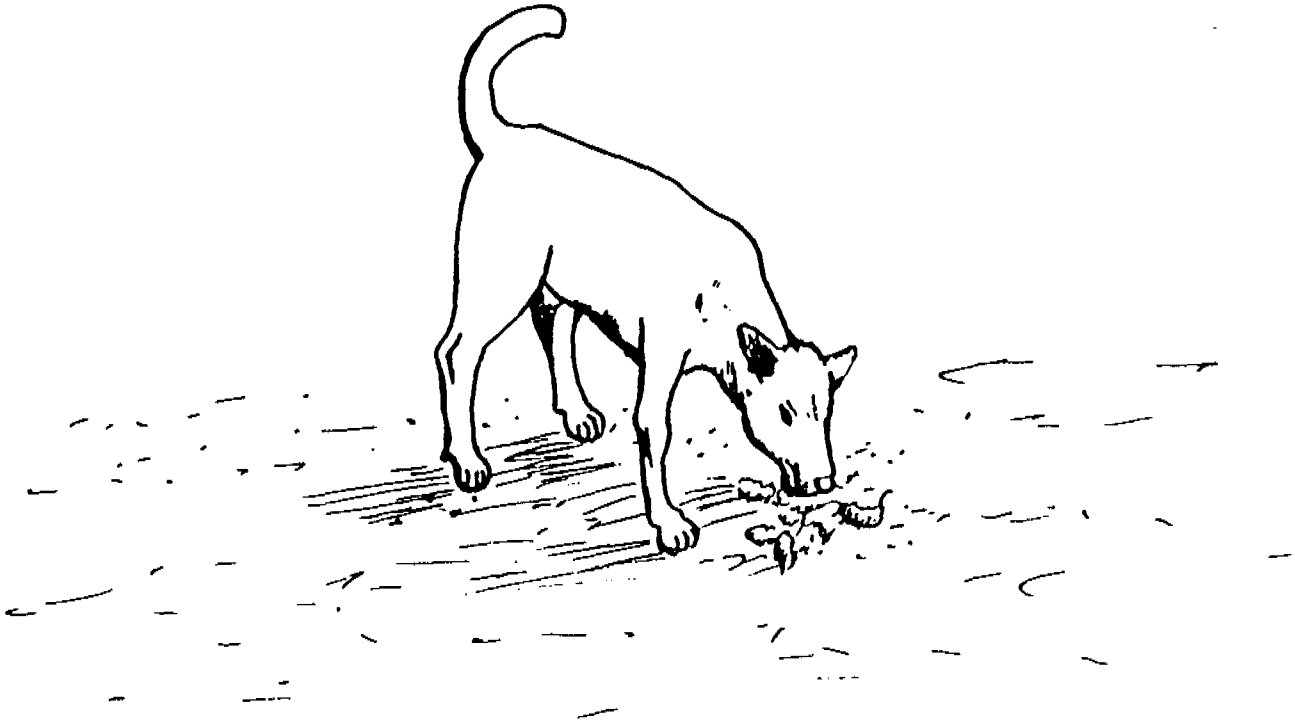
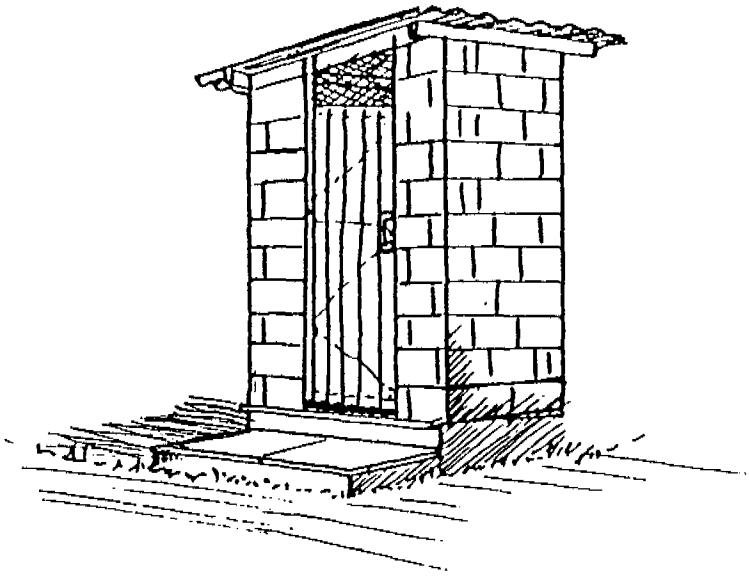
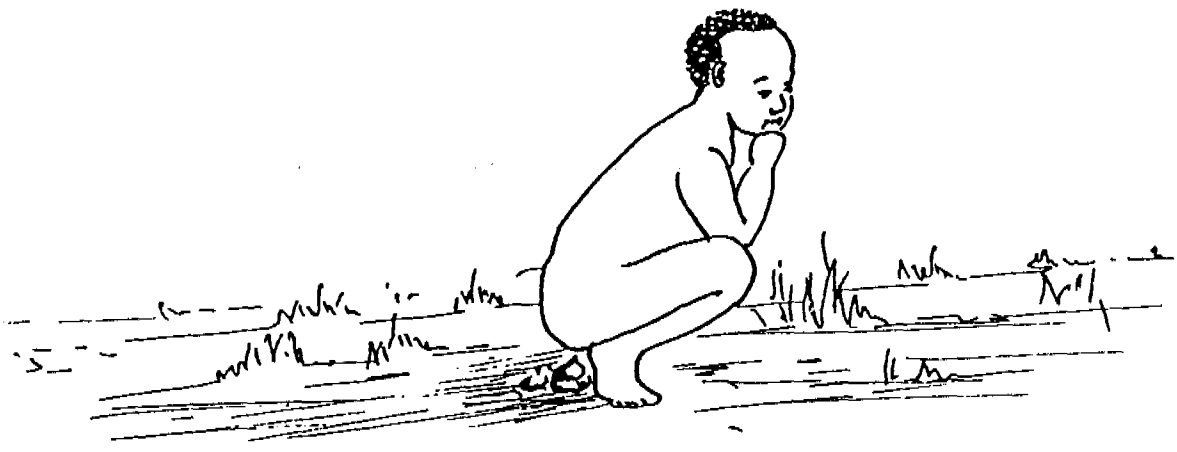


Figure 5.

SANITATION LADDER





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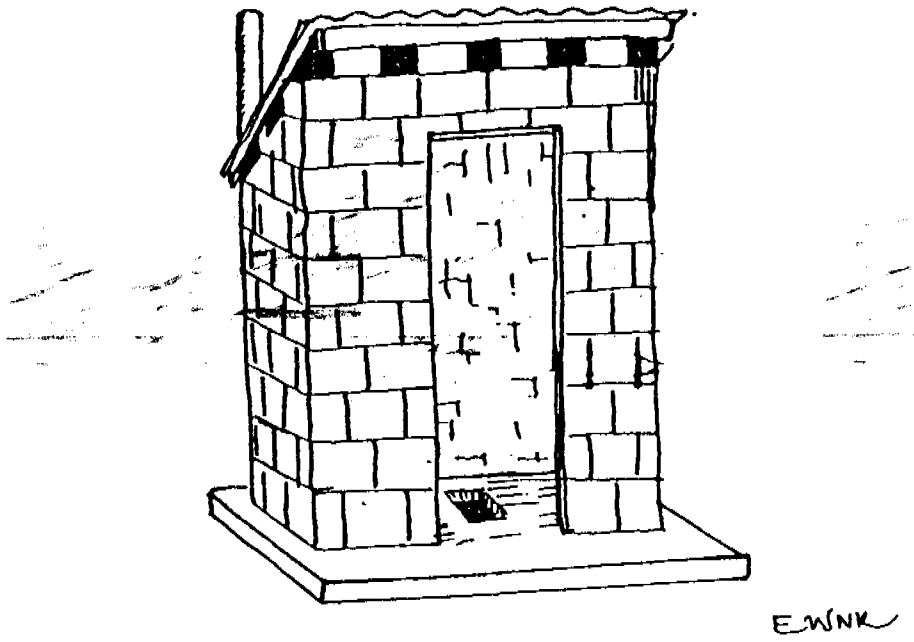
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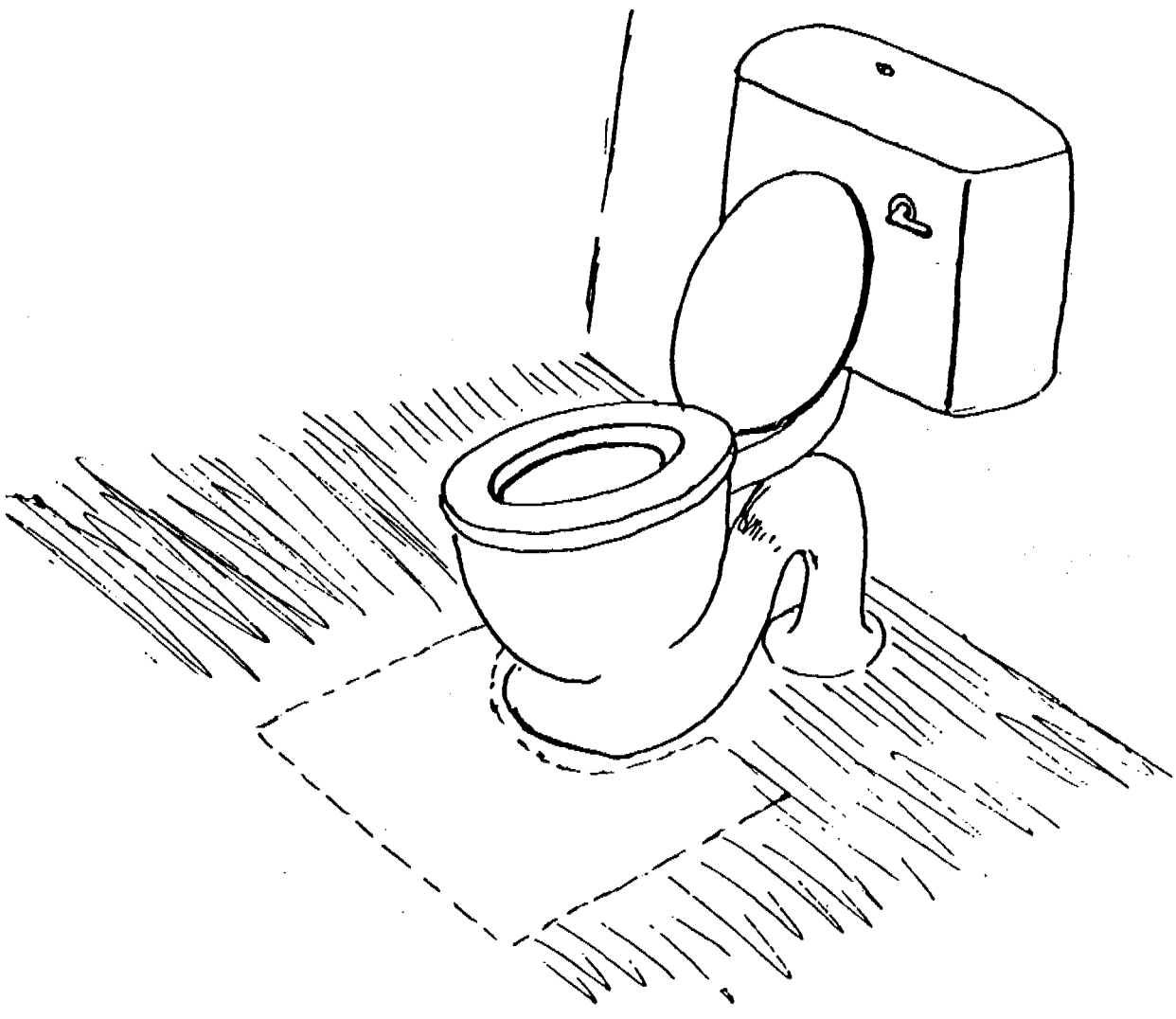

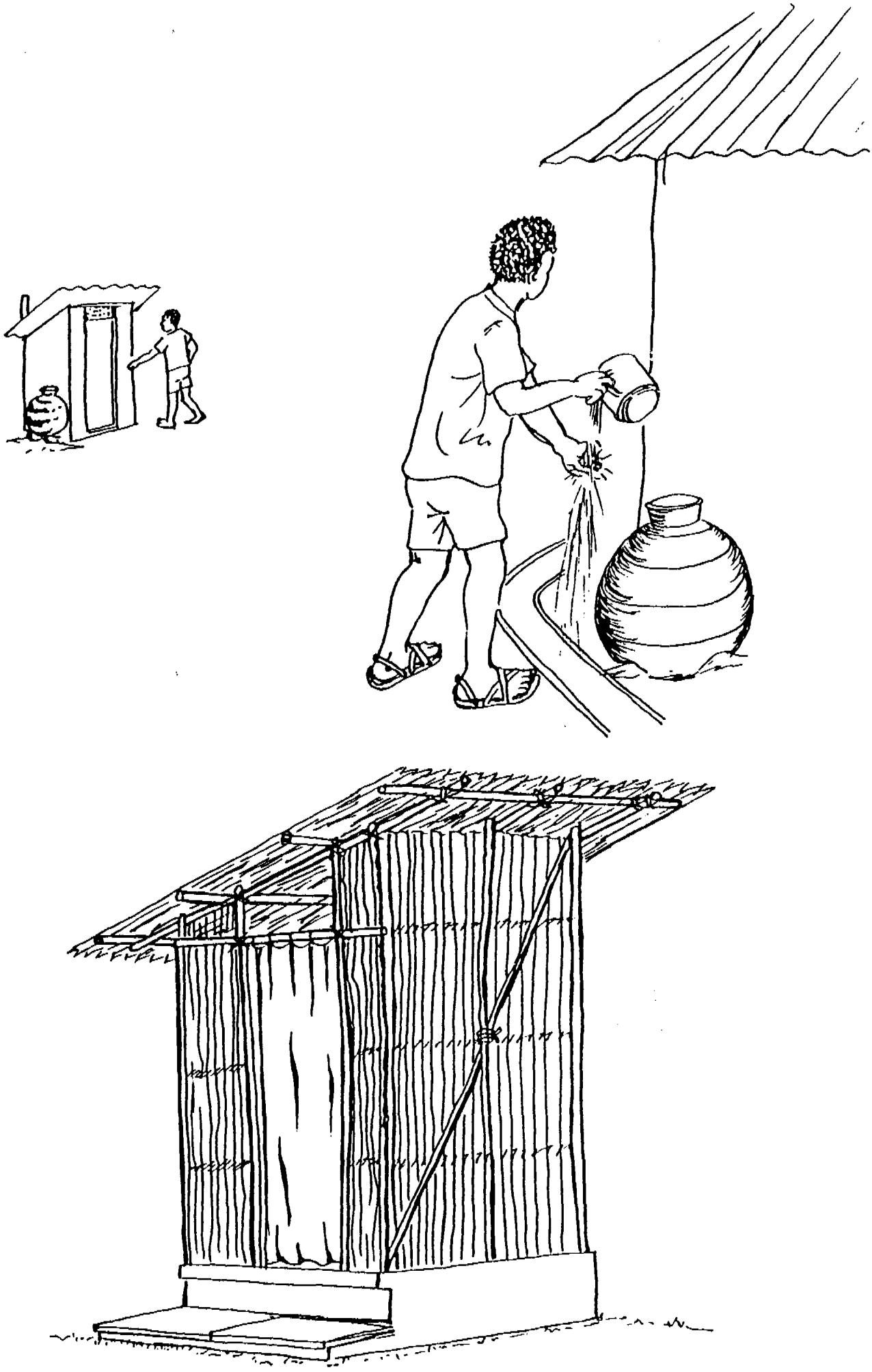

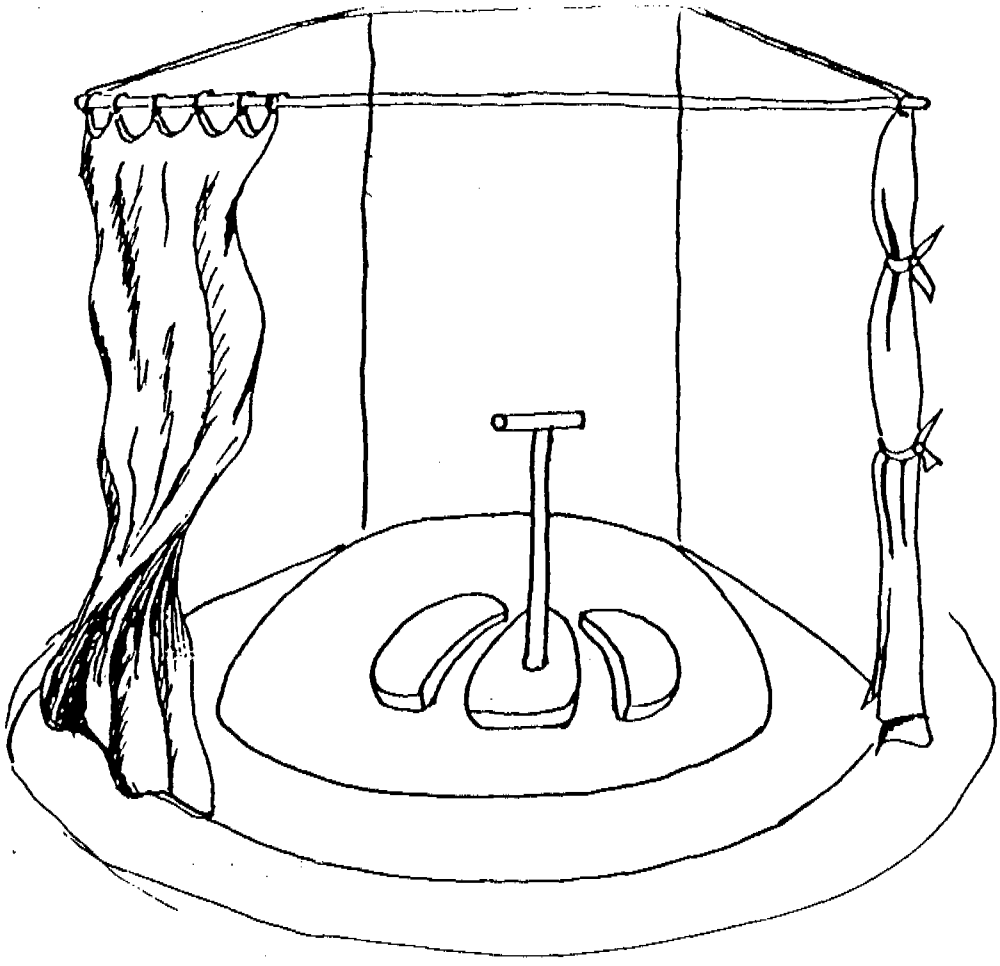

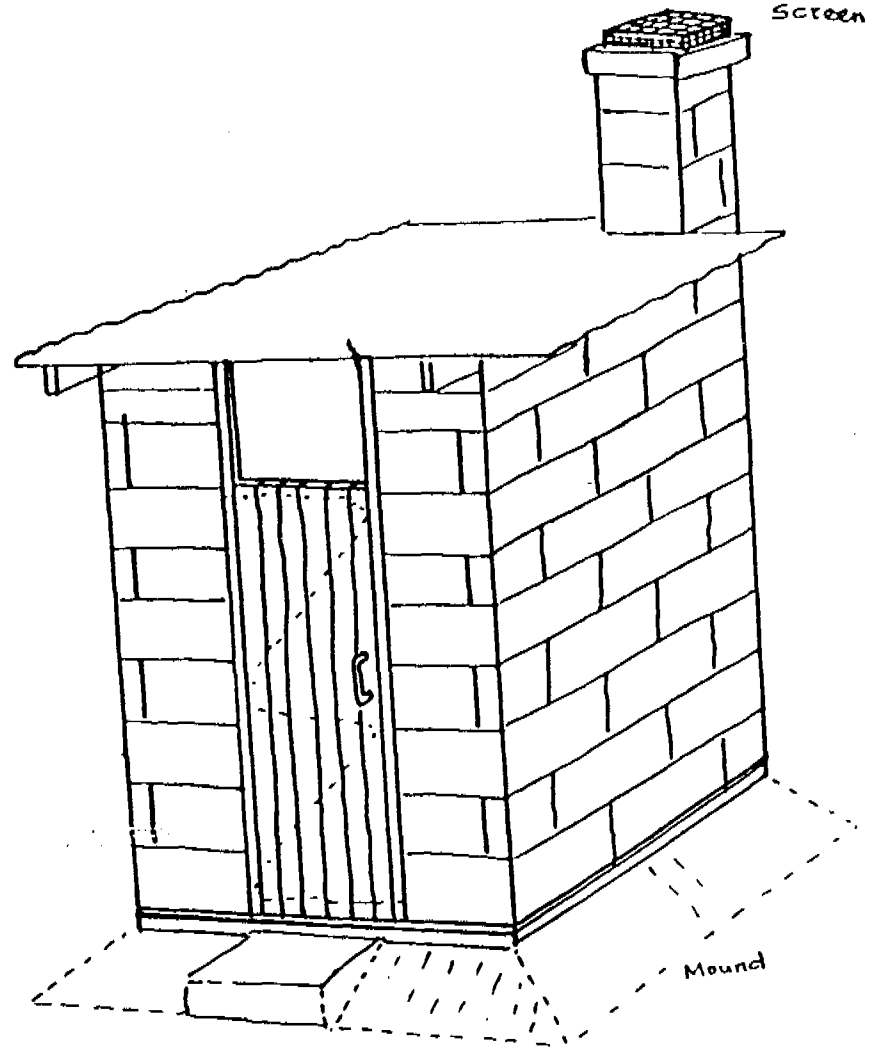
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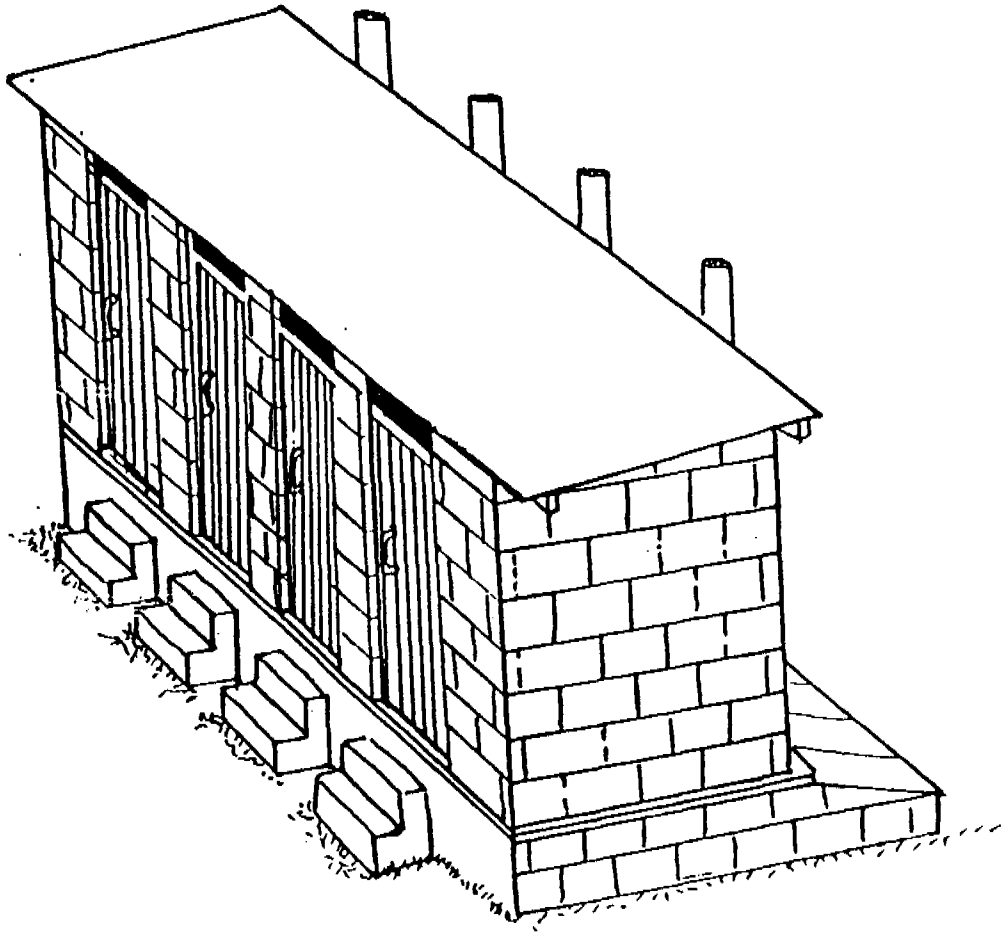

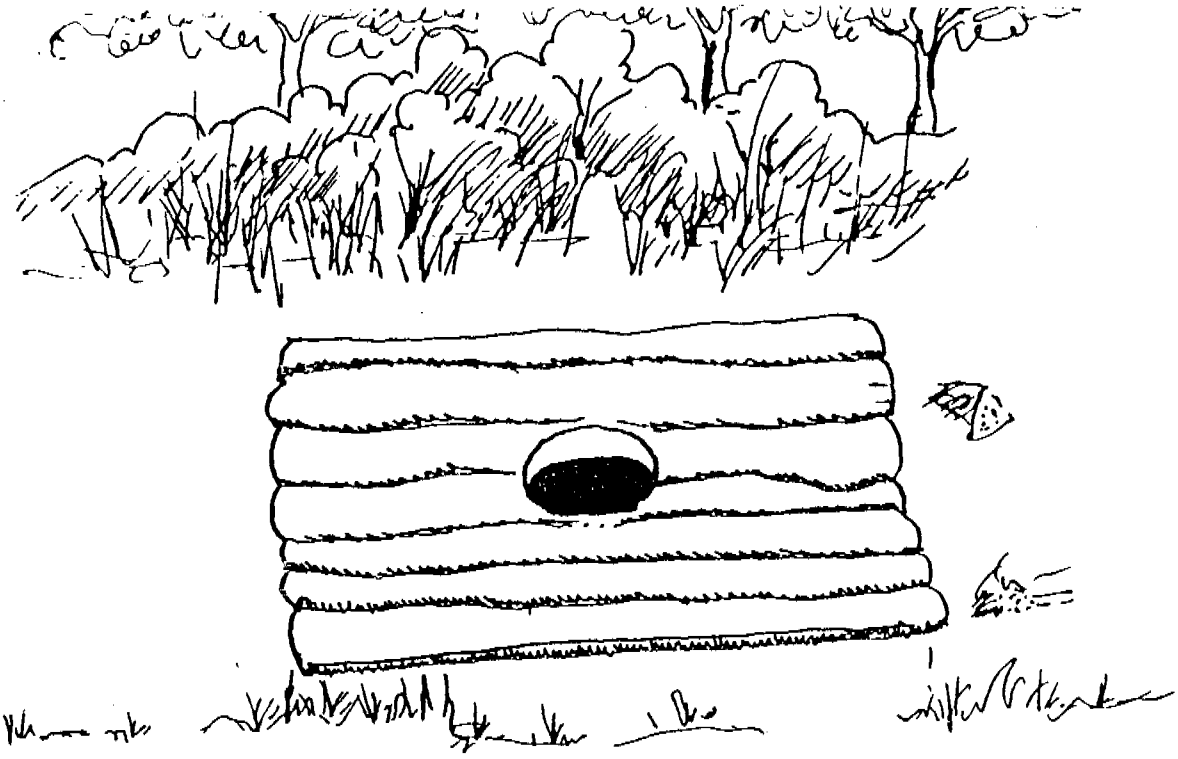

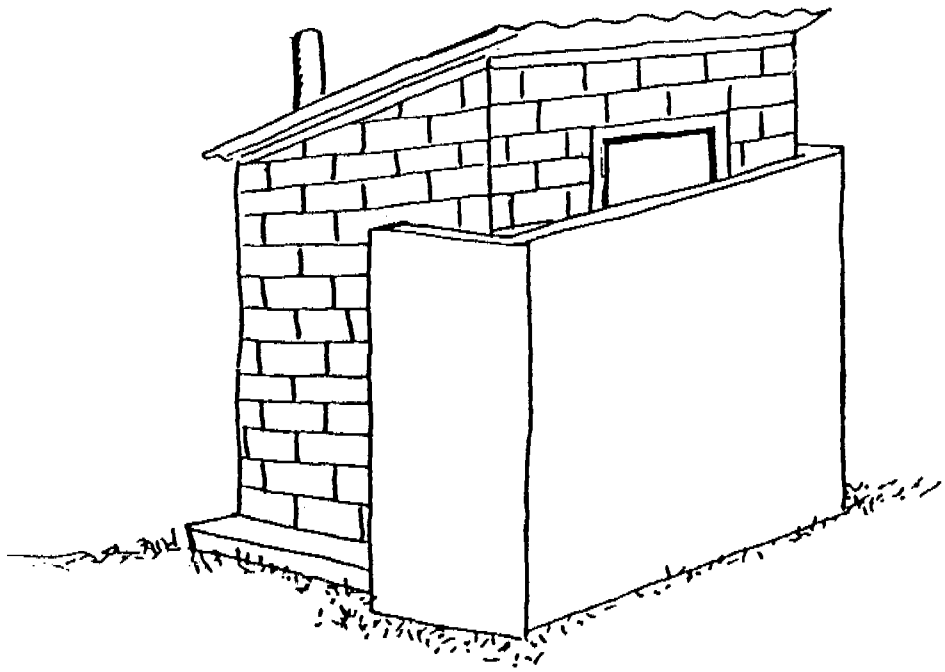

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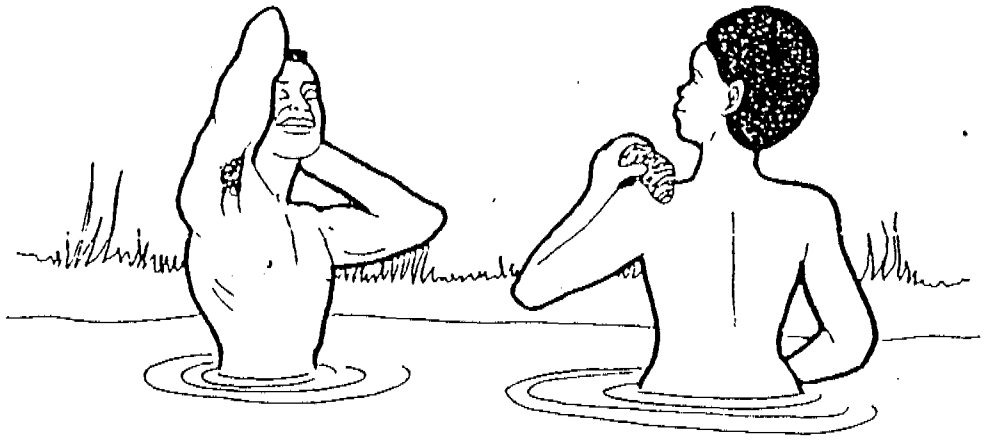

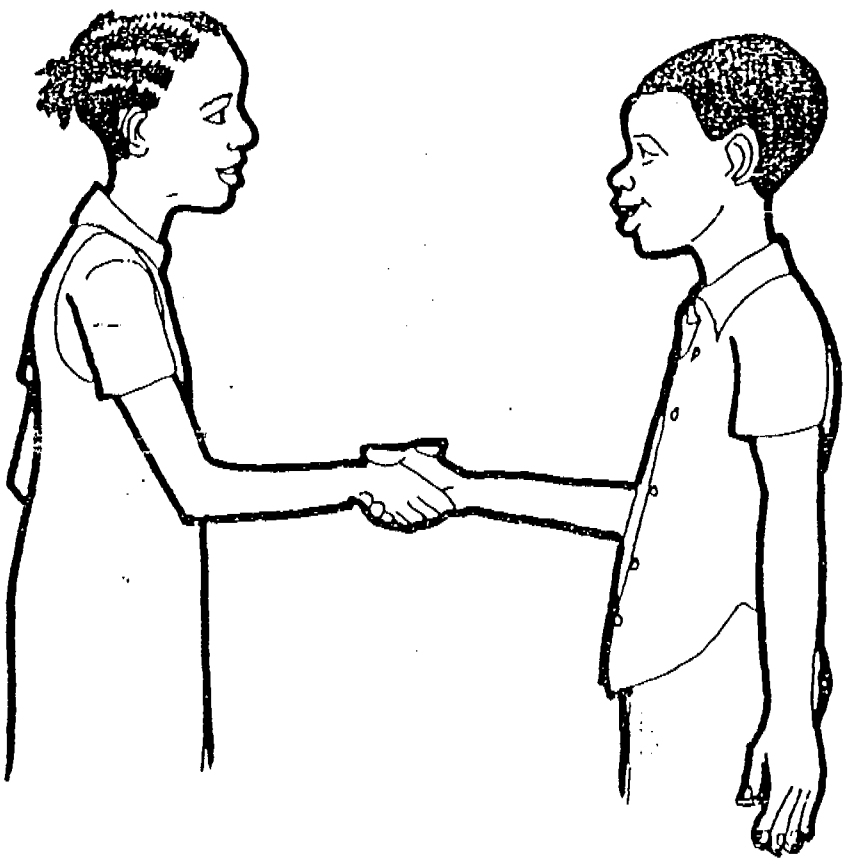

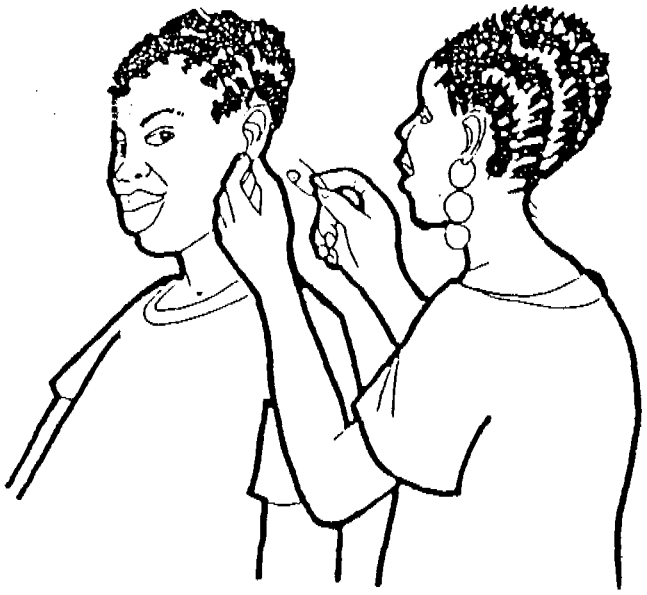

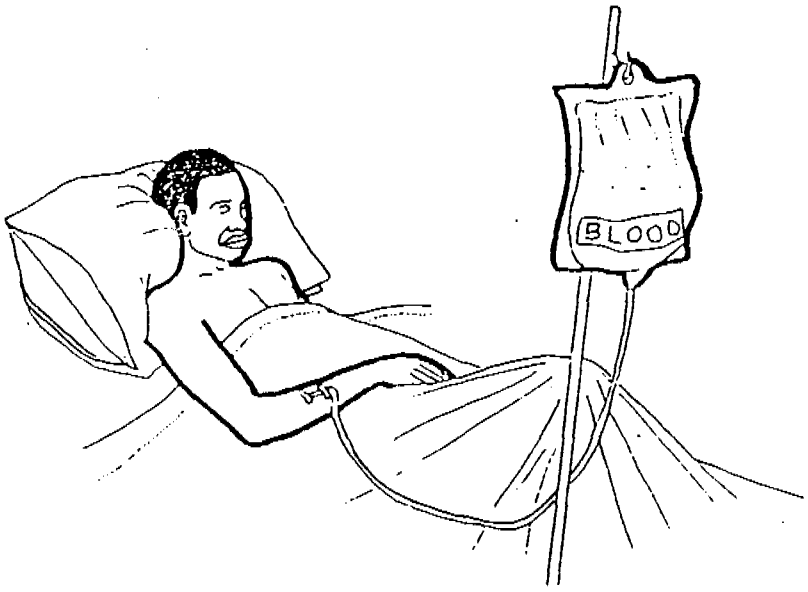
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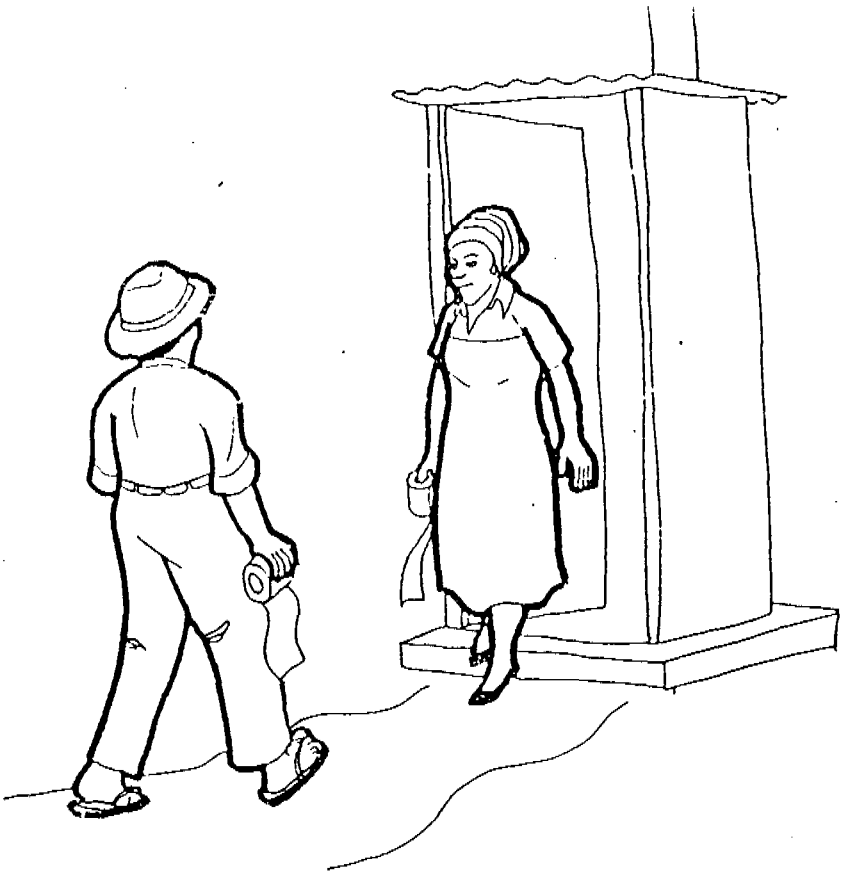

