E+A Unit.

Participatory Hygiene Education in Zimbabwe

An Evaluation for Irish Aid

(FINAL DRAFT)

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November 1997

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Executive Summary

Since 1993 the Government of Zimbabwe, through the Ministry of Health and Child Welfare has being supporting hygiene education through a participatory process known as the Participatory Hygiene Education and Sanitation Project. The objectives of the project are to:

- promote the development of health lifestyles through a sound hygiene education programme
- strengthen national policy on health and hygiene promotion through training of health workers, extension workers and community members
- develop monitoring and evaluation indicators and strategies
- provide support in the production and distribution of promotional and educational materials.

Following a request, channelled through UNICEF, Irish Aid agreed to support project activities for a three year period, August 1995 to July 1998, with a review in mid 1997. This document represents the findings of the review which was undertaken in August 1997. The Review, co-ordinated by UNICEF in Harare was conducted through:

- Filed visits: to districts in Mashonaland East and Central, Matebeleland North and South and Manicaland
- Interviews with a cross section of the actors involved
- A study of existing documents, training materials, progress reports and previously undertaken studies.

The Evaluation Team is of the opinion that the most value can be gained if a critique of the project is offered rather than a statement of perceived "success" and by any implication of "failure". Project evaluation exercises can tend to become "shopping lists" of inputs, outputs, achievements, shortfalls, constraints and recommendations. This information is obviously vital, but in an attempt to encourage future growth it is important to examine cause and effect. Before presenting a critical examination it is important to make the following points:

- the Project is extremely complex both from a conceptual viewpoint and an operational one;
- the significance of the project as a valuable learning exercise should not be underestimated;
- it is important therefore to consider its importance not only from an accountability and "job done" stance but also in terms of research and development implications;
- the Project by its very timing, background and nature is experimental; the basic foundations of participatory approaches were in place before the project was conceptualised. However the context is specific and prior to the Project unexplored to such depth;
- the Project has an implied responsibility to inform, particularly because of its development in a key area of interest, many regional countries, some being Irish Aid priority programme areas, which are pursuing participatory approaches to improve water supply and sanitation programmes. Many are not as far in development terms as Zimbabwe (in this context), and the lessons of the PHE experience are of undoubted value.

The following review is presented in the light of these points. The recommendations are made in light of considerable thought with regard to the most appropriate way to move forward given the sheer complexity of the Project.

The recommendations are intended to allow the Project to capitalise on the wealth of enthusiasm, dedication and support that is evident for the continuation of the development of participatory hygiene education. The recommendations should be considered against the following statement.

It is believed that the value and significance of the participatory hygiene education experience in Zimbabwe should not be underestimated. From the point of view of development per se both regionally and locally, the importance of the lessons learned by the Project is tremendous. The

PHE initiative places Zimbabwe at the forefront of development in the area of research into the sustainability of the approach; the foundations are relatively secure and the programme sufficiently advanced to enable meaningful evaluation of the impact of PHE to begin. The Project is operating within a dynamic research and development environment where the very practise of the approach is resulting in an incredibly steep learning curve. This fact should be recognised and capital made of its potential.

Establishing the context for the recommendations is very important and it is suggested that:

all the recommendations work within an integrated community based management framework that internalises the project cycle approach. This means that it is essential that the project cycle concept is fully understood. By this we mean that basically the project cycle should allow for two things to happen:

- that the actual process approach to PHE develops and grows, and that
- the effectiveness of the process approach is maximised through the application of functional management systems designed specifically to support it.

Essentially the process approach is based on a non prescriptive, non directive and developmental philosophy while functional management is specific, measurable, achievable, realistic and time-bound (SMART). In a project cycle approach to community based development the process can never reasonably exist if it is not managed in a strategically functional manner.

Finally it is recommended that Irish Aid continue its support for this very important project. The focus of future support should be in the areas of consolidation of the existing activities with a strong emphasis on research to inform future development. The process of introducing PHE to the remaining districts will be carried forward given that expectations have been raised and this should be supported for the remainder of the present phase of funding. However, plans for future activities, that is, beyond the current phase of funding, must be time bound and have measurable outputs and clear indicators for success. Therefore the recommendations outlined in detail in this document should be addressed during this present phase.

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THE TASK

The following report is a result of a review undertaken on behalf of Irish Aid of the Government of Ireland. The subject of the report is the Participatory Hygiene Education and Sanitation Project that is being executed by the Ministry of Health and Child Welfare and UNICEF, Zimbabwe.

The Evaluation Team, made up of four professionals, spent three weeks with the Project in an attempt to understand, analyse and critique the applied philosophy and strategy for implementation. The Team in compiling this report offers its collective opinion and hopefully accurately reflects the hopes and fears of those that work so closely to the Project on a day to day basis.

A summary of the terms of reference:

- To evaluate the degree of completion of the project and the actual relevance of the plan of action.

- To determine the extent to which the overall and immediate project objective have been met

- With regard to the specific area of of participatory hygiene education examine:

  Quality and relevance of training and approach
  Materials developed and produced
  Indicator identification and monitoring
  Impact on health and behaviour change
  Community involvement
  Implementation strategies

- With regard to the specific area of sanitation

  Implementation strategies chosen
  Quality of latrines constructed
  Training of builders
  Impact on health and the environment
  Community involvement

- With regard to family well protection examine:

  Quality of construction
  Implementation strategies
  Training of builders
  Impact on health and the environment
  Community involvement

- Examine the policy and programme context in which the project is set in relation to national and other donor funded activities

- Comment on the efficiency of the project and determine overall costs and benefits in monetary terms

- Critique the overall project in relation to environment, gender and poverty alleviation issues
- Assess the overall management of the project and comment on institutional sustainability and capacity building issues
- Identify any limitations and constraints that have arisen during the implementation

- Make recommendations in relation to continued future funding of the Project and any modifications and or adjustments that should be considered in any future planning mission

The Review, co-ordinated by UNICEF in Harare was conducted through:

Filed visits: to districts in Mashonaland East and Central, Matebeleland North and South and Manicaland

Interviews with a cross section of the actors involved

A study of existing documents, training materials, progress reports and previously undertaken studies.

A significant amount of reference is made to Kieth Wrights report (**Participatory Hygiene Education: A People Centres Approach to Behaviour Change in Hygiene**; K. Wright, UNICEF/MOHCW 1996) and extracts are reproduced in this report which add to the bulk of the document. While every effort has been made to keep this document as concise as possible the evaluation team feels that Mr Wrights report, compiled over one year earlier than this document, has important contributions to make in relation to the future direction of this project. Given the fact that Mr Wrights report had only just received approval from the MOHCW for publication and general circulation at the time of the evaluation it has been necessary to reproduce sections in this document. We would like to take this opportunity to acknowledge the contribution of Mr Wrights work.