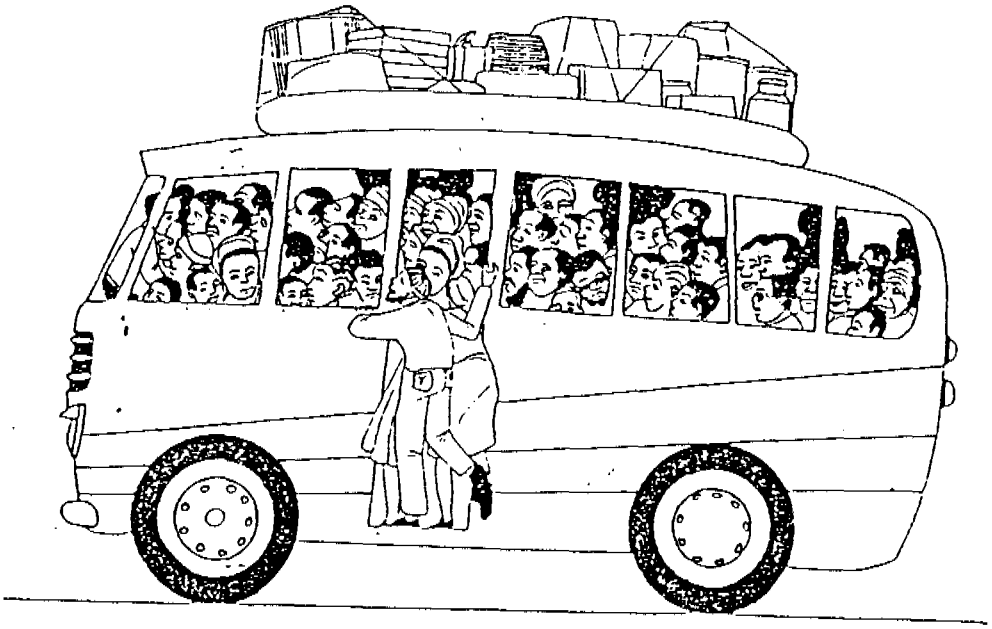

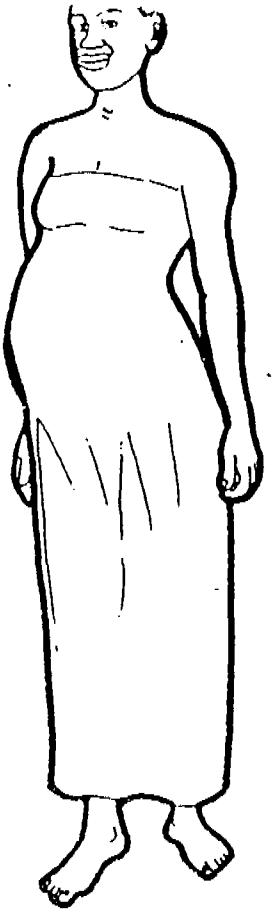

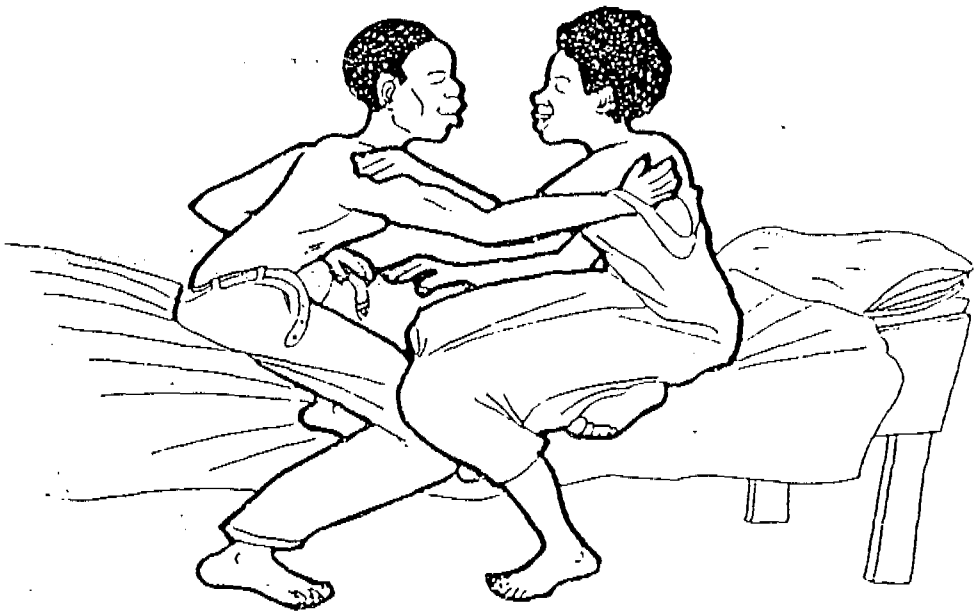

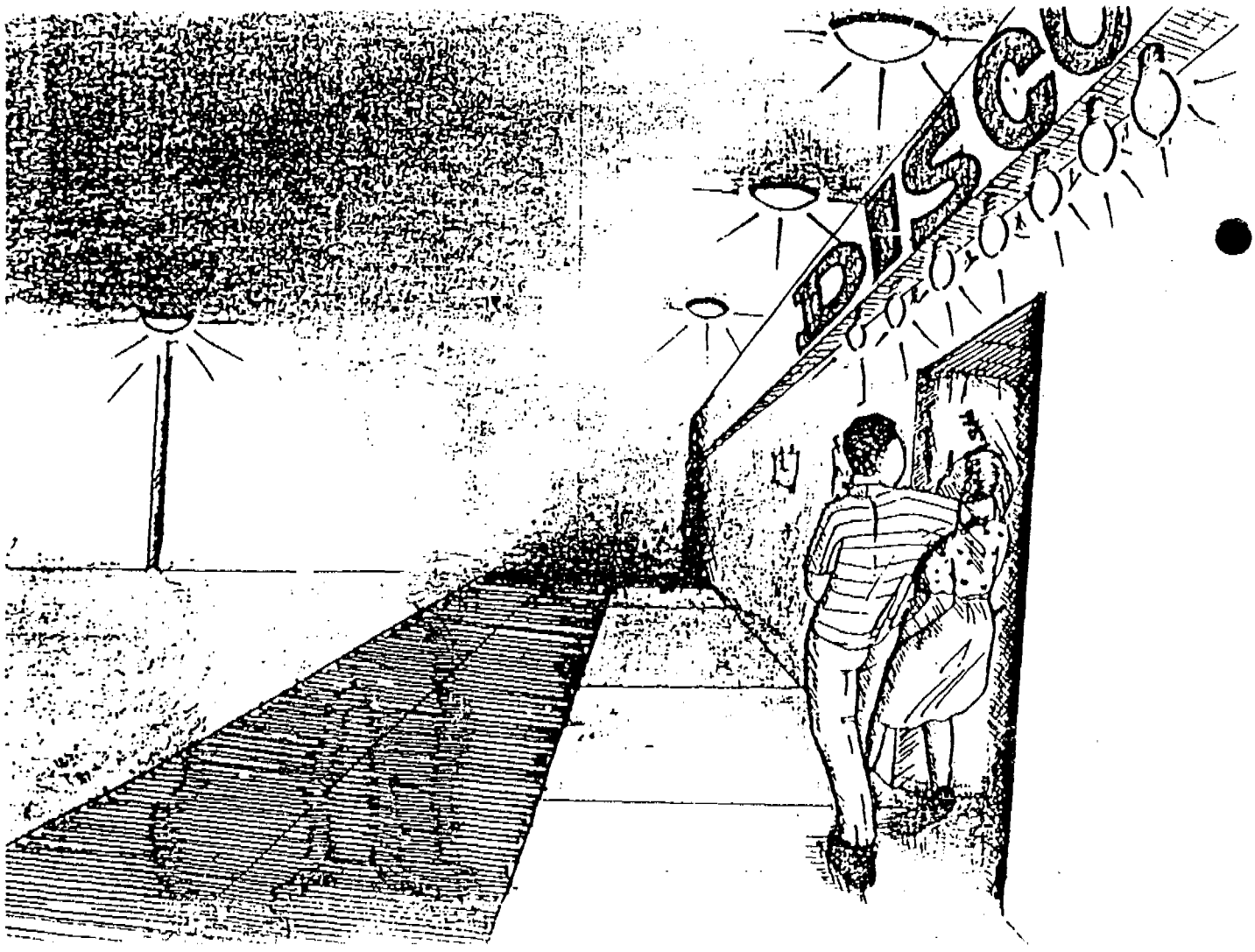
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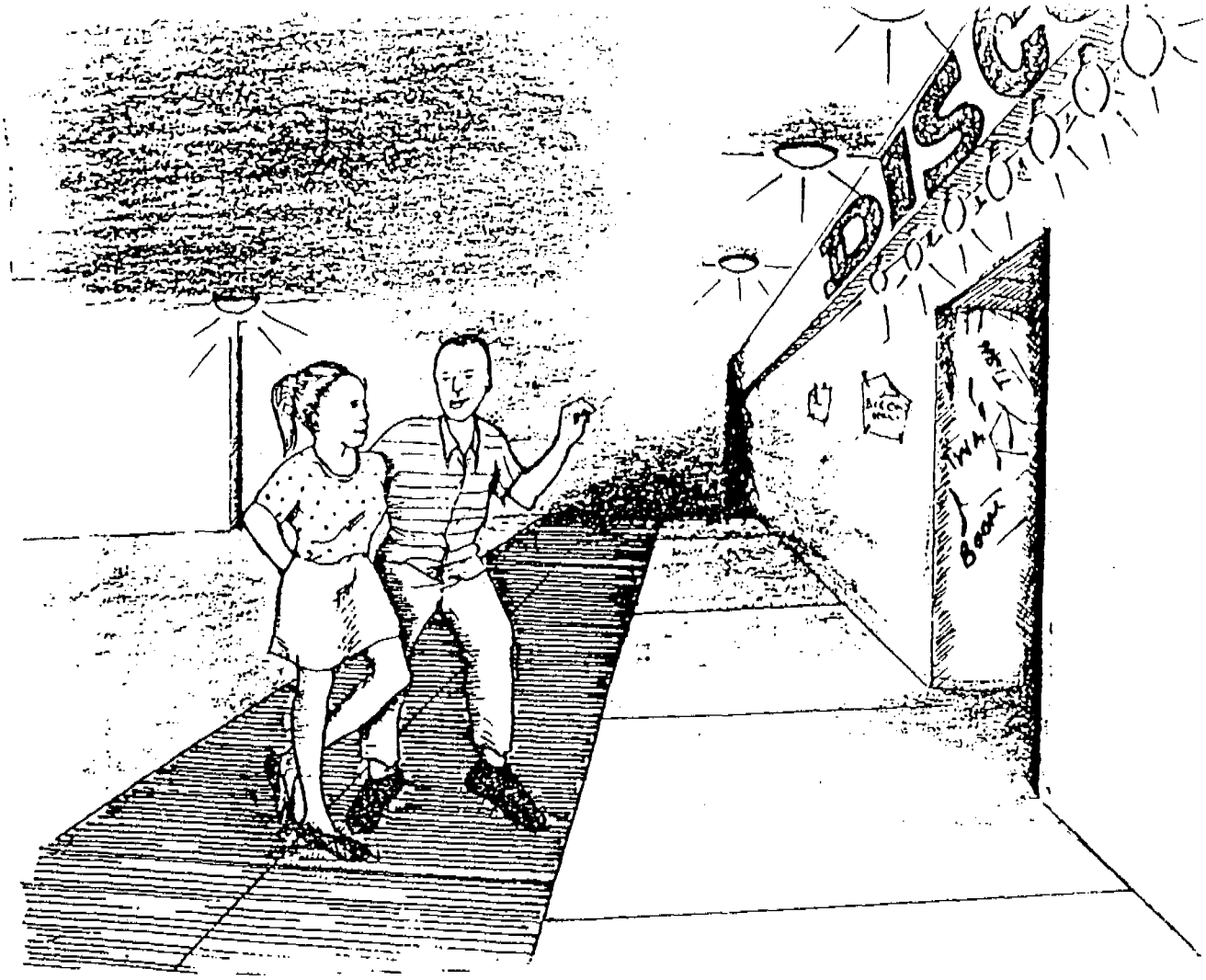
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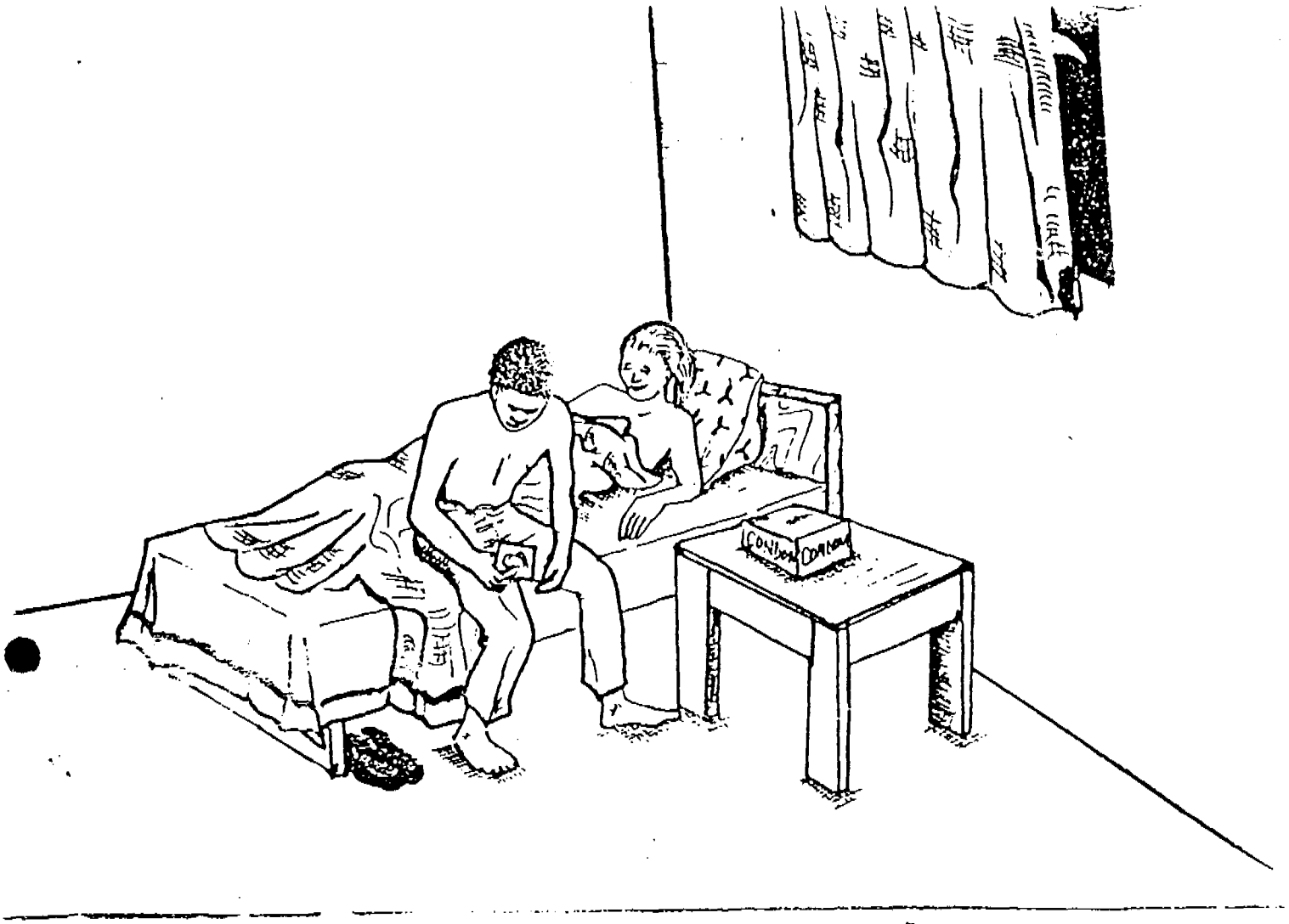
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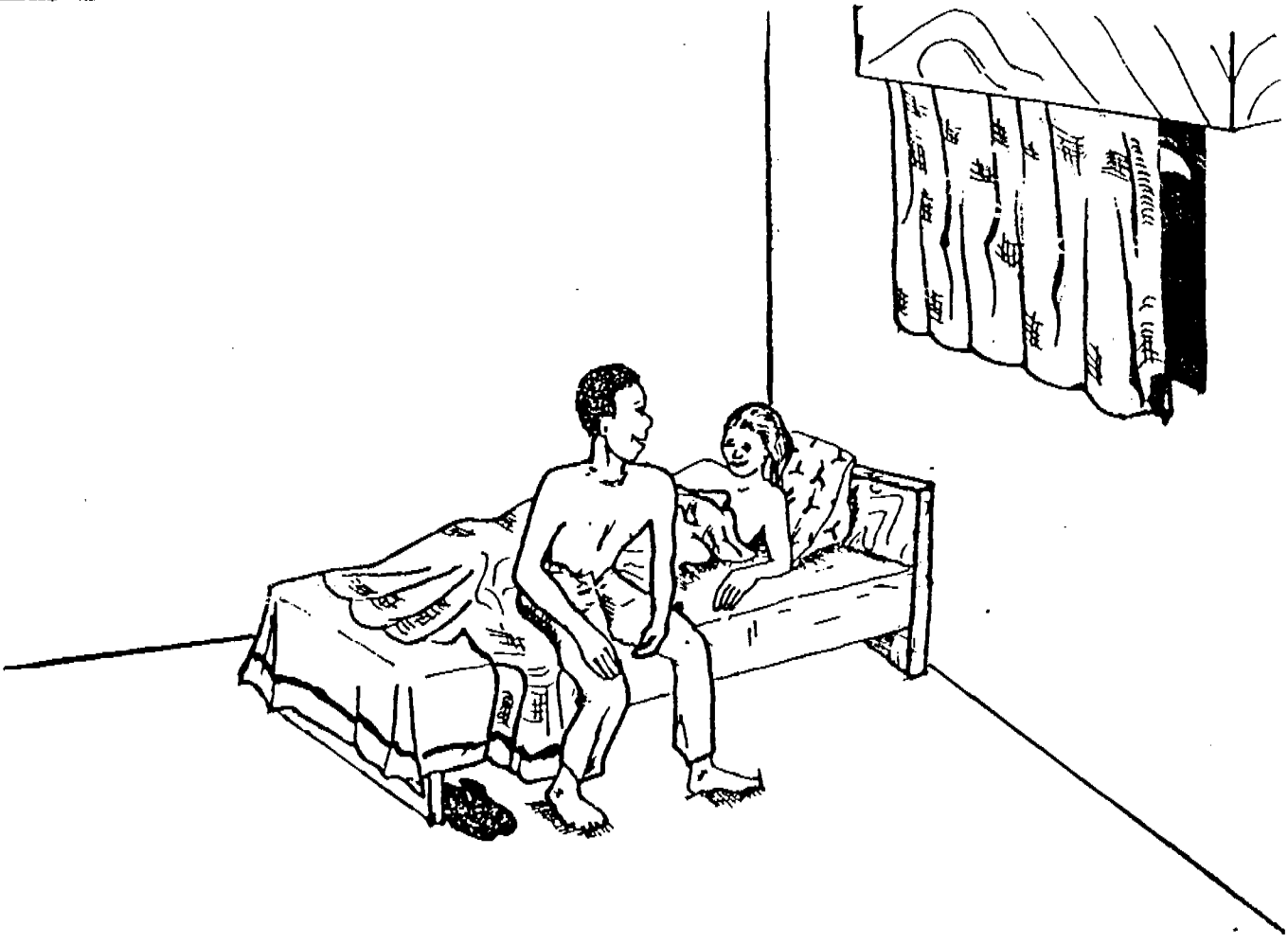


SEX?

DR AKILI SANA


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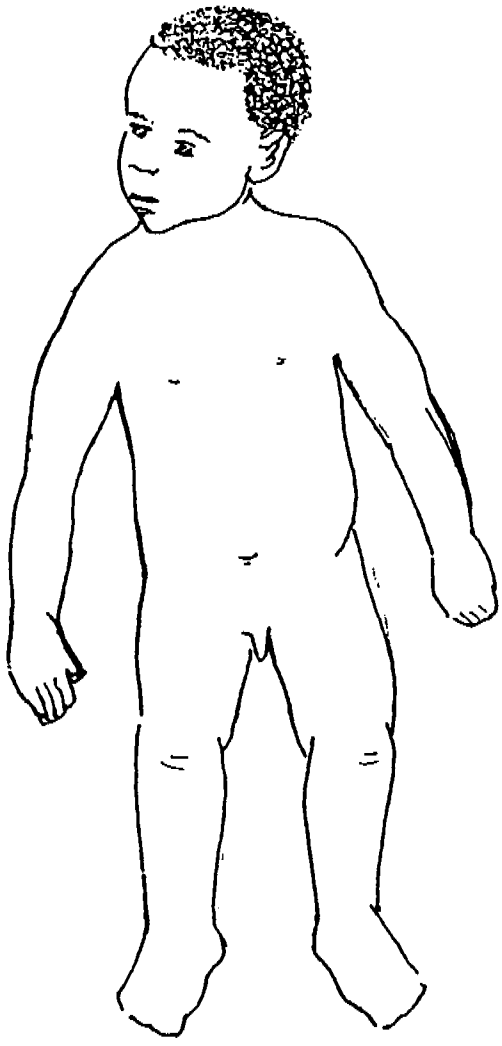

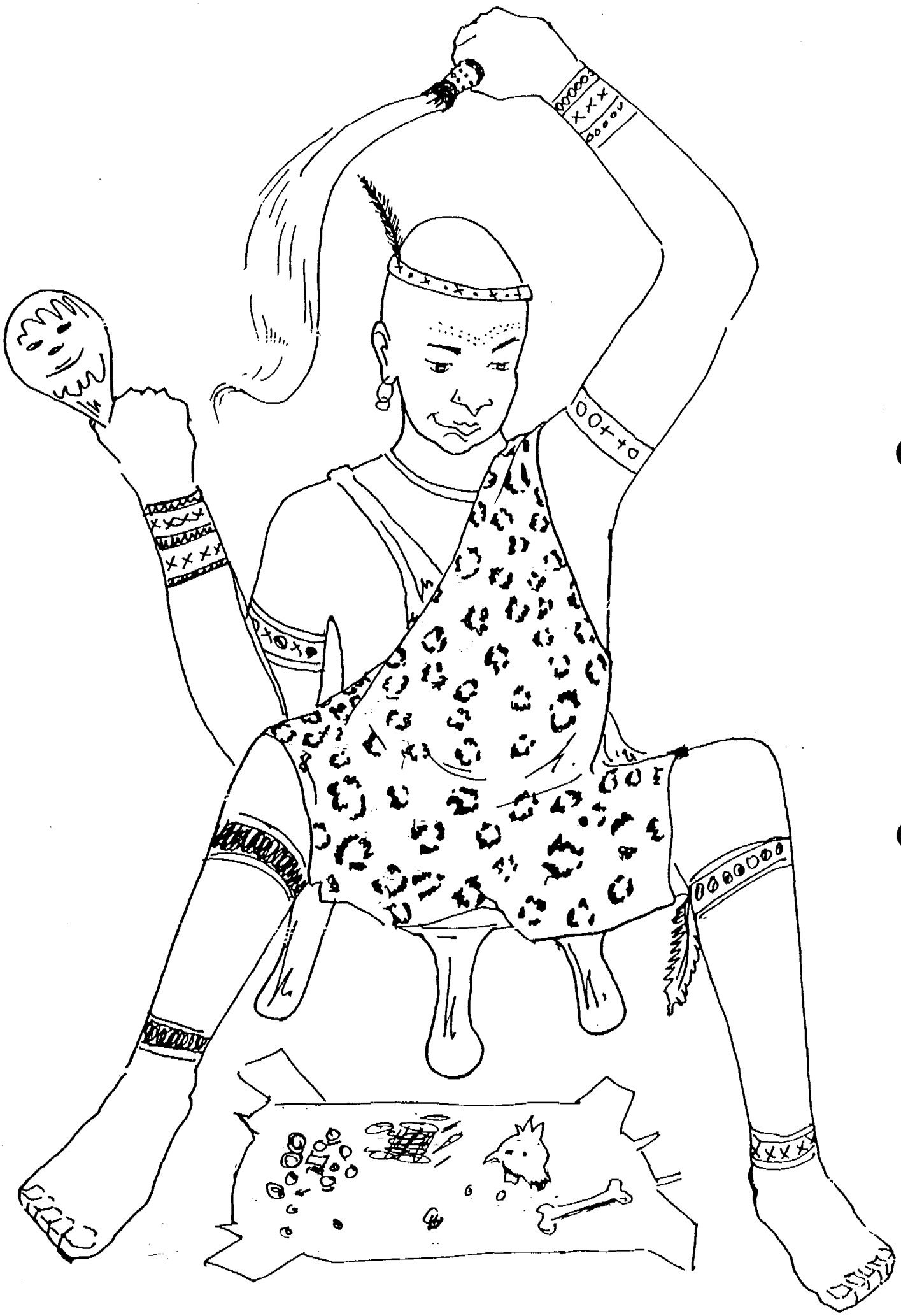

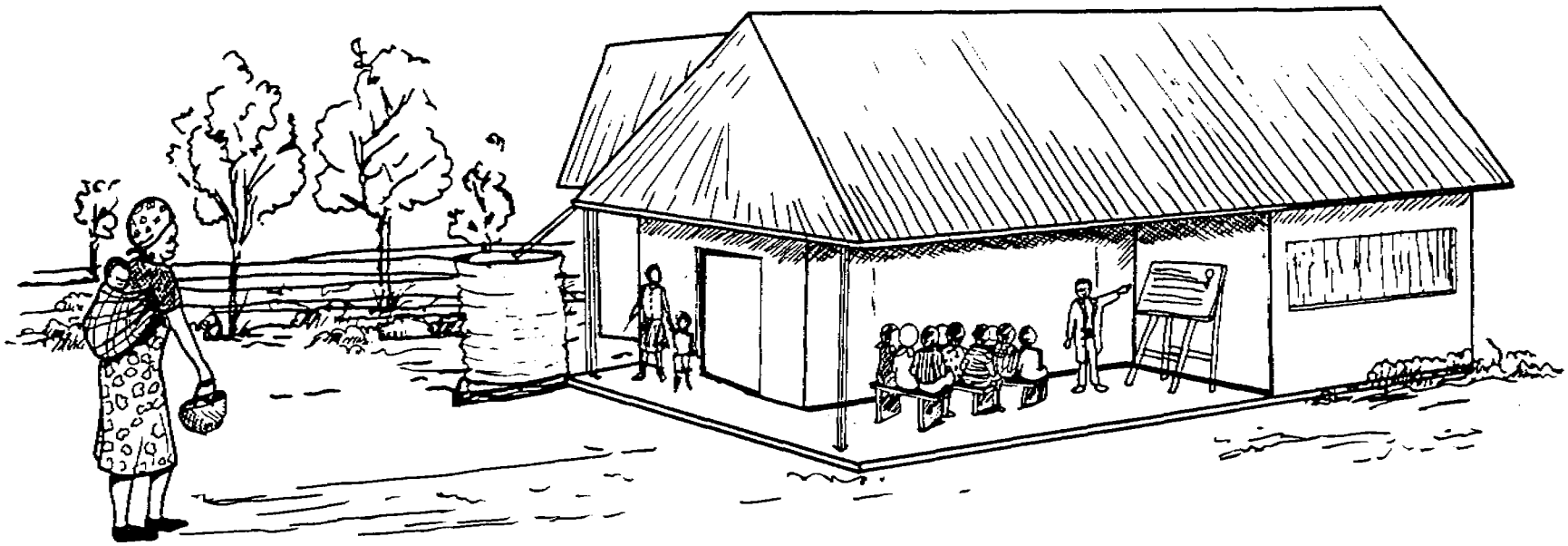

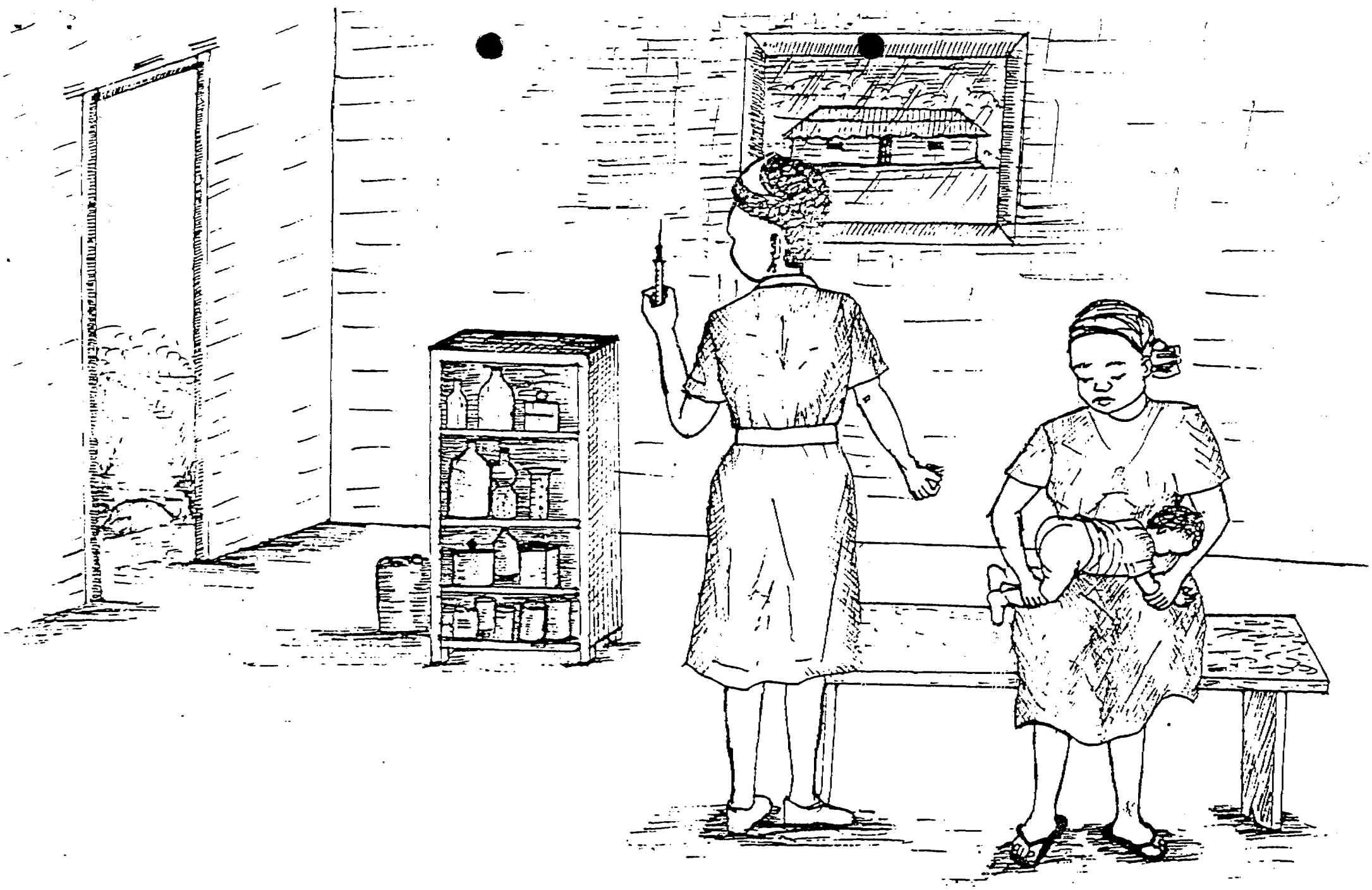

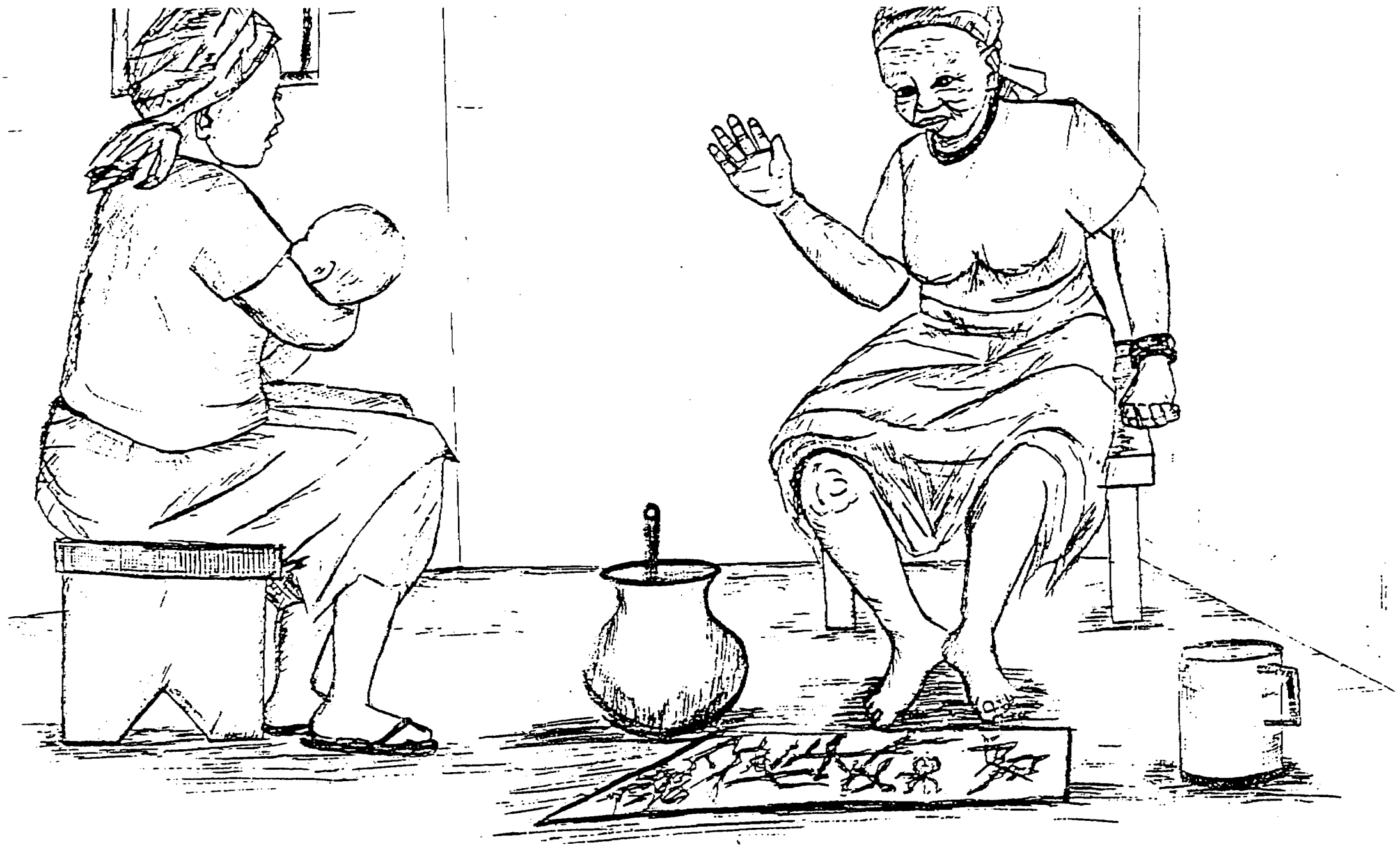

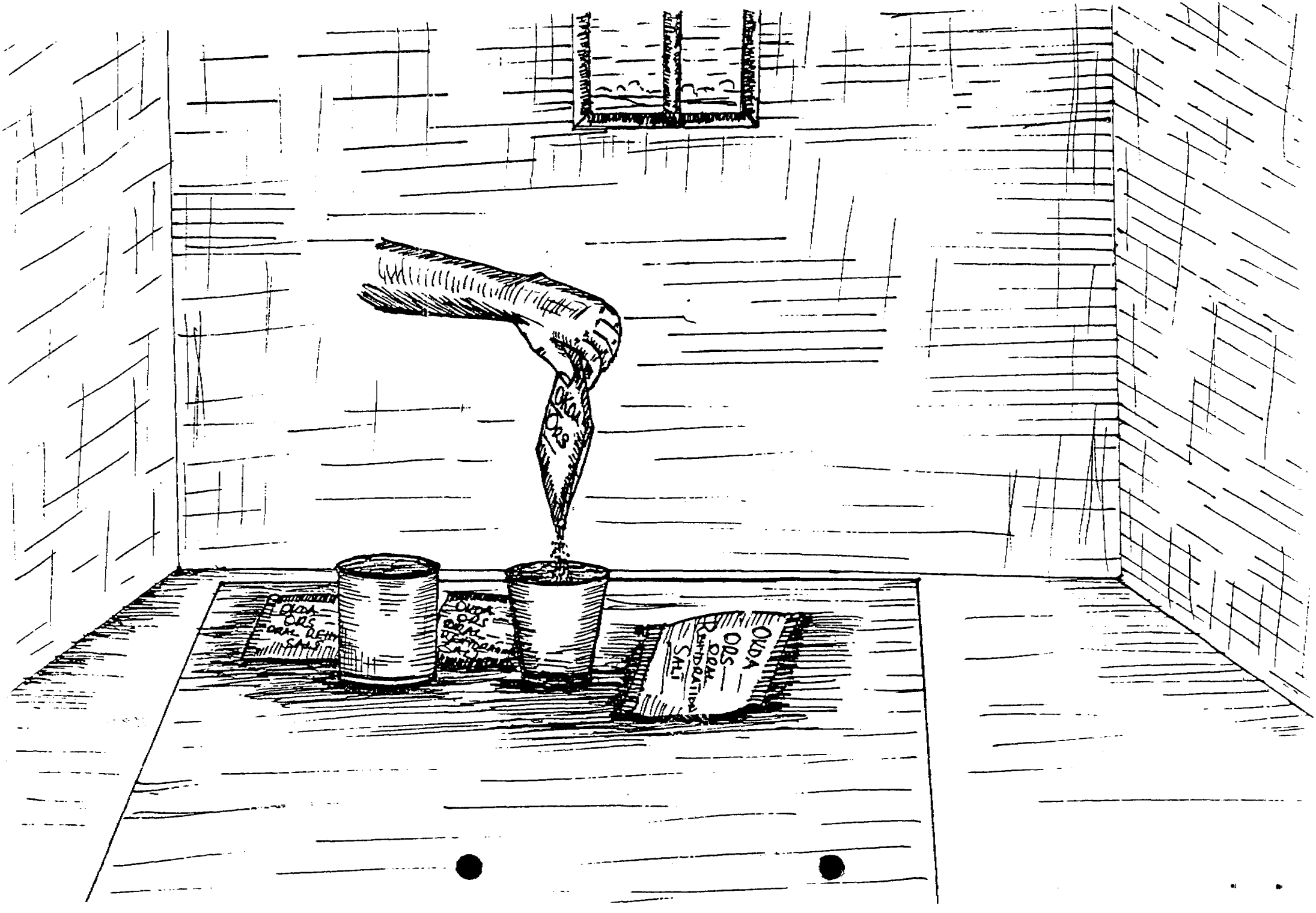
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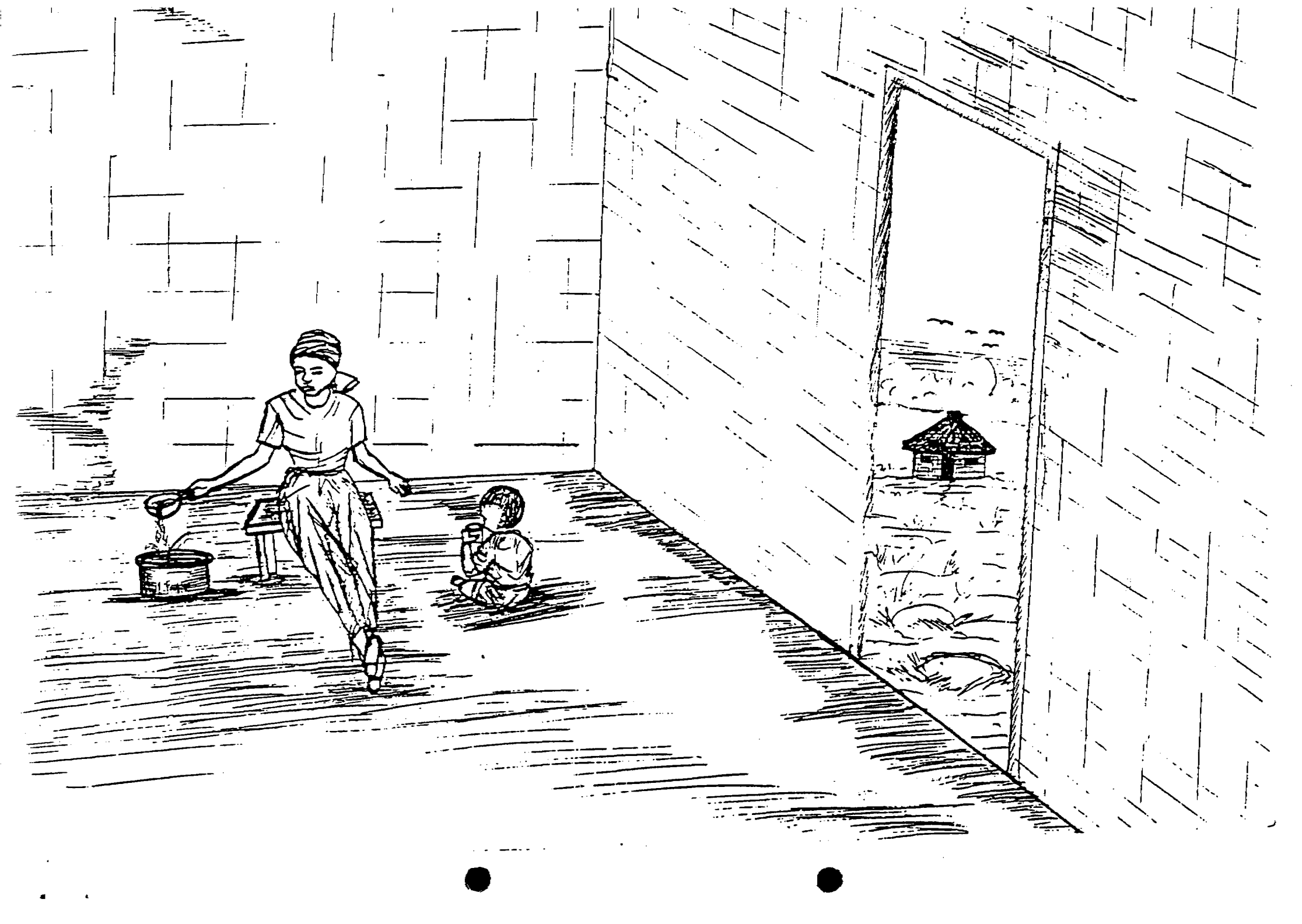

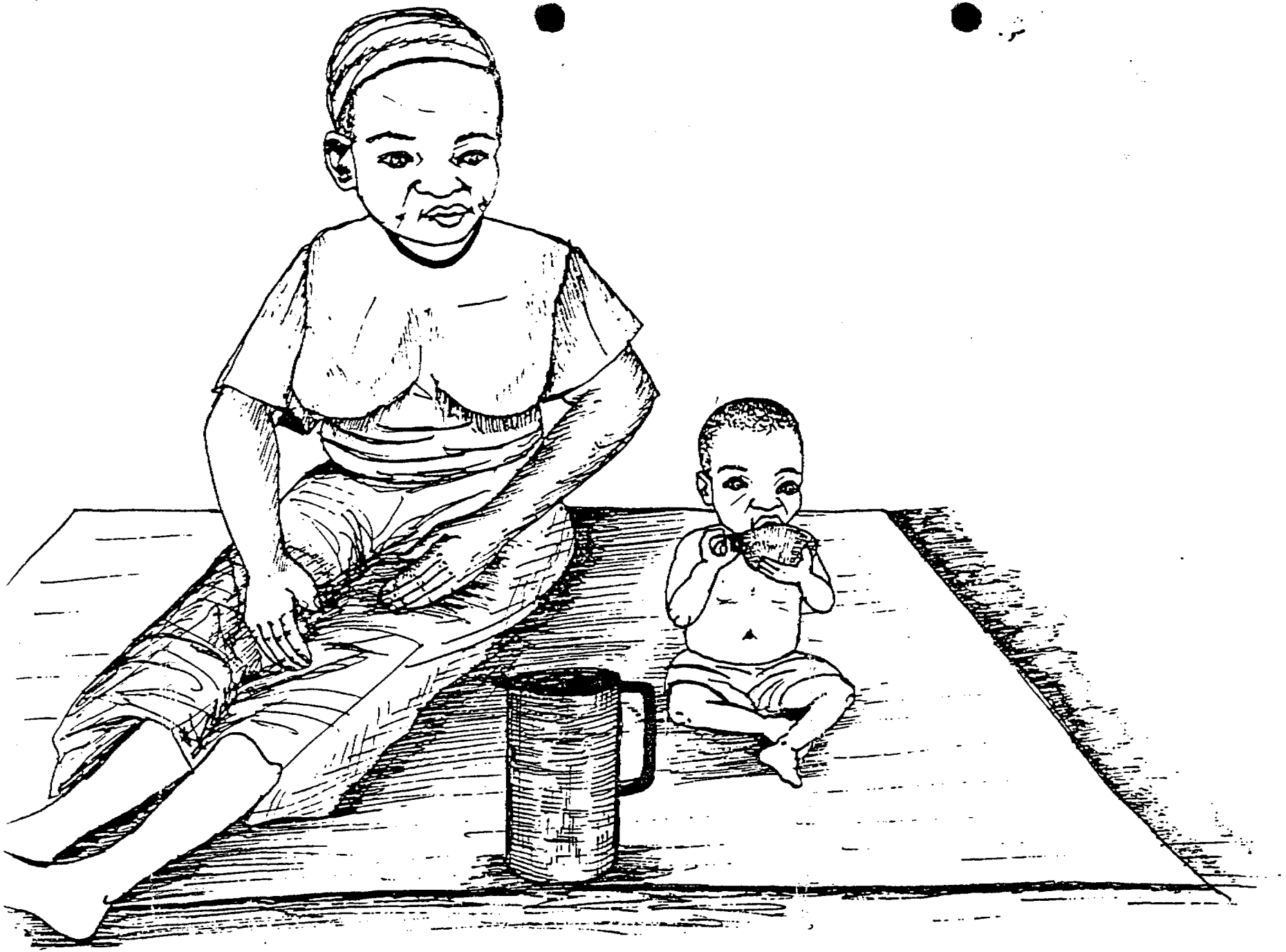

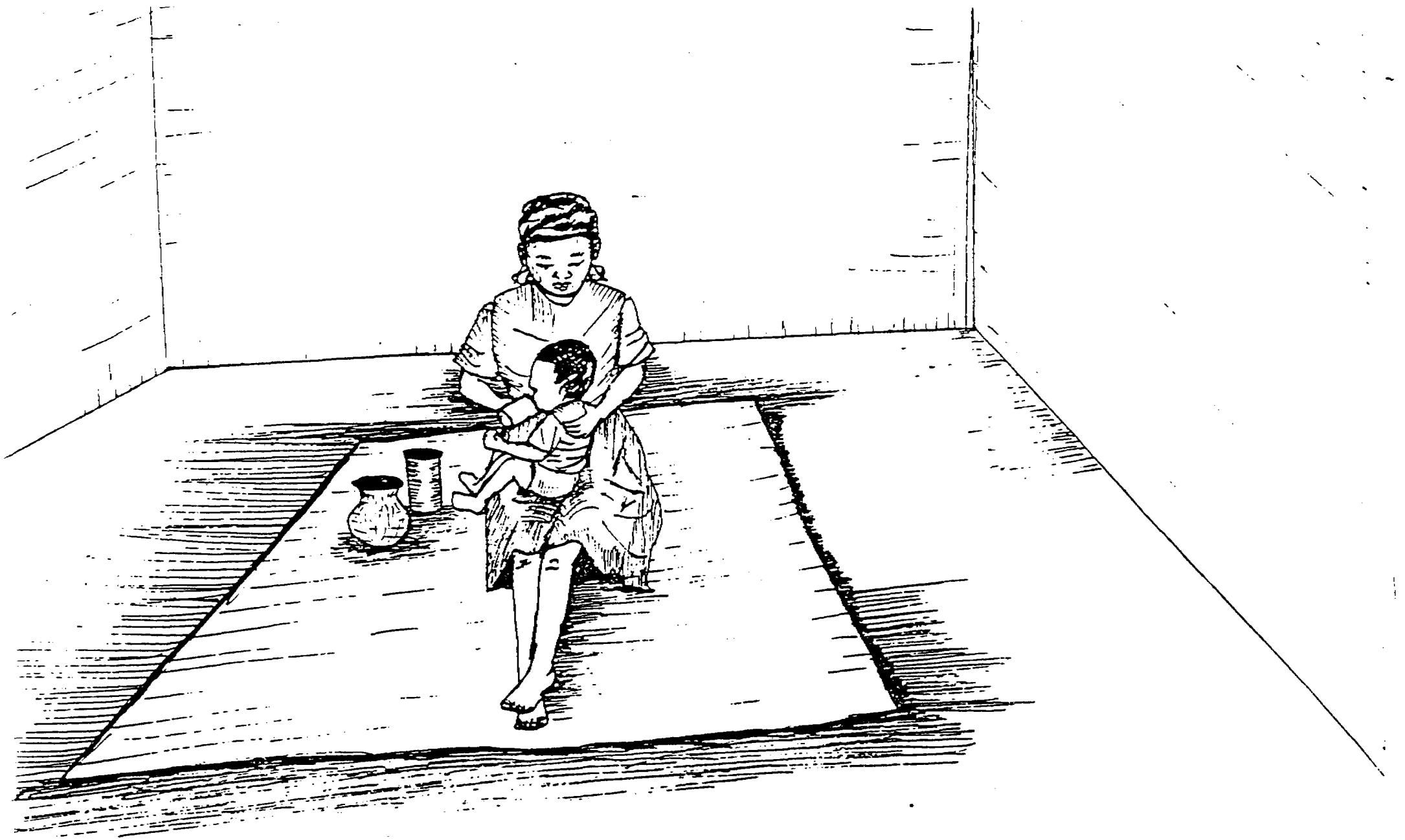

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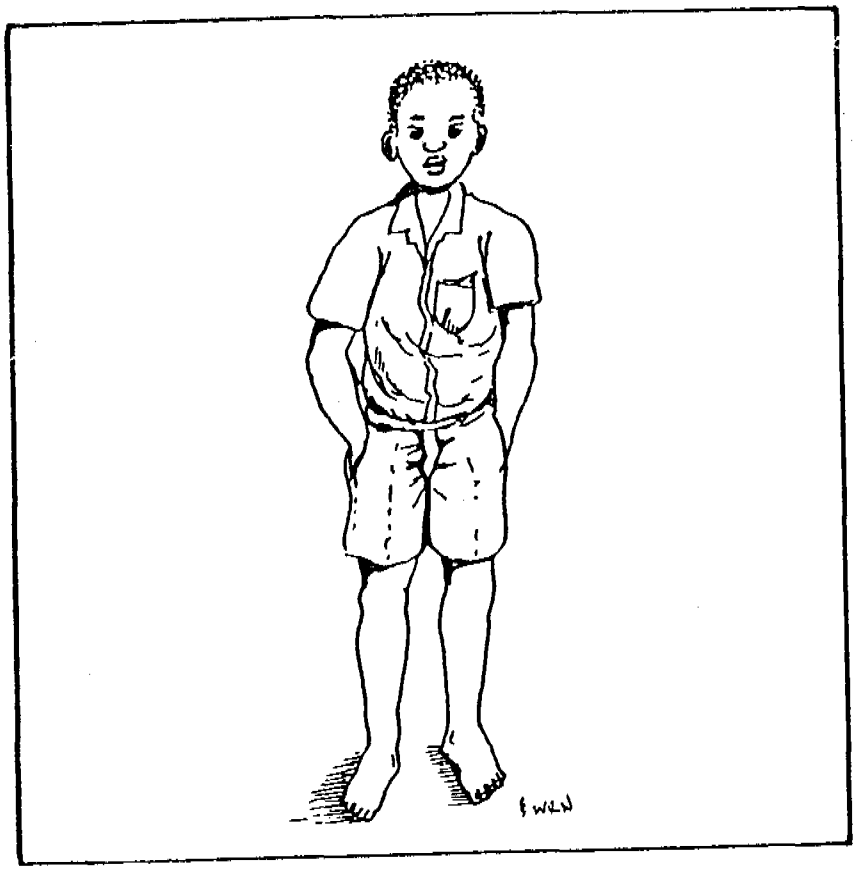

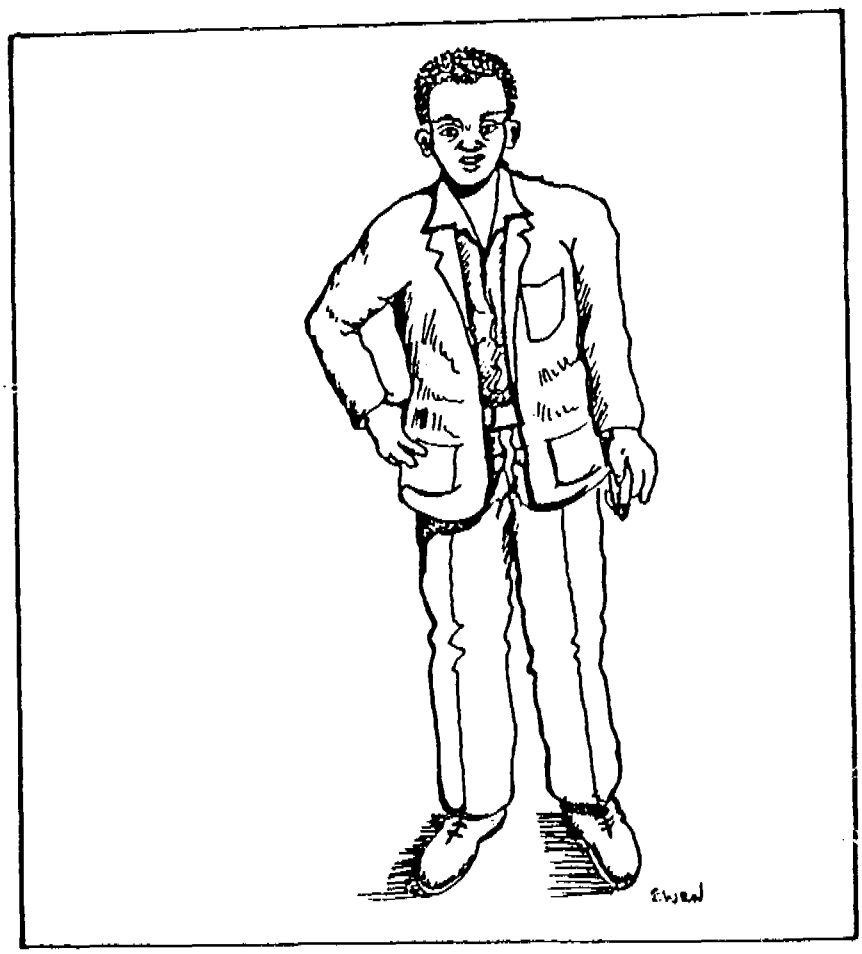

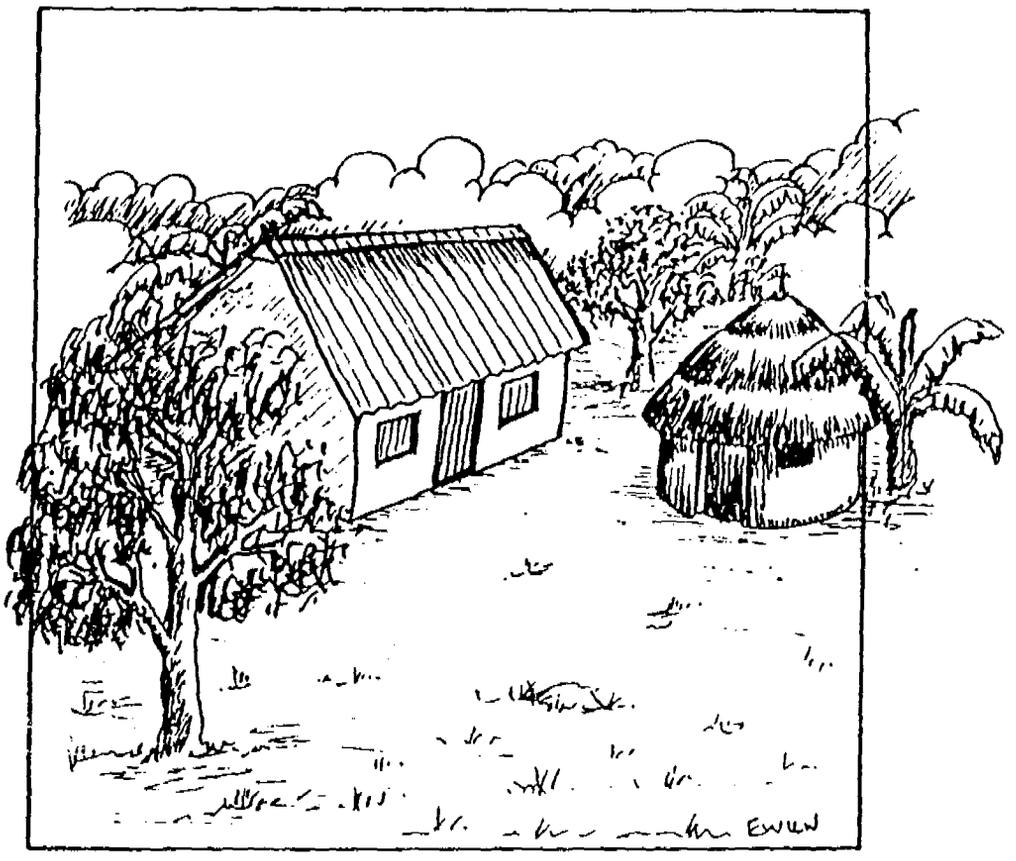

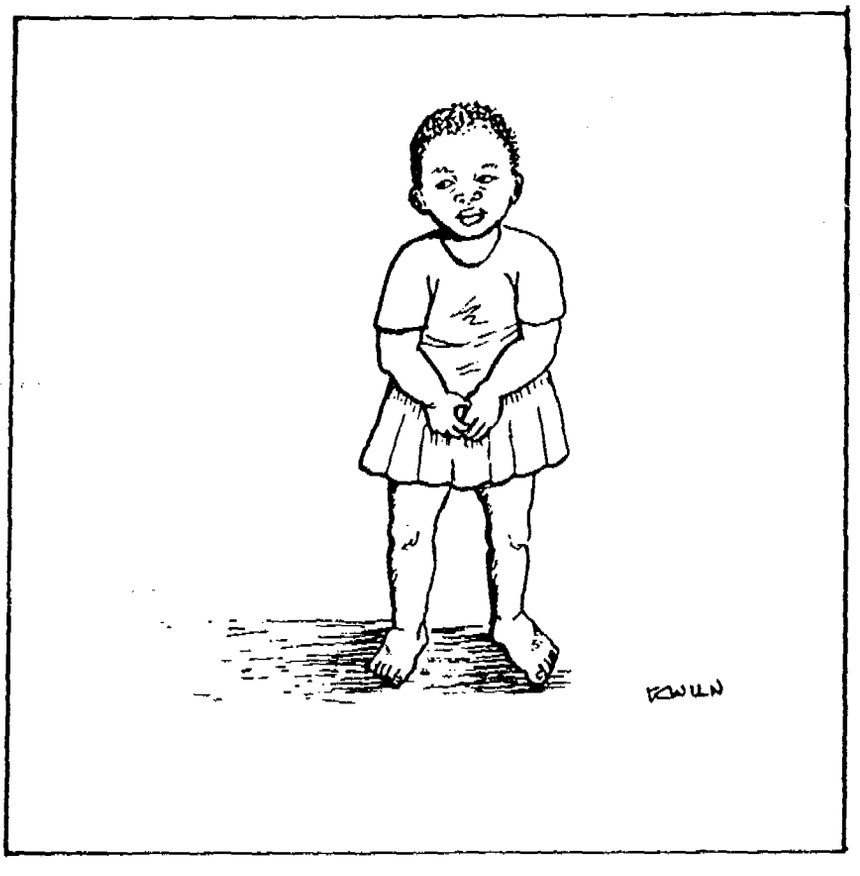

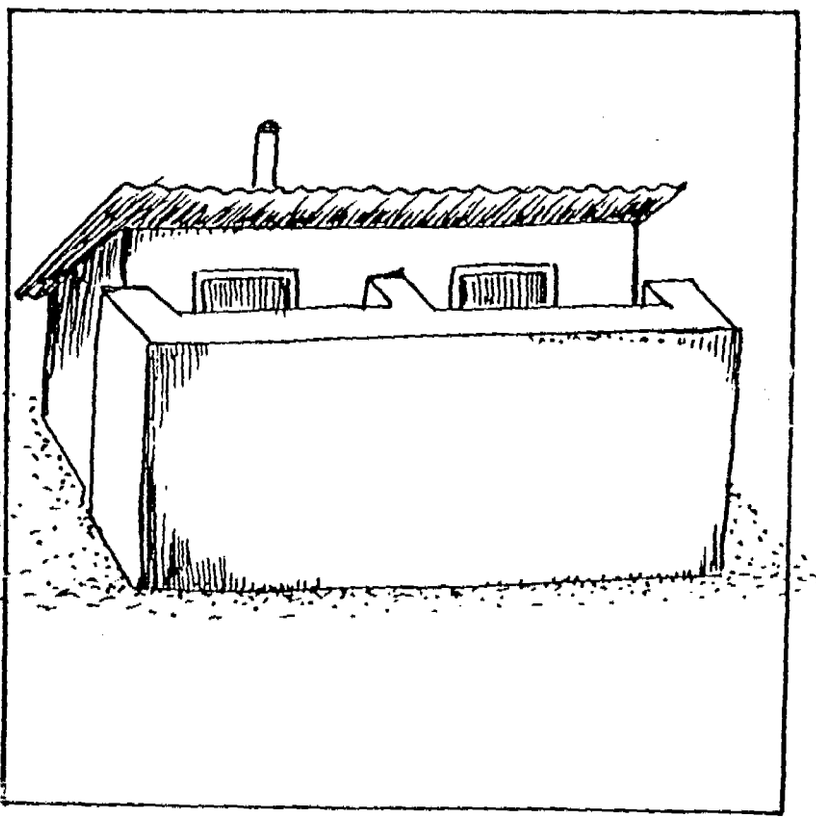

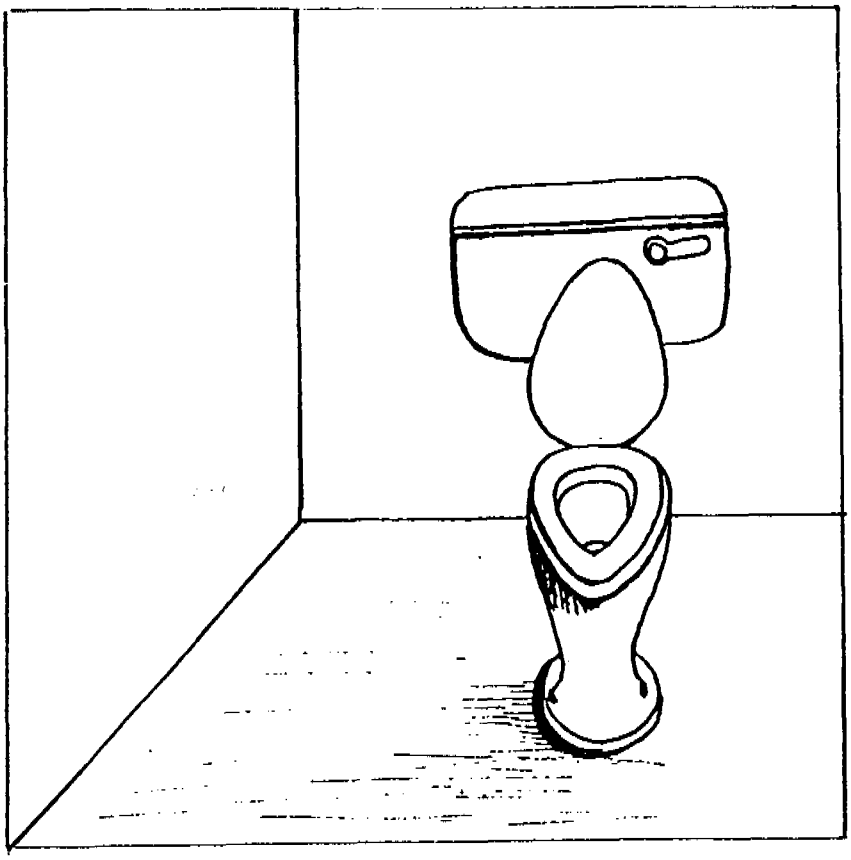

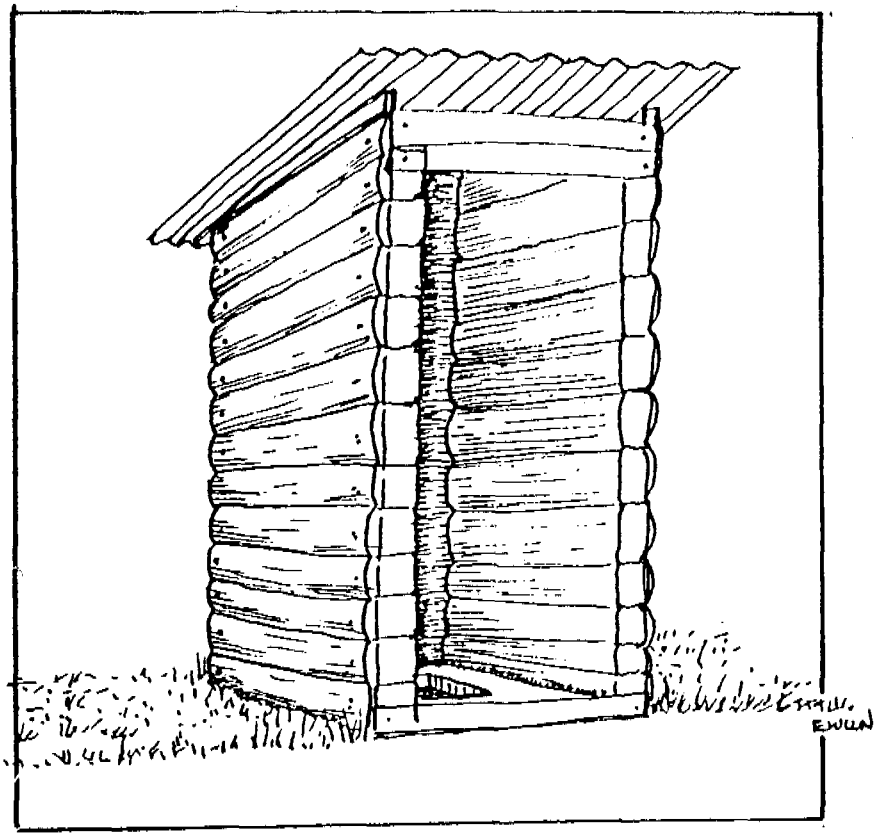

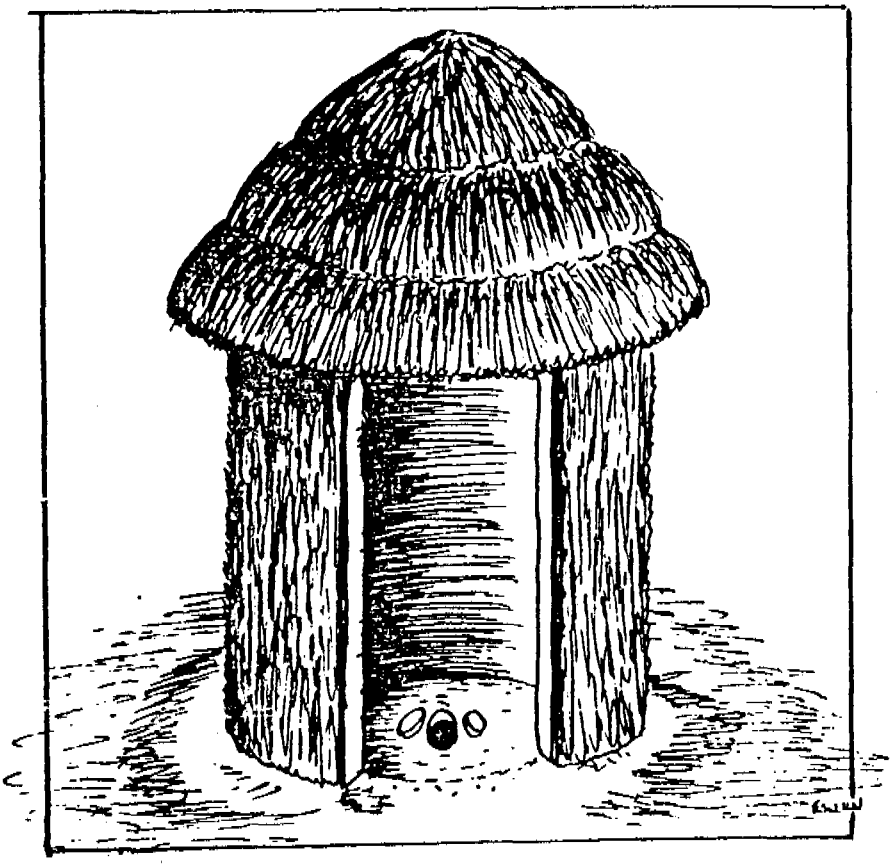

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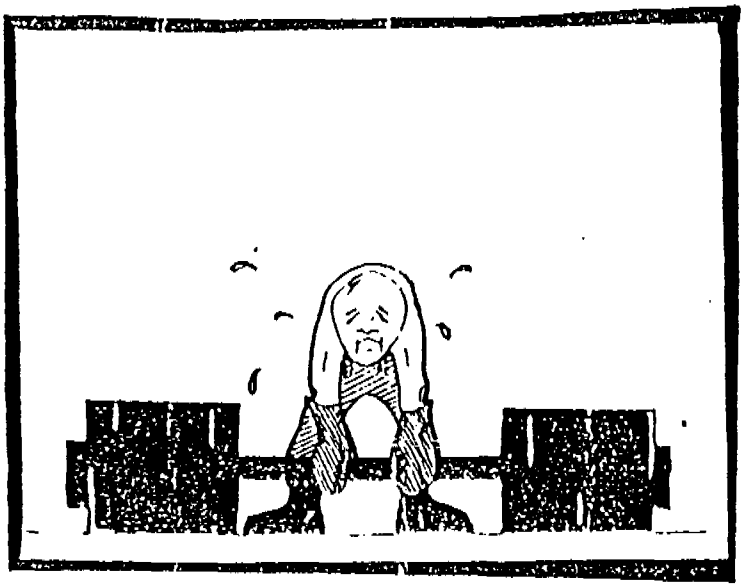