ACRONYMS AND ABBREVIATIONS

AGRITEX	Agricultural Extension Services
CBM	Community Based Maintenance/Maintenance
DANIDA	Danish International Development Agency
DCM	Decade Consultative Meeting
DDC	District Development Committee
DDF	District Development Fund
DWR	Department of Water Resources
DWSSC	District Water Supply and Sanitation Sub Committee
EHT	Environmental Health Technician
IRWSSP	Integrated Rural Water Supply and Sanitation Programme
Mat North	Matabeleland North
Mat South	Matabeleland South
MLGNH	Ministry of Local Government and National Housing
MLGRUD	Ministry of Local Government Rural and Urban Development
MNAECC	Ministry of National Affairs Employment Creation and Co-operatives
MOF	Ministry of Finance
MOH & CW	Ministry of Health and Child Welfare
MRRND	Ministry of Rural Resources and Water Development
NAC	National Action Committee
NCU	National Co-ordination Unit
NEPC	National Economic Planning Commission
NGO	Non - Governmental Organisations
NORAD	Norwegian Agency for Development
ODA (DFID)	Overseas Development Agency (DFID)
PDC	Provincial Development Committee
PEHO	Principal Environmental Health Officer
PEHT	Provincial Environmental Health Technician
PHE	Participatory Hygiene Education
PREHO	Principal Environmental Health Officer
PROWWESS	Promotion of the Role of Women in Water and Environmental Sanitation Services
PWSSC	Provincial Water Supply and Sanitation Sub Committee
RDC	Rural District Council
RNWMP	Rural National Water Master Plan
SIDA	Swedish International Development Agency
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCW	Village Community Worker
VIDCO	Village Development Committee
WADCO	Ward Development Committee
WHO	World Health Organisation

PEOPLE MET

NAME	Title/Organisation	Location
Chademana S R Mr	Acting DEHO	
Chili Mr.	EHT	Gwanda
Dewa Mr	Assistant DA	Umzingwane
Dooley T Ms	Project Officer	Unicef
Jaravaza Ms	Provincial Hydrologist	Mash East
Jarn Mr	Field Officer	Umzingwane
Jhoto Mr	Supervisor	Umzingwane
Khupe S Mr	A/Project Officer	Unicef
Maeda J Mr	Res. Representative	Unicef
Masuka S Mr	Project Manager	Africare
Matiringe C Mr	PREHO	Makoni
Mwaunganidze Mrs	Project Officer	UNICEF
Mboko Mr	PEMT	Goromonzi
Mlilo O Mr	Council Chair	Gwanda RDC
Moyo F Mr	DEMO	Lupane
Mthuthuki Mr	PFO	Mat South
Mucheni Mr	Field Supervisor	DDF Hwedza
Mudoti C Mr.	District Clerk	DDF Hwedza
Mudzingwa E Mr	EHT	Goromonzi
Munjere C Mr	Senior Hydrologist	DDF
Munemo C Mr	Field Officer	DDF Hwedza
Muphosa S Mr	PEHO	Mat. North
Mupingo K Mr	DA	Hwedza
Musango T R Mr	PEHT	Makoni
Musingarabwe Mr SS	Director EHS	MOHCW
Mutongomanga L Mr	EHT	Mutasa
Muzamhindo R Mr	Chief Water Engineer	DDF
Mwarumba C Mr	EHT	Makoni
Mwiisi Mr	D/A	Mutoko
Ncube Mr	EHT	Esigodini
Ndebele J Mr	SEHT	Lupane
Nyamayero Mr	F/O	Mutoko
Nyoni Mr	EHT	Esigodini
Nyoni Mrs	EHT	Esigodini
Rajbhandari B Mr	Project Officer	WES Unicef
Rukasha W Mr	PEHO	MOH&CW
Senda B Mr	PEHT	Lupane
Senyaui Mr	Hydrologist	DWR
Sibandu P Ms	EHT	Lupane
Sibandu R Mr	CEO	Gwanda RDC
Sibanda S K Mr	MNAECC	Gwanda
Sithole C Ms	EHT	Lupane
Tandi W M Mr	PEHT	Mutasa
Toriro Mr	O & M Technician	DDF
Zulu S Mr	Hydrologit	Mat South

DEFINITIONS

The following definitions are provided to help the reader better understand the context in which the evaluation team considered the activities of the PHE project.

By **Community Management** we mean:

that the community has the full potential and ability to organise self determined change through taking authority, responsibility, accountability and control for their own development

By **Gender** we mean:

the context of both women's and men's lives that can together affect self determined change- gender is not a women's issue alone.

By **Process** we mean:

The process is the utilisation of an approach to change hygiene behaviour through participatory methods. The process should not be confused with the tools, methods and techniques that are deployed as vehicles to operationalise it. The process is one of participation, negotiation, dialogue and sharing through respect for all ideas. It is about maximising the opportunities for key behaviour change

By **Philosophy** we mean:

the SARAR philosophy and a belief in the strengths of participatory methods and tools that underpin the project, an approach that is non-prescriptive, non-directive and developmental.

By **Tool** we mean:

A tool being an instrument that is used during a learning process that is designed to attract people to participate and focus on a specific topic.

By **Training** we mean:

Empowering participants in training with the necessary attitude, skills and knowledge to allow them facilitate the PHE process.

Acknowledgements

The review team would like to take this opportunity to offer our sincere thanks to those who gave their time and energy to help facilitate this review exercise. A special thanks is extended to staff at the Ministry of Health and Child Welfare, in particular Mr Willie Rukasha who took the time to travel extensively with us and provided us with invaluable knowledge and experience during the review exercise.

In addition we would like to express our gratitude to all the staff at UNICEF for their logistical and administrative support during the review process. We would especially like to thank Therese Dooley and Shadrak Khupe, both UNICEF Project Officers, who supported us with their vast experience in the area of participatory hygiene education.

Finally we would like to thank all the field staff we had the opportunity to meet and who gave time to demonstrate the PHE methodologies and share their experiences.

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August 1997

1 SETTING THE CONTEXT

1.1 Background

This report offers a considered evaluation of the Irish Aid funded components of the participatory hygiene education activities in Zimbabwe. The Participatory Hygiene Education and Sanitation Project, facilitated in conjunction with UNICEF, resides in the Ministry of Health and Child Welfare of the Government of Zimbabwe and is implemented against the following background. Rural water and sanitation in Zimbabwe is facilitated through the Integrated Rural Water and Sanitation Programme (IRWSSP). The objective of the IRWSSP is to:

"improve the standard of living and health of the rural population through the provision of safe sanitation facilities and clean water"

Among the specific objectives is the desire to:

- promote positive hygiene behaviour change through
- educating communities in good behaviour
- set up sustainable operations and maintenance systems
- construct protected water facilities
- provide VIP latrines to every household

Hygiene education, an element of the IRWSSP, is seen as being important in reducing the life threatening problems associated with water borne and water washed disease.

In 1992 it was indicated that six of the main causes of hospital out patient attendance for children under five years in Zimbabwe were water related diseases. The most common diseases included malaria, diarrhoea, scabies, eye infections and schistosomiasis. Even with an improvement in infrastructural development in rural water supply and sanitation facilities, (65% coverage for water and 22% for latrines), there appeared to be no significant benefits related the health of the community.

This situation was endorsed in a regional workshop held in 1993 hosted by the Institute for Water and Sanitation Development, Zimbabwe and attended by representatives from Zimbabwe, Malawi, Mozambique, Lesotho and Zambia. The participants reached a consensus that significant behaviour efforts to activate change.

In the case of Zimbabwe it was noted that within the community there had been a significant transfer of information resulting in the existence of knowledge about good and bad hygiene behaviour. However, participants concluded that this knowledge did not manifest itself as actual behaviour change. Furthermore, the workshop observed that materials for hygiene education promotion existed and were continuing to be developed but they were often lost or were difficult to access.