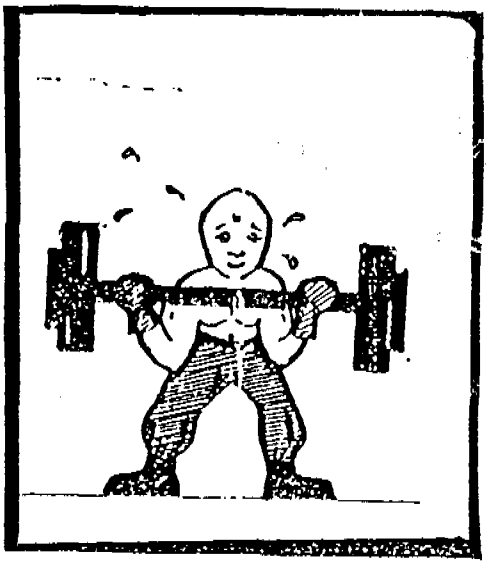

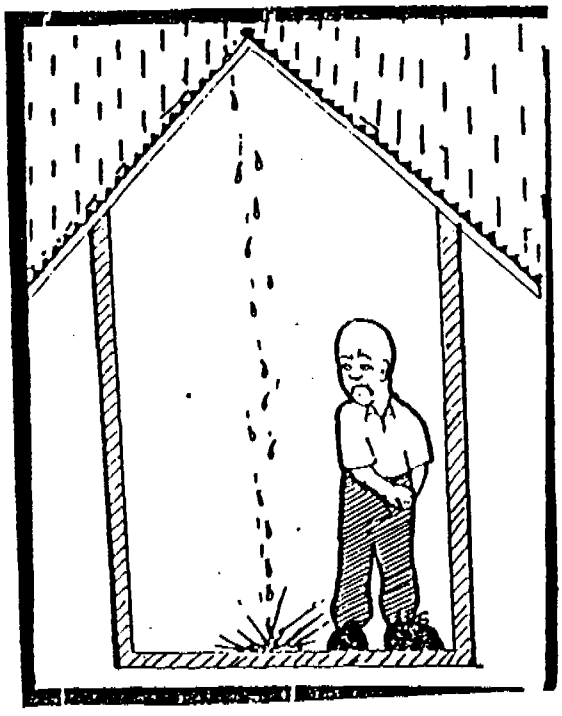

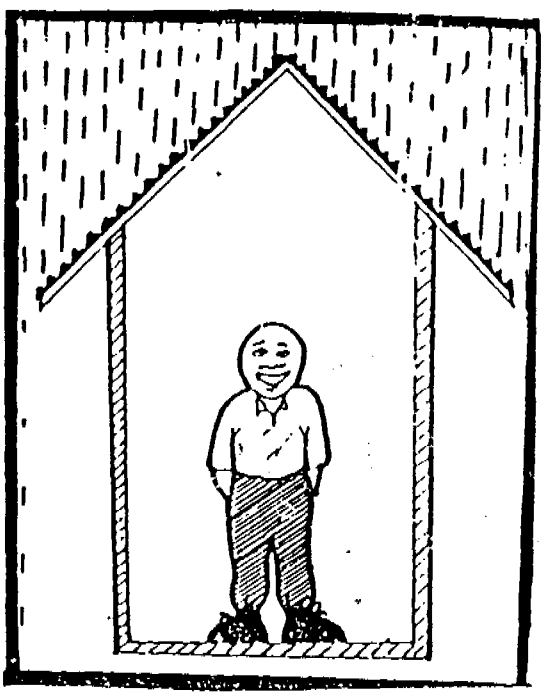

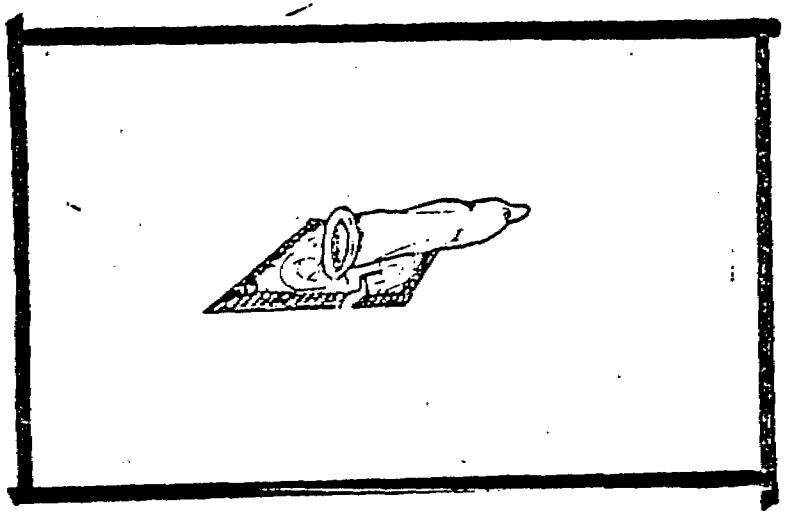

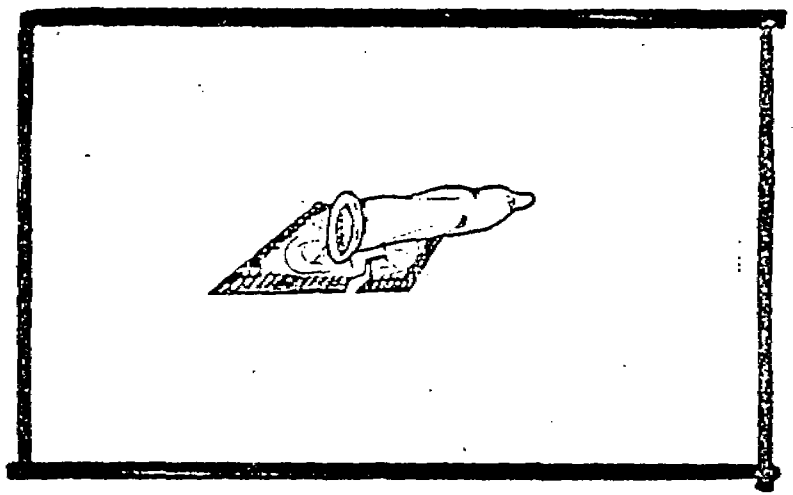

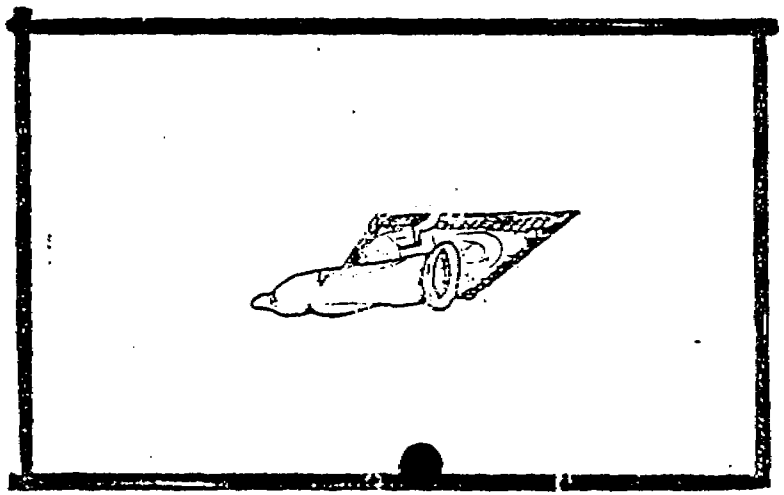

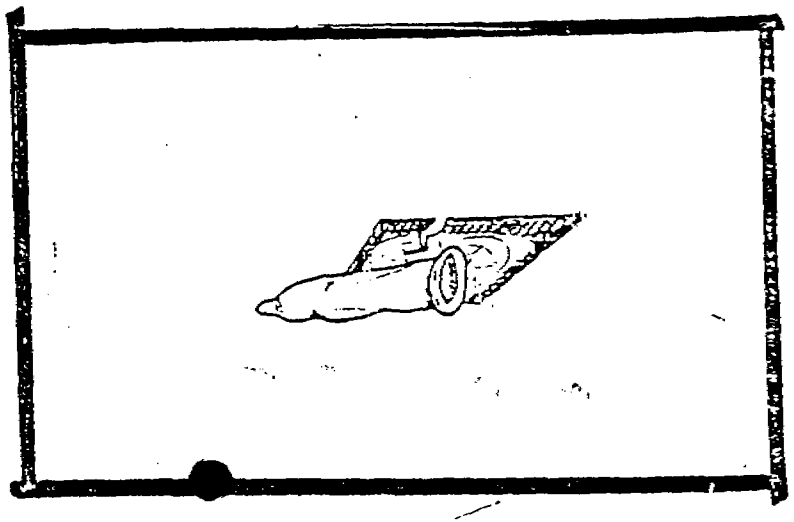

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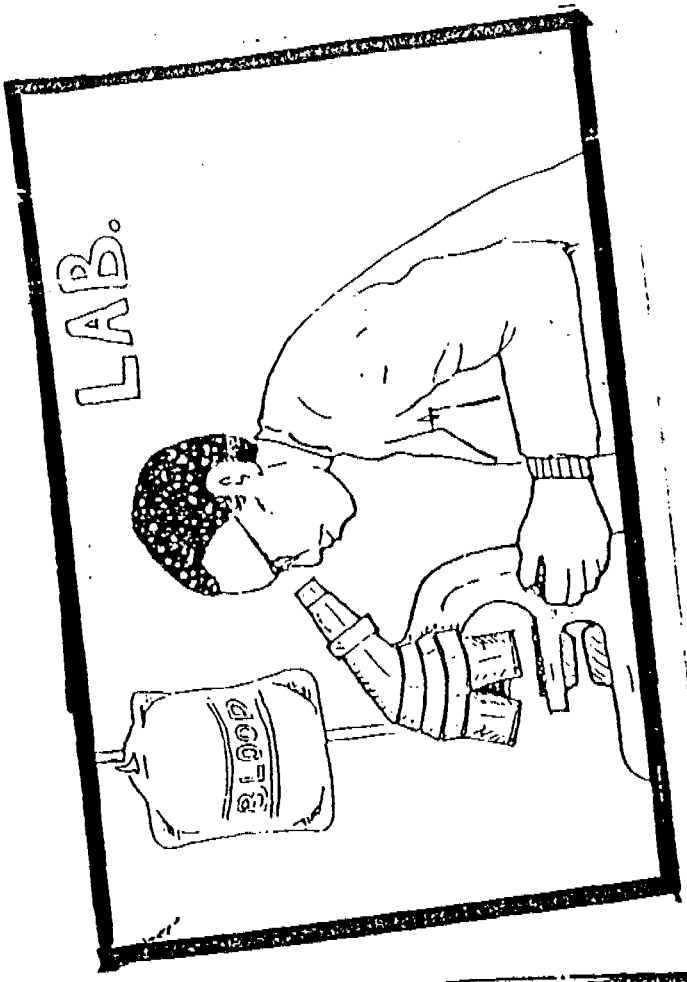
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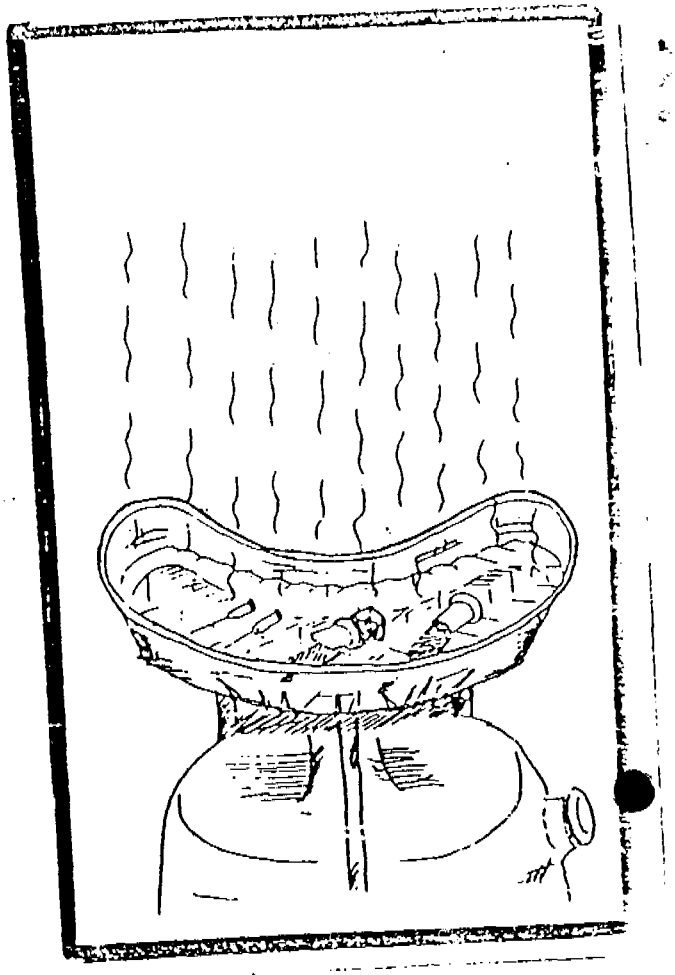
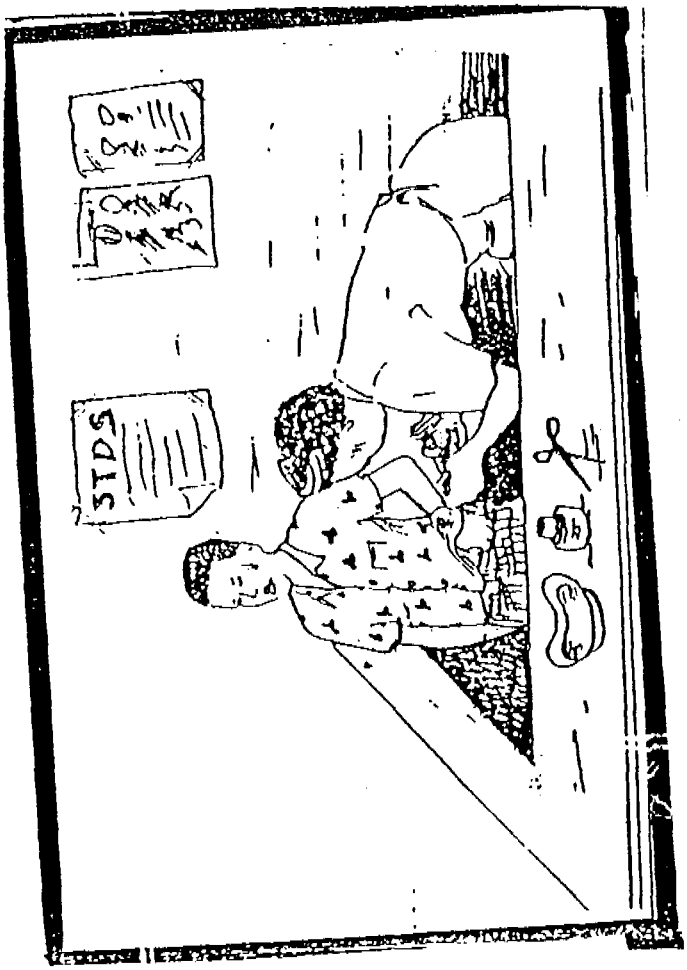
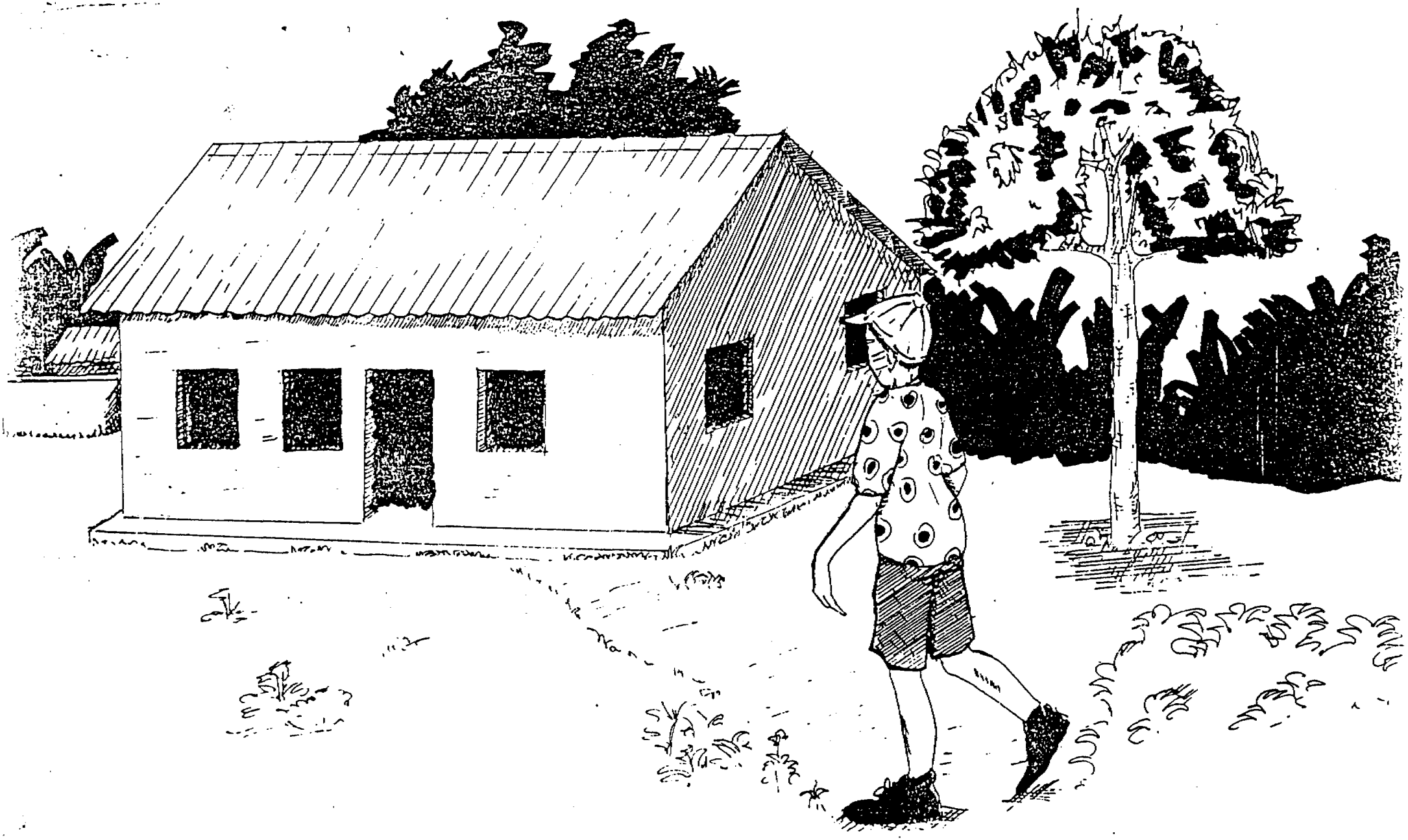
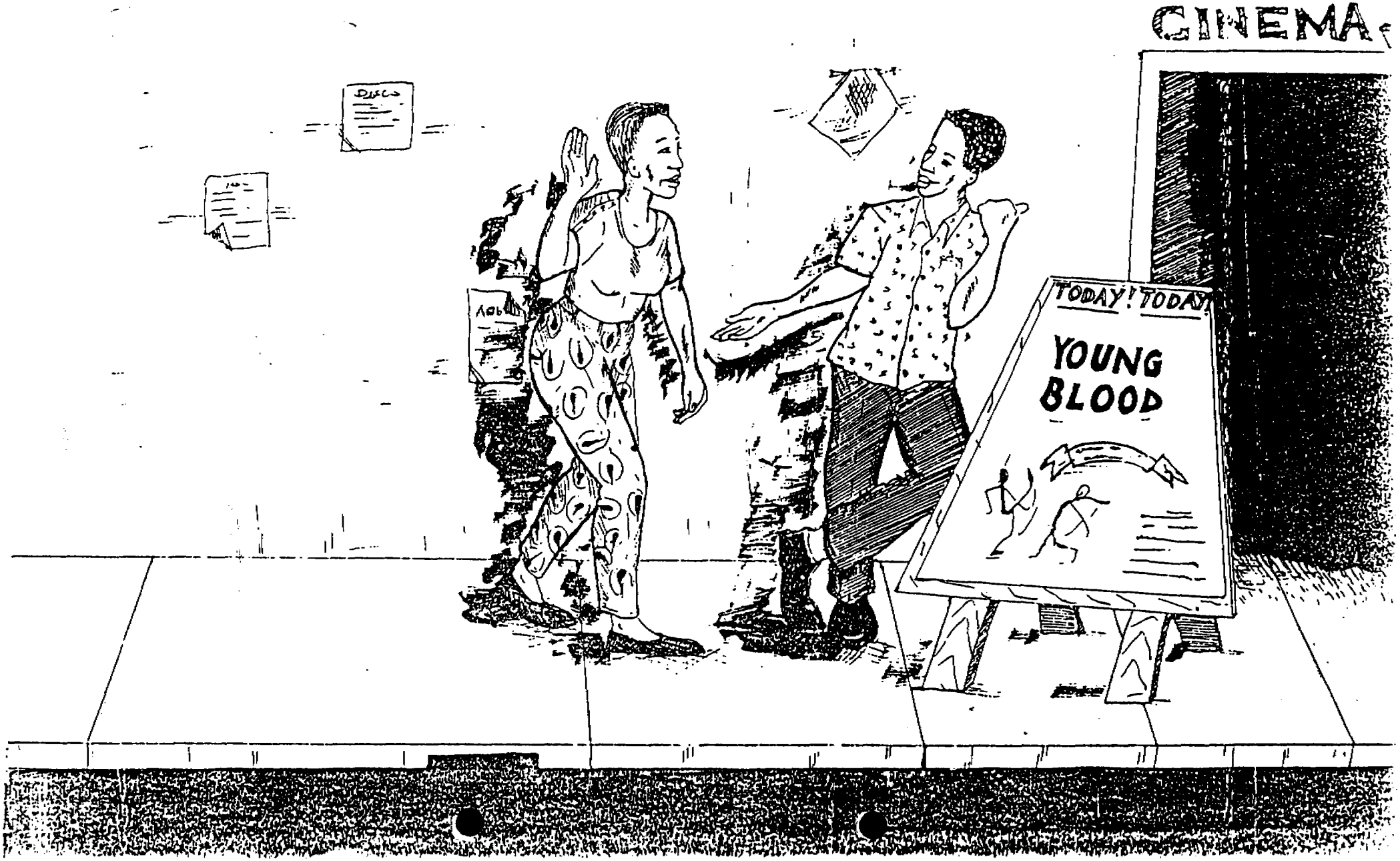



STDS

UNSERIALISED POSTERS




CINEMA
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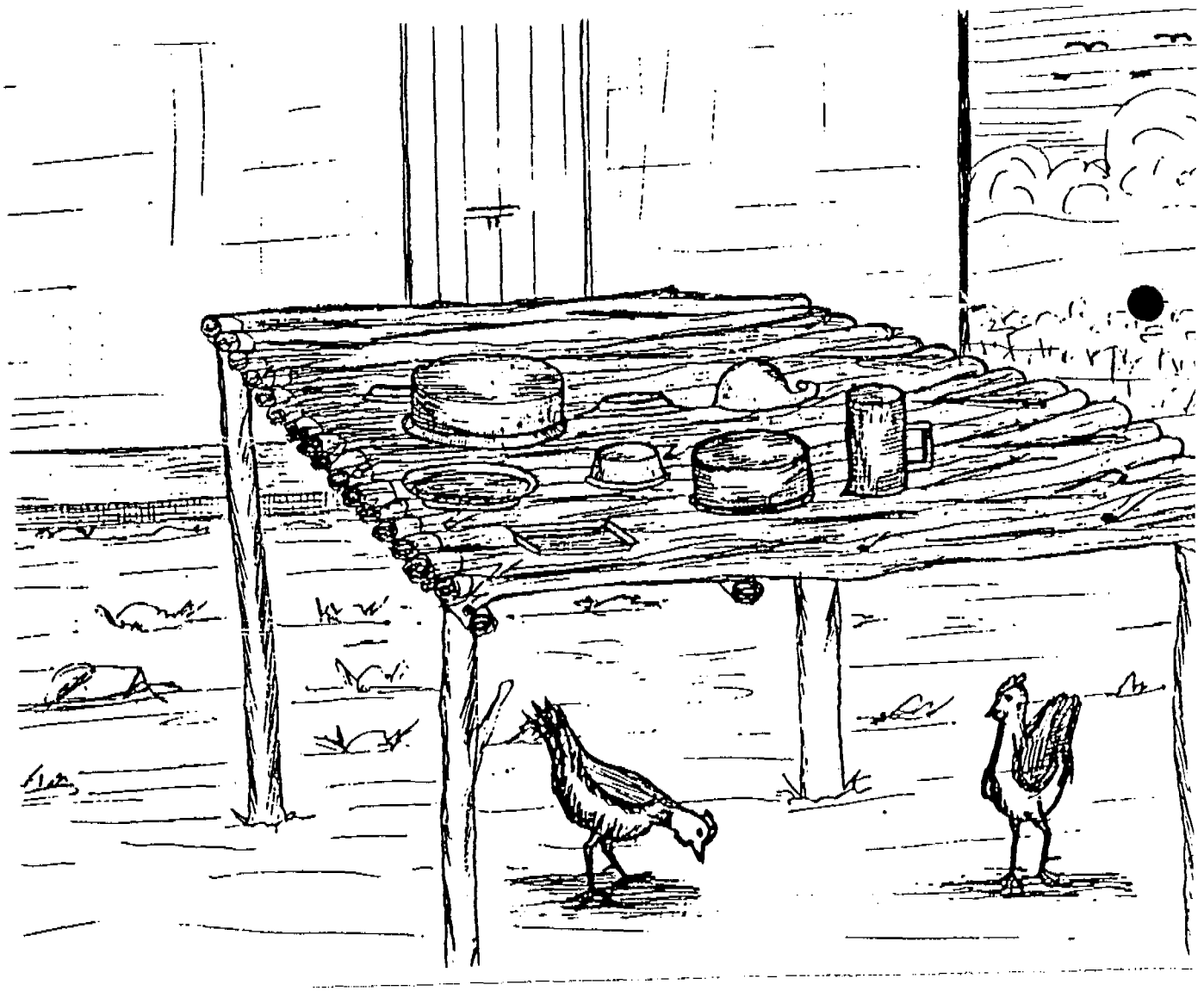
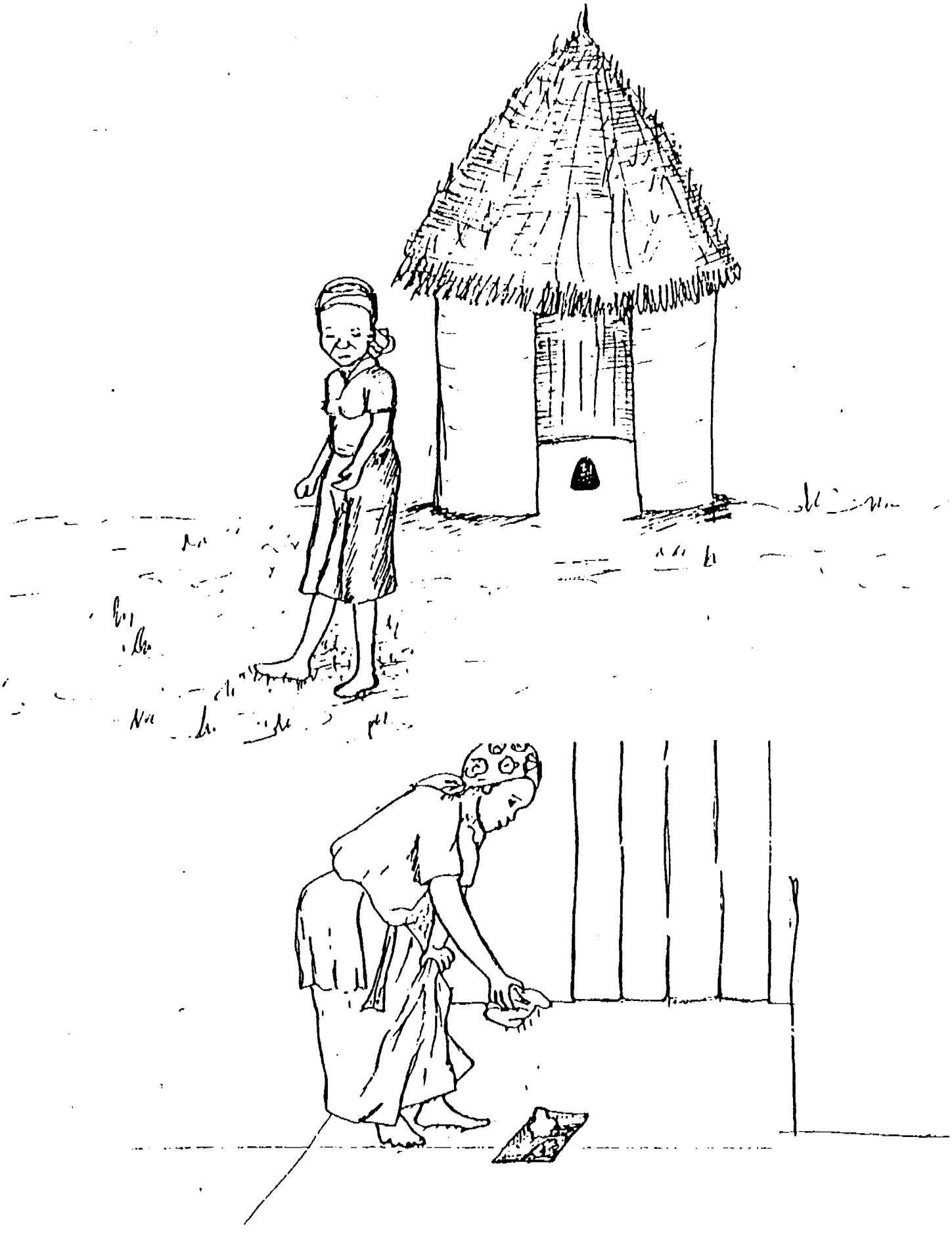
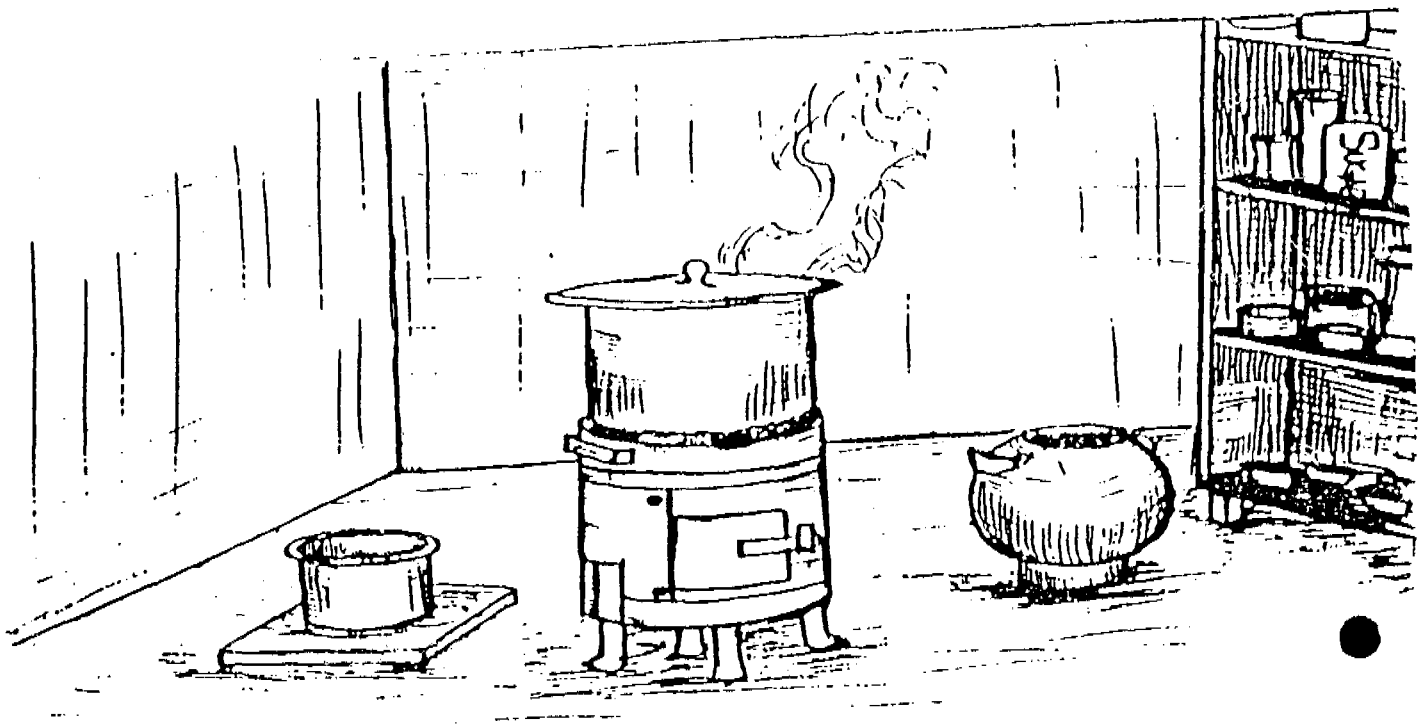
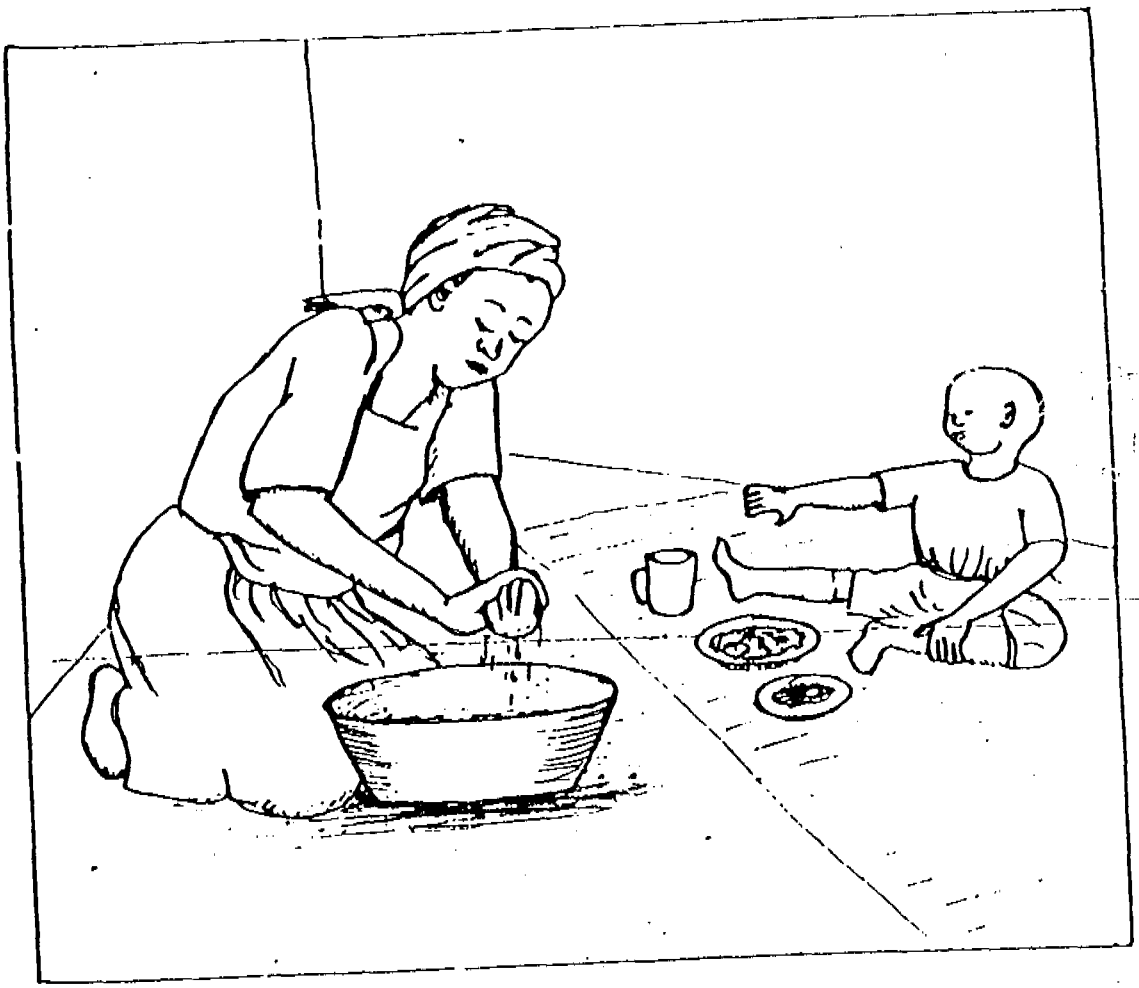
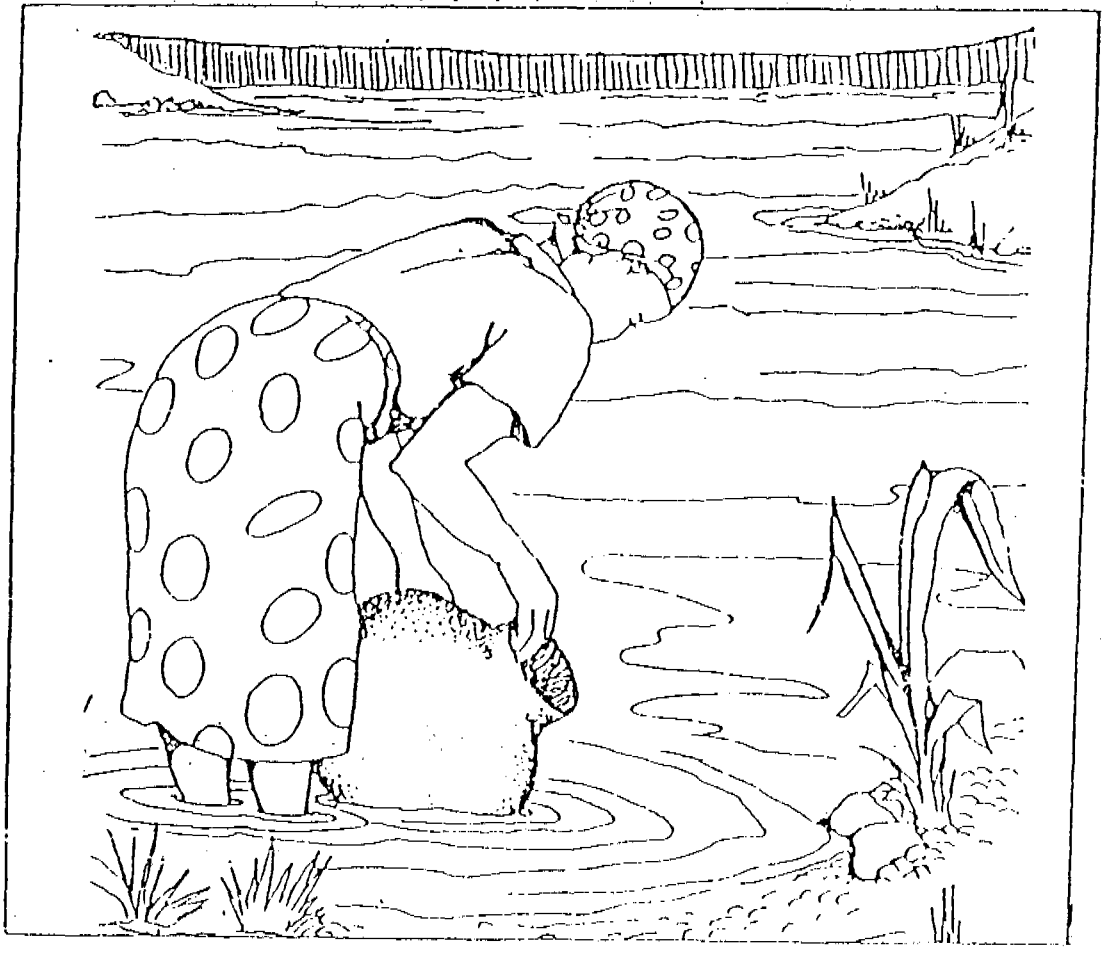
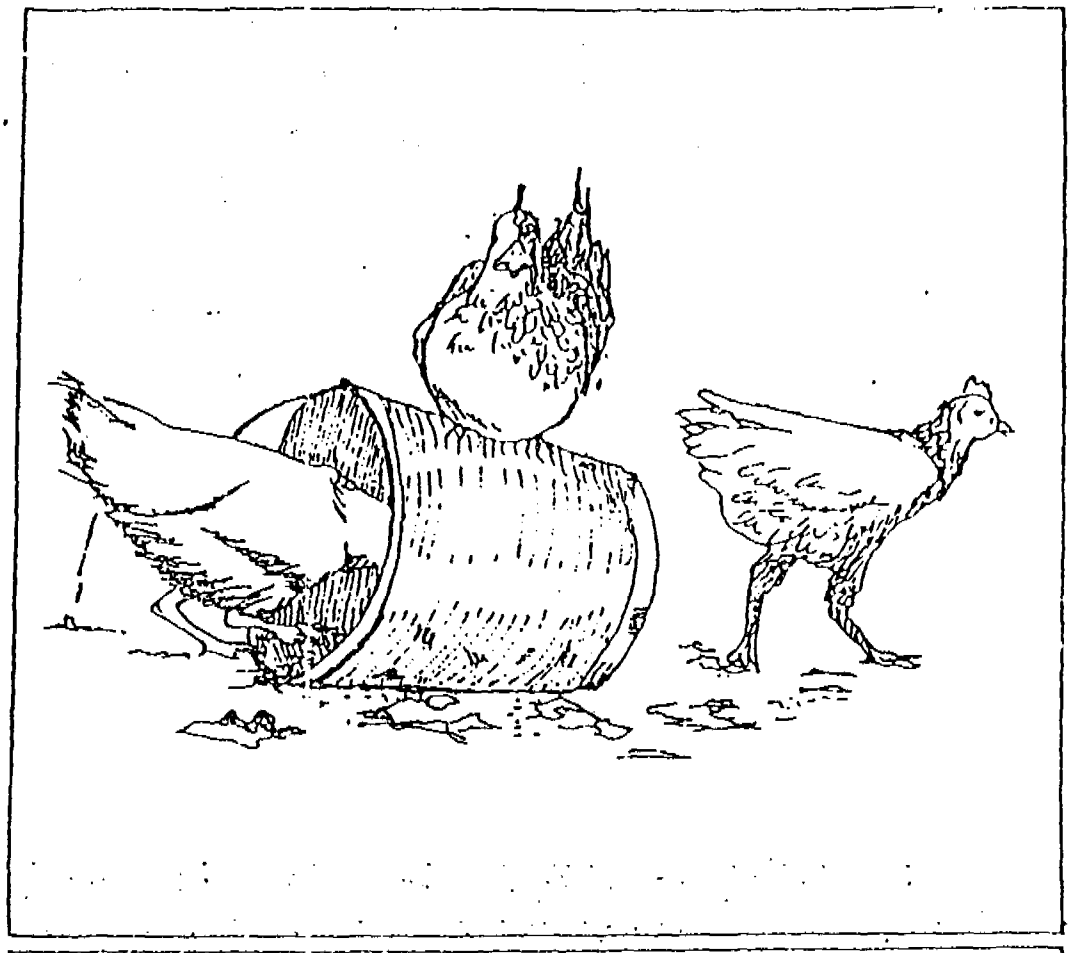


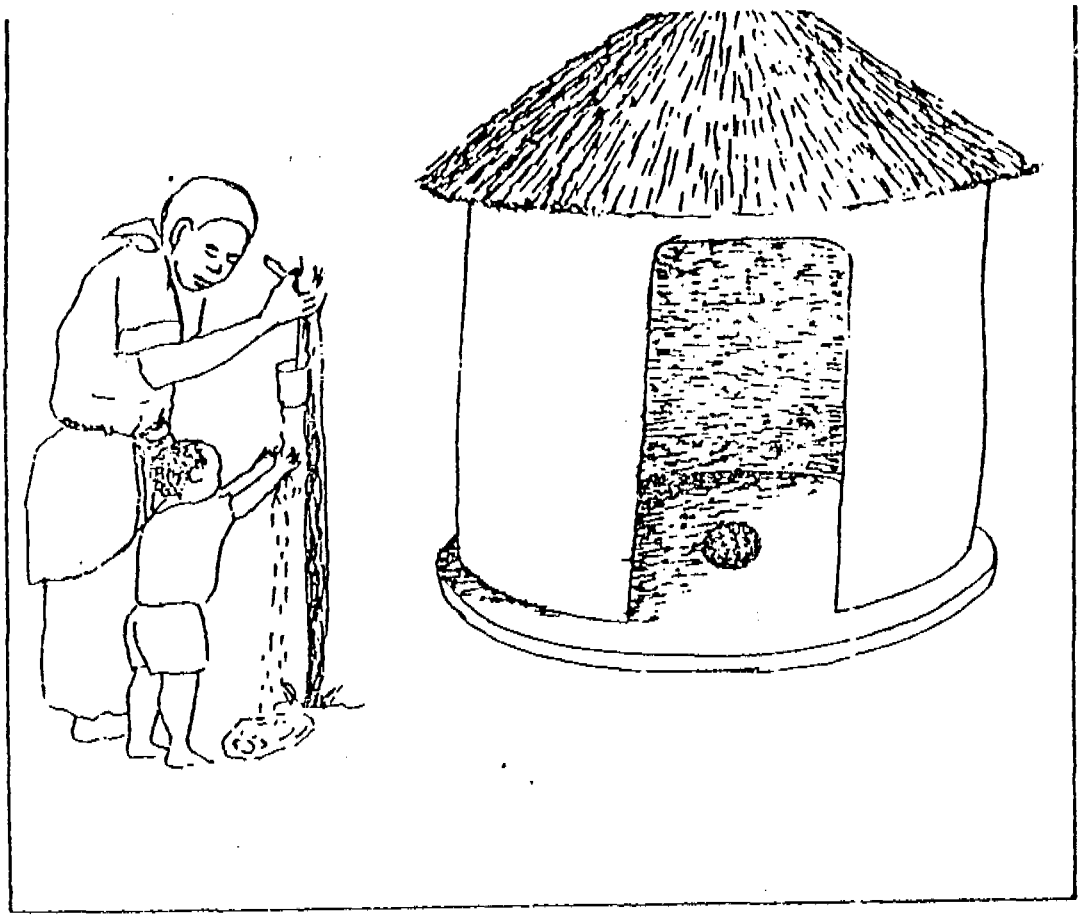


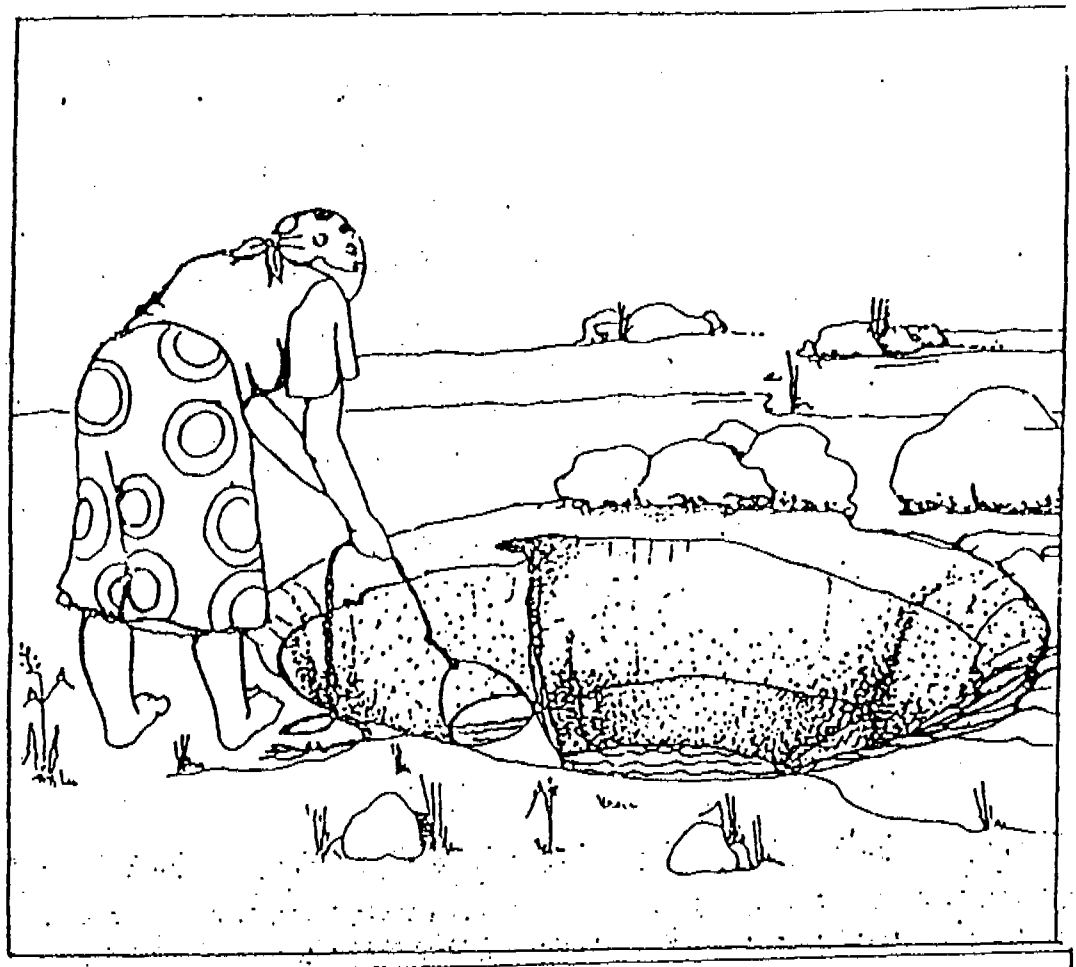


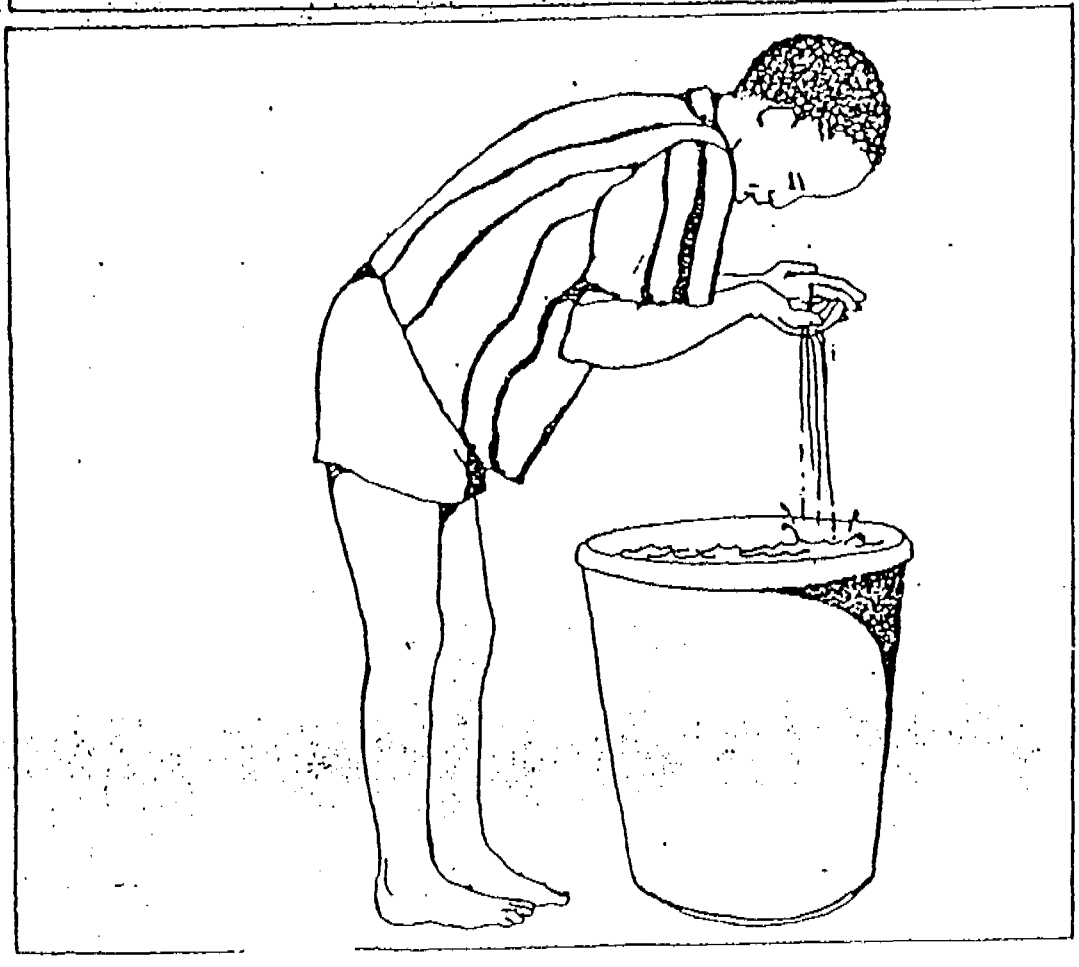


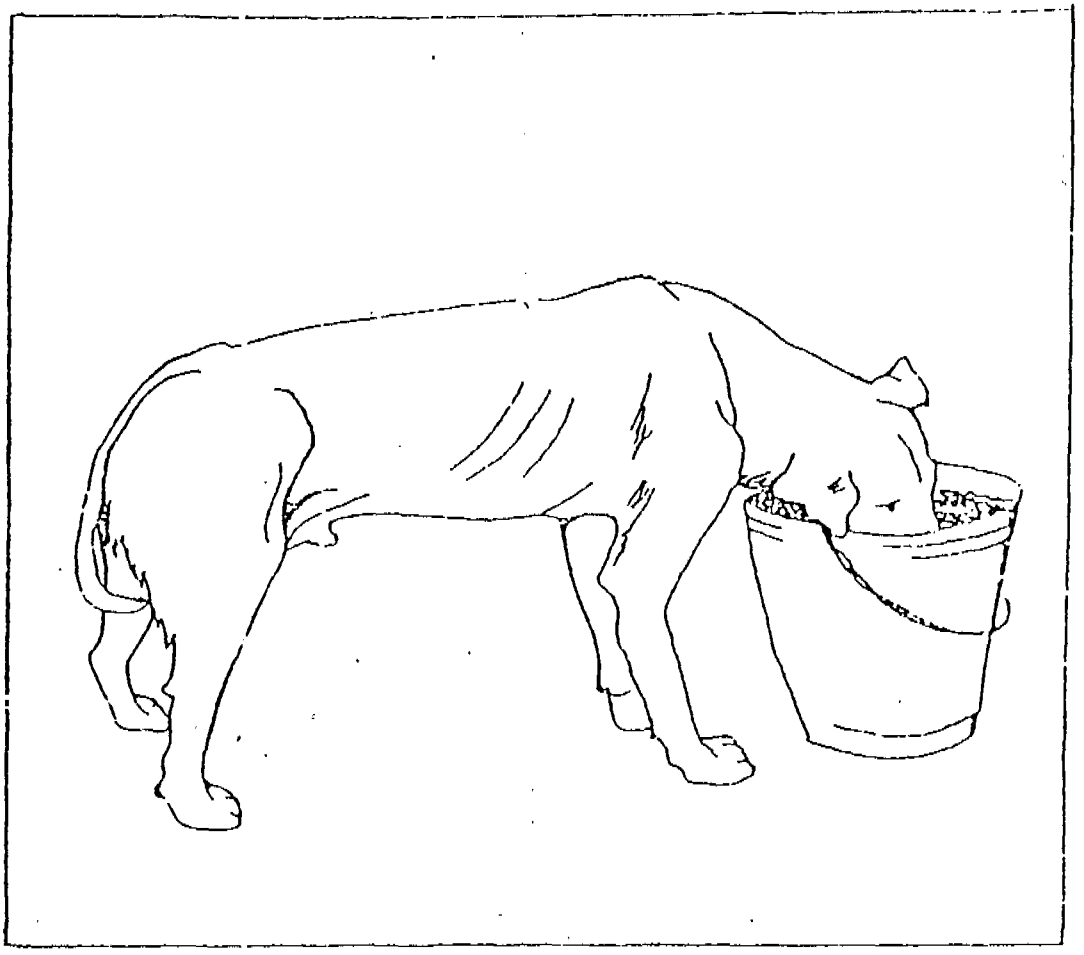


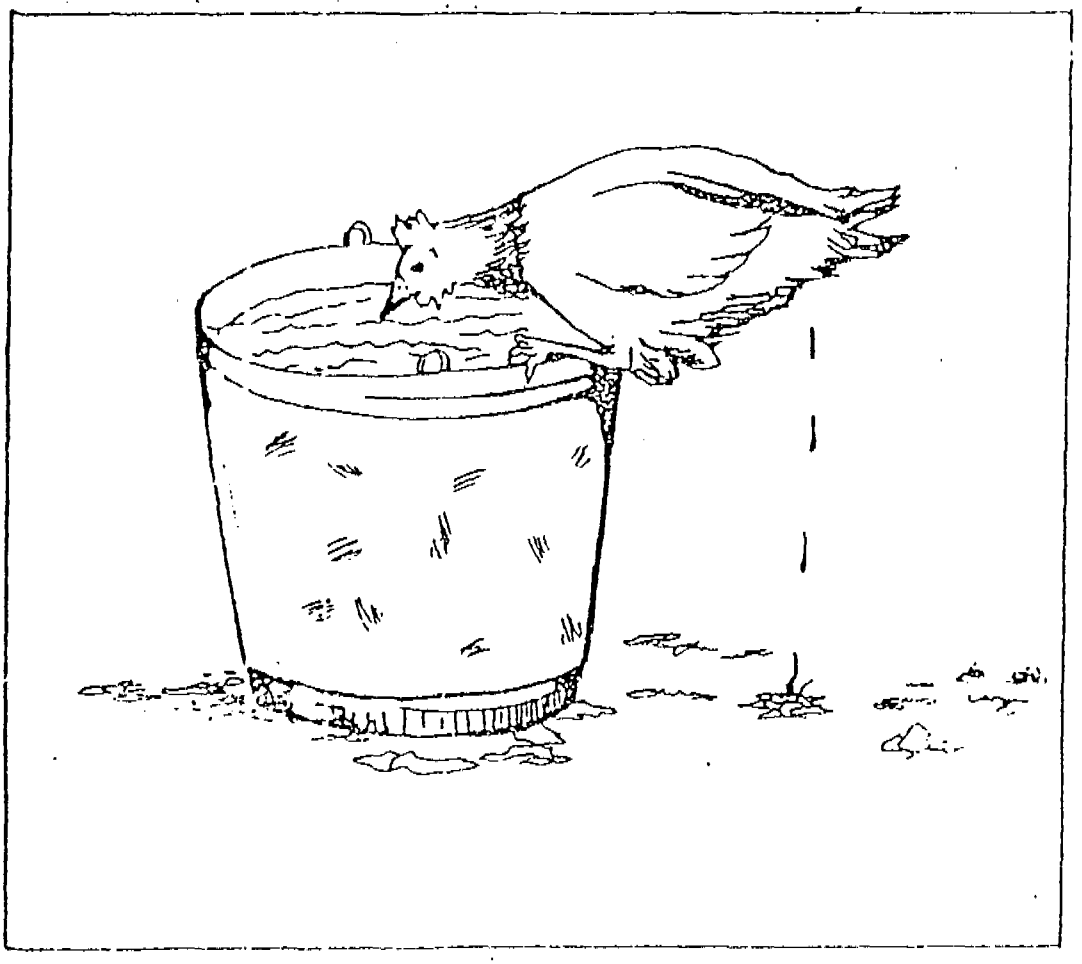


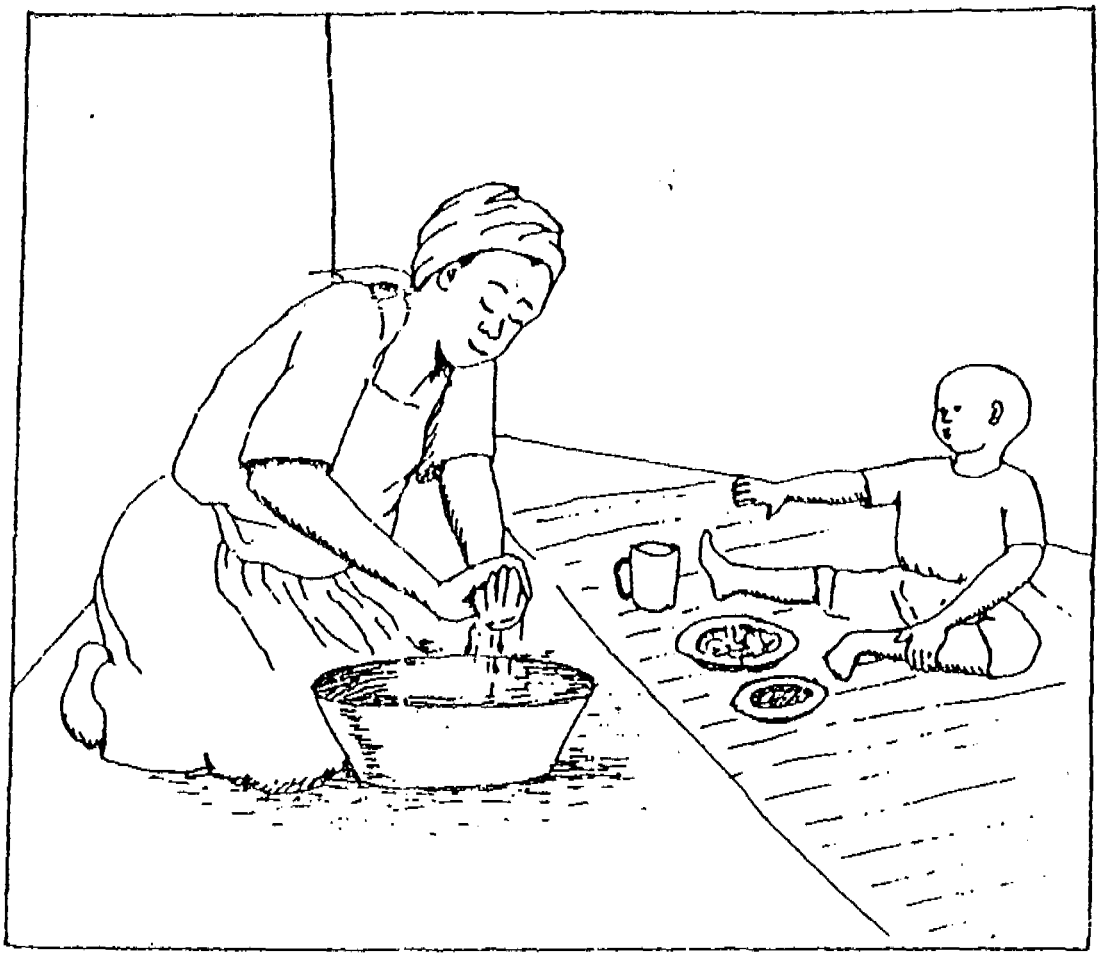


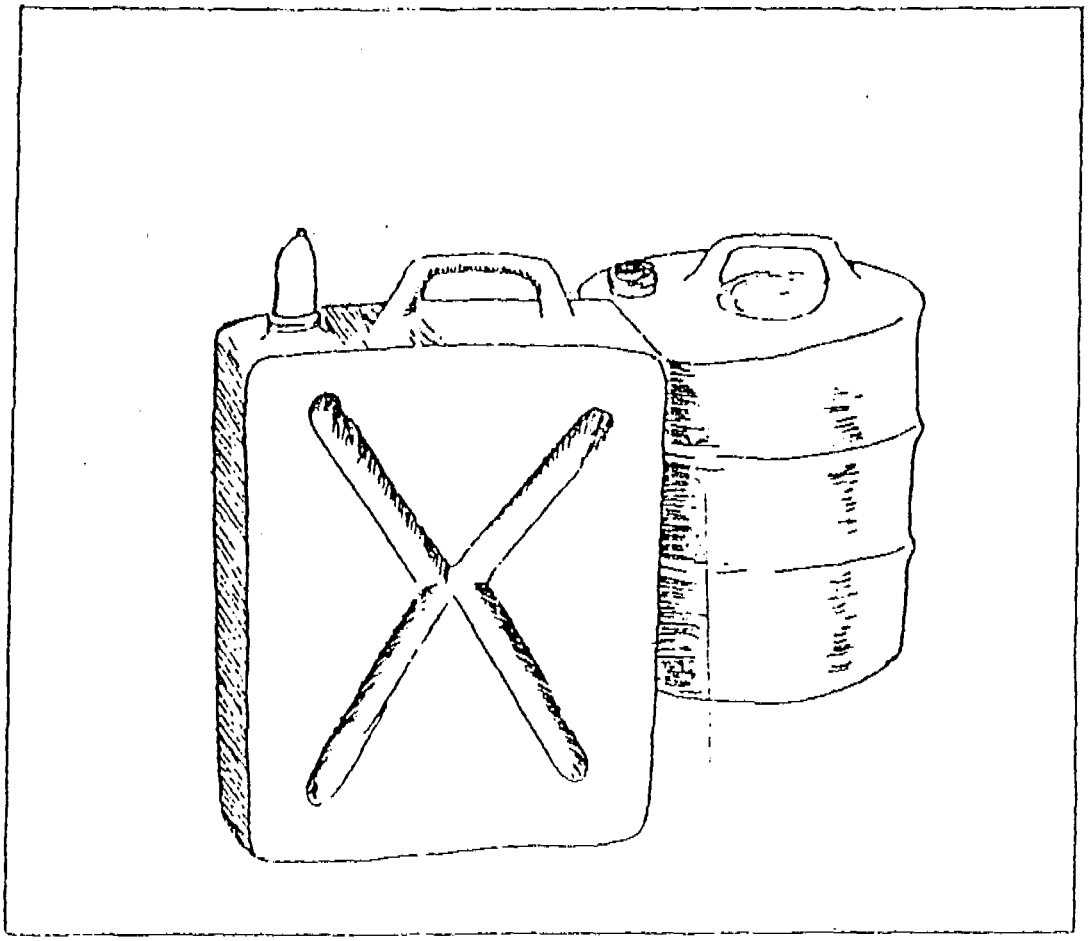






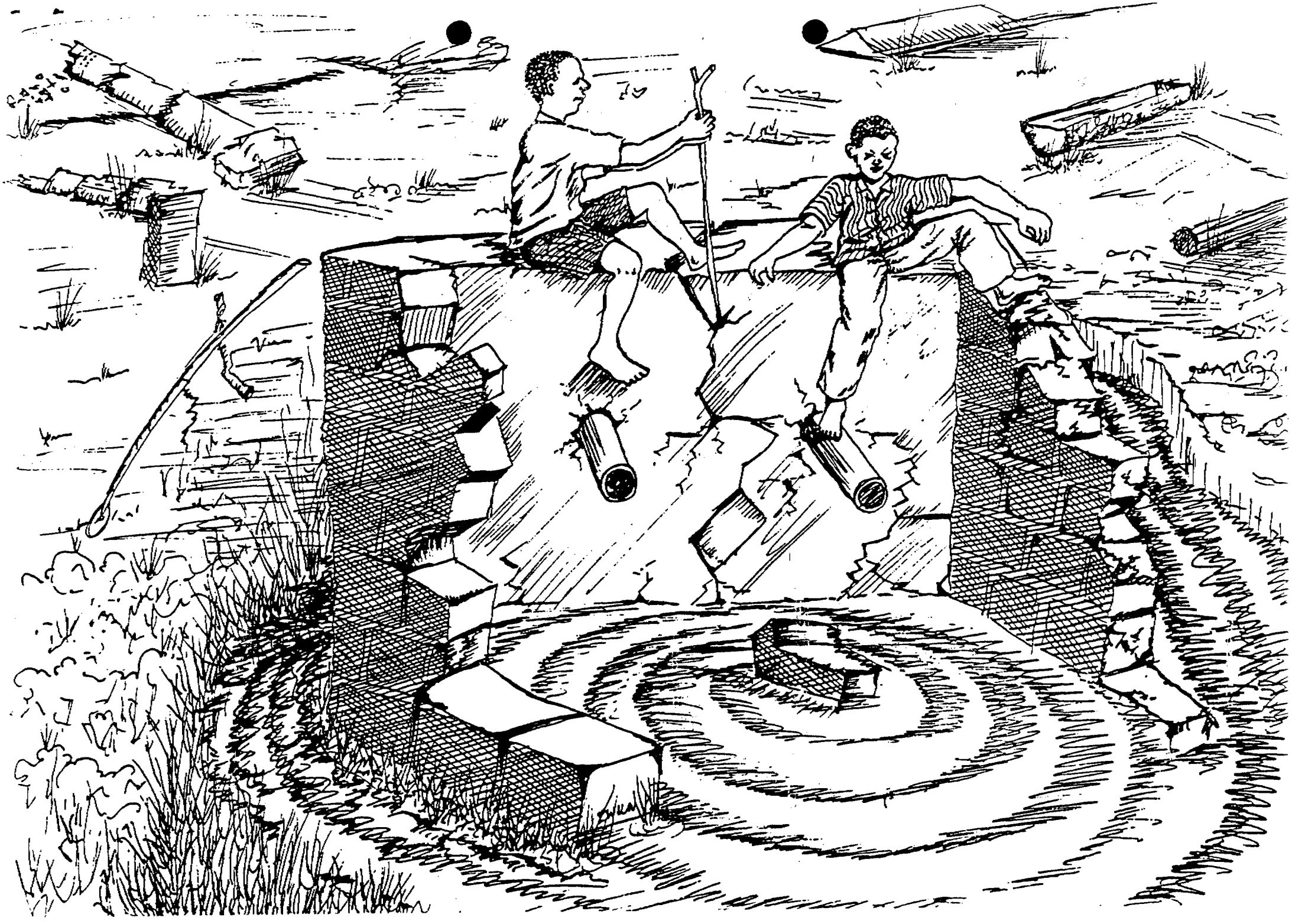


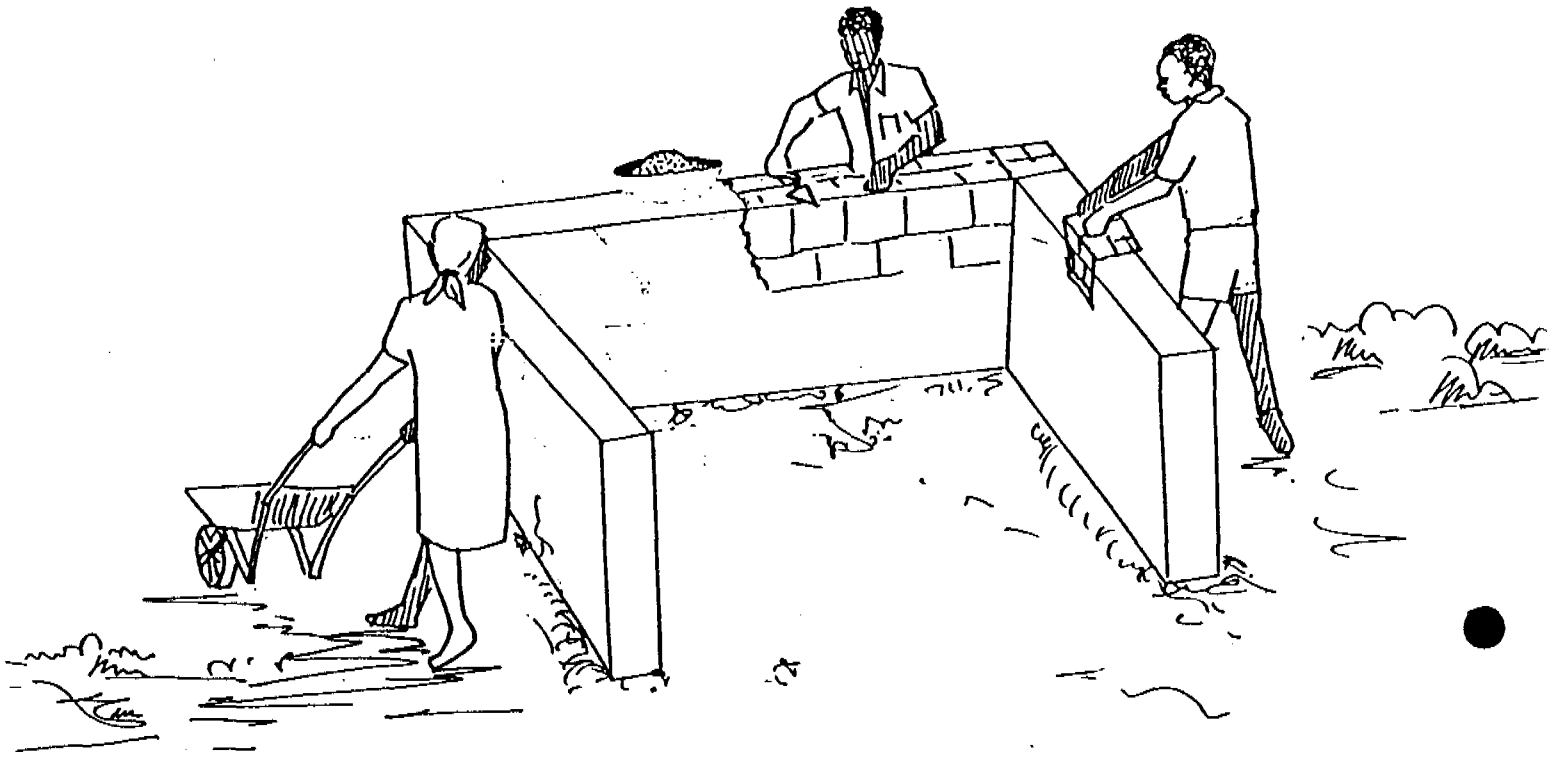


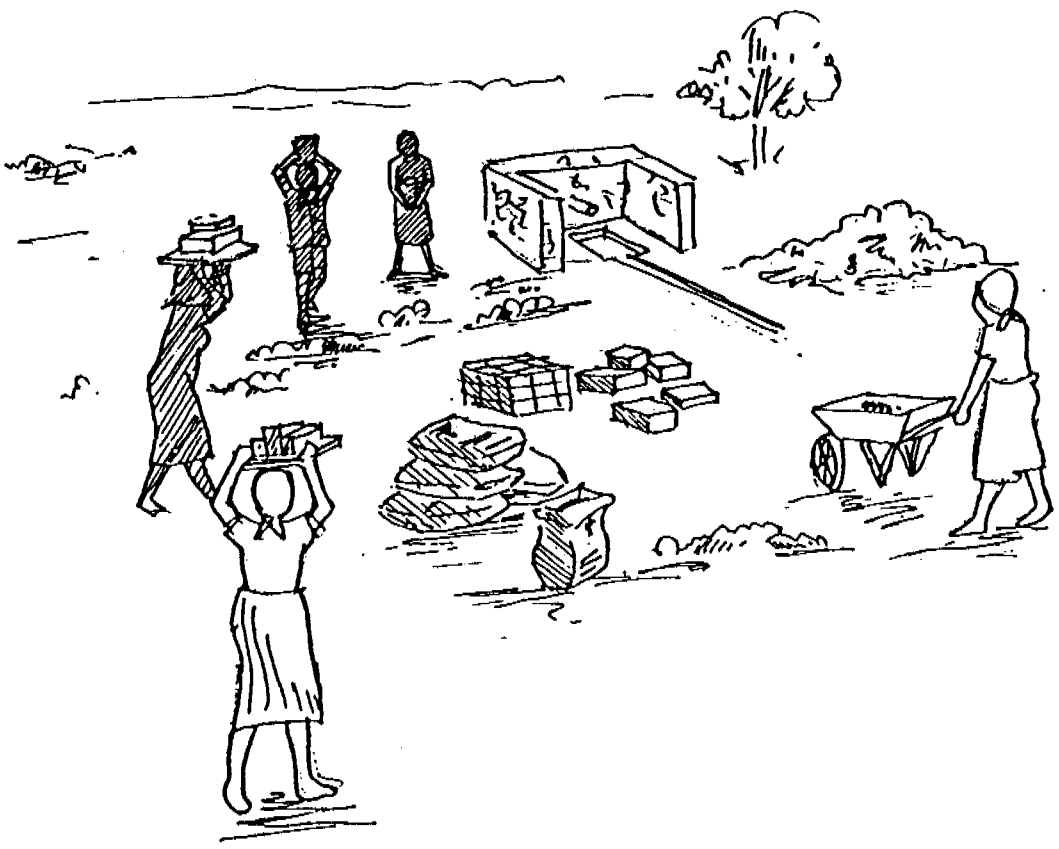


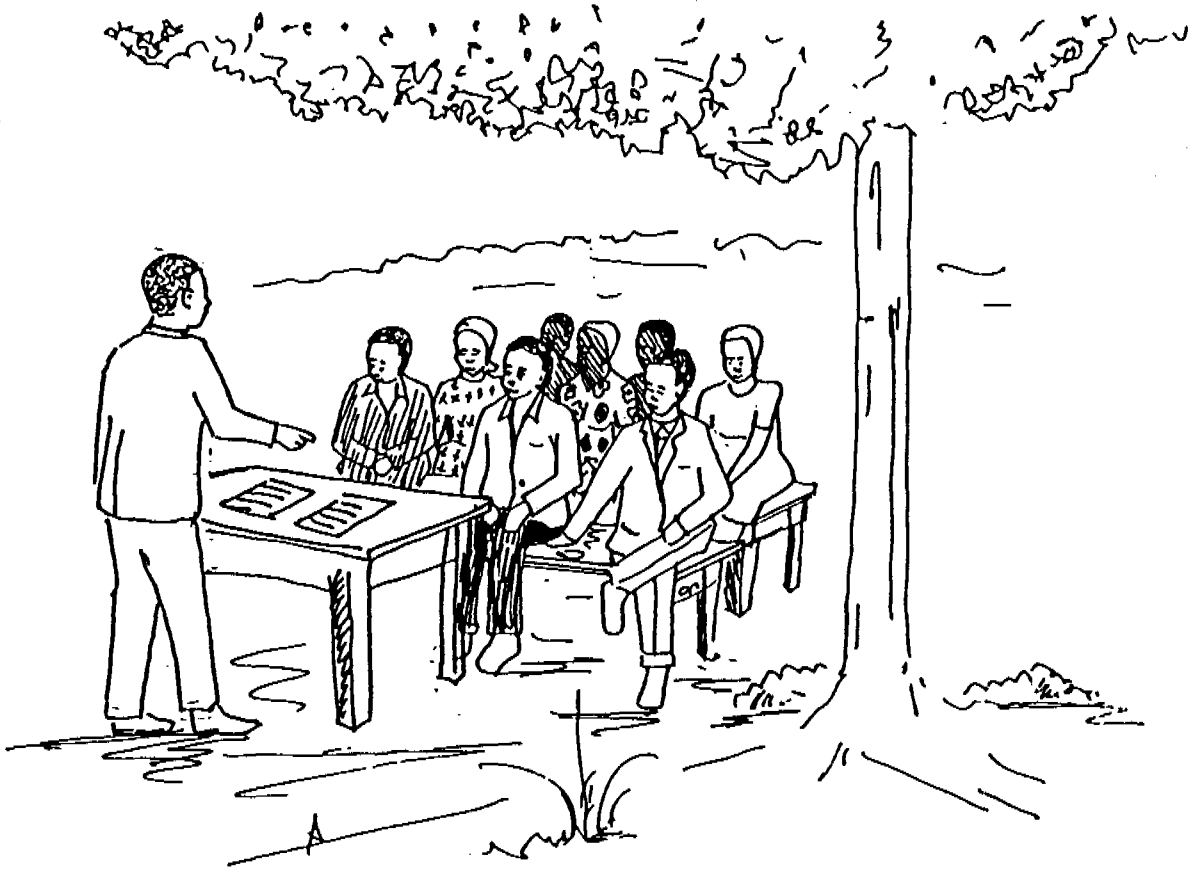
STORY WITH A GAP

PHAST TOOL KIT, BARINGO , KENYA 1994



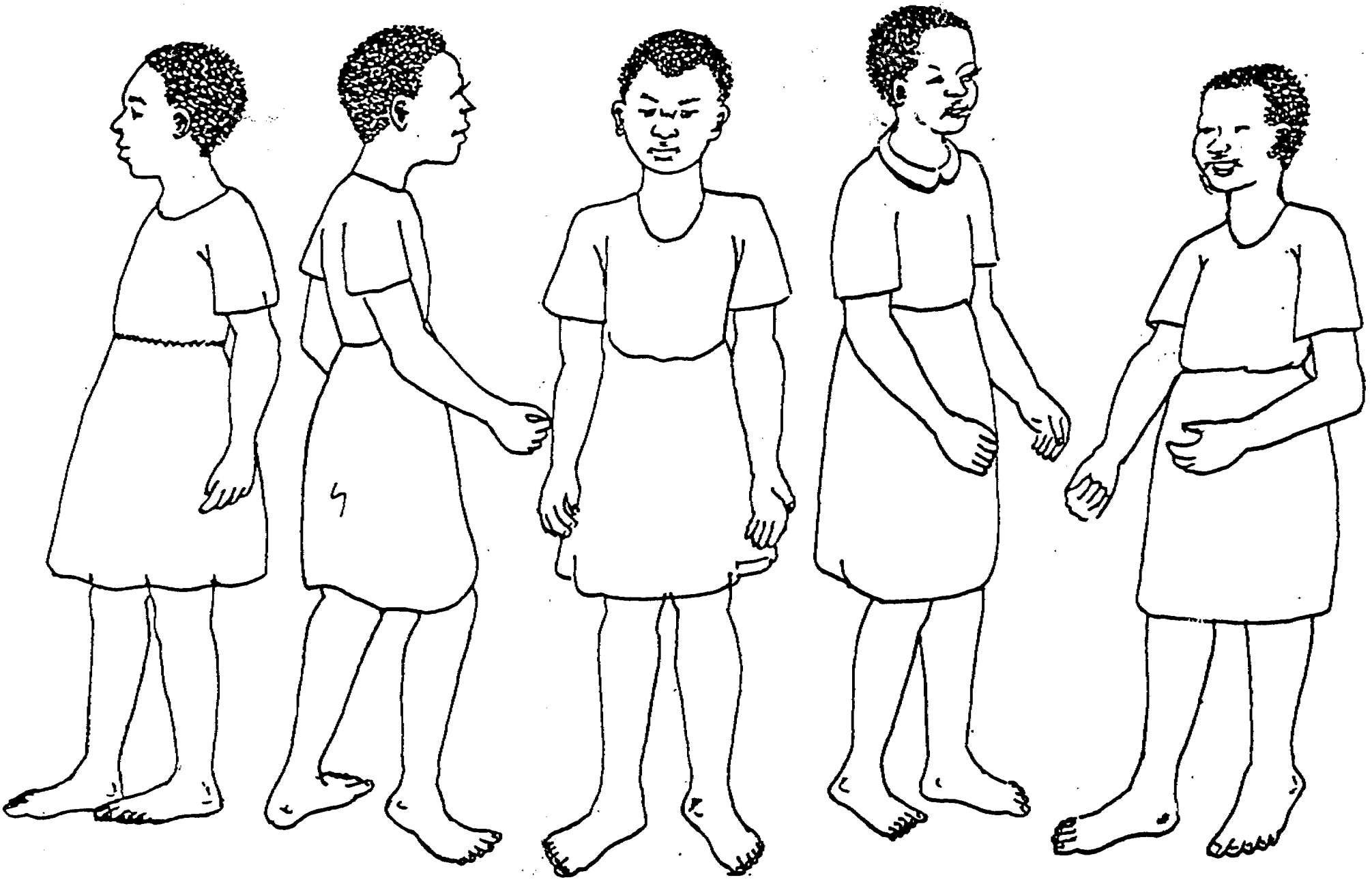


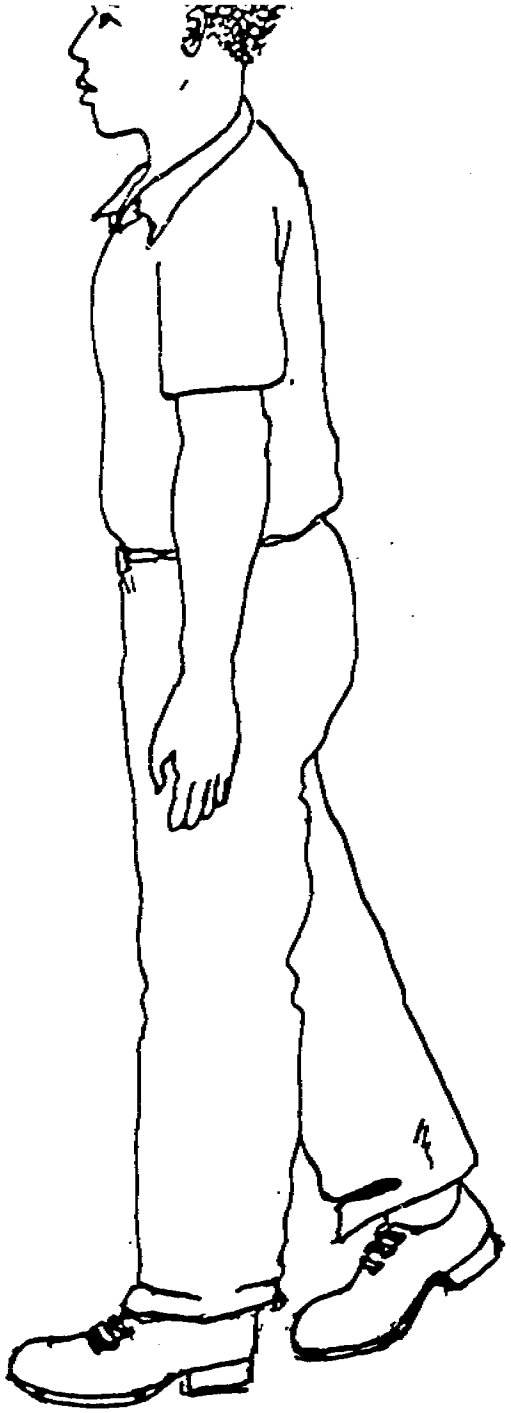


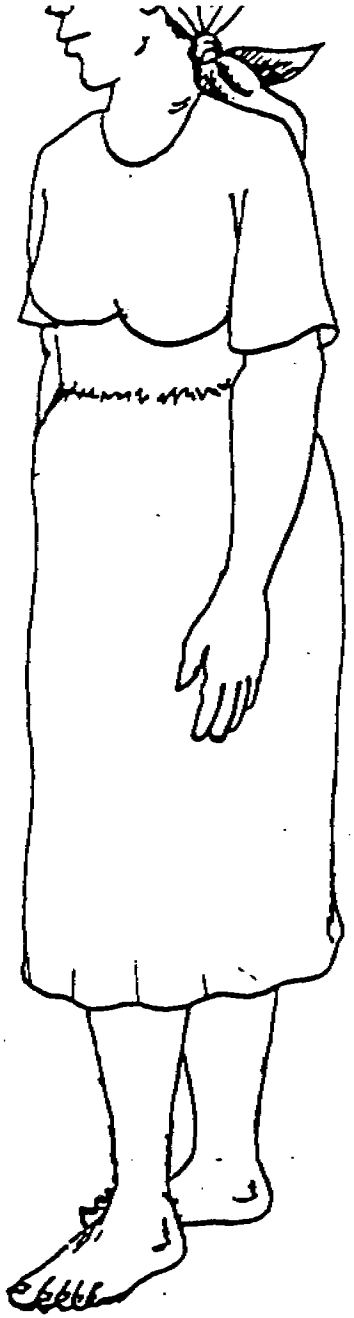


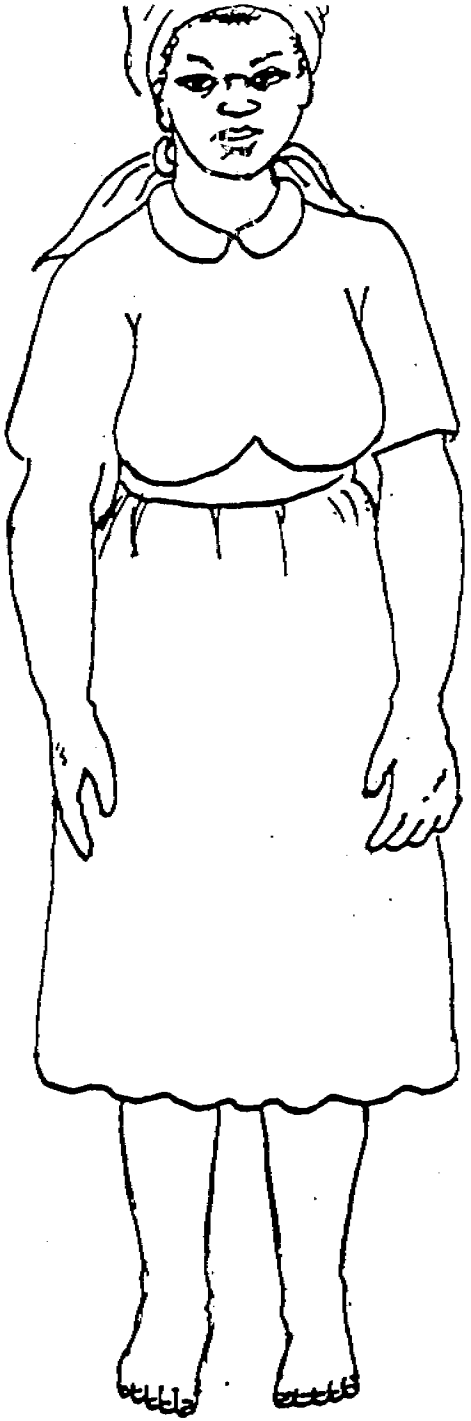
FLEXI-FLANS

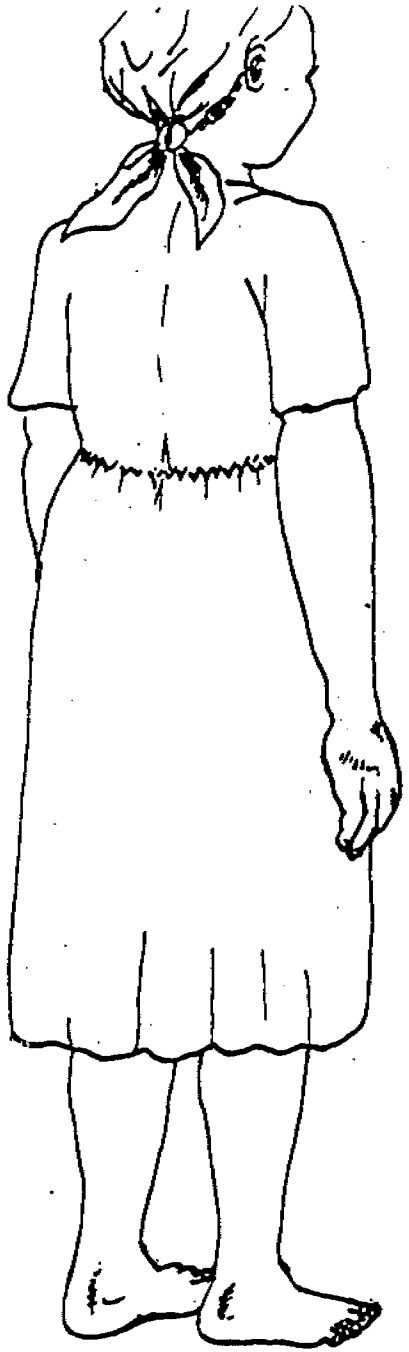
PHAST TOOL-KIT, BARINGO, KENYA 1994

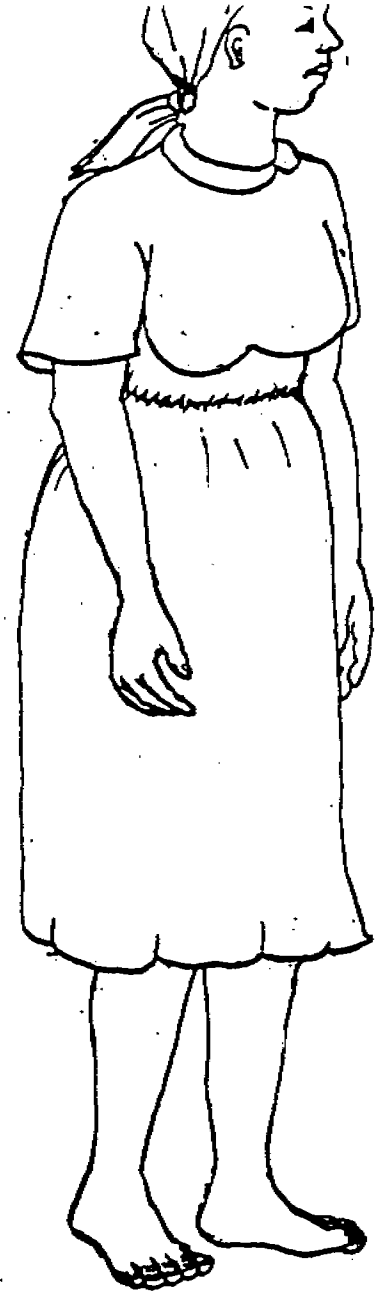


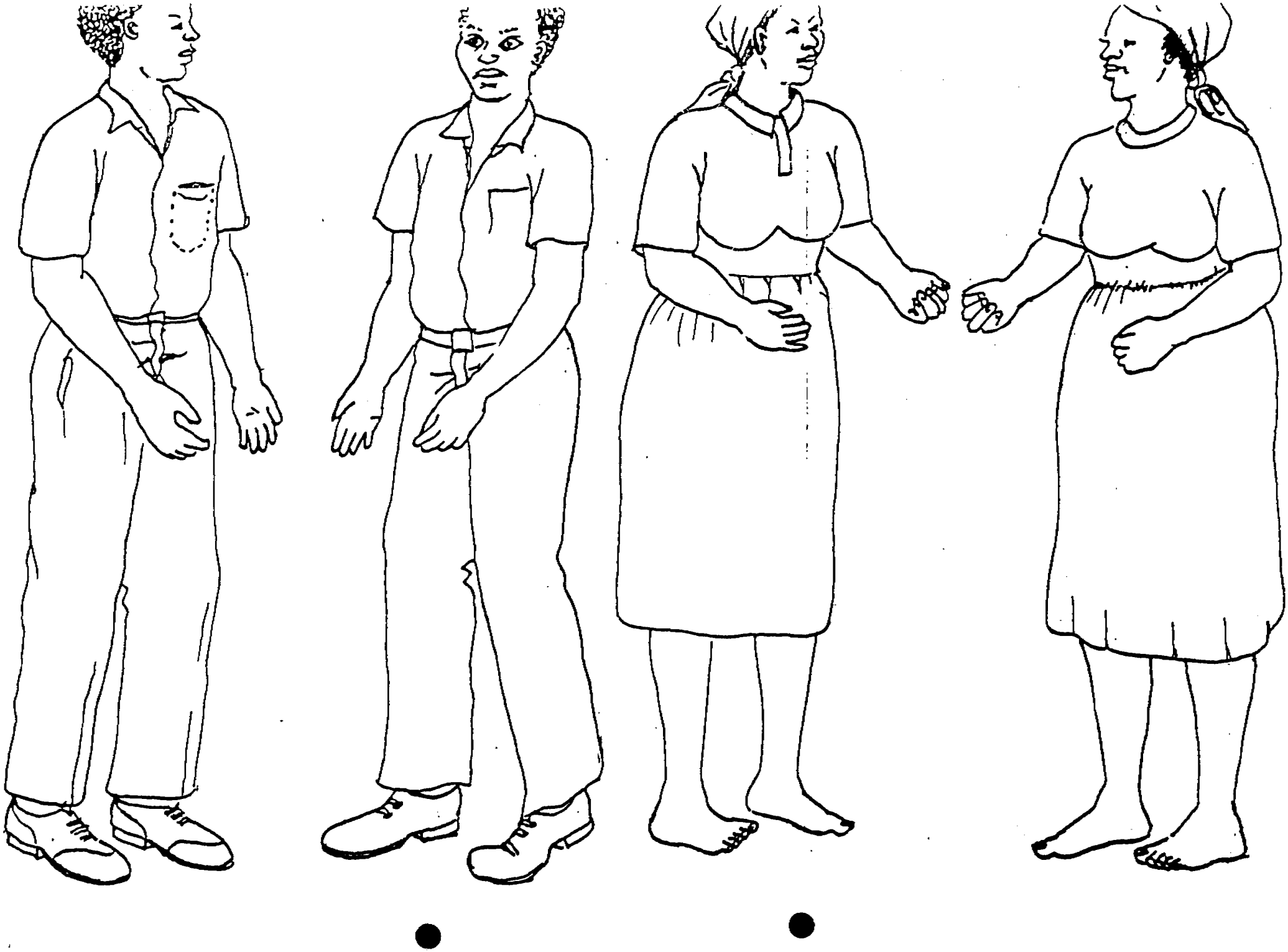


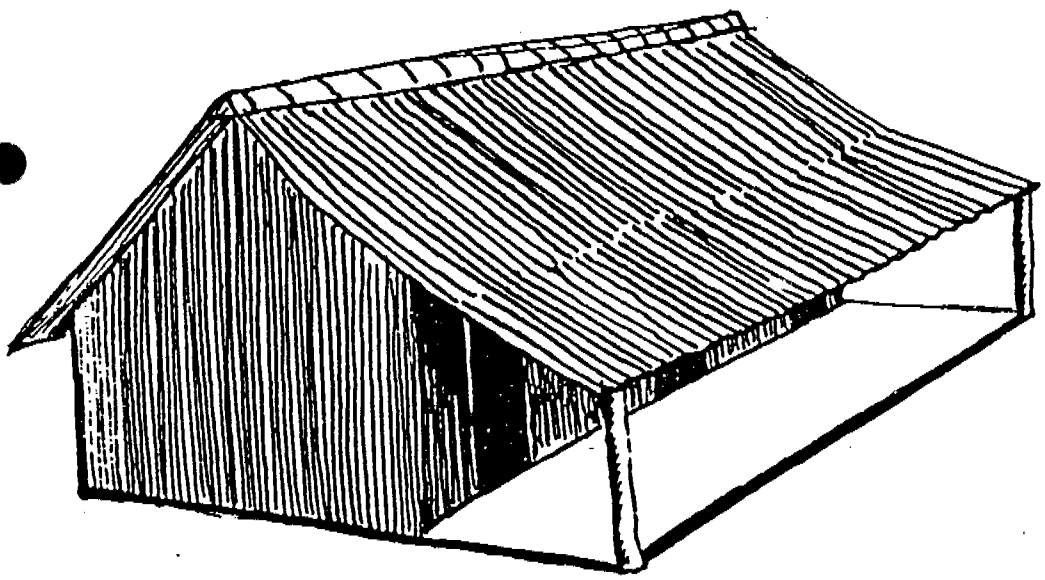


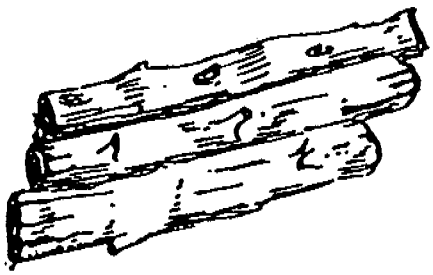


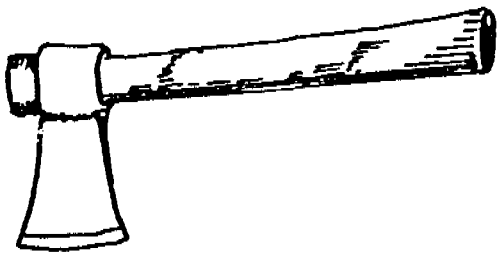


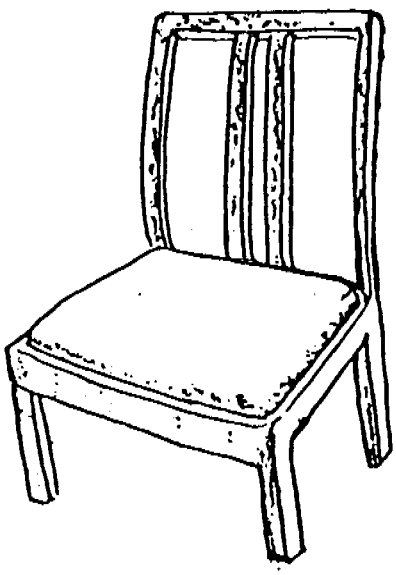


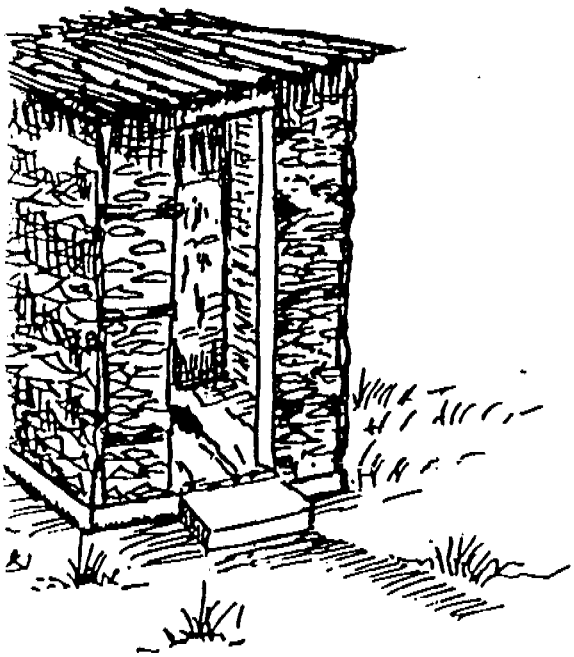


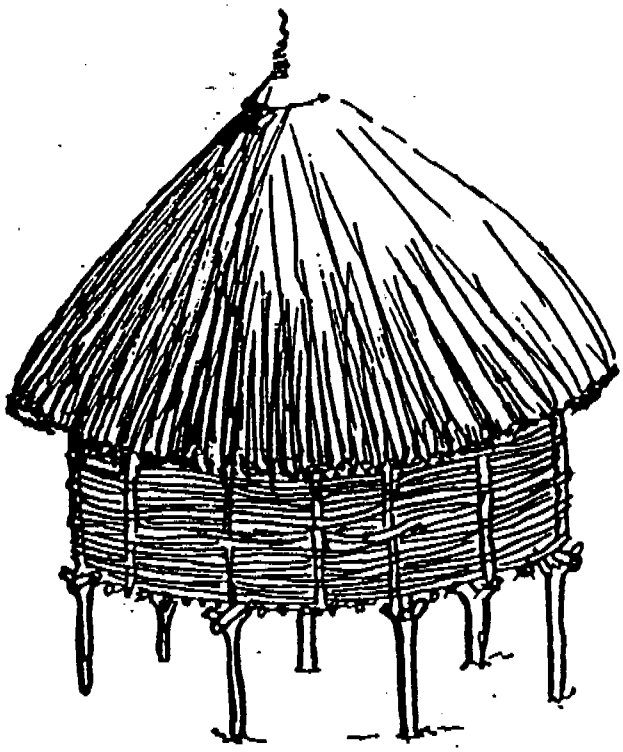


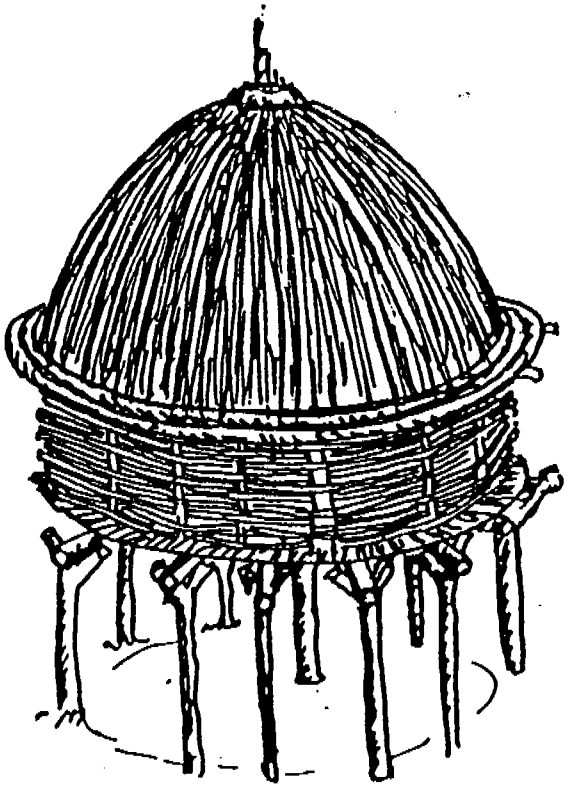


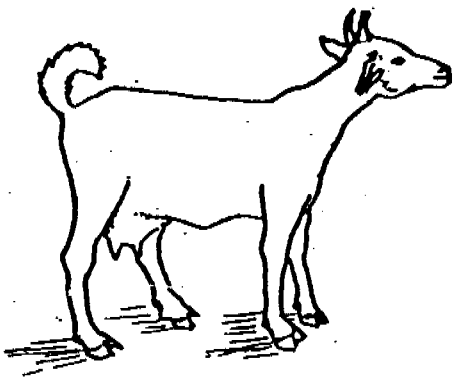


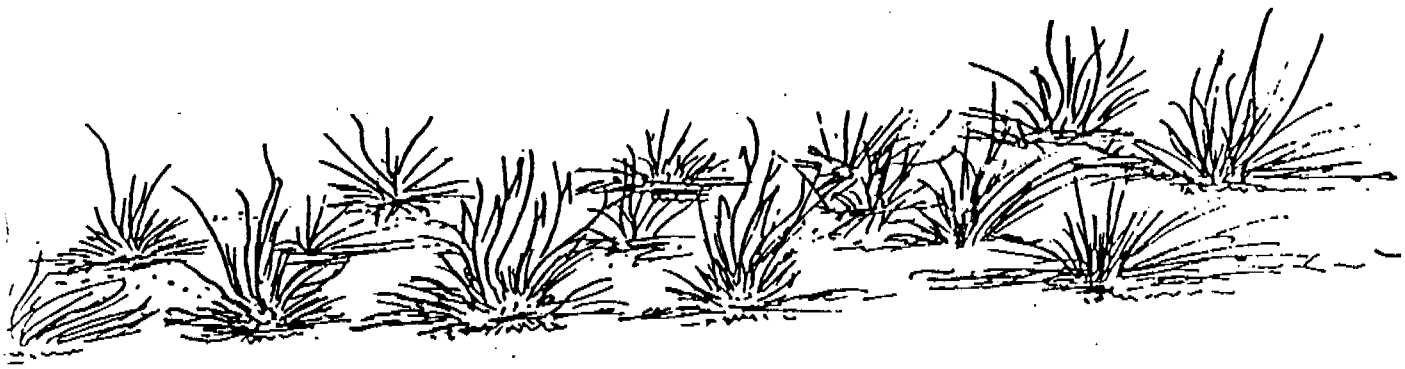


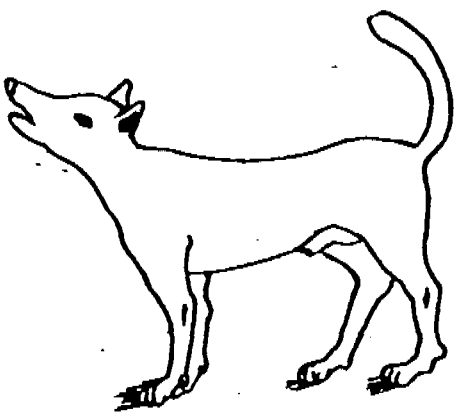


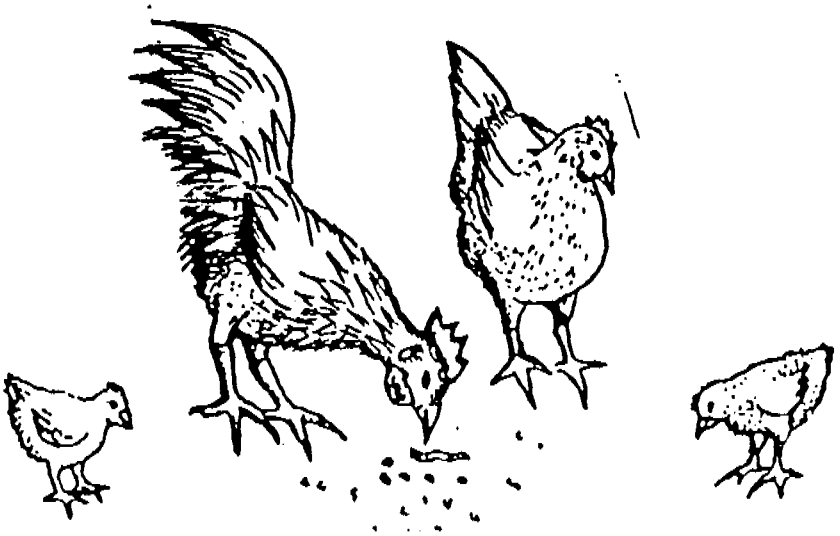


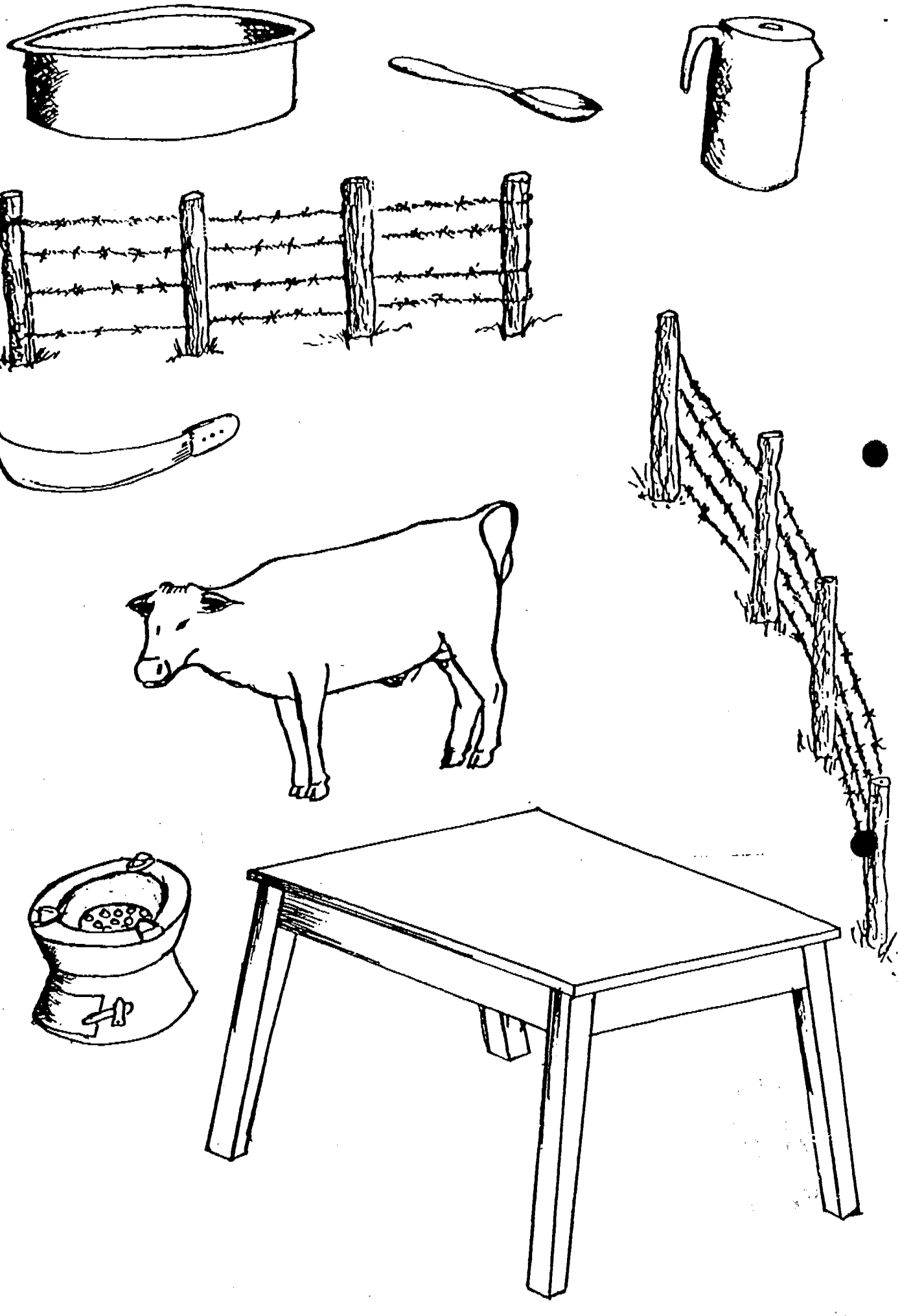


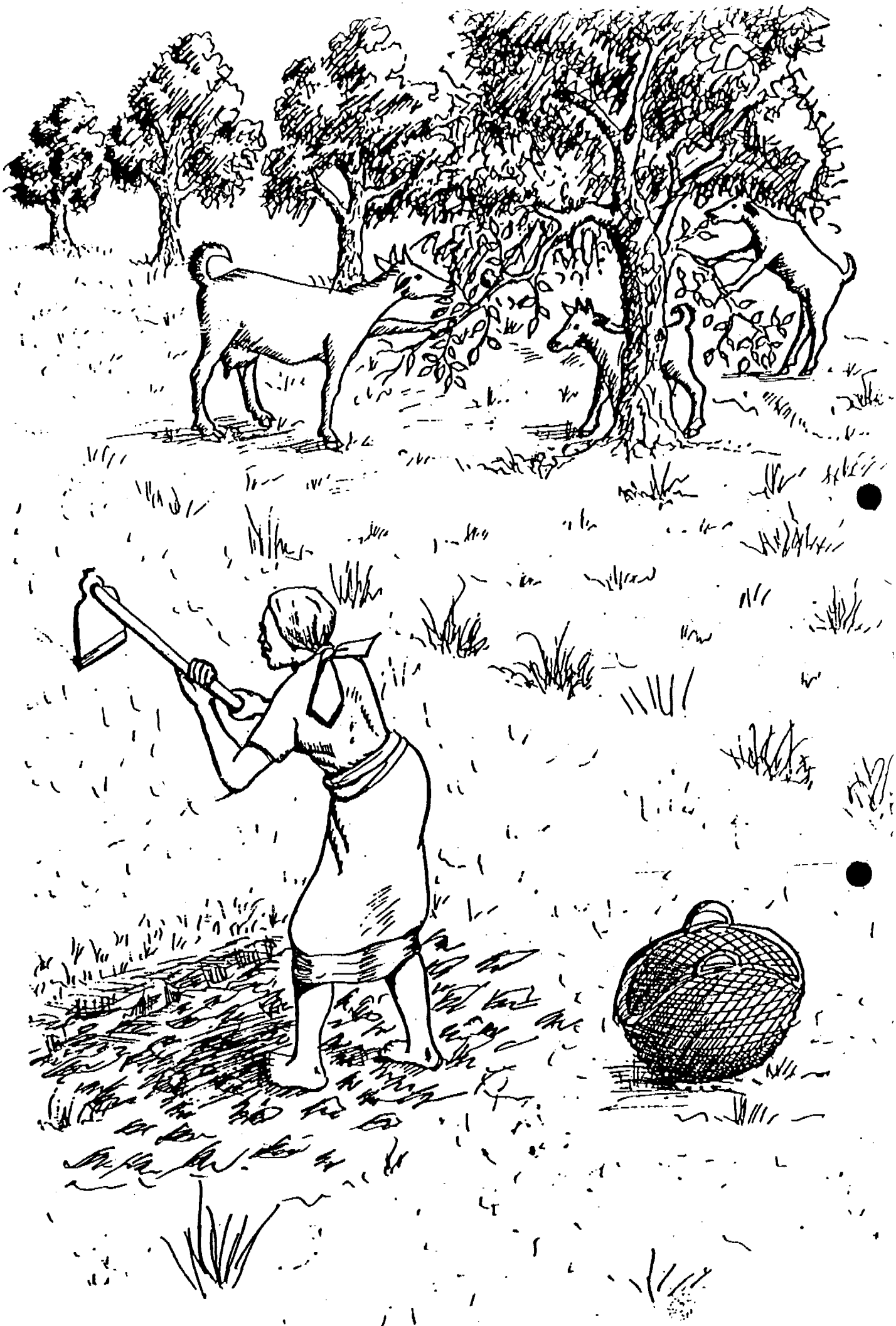


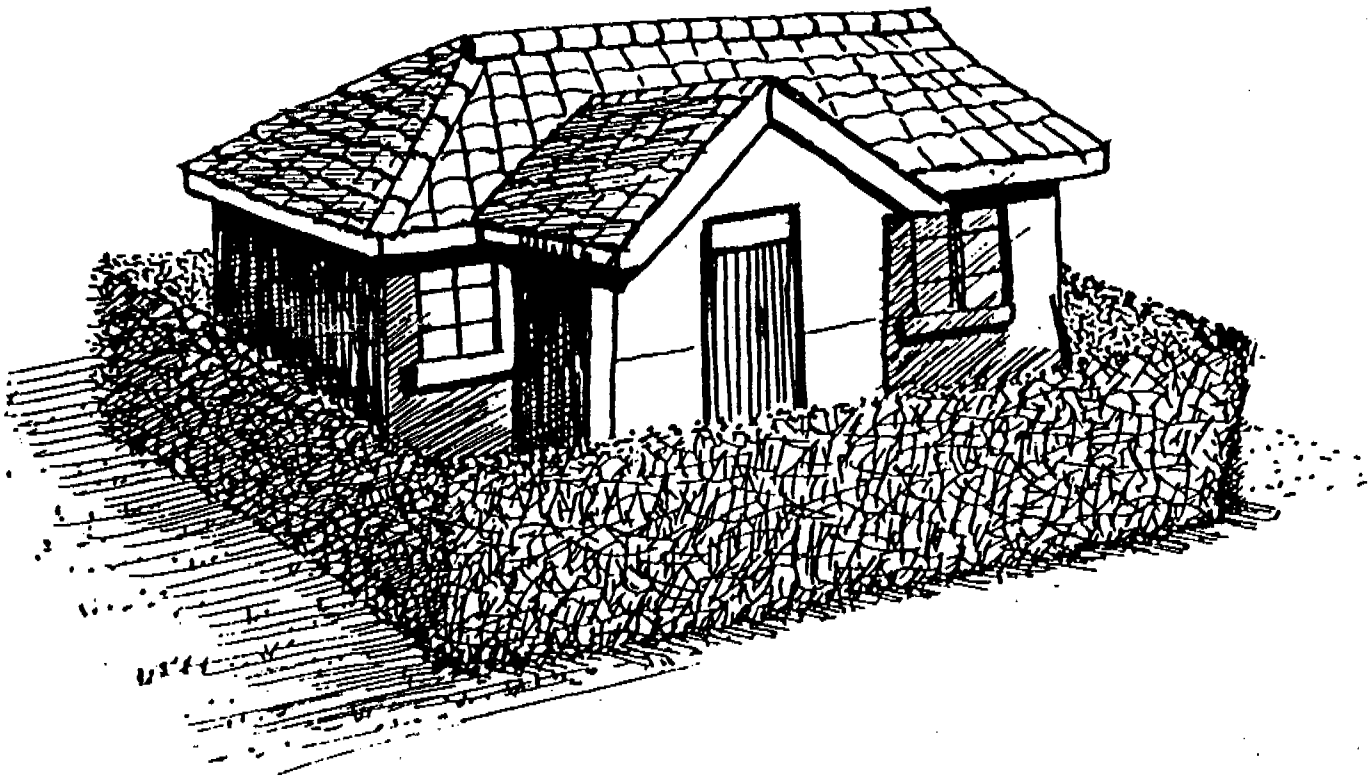


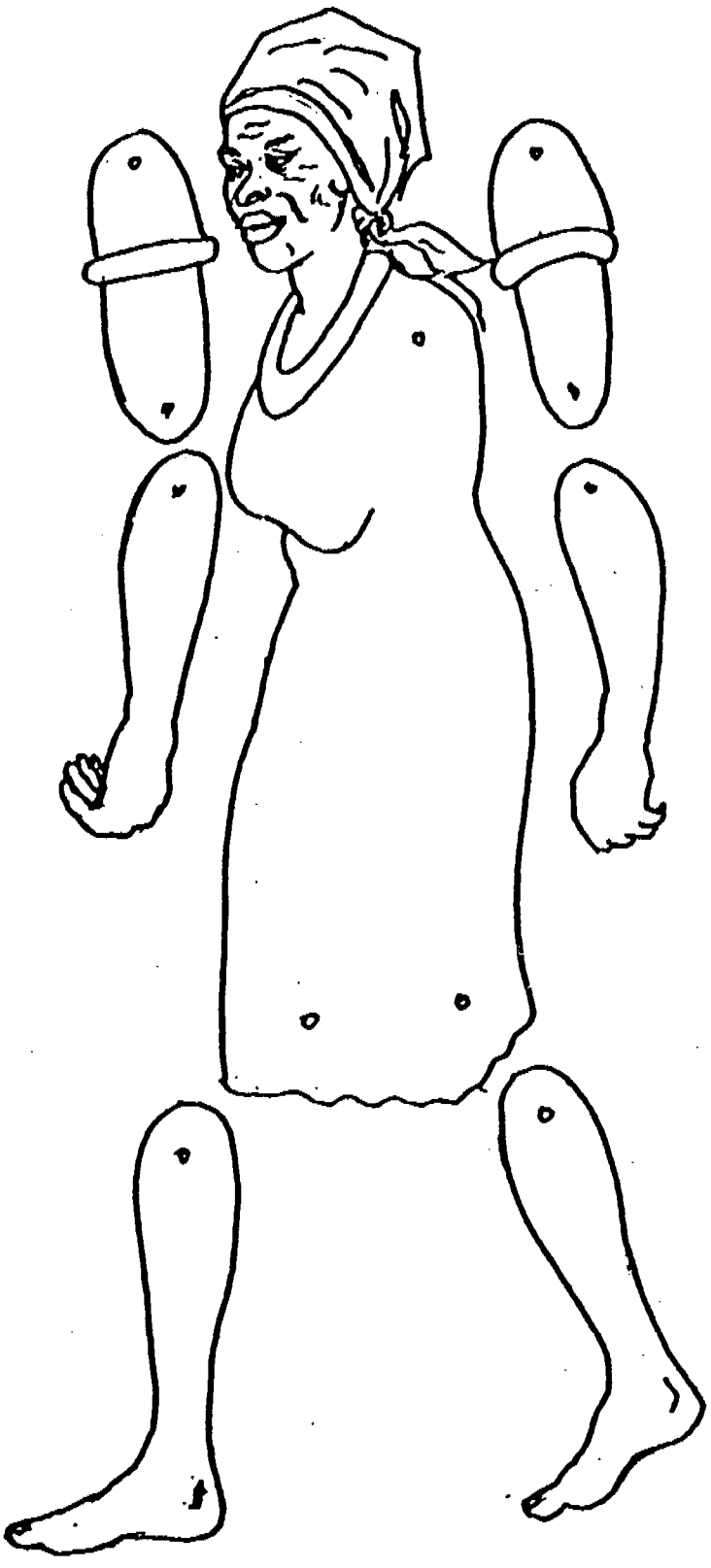


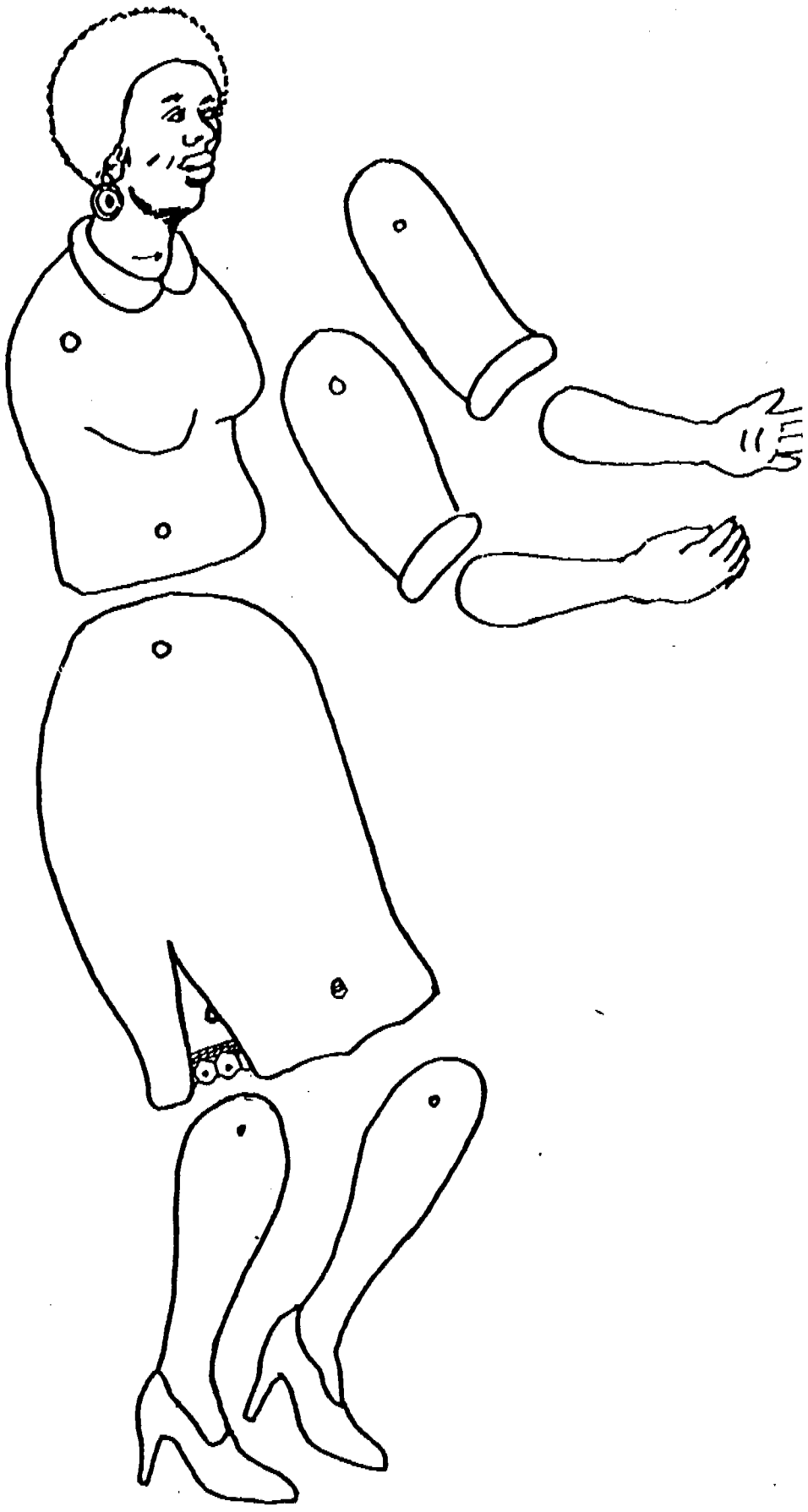


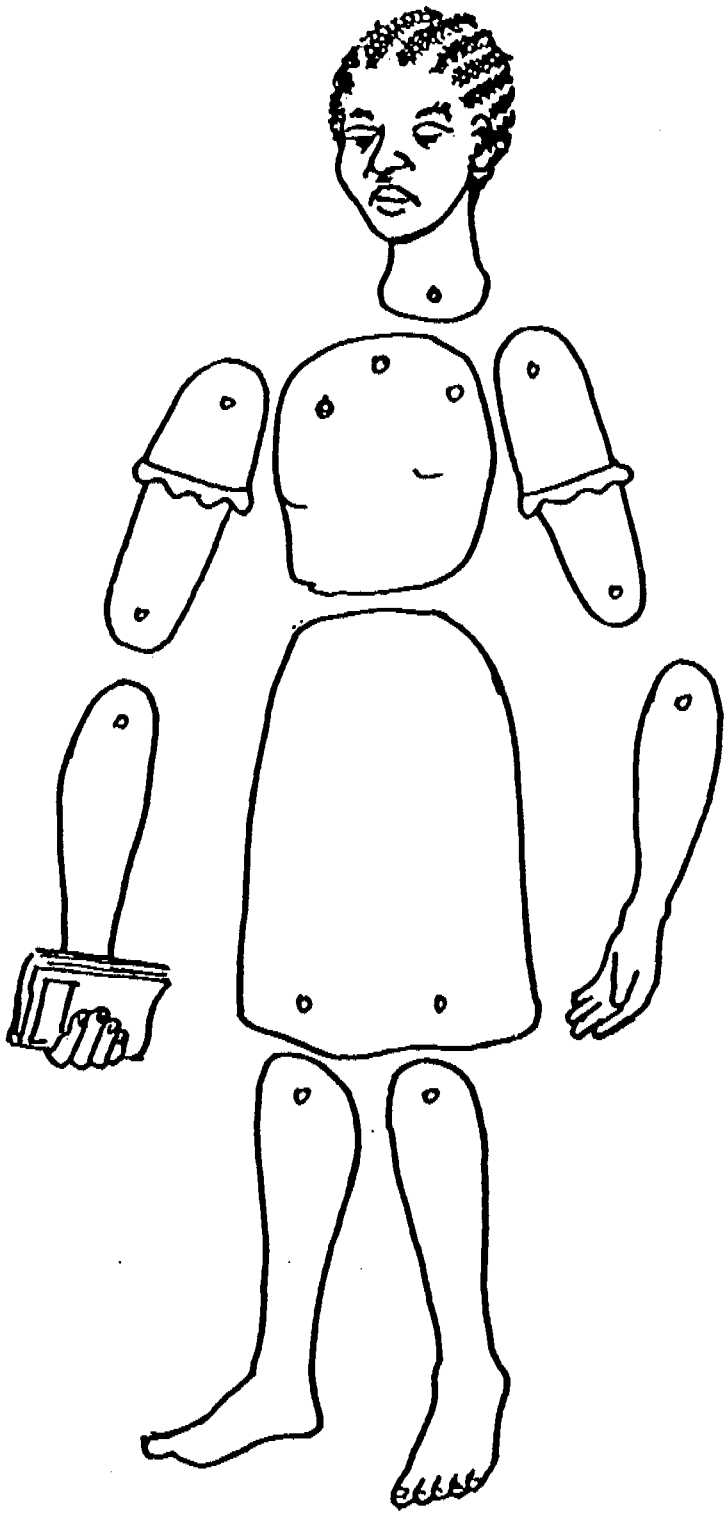


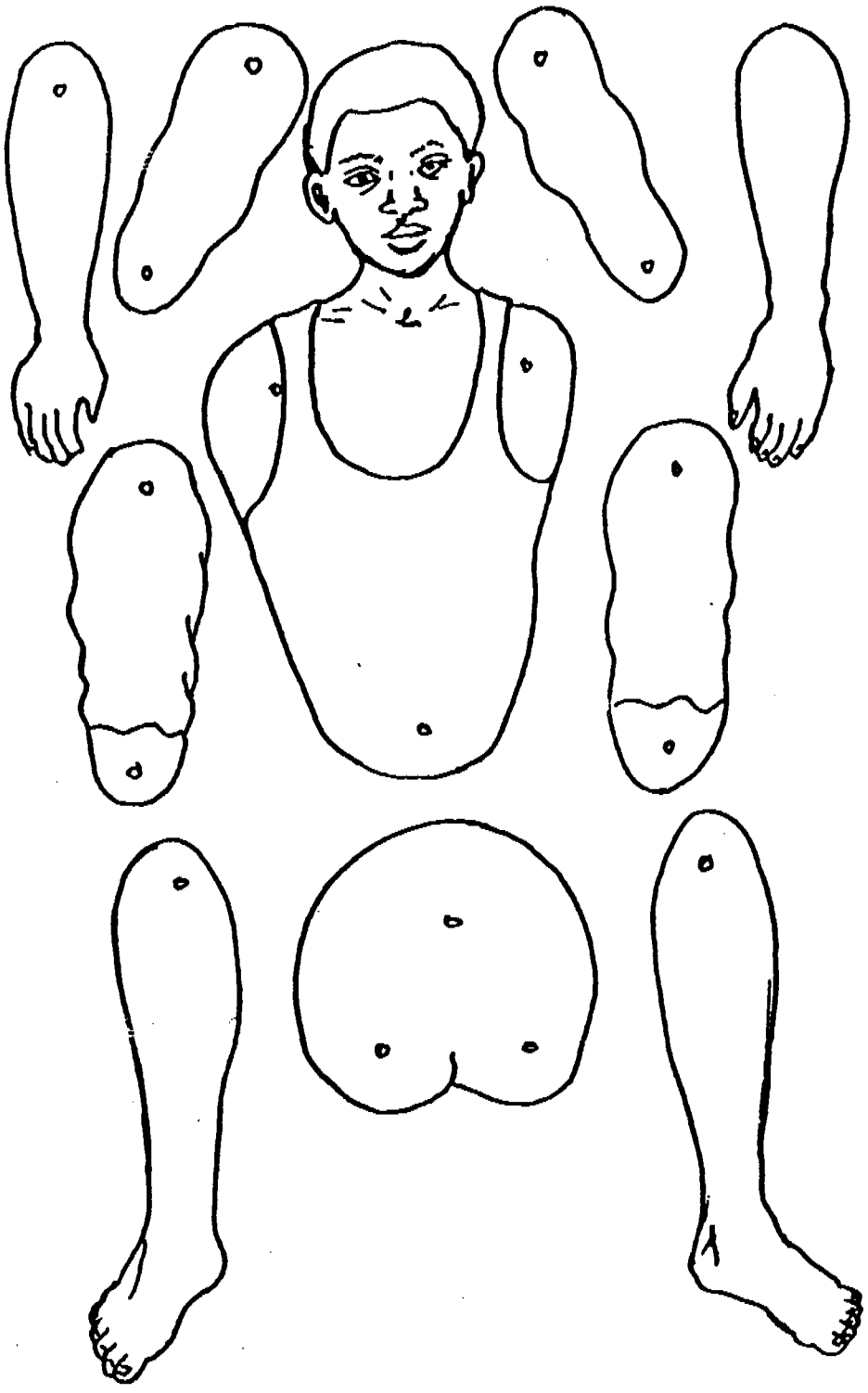


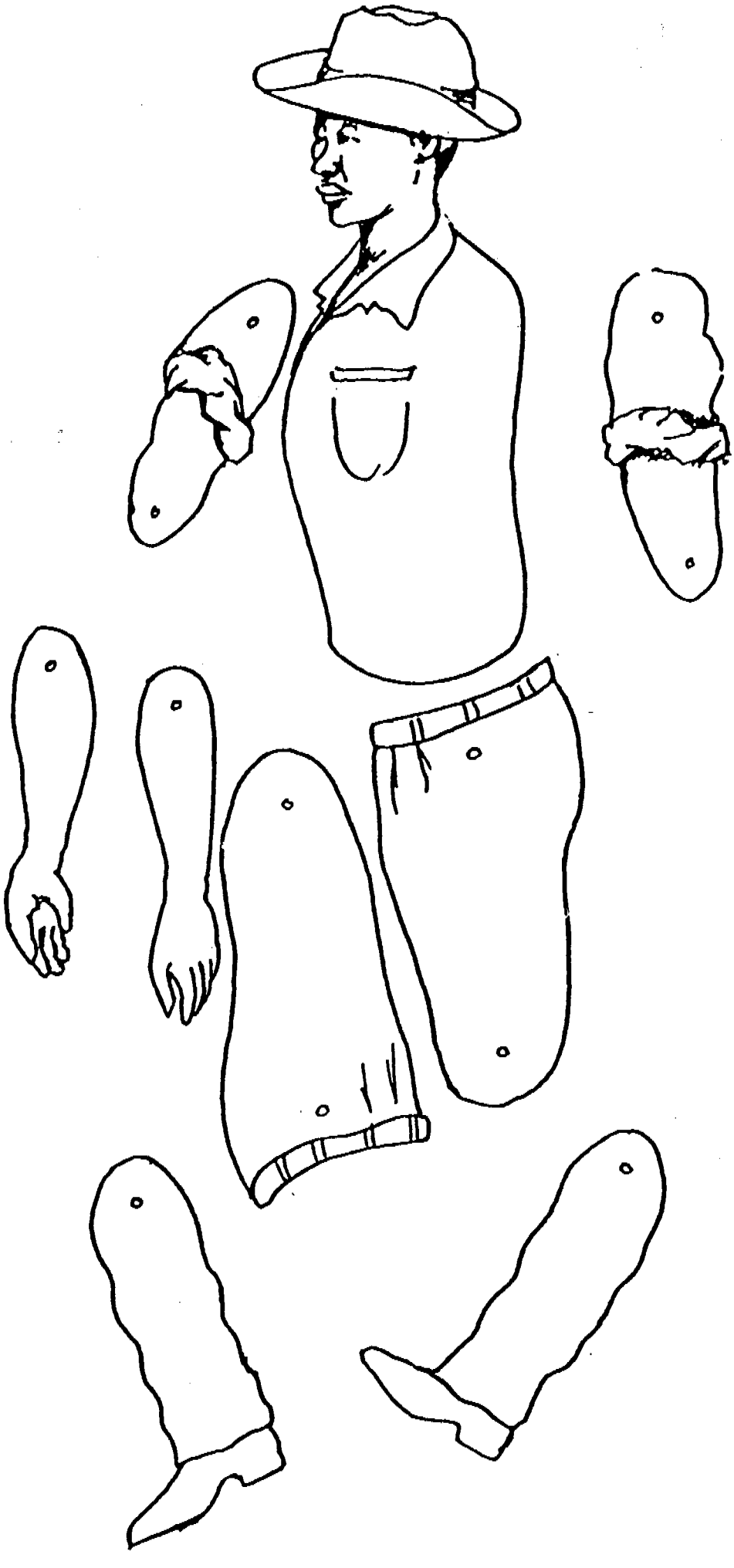


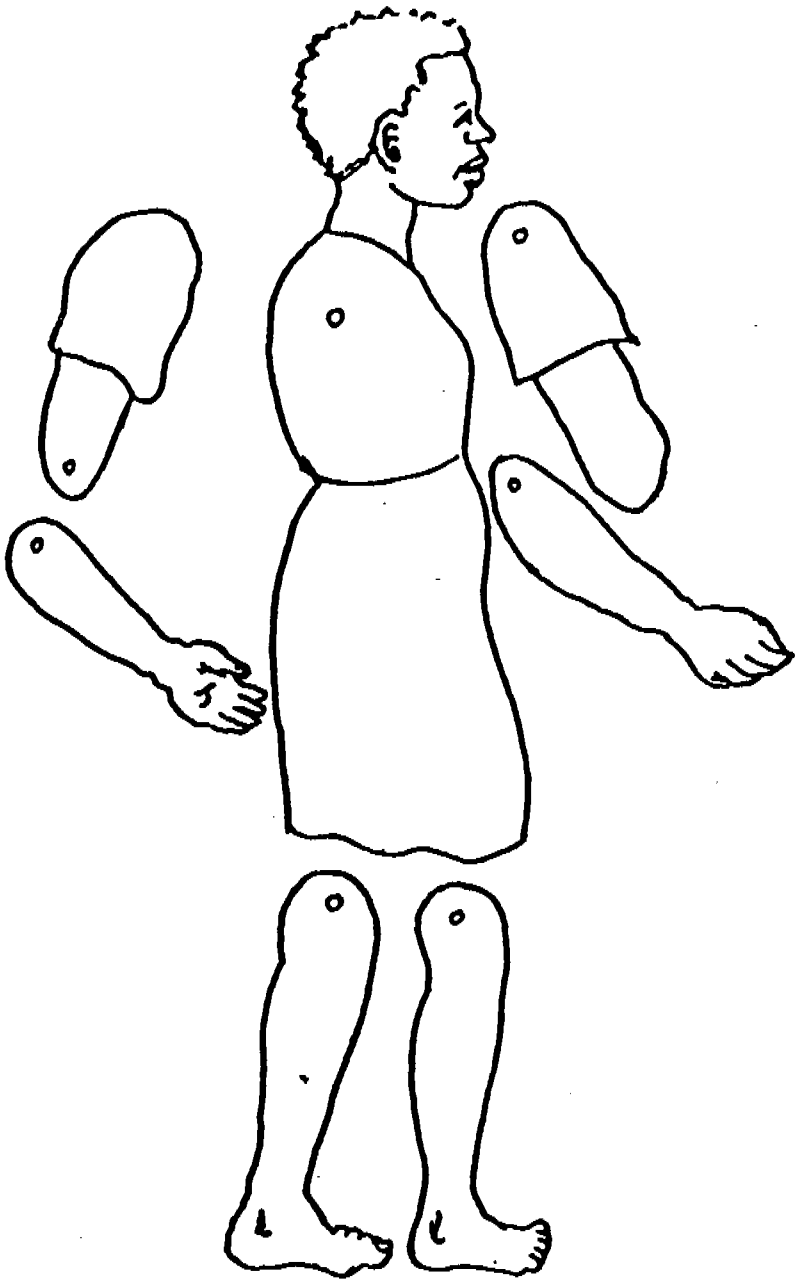


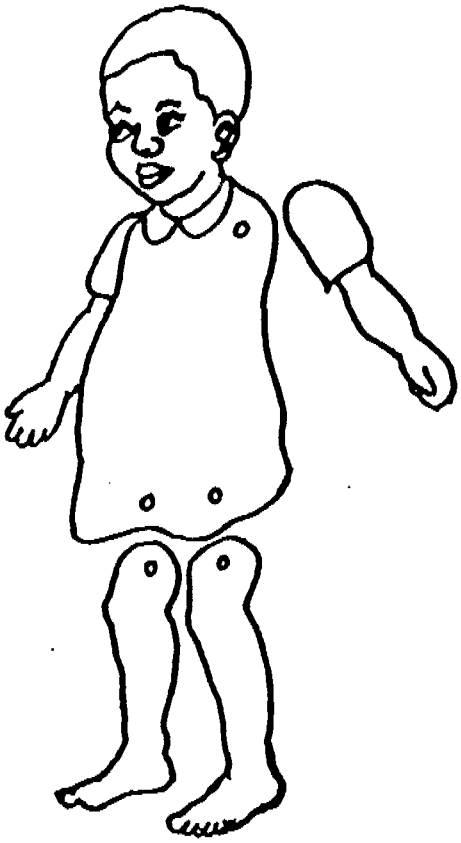


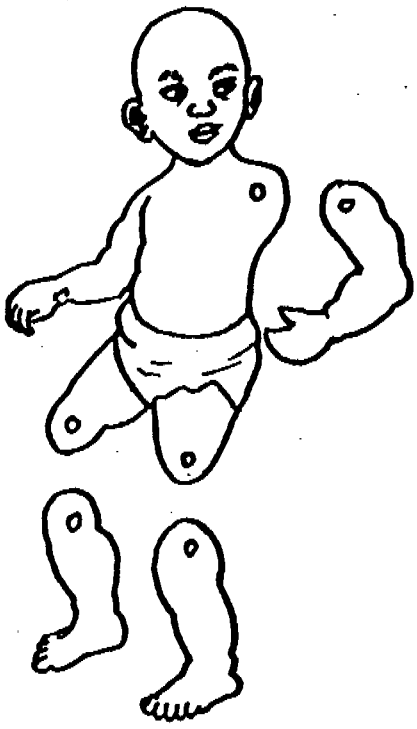


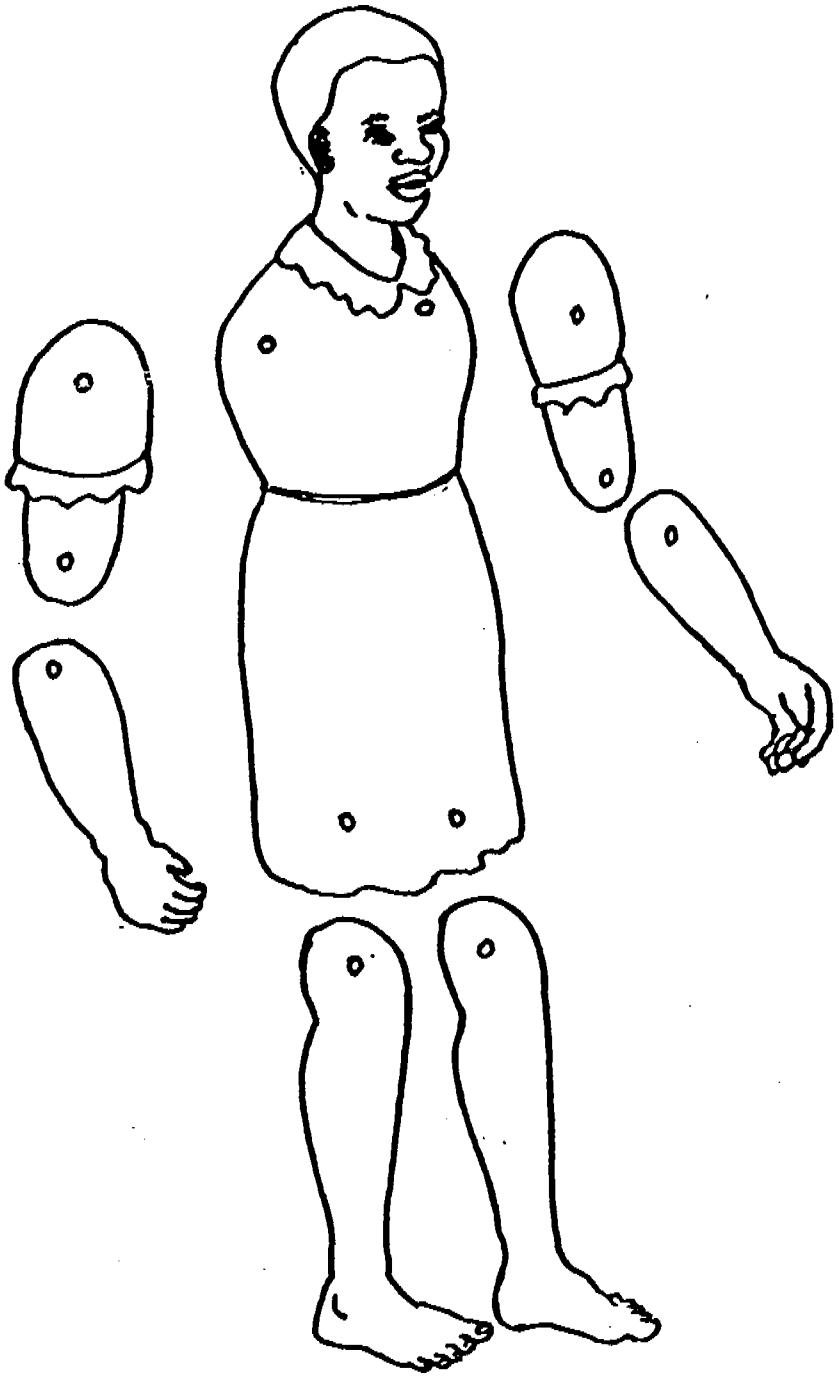


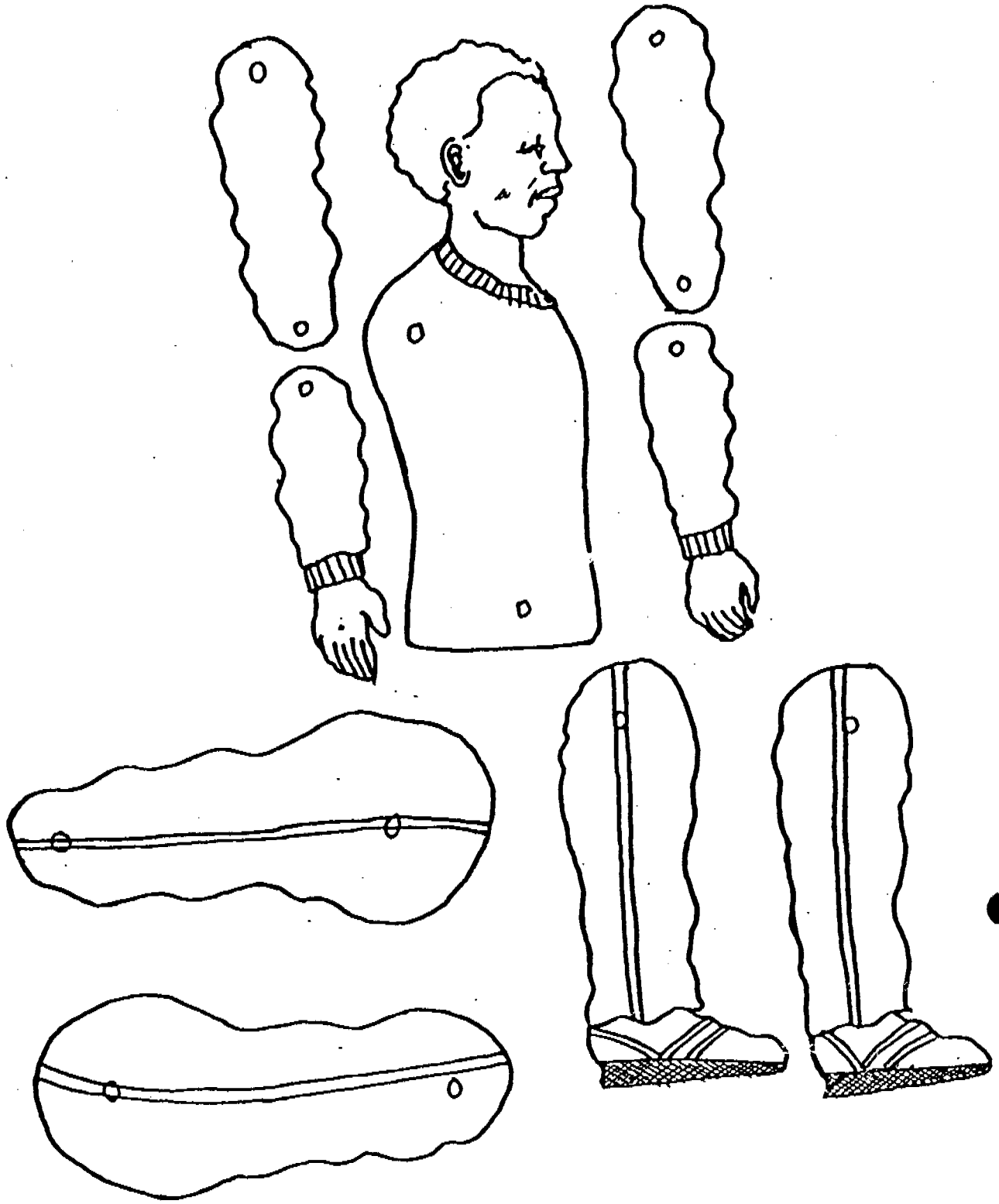