It became apparent that the implementing agencies working to promote hygiene education were often not aware of what was happening else where in relation to the work or indeed of an overall common strategy. The situation was less than ideal and the workshop concluded that new methods for hygiene education promotion to induce behaviour change were called for. The Environmental Health Department in the Ministry of Health and Child Welfare holds responsibility for the promotion of hygiene education within the framework of the IRWSSP. Sector reviews to consider the progress of the IRWSSP questioned the area of hygiene education expressing concern around:

- the non -availability of an articulated strategy
- inadequate indicators for monitoring the process of hygiene education

- the actual impact of hygiene education activities
- the general belief that there was a lack of direction in relation to hygiene education

Hygiene education was seen as an on-going activity with no specific plans and outputs which was directed from the top with very little participation of the community. Even the Ministry of Health and Child Welfare and the National Action Committee (NAC) were not clear about the thrust hygiene education was to take hence the meager annual budgetary allocations of around Z $ 4 000 for the promotion of hygiene education in those districts implementing IRWSS projects.

In a move aimed at strengthening hygiene education, a consultant post was formed within the Ministry of Health and Child Welfare to take responsibility for addressing the issues of concern.

1.2 The Regional Perspective and the Emergence of Participatory Hygiene Education

In 1993 the World Health Organisation (WHO) and the UNDP/World Bank Water and Sanitation Group (East Africa), introduced an initiative in which participatory methods, earlier pioneered by the promotion of the role of women in water and environmental sanitation services (PROWWESS), would be used for the promotion of hygiene education and sanitation. The initiative was called Participatory Hygiene Education Promotion which later became known as PHAST.

This initiative reflected the concerns of many that the existing strategies were proving ineffective. It was now envisaged that the application of participatory approaches would lead to community empowerment that in turn would induce behaviour change. The new approach would serve to strengthen and support existing attempts to bring about key behaviour change in the community.

Five countries, Zimbabwe, Uganda, Botswana, Kenya and Ethiopia were invited to a Regional Workshop in Uganda to adapt existing participatory tools for the promotion of hygiene education and sanitation and to subsequently pilot them. The intention was that each country would adapt and pilot the participatory tools to meet the needs of their local conditions and culture. For most countries piloting started in mid - 1994.

1.3 Introduction of Participatory Hygiene Education in Zimbabwe

In 1993, following the Regional Workshop in Uganda, the Ministry of Health and Child Welfare approved the pilot of the use of participatory hygiene education in Zimbabwe. In February 1994 a pre-planning workshop was held to select the districts that would pilot the approach. At the same workshop the participatory tools were adapted in preparation for future training initiatives and the implementation of the pilot. The workshop was a collaborative effort between the Ministry of Health and Child Welfare, IWSD, SIDA and UNICEF.

The pilot districts, Goromonzi, Mutasa and Beitbridge were selected because they already had existing sanitation initiatives and in the case of Beitbridge and Mutasa, financial support for the activities. Goromonzi was selected for its particular dynamics - the district, very close to Harare, was recording schistosomiasis in the country.

In March 1994, UNICEF at the invitation of the MOH&CW supported a training workshop held for representatives of the Pilot Districts. The objective being to train the Pilot Districts in the use of participatory methods for hygiene education promotion, adapt the tools and further develop new tools. The main workshop outputs were:

- implementation plans
- prototype participatory tool kit

Guidelines were deliberately not provided to the Districts who instead were asked to:

- develop district specific frameworks for implementation
- test the tools
- report back progress during a national review workshop.

At the request of the MOH&CW financial and material support for the process was provided by UNICEF. The initiative marked the beginning of participatory hygiene education in Zimbabwe.

1.4 National Review Workshop

The National Review Workshop took place in September 1994 when the Pilot Districts reported their progress. The Workshop reviewed the use of the participatory approach and tools and identified any key behaviour changes that had been noticed. Additionally, information and experiences were shared concerning the acceptance at community level of the use of participatory approaches and the clarity and understanding of the pictures that made up the tools. The Pilot Districts considered that the experience as positive and that there were indications of key behaviour change in the community. Specific use of the participatory approach during this period included:

- an adoption of the tools to address the problems of bilharzia, a priority health concern for Goromonzi District
- the use of participatory tools to address the issue of kitchen hygiene and hand washing in Beitbridge District

The Districts observed a number of key behaviour changes including:

- changes in hand washing practice
- an increased demand for protected wells
- a demand for the construction of latrines
- a demand for use of similar methods in HIV/AIDs programmes
- an increased understanding and interest in hygiene
- education from a cross section of the community including school children and teachers.

It was also confirmed that:

- considerable latent knowledge existed at community level
- process and impact indicators needed to be established if effective monitoring of change was to take place
- a positive attitude towards the value of participation coupled with a belief in the community's ability to self determine change was needed by facilitators if implementation was to be successful.

The results of the National Review Workshop were presented to a regional review workshop in December 1994. The Regional Review Workshop aimed at sharing implementation experiences and discussing the future use of participatory approaches in relation to institutionalisation, expansion, promotion monitoring and evaluation of the initiative. The workshop agreed that the methodology was proving appropriate for the promotion of hygiene education and sanitation.

1.5 The Institutionalisation of Participatory Hygiene Education

In 1995 the concept of using participatory methods for the promotion of hygiene education was presented in the annual Sector Review meeting. A collaborative forum, the meeting brought together donors, NGOs and government agencies working in the Sector to review progress,

discuss policy and map out future direction. The MOH&CW brought the participatory tools to the meeting and succeeded in creating awareness of the approach among policy makers through hands on experience.

As a result, participatory hygiene education received the blessing of the National Action Committee (NAC), the policy making body for the Sector and the MOH&CW publicly adopted the use of participatory methods for the promotion of hygiene education.

Interest in and the use of the participatory approaches gained momentum in response to the institutional push and through informal channels as districts previously not involved became aware of the initiative. The new districts sought training and support from the Pilot Districts through informal arrangements independent of the support of the national level. This informal expansion meant that when the MOH&CW started to take the initiative to scale it was unable to manage the process in the strategic way that had been envisaged. The result was that interest in the approach and demand for training went beyond the expectations and capacity of the MOH&CW with some provinces and districts requesting training while others made their own informal arrangements.

1.6 The Involvement of Irish Aid in the Participatory Hygiene Education Initiative

Originally it was envisaged that districts would utilise existing internal funds to facilitate the adoption of participatory hygiene education. However, as the activity started mid-way through a financial year the funding required for the development of the participatory tool kit was not available. Additional funding was difficult to access as most funding agreements had been signed. Against this background UNICEF, itself getting requests from the MOH&CW to support training and the development of materials, approached the Government of Ireland, through Irish Aid, to fund specific components of the growing participatory hygiene education initiative. The Participatory Hygiene Education and Sanitation Project, funded by Irish Aid through UNICEF and on behalf of the Government of Zimbabwe, commenced in 1995 with the overall objective of: improving the quality of life and health standards of the poorest sectors of Zimbabwe's population through an intensive programme of participatory hygiene education supported by the construction of hygiene enabling facilities.

The Project stated two immediate objectives:

- to identify and change key hygiene risk behaviours that will maximise the health impact of water and sanitation improvements
- to increase the rate of latrine construction and associated works in order to contribute to the achievement of the national goal of 50% coverage by the year 2000.