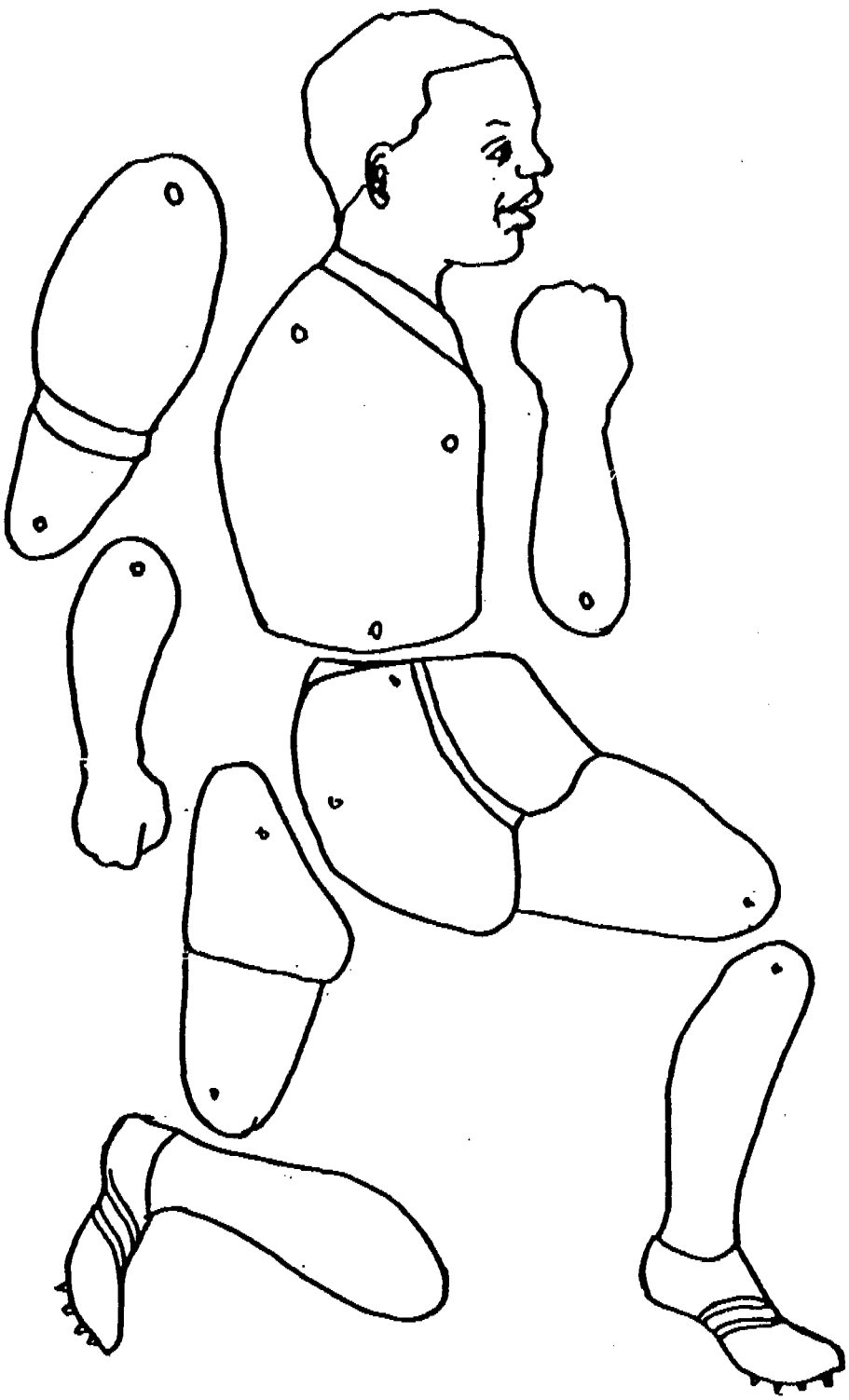


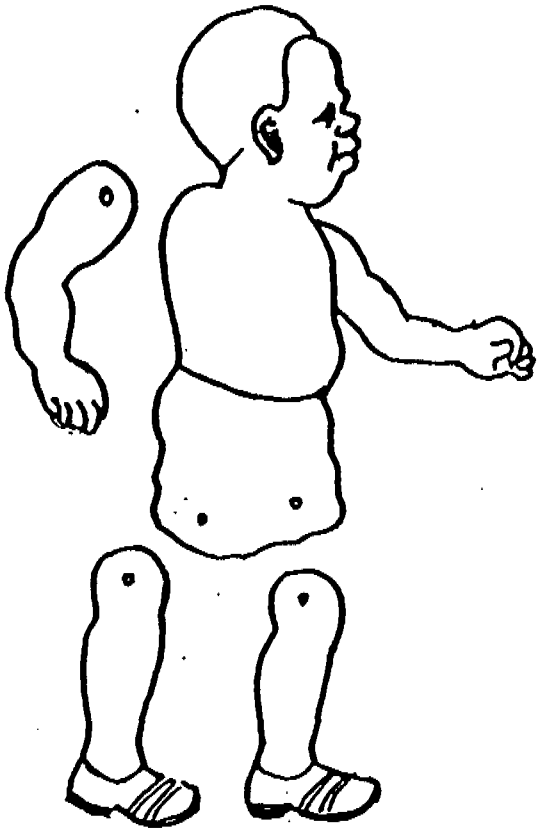


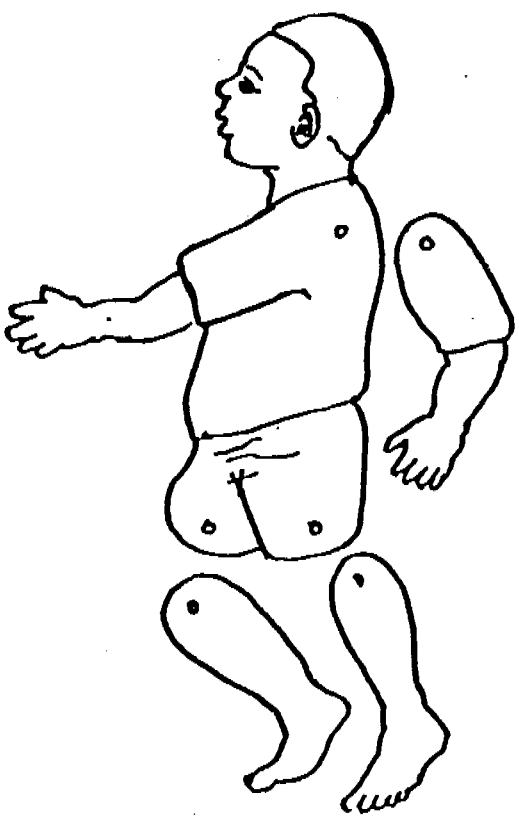


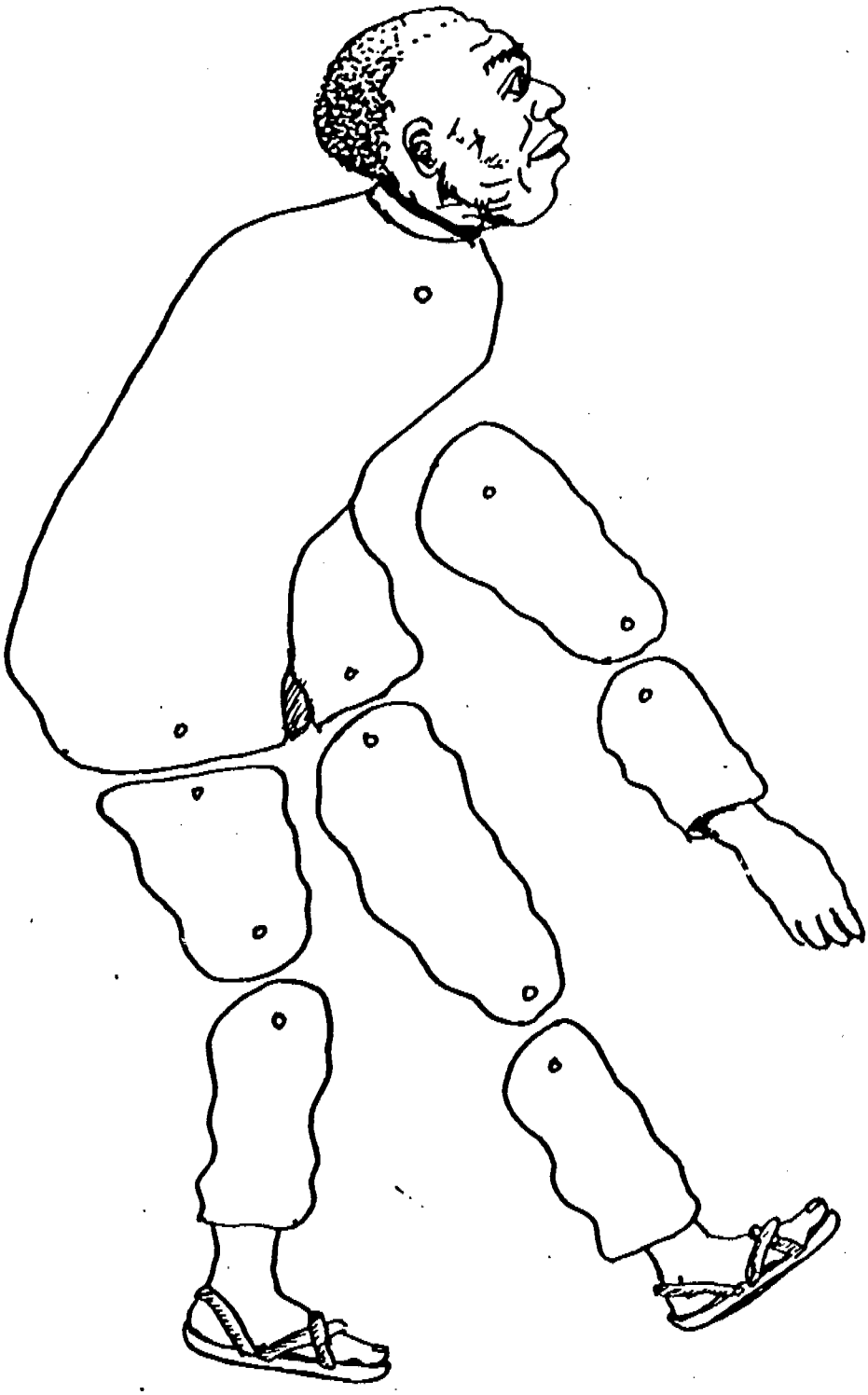


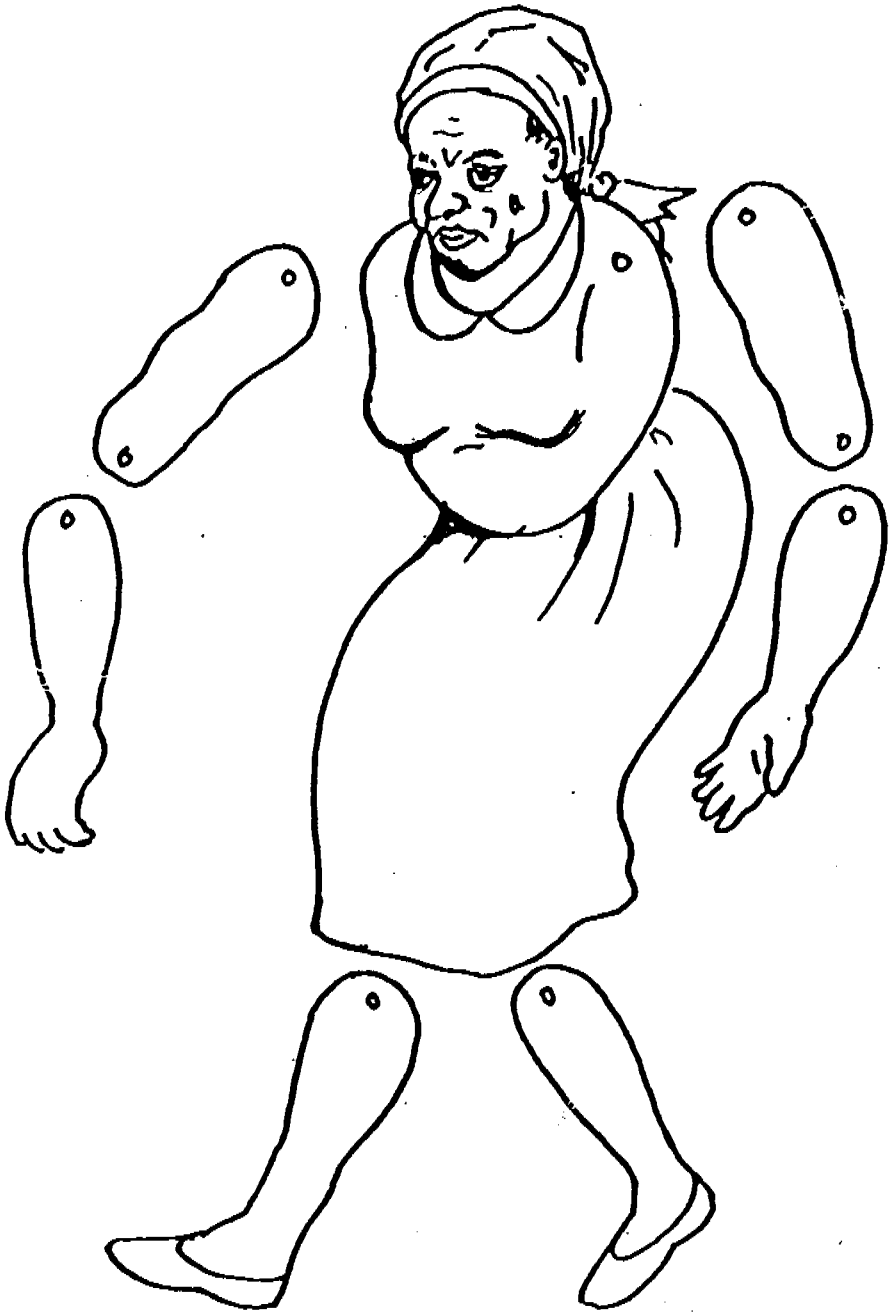


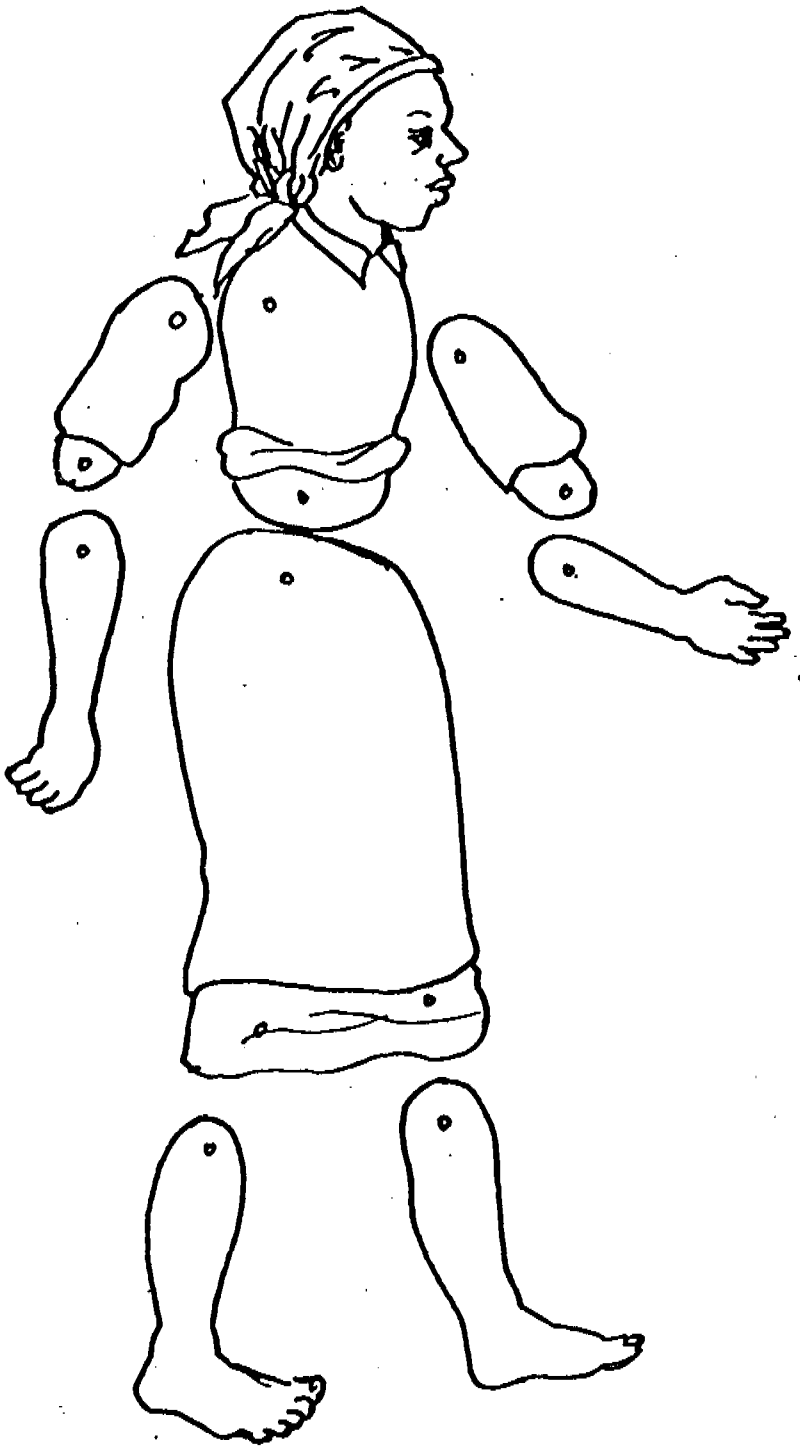


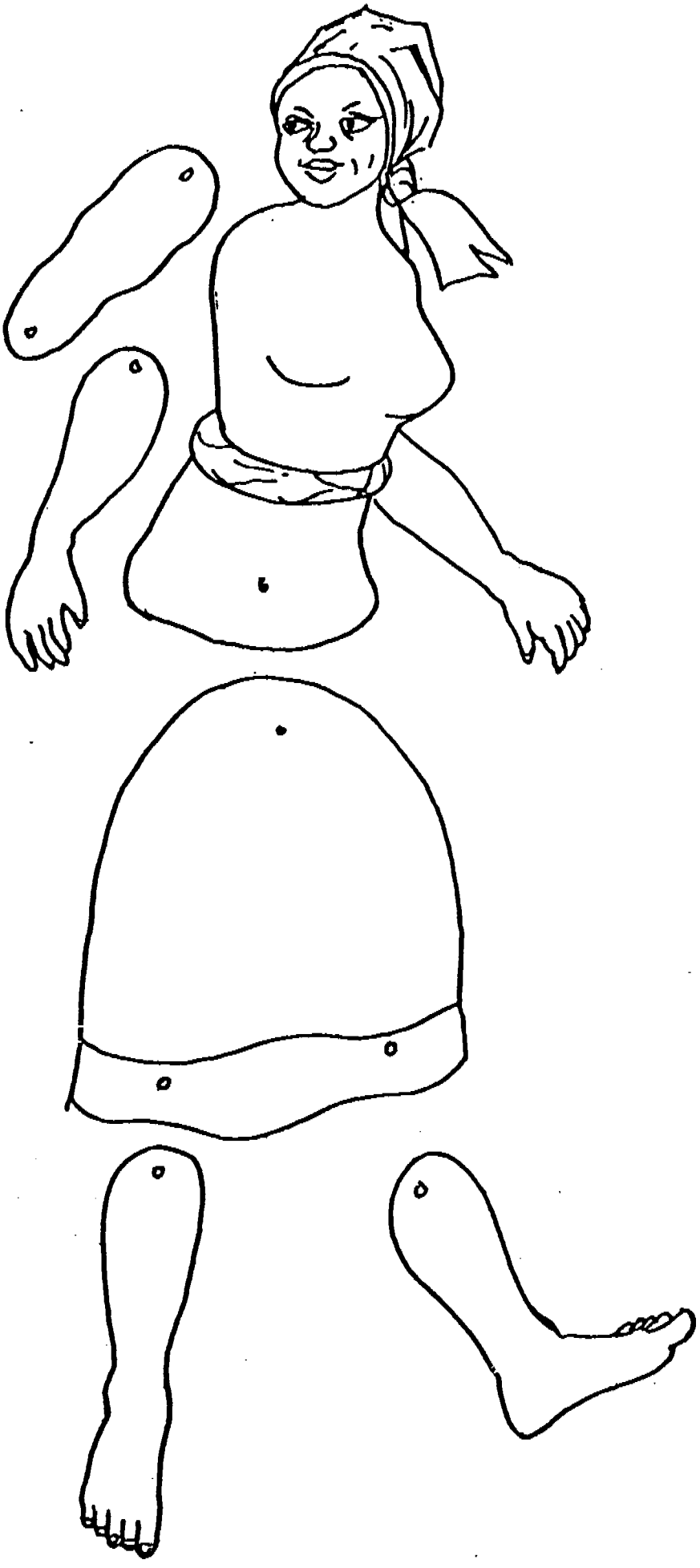


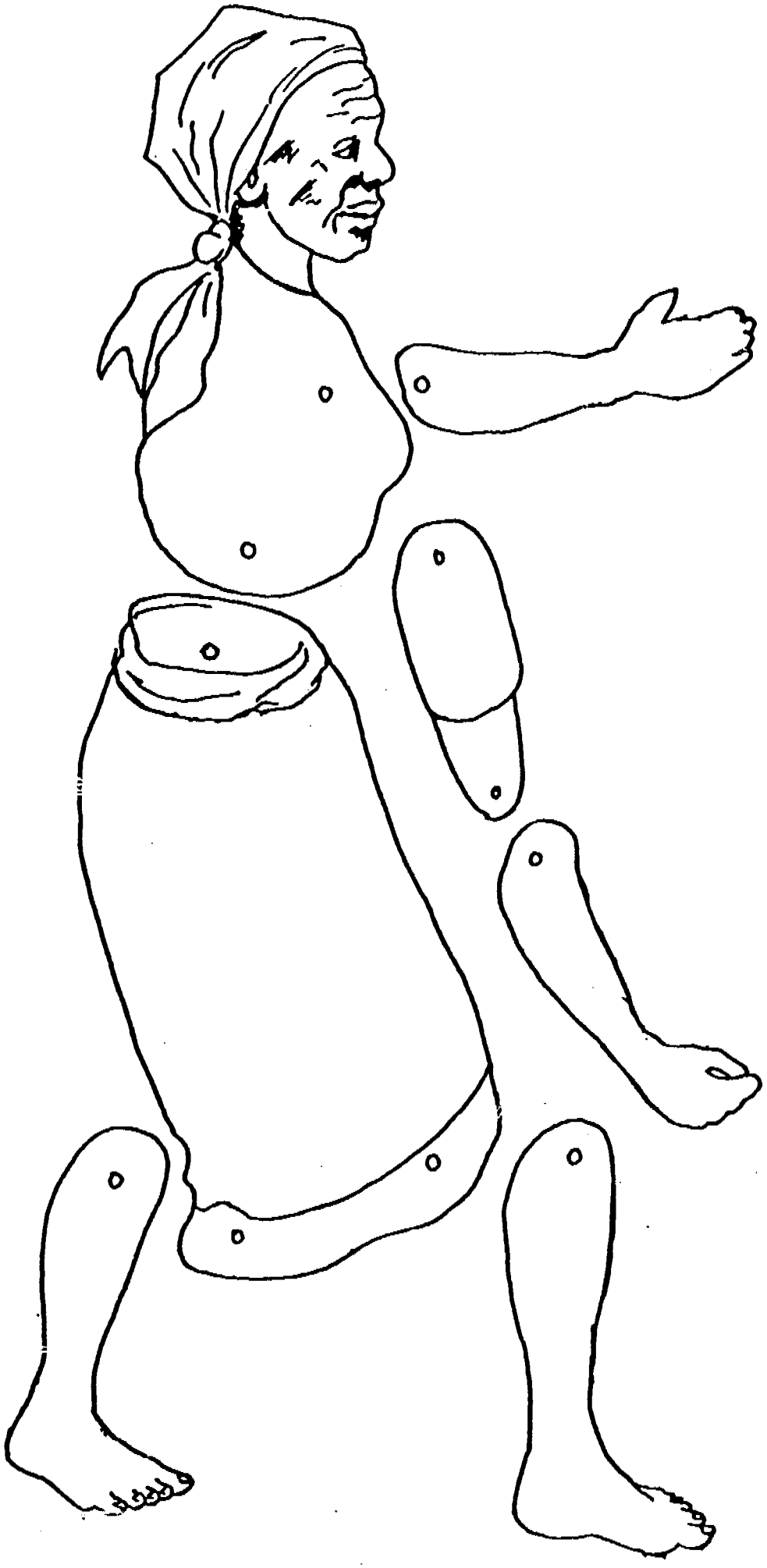


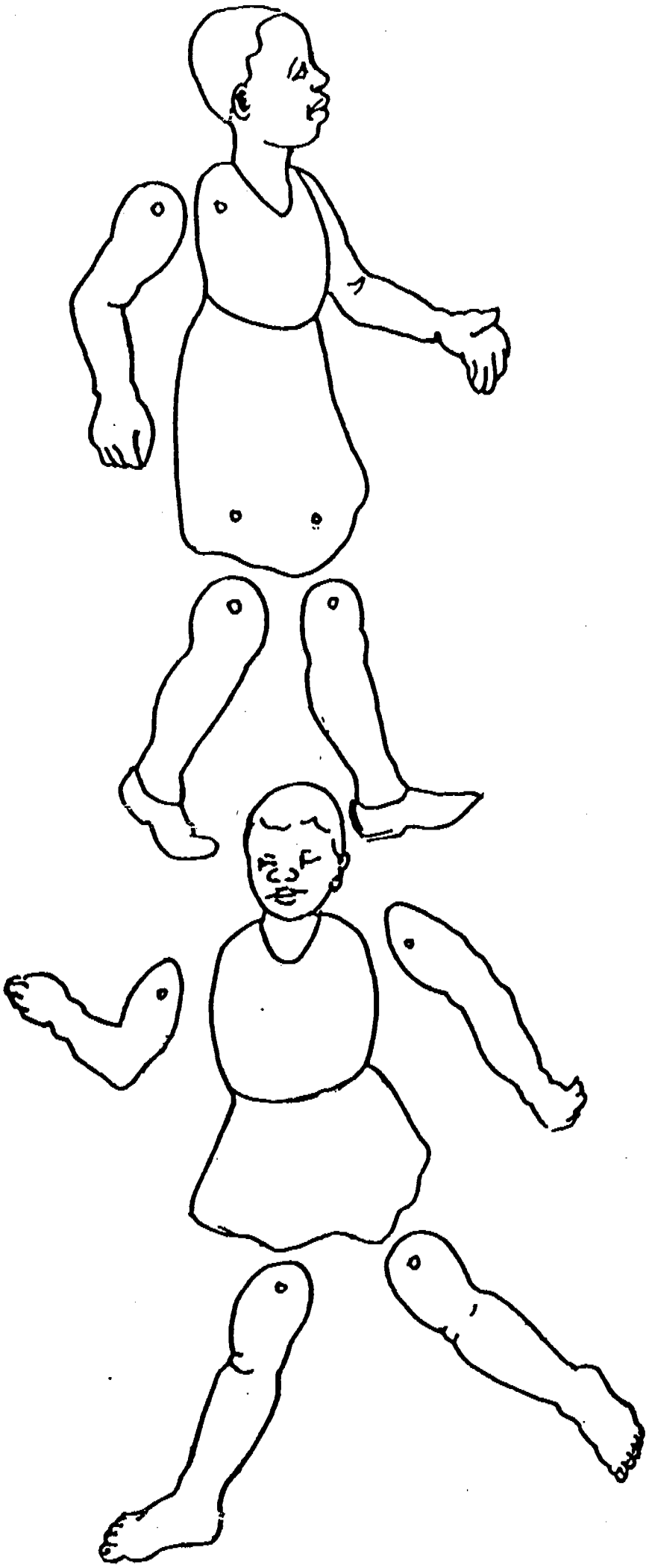


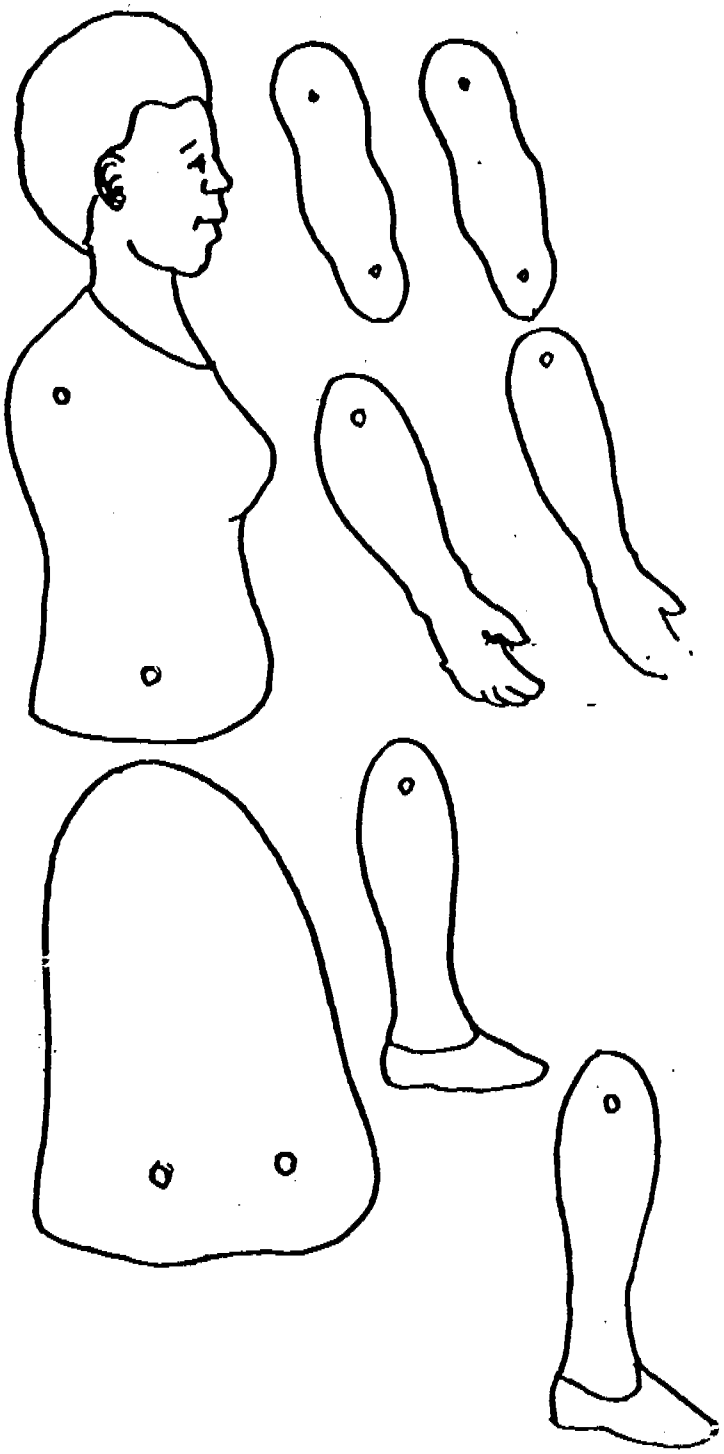


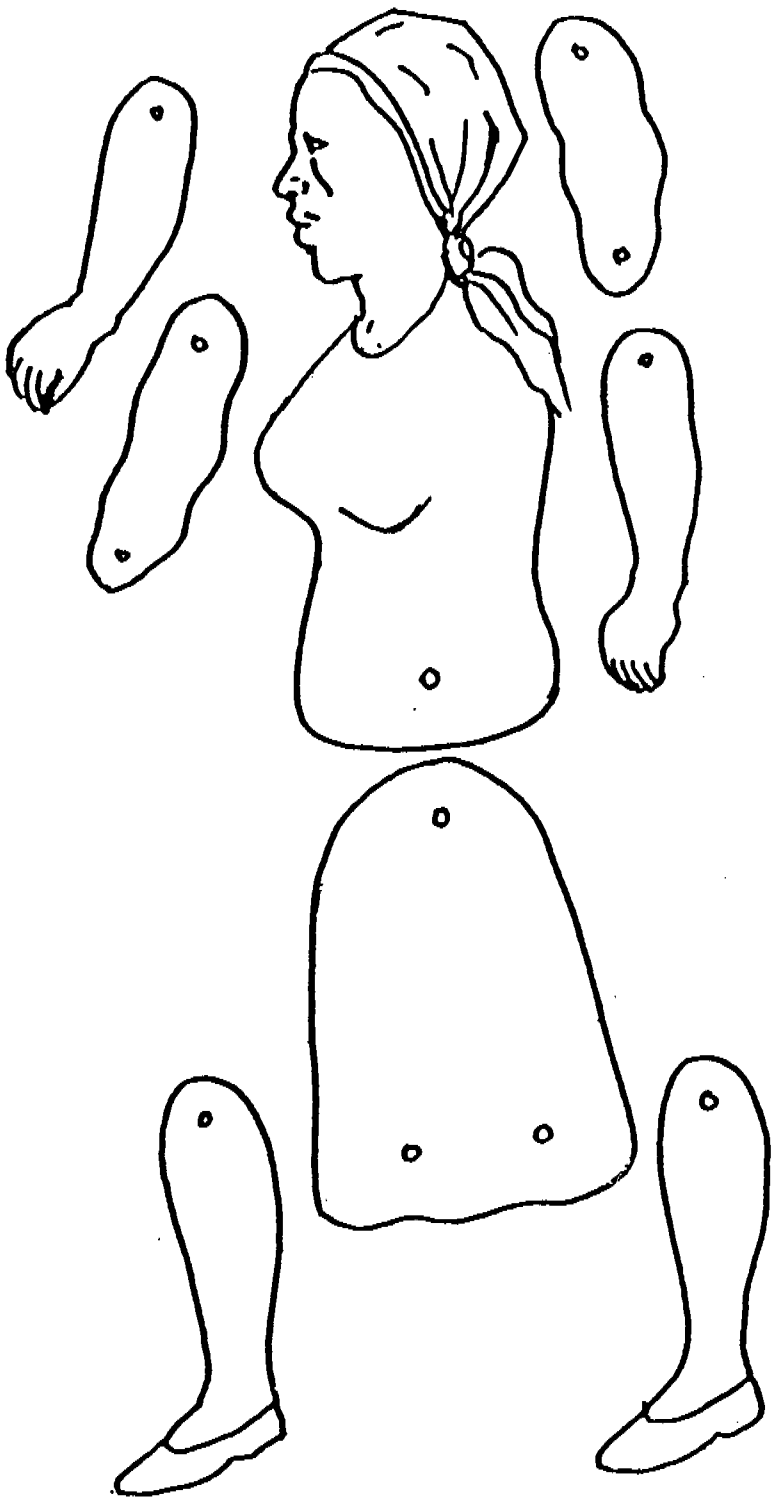












OPEN-ENDED STORY

OPEN-ENDED PROBLEM DRAMA

Question: Which story is open-ended and which is closed?

Story One

Once upon a time there lived a young man called Wao in the village of Thika. He went to school and completed his primary education before getting married.

When he had been married for some years, the burden of bringing up his family became more cumbersome. Together with his wife, they decided that Wao should go to the big city and seek employment. Luckily as soon as he got to the city, he was hired as a Clerk in a large departmental store drawing a handsome salary. Out of sight out of mind so the saying goes. Wao forgot all about his family. He made new acquaintances and squandered away his livelihood. All cries for help assistance from his wife and children went unattended.

One morning, Wao got to his place of work and found himself declared redundant. Quickly his meagre savings were used up. He had no job, no jobs, no friends to come to his assistance. However, a former workmate, Kanga, said to him, why worry - you are married, you have a family - just pack-up and return home. In his conscious - he knew not how to do this. His other colleague, Owen, said - look for a new job.

Story Two

John lived with his wife, Mary and their 2 years old boy Paul in the village of Najja. Their village had a lot of rainfall throughout the year and was fertile. They grew a lot of banana and beans. Bananas was their staple food and sold off the beans to get cash. The eggs from the hens they kept were only eaten by the husband. The customs of the area forbid women and children from eating eggs and chicken.