The MOH&CW, through the Department of Environmental Health became responsible for the overall implementation of the Project. PHE as the Project became known, was to be seen as an integral part of the Ministry's activities, complimenting those of NORAD, SIDA, DANIDA, the ODA (now DFID) and WHO that also supported the IRWSSP.

2. POLICY PERSPECTIVES

2.1 The Milestones Towards the IRWSSP

A number of policy related initiatives have influenced the development of the Project and in light of the background it is important to have an overview of these. The following initiatives represent milestones in the ongoing development of rural water and sanitation in Zimbabwe.

The UN Water and Sanitation Decade, 1981 – 1991 that:

- encouraged the development of national programmes
- advocated for an increase in external funding for water and sanitation activities
- looked to increase the coverage of water and sanitation facilities to ensure the availability of clean water and safe excreta disposal

The Zimbabwe Water and Sanitation Decade, 1982-1992 that:

- was a direct result of the emergence of the Water and Sanitation Sector that previous to the UN Water and Sanitation Decade did not exist.

The Rural National Water Master Plan (RNWMP), 1986 that:

- addressed the existing problems of programme fragmentation and duplication
- provided the policy framework within which water and sanitation programmes were to be implemented
- encouraged the development of an integrated approach to the development of the Water and Sanitation Sector as it is currently constituted with the National Action Committee (NAC) and its Provincial and District Water Supply and Sanitation Sub-committees.
- advised that the planning and implementation of water and sanitation activities was to be done jointly by all the stakeholders

The Prime Ministers Directive, 1984 that:

- encouraged decentralised planning in the form of a demand driven approach starting with the community, through to the ward, district, province and national level
- to date remains the mode of planning for water and sanitation in Zimbabwe.

The Provincial Act of 1985 and the Rural District Council Act of 1988 that:

- promote the decentralised planning and management of development activities within their spheres of influence.

The Decade Consultative Meeting (DCM), 1990 that:

- was a regional meeting held in Harare
- assessed the progress that had been made in addressing the various principles of the UN Water and Sanitation Decade
- acknowledged the significant progress that had been made in the provision of hardware components in water and sanitation programmes
- noted that the software components of water and sanitation programmes are important sustainability factors
- the software components were lagging behind in terms of programme priority
- concluded, among other things that the future responsibility and authority for planning, financial control, implementation and operations and maintenance of rural water supply and

sanitation, including technology choice, must increasingly be borne by the local authority and the community, ultimately leading to complete management through local structures
- stated that the development of the Water and Sanitation Sector in Zimbabwe should be largely guided by the latter resolution.

The Sector Review Meeting, Nyanga, 1992 that:

- was attended by government agencies, external support agencies and NGOs all supporting the development of water and sanitation activities
- defined the ideal situation that the NAC expected for the implementation of water and sanitation activities by the year 2000 - called Vision 2000
- envisaged a situation where the community would be well organised and active in determining their own destiny
- said RDCs would be more accountable and responsible for managing water and sanitation projects and supporting community initiatives in the management of the programme
- agreed government would play a more facilitative and advisory role agreed NGOs would be active in supporting community initiatives.
- The Vision 2000 Workshop, 1992 that:
- saw a decision by the NAC to pilot the decentralised implementation of water and sanitation projects through the RDC in the following districts: Mberengwa, Nyanga and Kadoma
- agreed implementation of the decentralised pilot programme would happen during the 1992/93 financial year

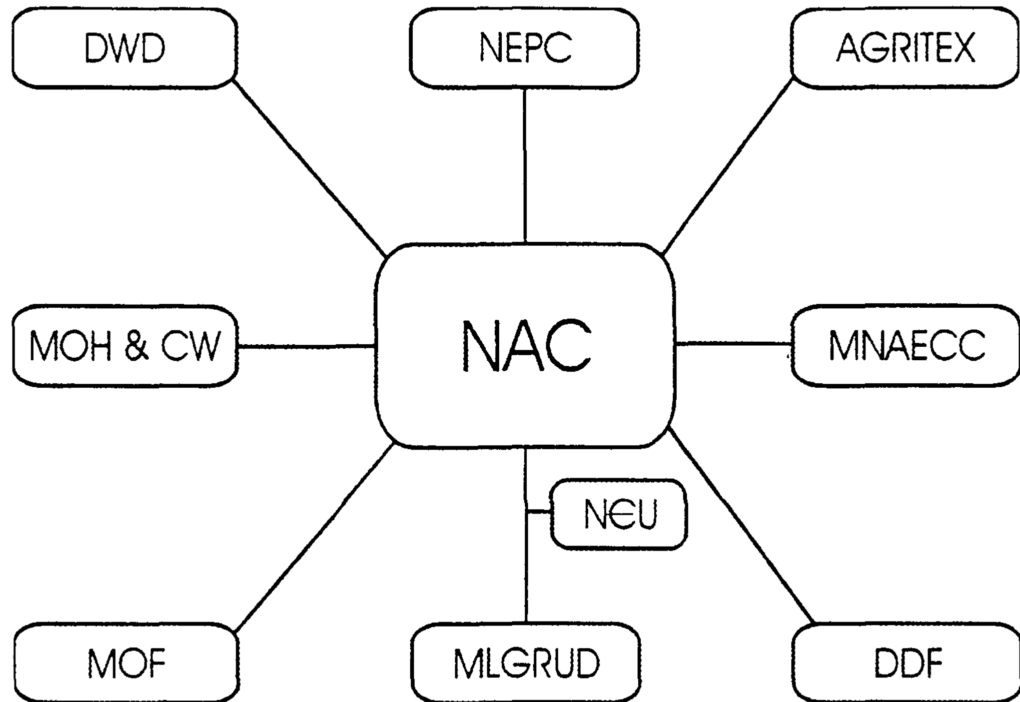
The Operational Framework for the IRWSSP

The Integrated Rural Water Supply and Sanitation Programme (IRWSSP) is managed by the NAC. The NAC is composed of seven Government Ministries/Departments. Programme planning and implementation is conducted intersectorally with each ember having additional specific responsibilities. The member ministries and departments, together with their specific roles and responsibilities are described in the following table.

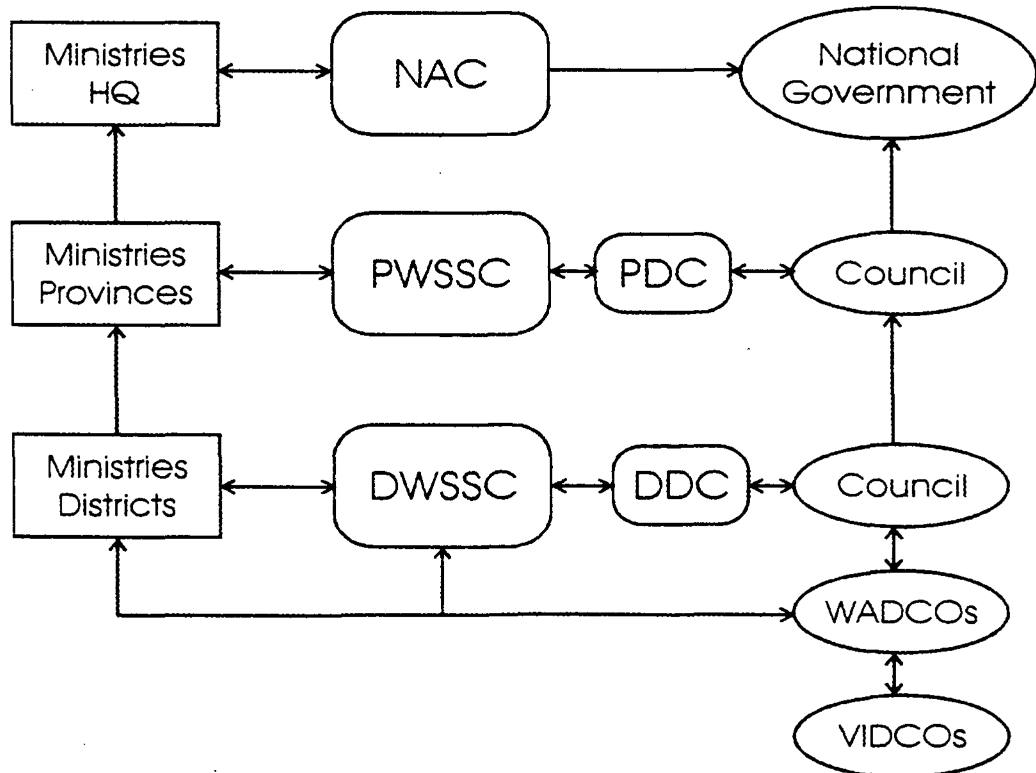
SECTOR AGENCY	RESPONSIBILITIES
Ministry of Health and Child Welfare (MOH&CW)	Hand dug wells protected springs sanitation health and hygiene education
District Development Fund (DDF)	Deep wells, borehole siting and drilling, hand pump operations and maintenance
Ministry of National Affairs Employment Creation and Co-operatives.	Community mobilisation and training
Agricultural Extension Services (AGRITEX)	Land use planning
Department of Water Resources (DWR)	Water point siting, borehole drilling and hydrogeological surveys
National Economic Planning Commission (NEPC)	Project appraisal, monitoring and evaluation and donor co-ordination
Ministry of Finance (MOF)	Disbursement of funds
Ministry of Rural Resources and Water Development (MRRWD	Planning and co-ordination

The NAC Structure

At the national level, the NAC operates through a system of sub-committees each having specific responsibilities under the programme.



At the Provincial level the Provincial Water Supply and sanitation Sub-Committee (PWSSC) co-ordinates programme implementation and provides the necessary support and training to the District Water Supply and Sanitation Sub-Committee (DWSSC). At the District level the RDC is now in charge of programme implementation in line with the new policy of decentralisation.



The NAC has a Secretariat, The National Co-ordination Unit (NCU) which manages the programme on a day to day basis. Specifically the NCU is responsible for :

- the preparation of sector plans and budgets
- assisting in overall co-ordination; programming, planning, design, evaluation and reporting
- assisting in maintaining rational division of labour among agencies
- securing funds for the Sector
- donor and NGO support to the water and sanitation programme

2.3 Relationships between the IRWSSP and the donor/NGO community

The Integrated Rural Water and Sanitation Programme is currently supported by a number of donors with the majority of agreements being bilateral implemented in over forty districts.

Two donor funding mechanisms are currently been used:

- the normal system - through the National Development Fund in the Ministry of Finance, to the Ministry of Local Government and eventually to the Rural District Council who can use government institutions or the private sector to implement the programme on their behalf

- "direct disbursement method" where despite the existence of a bilateral agreement, the money is not channelled through the National Development Fund in the Ministry of Finance but is managed directly by the donor

NGOs play a very significant role in the provision of water and sanitation facilities and services either alone or in conjunction with the Government. However, it is a government policy that despite their autonomy what ever they are interesting in funding should be part of a district development plan. To encourage good communication with NGOs the Government encourages their participation in the District Water and Sanitation Sub-Committee (DWSSC), where they operate, to facilitate the exchange of information.

Standardisation as a Policy

In order to avoid a proliferation of different technologies and systems, the NAC standardised the various components of the programme to ensure its sustainability. To enhance uniform planning, implementation and management of the programme, the NAC developed the District Co-ordination Hand Book which gives guidelines on the development of the Sector. Although the Handbook is now outdated and thus requires revision to capture the current changes in the Sector, for example decentralisation, it still remains as the guiding instrument for the programme.

In relation to technology, the NAC has limited this to the provision of:

- shallow and deep wells
- boreholes
- the rehabilitation of existing water points
- the construction of Blair latrines.

In promoting these technology options there is the recognition of the need to ensure programme sustainability through:

- health and hygiene education
- community involvement in planning, implementation and management
- subsidies

3 DETERMINING THE PHILOSOPHY AND STRATEGY

The Participatory Hygiene Education and Sanitation Project is context specific in that the tools and materials focus on key behaviour change in relation to water and sanitation. In order to explain the Project implementation strategy it is necessary to provide an overview of the existing strategies that are employed by the IRWSSP and hygiene education practitioners, and the philosophies that have influenced the emergence of PHE.

3.1 The IRWSSP Implementation Strategy

The IRWSSP is implemented in the following way with the main unit for project operation being the ward level where there are three inter-linked phases:

- community/mobilisation

- the initial support and co-operation of the community is solicited through the community based institutions - the VIDCO and the WADCO
- ward contact meetings are held to introduce the project to the community quick action and follow up takes place to help to ensure community commitment and avoid disillusionment
- the VIDCO and WADCO become the official development structures, playing an important role during the project implementation stage and beyond

- training and education

- the VIDCO and WADCO receive training and education about the IRWSSP framework for operation and implementation procedures
- the training becomes the basis for the formation of a water point committee
- health education workshops are initiated with the community
- if necessary the recruitment of community builders and trainers takes place

- installation and community operation and maintenance

- the community are involved in pre-siting activities
- consultative planning tools are utilised with the community
- installation takes place
- the community is advised of their roles and responsibilities
- community based maintenance systems are put in place

The strategy is considered to be consultative and intersectoral in its approach.

How PHE relates to the IRWSSP Implementation Strategy

Participatory hygiene education began to boost the hygiene education component of this project since it was viewed to be weak But a number of valuable lessons were to be learned form the IRWSSP implementation strategy:

- in reality, in spite of the implementation strategy, many IRWSSP projects were proving to be prescriptive and the PHE initiative was making attempts to avoid this
- the insignificance of existing budgets meant that little could be initiated in the area of hygiene education
- there was little understanding of hygiene education in the IRWSSP
- there was little appreciation outside MOH&CW for the value and potential of participatory hygiene education.

However PHE was integrated into the strategy through the training of the DWSSC so that they would gain a better appreciation of PHE in this context.

As the value and strength of participatory approaches became evident during the implementation period awareness at all levels was affirmed. This had particular affect at policy level where the NAC backed the move that PHE should become an integral component of the IRWSSP.