One day a health worker visited the family and found that the boy was suffering from malnutrition when he asked the parents they explained that the boys condition which they called "OBWOSI" was caused by the mother's pregnancy i.e. because the mother was pregnant again. When the health worker investigated further, found more about the customs of the area and the feeding pattern of the family. After that discovery, the health worker took time to explain to the parents the cause of the boys, condition. He explained that the boy was denied proteins foods like eggs, beans etc. and that resulted in this condition called Kwashiorkor. After a long time the parents accepted the Health Worker's explanation and advice.

The participants were to decide which story was open ended and which was pre-determined. The participants were also to give three characteristics that make an open ended story and to devise one open ended story of their own.

Story Three

There once was a man named John, who lived with his wife mary and son Paul in a village called Katla. Katla had a plentiful supply of water, the climate was good and the soil was rich. John and Mary planted many crops, including beans to sell for cash. They were also raising chicken. May and Paul were not allowed to eat the beans, which were for sale, they weren't allowed to eat any eggs or chicken either because these were only considered suitable for the man of the family.

One day they were visited by a Community Health Worker. He saw that Paul was malnourished. He tried to find out the cause. The parents said that they thought it was because Mary was pregnant. The CHW was puzzled-how could this have any effect. He eventually found out that Paul was malnourished because although there was sufficient nutritious food available John was eating most of it himself.