3.3 "Traditional" Hygiene Education Approaches

As stated traditional strategy for the delivery of health and hygiene education had proved to be ineffective. This view, borne out by the EHTs that were spoken to during the evaluation exercise was based on the fact that the strategy was:

- largely in-articulated and unclear
- didactic in its approach to hygiene education
- based on a wholly prescriptive philosophy
- viewed as a support or add-on activity to the construction of water points and/or latrines
- uncreative and boring for the administrator and the community
- unable to provide tangible objectives and recognisable output
- de-motivating for all concerned

The strategy resulted in a continuing emphasis of the importance of hardware and technical activity at the expense of the soft educational components of water and sanitation programmes. Indeed ward implementation graphs often showed that hygiene education was carried out just before construction with the overall objective being to secure community support and interest in the project rather than to influence key behaviour change. Hygiene education was often expressed as "ongoing" and "routine" and this lack of clarity contributed the decline in budgets and absence of accountability in the IRWSSP.

In practice the implementation strategy was left entirely up to the individual EHT who made operational decisions within the existing ward framework. There was an underlying assumption that the basic 3 year EHT training provided through the MOH&CW training schools would be adequate to equip EHTs with the necessary skills, knowledge and attitudes to promote hygiene education. However the training philosophy did not take in to account the need for specialised skills in the area of facilitation, analysis and synthesis.

The resulting delivery, often based on clinical records was wholly reactive through:

- "health lectures" - often held at clinics and aimed at women coming for medical treatment
- lectures to new members of water and sanitation sub-committees in preparation for their duties
- lectures to community leaders when IRWSSP projects were being introduced
- lectures to latrine builders and other similar "opportune" groups

The style and mode of delivery assumed that the problem lay with the community in that a knowledge gap existed and that the role of the EHT was to fill the knowledge gap by giving "a talk" to the community.

The existence of knowledge may not always mean that the community or individual understand the intended use of that knowledge. For example, during a community session in which the participatory tool called "three pile sorting" was used, a community member took the picture of a snail and placed it under "bad hygiene Behaviour". On being asked why it was "bad", he indicated that he did not know but that since childhood he had always been told that, "a snail is bad" and that one should wear shoes to avoid contact with it.

This example highlights the short-cutting effect of didactic approaches. The approach proved successful in that it pointed to the problem (the snail being a potential host of disease) and solution (the avoidance of contact with the snail) but failed to analyse or provide clarification of the deeper causes of the problem, how it affects the community and what solutions may be proposed.

So, hygiene education in the years preceding 1993, remained without focus, lacking in measurable objectives and without any means for measuring both the process and impact. The methods being used for hygiene promotion were able to impart knowledge but were not able to induce key behaviour change in communities.

It is important to acknowledge however, the efforts made by the MOHCW in 1990 with respect to the introduction of participatory methods in sanitation programmes. MOHCW held national facilitators workshops which lasted 2 days in January 1990 and a national workshop (2 days) in February where provincial and district EHOs, HEOs and some EHTs attended. This initiative was never evaluated to check how far the training was done at provincial and district level.

3.4 The Development of Participatory Approaches in Zimbabwe

The use of participatory methods is not new in Zimbabwe. In the early 80's the then Ministry of Community Development and Women's Affairs used participatory methods in the training of VIDCO and WADCOs and produced some manuals on the use of participatory methods.

Other independent initiatives were being carried out by NGO's and at the Regional level. Participatory methods were being promoted through the UNDP/World Bank programme called PROWWESS. It was as through this initiative that during 1986, the Save the Children Fund [UK] introduced participatory methods to their Farm Health Worker Programme. The experiences of the "PROWWESS" initiative were also used in the development and production of participatory tools and methods that were published by Lyra Srivasan in "Tools for Community Participation". Since 1992, the Institute of Water and Sanitation Development in Harare, then known as the Training Centre for Water and Sanitation has offered training in participatory methods. The training focused on sector personnel, mostly from the MOH&CW, MNAECC, MLGRUD, who applied through their own initiative to participate in the training. In the early days the methods were mostly focused towards involving communities, especially women, in the planning, implementation management and evaluation of water and sanitation projects.

These early attempts to promote participatory methods did not prove to be particularly successful due to the lack of an overall strategy and framework within which these methods could be applied beyond a philosophical stage. Furthermore, in retrospect, it has become apparent that institutional support is necessary for the successful promotion and use of participatory methods. This at the time was illustrated by the fact that exposure to new participatory approaches was limited to senior officers and not cascaded to the EHT's who were at the implementation level.

3.5 The Philosophy and Development of Participatory Methods Specifically For Hygiene Education

The development of context specific participatory methods that focused on messages for key hygiene behaviour change, emerged through the UNDP/World Bank PHAST initiative. The background to this initiative is described in the introductory section of the report. As indicated the ideas behind PHAST came at a time when Zimbabwe was questioning the validity and relevance of its whole approach to hygiene education.

The PHAST initiative provided not only a new philosophy but also:

- room for the development of clearly defined objectives specific to the needs of improving the health status of the community through improved hygiene practices
- the realisation for the need for and the means to measure progress and monitor impact.

The philosophy and implementation strategy that PHAST adopted was deliberately:

- developmental
- based on the localised adoption, testing and piloting of participatory tools
- geared to allow the participating countries to develop country specific participatory techniques and programmes that would benefit from regional support
- a process approach to the facilitation of hygiene education

The development of an operational strategy for the growth of participatory hygiene education activity in Zimbabwe was based on the PHAST philosophy.

Earlier attempts at promoting the use of participatory methods in hygiene promotion did not succeed. The main reasons for are outlined in Keith Wright's report as:

- lack of a definite implementation strategy
- lack of follow up or defined mechanism for reporting
- the tools used in training were not made available for implementation
- there was no felt need to change the extension and education practices
- there was no supportive policy that encouraged participatory approaches

Earlier attempts therefore were initiated at the top but without adequate support for the field staff who were supposed to implement the methodology. To challenge this PHE adopted a "bottom up" or "demand driven" approach.

The underpinning philosophy of participatory hygiene education is that change can not be wished upon people and that change is a process that evolves as community members get involved in identifying their own risk behaviour, analysing that and evaluating options for solving the problem.

Normally communities do not respond to being forced to change through pre-determined problems and solutions. Indeed the mechanism for even giving those pre-determined solutions is often not conducive for behaviour change. PHE therefore sought a methodology that will promote understanding and community action. Participatory hygiene education is built on the philosophy and methodology of SARAR which stands for:

Self esteem
Associative strength
Resourcefulness
Action planning
Responsibility

The SARAR philosophy recognises that as a number of individuals a community tends to be weak but when they form a group they become powerful. Although hygiene behaviour change takes place at the individual level, the positive or negative impact from change or lack of it tends to affect the community at large.

SARAR recognises that due to past approaches that have left individuals feeling inadequate, the community may not be aware of their latent collective capacity and capability. The methodology seeks to promote this resourcefulness. In an analysis of SARAR, it is noted that the methodology is promoting all the attributes of community management which are:
the authority to plan, organise and take control and responsibility through accountability for self determined development.

Within the PHE approach communities use their experiences to control their destiny as opposed to being controlled by it. Hygiene education becomes a process of sharing information and

finding systematic solutions between the facilitator and the community. A participatory hygiene education process seeks to:

- create a non threatening atmosphere in which people are free to discuss and ask questions
- use visuals (pictures) to ensure embarrassing issues are not personalised
- generate an environment for analysis in which both the literate and illiterate can participate
- create a sharing process in which the facilitator brings his/her academic professional knowledge and the community bring their experience-based knowledge
- provide an environment where group sessions promote learning from each other and therefore the proposed solutions become more believable

The SARAR philosophy assumes a cyclic approach in which one activity in the process will lead to the next and so on or that underlying some activities will be more than one objective. For example, there are no specific tools or mechanism for promoting better group dynamics, but the way the facilitator sets splits the groups and sets the tasks will promote that. While the task may be problem identification, a sub objective is to promote community resourcefulness.

3.6 The Project's Operational Strategy

Once participatory hygiene education principles were adopted in Zimbabwe several decisions were made that influenced the Project's operational strategy. These are summarised as they appear in Keith Wright's report and are captured below: "The Watershed Decisions" represent the framework for operation.

In presenting the following "watershed decisions", Wright stated that "their existence has considerably influenced the character of the Project". The decisions are reported as follows: (Participatory Hygiene Education: A People Centred Approach to Behaviour Change; K Wright, UNICEF/MOHCW 1996)

The process would start with the development of methods and tools at the village level with EHT's taking the lead role;

National coverage was not to be a short term goal. Coverage would come as the Project gathers skills and strengths to provide the necessary follow up support to everyone involved

The Project would be allowed to grow slowly. Initially working in 2 wards each in 3 districts. A year later to be working in a further 2/3 wards in the same districts and in 1 district in 3 new provinces (with 2 wards in each of the districts);

The Project would not prescribe to the districts how the PHE methods and tools would be introduced to the extension staff and how the PHE would be used in the village level work;

Th Project would be based on bottom up planning. Funding would be based on the plans made by the district/province;

The tools would be a central part of the Project in the early years. The tools would be a practical instrument that everyone could use as they made the transition from the didactic communication method the participatory method;

Every extension worker would have easy access to a set of tools (once they were trained in their use);

The tools would be made out of less durable material and the visuals be single line drawings. This would allow the Project to afford to have sets of tools available for all extension workers

The process by which the tools would be developed was very important. It had to be carried out in a way that would make the tools and methods acceptable to the environmental health staff and other extension workers;

The way in which the Project operated would be a role model on how to be people centred, open and inclusive of all ideas and suggestions in the community work;

The way in which training workshops would be facilitated would be a role model in how to conduct learning centred sessions, where learning is primarily through self-discovery, that could be directly applied to the community work;

The field staff should not be trained alone. If that were to happen they would be isolated and without support as they tried to implement new ways of working. Teams representing all levels within the province should be trained together;

The Project would not be a separate vertical project of implementation of its own activities in the community. It would be a project that establishes participatory methods and tools into ongoing hygiene and sanitation work;

The training should be inclusive. Officers who are working in a similar field, e.g., MNAECC, CBM, RDC, Nurses would be able to participate;

The training would not be organised on a cascade system. Cross section groups would be trained together so that they could make implementation groups;

Wright also observed that:

The Project did not sate that it was to be a materials production project or that it was to be a training project. It does run the danger of being seen that way. The Project plans to concentrate its effort on the community level application of PHE. Materials and training are seen as a means and not an end in themselves.

Of most significance is the fact that the Project philosophy and strategy is based on a process approach. The operational strategy focuses on the Project's core intention to use participatory methods, initially through the use of tools to achieve the Project objectives. To critique the operational strategy it is necessary to isolate its main elements before commenting on the overall approach. While it is fully accepted that the Project has not viewed its development in isolated parts it is necessary to:

- the underpinning philosophy
- the process
- training
- materials and tools
- scale and coverage
- gender

4 THE CRITIQUE

4.1 Presentation

The critique is presented in the following format:

heading - describing the particular element related to the Project's operational strategy
the achievements - often qualitative but sometimes quantitative
the strengths - in relation to effect on the overall project objectives
the weaknesses - in relation to effect on overall project objectives
the constraints - in either theoretical or practical terms
the opportunities - in the context of the project

The comments are as far as possible element-specific within the context of the overall project framework and objectives.

4.2 The Underpinning Philosophy

As described the SARAR philosophy and a belief in the strengths of participatory methods and tools underpin the Project. The approach is deliberately:

- non prescriptive
- non directive
- developmental

This approach is deep rooted in the philosophy that the community has the full potential and ability to organise self determined change through taking authority, responsibility, accountability and control of the process.

The achievements

The most notable achievements in relation to the underpinning philosophy are that:

- at the policy level the basic philosophy has been accepted and acknowledged
- many field workers and members of the community have embraced the opportunities that the philosophy in practice presents
- the underpinning ideals are emerging as practical steps towards community management both within the Water and Sanitation Sector and beyond
- ownership of the basic philosophy is articulated horizontally and vertically within the Project's sphere of influence and it is not limited to the executing agencies

The strengths

The strengths of the philosophy per se are already described however in the context of the Project the following point is made:

- the philosophy is challenging existing beliefs and traditional approaches particularly in terms of the relationship between hardware and software issues, basic decision making principles and the right of empowerment.

The weaknesses

The weaknesses in the philosophy are that:
- it is not always understood beyond an ability to offer a basic description of the philosophy. This is particularly noticeable at field level where misunderstanding or poor understanding is

in some cases leading to an early dismissal of the overall approach. The effect of limited conceptual understanding could lead, and in many cases already has led, to a failure to facilitate the process in a pro-active, strategic manner.

- it can be used in a manipulatively by having it in place in principle but not fully internalised by its facilitators who then continue to work in reactive ways.

The constraints

The main constraints are that:

- there is little understanding beyond acknowledgement of the philosophy which is further exacerbated by pockets of reluctance to change. This constraint can not be simply dealt with and is about openness and the ability to absorb new ideas.
- there is a danger that lip-service may be paid to the value of the philosophy by those who believe in retaining power and influence.
- to be able to conceptualise the philosophy and then internalise it takes time, experience and considerable reflection. It is not known at what stage many facilitators are but it is felt that for many the process of changing attitudes and perception is only just beginning. The fact that the Project is so heavily reliant on people and human nature is not in itself a constraint. However, if a system of professional support is not developed the learning process will be unaided and undocumented and this will affect the quality of future developments.

It is noted however that the lack of confidence in the use of participatory approaches may be mistaken for reluctance to change but this may not necessarily result in a total dismissal of the overall approach. These observations have been previously noted by the project and efforts are being made to address this.

The opportunities

The opportunities that exist are a reflection of the Project's effectiveness in terms of challenging embedded perceptions and facilitating change.

The opportunities include:

- consolidated use of the participatory tools to continue to challenge reluctance to change at all levels
- continued advocacy to influence commitment to the process beyond widespread acknowledgement
- continued and enhanced networking within the Sector and in new sectors that are considering the value of the philosophy in mission terms, notably community based management, general health education and decentralisation
- the urgent need to elaborate the philosophy as the framework for implementation of the project cycle for participatory hygiene education.

4.3 The Process

The process is the backbone of the Project and belief in it is certainly its greatest strength. The process is essentially the utilisation of the approach to change hygiene behaviour through participatory methods. Like all processes it is evolving and its impact is emerging at every level of influence. The process is people centred and therefore people dependent and should be viewed in relation to the philosophy that underpins it.
The process should not be confused with the tools, methods and techniques that are deployed as vehicles to operationalise it. The process is essentially one of participation, negotiation, dialogue

and sharing through respect for all ideas and opinions. It is about maximising the opportunities for key behaviour change.