The CHW counselled the family. He explained to them that Paul needed to eat more nutritious food, particularly eggs and beans. Mary and John understood that the CHW had a point. They gave him eggs an beans and his health improved. The family happy and decided to throw a party for the CHW.

Story Four

Nakato was young widow aged 22. Her husband had just died in a road accident. She was left to bring up their 1 year old child. Nakato decided to go to live with her Mother-in-law, Nasuma. Shortly after she had moved into Nasuma's compound Nakato's child became ill, he had bad diarrhoea.

Nakato didn't know why he was ill or what to do about it. Nasuma treated the child with barbs but he didn't get any better. Nasuma advised Nakato to take her grandson to the local witchdoctor. One day the village leader came to visit. He could see that the child was seriously ill and told Nakato to take him to the district clinic as soon as possible.

Nasuma insisted that as the grandmother her advice should be followed. The leader said he was in charge of the village and should be listened to. Nakato was confused who should she listen to? If she didn't listen to her Mother-in-law she might be turned out of her home. If she didn't listen to the leader she might be asked to leave the village or even be arrested.

RESISTANCE TO CHANGE
CONTINUUM A+B

IM WILLING TO DEMONSTRATE

THE SOLUTION TO OTHERS AND

ADVOCATE CHANGE

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IM READY TO TRY SOME ACTION

==========

I SEE THE PROBLEM AND IM

INTERESTED IN LEARNING

MORE ABOUT IT

==========

THERE IS A PROBLEM BUT IM

AFRAID OF CHANGING FOR

FEAR OF LOSS

==========

THERE'S NO PROBLEM

==========

YES, THERE IS A PROBLEM

BUT I HAVE MY DOUBTS

= =

THERE MAY BE A PROBLEM

BUT IT'S NOT MY

RESPONSIBILITY

= =

JOHARI'S WINDOW