The Achievements

The achievements purely in relation to the success of the process are difficult to view in isolation but an attempt is made to see them as different to the outputs that are a result of the more apparent enabling factors.

The achievements are that:

- the process has been embraced by many cadre as an enabling framework for a more effective way to deliver hygiene messages
- the process is allowing for the development of flatter and more equitable environments
- the process has given a voice to members of the community, particularly women who were previously undermined
- the process is influencing interaction at all levels and is strengthening the powers of the community
- the process is increasing the acceptability and scope for intersectoral collaboration, partnership and co-operation
- the process is fostering community cohesion, a greater sense of direction in terms of health and hygiene and ownership of the decision to change behaviour
- the institutionalisation of the methodology has meant that the process has policy support and backing, both necessary for successful implementation. As noted earlier attempts introduced in the late 80s were not backed up by policy and were therefore not effective
- the process has enabled the communities to participate actively in malaria control, plague control and school sanitation.

The Strengths

The main strengths of the process are that:

- its institutionalisation has meant that it has policy support and backing which is considered necessary for successful implementation.
- although there are obvious disadvantages to its rapid adoption it does indicate the high level of interest and acceptability that the approach has generated.
- there is a certain tangible belief in it.
- it is increasingly said to be responsible for key behaviour change and while it is recognised that many other factors contribute to this, it nevertheless highlights the emerging effectiveness of the approach.
- it supports in practical terms the initiatives of the MOH&CW in trying to move from a top-down, technical approach to a bottom-up learner centred approach. As increasing questions are asked about the development of more meaningful roles for the community the PHE process is articulating them through its actual application.
- it supports the underpinning values of Vision 2000.
- it directly links community health and well being to the provision of safe water and sanitation and appropriate hygiene behaviour.

The Weaknesses

The main weaknesses are that:

- the use of the tools a central focus of the approach (a concept which evolved in the field and not as a conscious decision of the project), has meant that the tools are often described as the actual process. This is misleading and often threatens to weaken understanding of the

participatory nature of the process. This decision has also limited the scope and breadth of the existence of additional participatory methods that are non-picture bound. While some EHTs have adapted the tools to suit different situations, some have become disillusioned when they cannot transfer them to meet the needs of other topics outside the area of key hygiene behaviour change. This suggests that a better understanding of the process is required at the field level.
- there is a real risk that in many situations the application of the process will remain reactive, meeting perceived community problems as translated through clinic data rather than priorities that have been articulated by the community.
- the development and growth of the process is limited by how the implementation and support mechanisms for it are being planned and managed.
- the lack of impact monitoring and regular monitoring and evaluation mechanisms is a major weakness in that these activities should inform future initiatives.

The Constraints

The constraints are that:

- although the process was designed to be integrated into the normal working itinerary it is offten not understood in relation to the project cycle approach to development and this reduces its chance of sustainability.
- the process is constrained by the misunderstanding that it can be applied, through the use of tools, in a one off situation.

The Opportunities

The main opportunities that exist are that:

- as a wide range of people have been exposed to the process it should be possible to develop similar processes in other sectors, notably Agritex and Health.
- the process provides considerable scope in the area of research and development. By its very nature the process is evolving and continued documentation of its development will inform future direction and the wider development field.
- as the process compliments the other strategies that are emerging to maximise the sustainability of rural water supply and sanitation an ideal opportunity exists to bring together the PHE process and community based management and decentralisation.

4.4 Training

The area of training is very complex and while the Project emphasises that it is not a training project per se, training is nevertheless a large part of it. For these reasons training in this section of the Report is broken in to three areas:

the strategy
the content and approach
the quality and relevance of the training

Each area is described using the same format as the rest of the critique.

The strategy

The Project has chosen to adopt a system of training that intends to furnish cadre with the attitudes, knowledge and skills to facilitate participatory hygiene education with the community. Who is trained is very dependent on the perceived needs of a district and includes a vertical cross section of people including: - GOZ personnel from the ministries involved in IRWSSP, health, agriculture and community mobilisation, NGO personnel, community representatives and animators and the local council.

The training strategy is based on three stages:

Stage One provides input for a provincial team consisting of officers from the provincial office together with representatives of a number of districts and sub-districts, the latter being extension personnel. The output for Stage One is expected to be a trained team that can both initiate community based PHE and train a district(s) to replicate the process. Stage One takes ten days and is workshop based with field visits to the community.

Stage Two provides input for the remaining districts that were not trained in Stage One. The target group is not predetermined and sometimes, but not always, includes a vertical cross section from the following groups:

- Rural District Council; PO
- Ministry of National Affairs; Training Officer
- DDF; Field Officer
- MOHCW; District Environmental Health Officer and other EHTs
- AGRITEX Field Officer
- District Co-ordinator
- NGOs - if active in the district
- MOE; sometimes
- District Nurse, on some occasions

Stage Two is implemented through a number of workshops that target different districts until all the districts in one province are trained. The output for Stage Two is expected to be a trained team of cadre who all potentially work with the community and/or are able to further train colleagues to do the same. Stage Two takes approximately six days and is workshop based with field visits to the community.

Stage Three provides input by specific district and is determined by those who participated in Stage Two. Any number of different people may be trained and sometimes but not always they include the following: -

- VCWs
- FHWs
- Councillors
- Local Leaders
- Teachers
- VHPs

The output for Stage Three is commonly a pool of people who are equipped to assist the process of PHE delivery.Stage Three takes two or three days and is workshop and community based.

The Achievements

The main achievements are that:

- the strategy is a brave attempt to break some of the barriers that exist to participation and the acceptance of new methods and approaches.
- undoubtedly mass coverage of the vision of PHE has been achieved and people can generally articulate with some degree of confidence what they perceive PHE to be.
- the strategy has gone some way to introduce the concept of participatory approaches and methods to ministries and individuals that are outside the traditional boundaries of hygiene education related to water and sanitation.
- notably the strategy is challenging traditional non-participatory methods to deliver health and hygiene messages and is affirming the belief that communities themselves can manage the process of change.

The Strengths

The main strengths are that:

- the strategy is participatory in its approach and philosophy.
- the strategy advocates that training is not an end itself but a means to an end.
- attempts are made where possible to provide a template that will fit over or compliment any existing district or ward level health education training.

The Weaknesses

The main weaknesses are that:

- the strategy devolves all implementation decisions following the stages of training of trainers to the districts. This decision means that the training inputs can become diluted at the different stages and therefore the actual quality of what is learned is open to question and interpretation. There is no known or accepted standard.
- the problems are further compounded in the tracking of the activities that comprise the training strategy and the resulting outputs.
- the lack of a clearly defined and implemented reporting system means that it is very difficult to gain an accurate picture of events in relation to training and subsequent outputs (it is noted that most training sessions are documented at the district level although these are not available nationally).
- the frequency of activities that fall under the umbrella of training is dependent on funds, existing initiatives and priorities in a district, the quality of the management of the process and the will of those who already have the PHE knowledge. The result is a series of largely uncoordinated inputs and reactive training activities that somehow reflect the intended strategy. The exact outputs resulting from the training related activities in quantitative terms are not known and in qualitative terms are not clearly gathered and documented in a manner that allows for the formalisation of evidence of the success of these outputs.
- currently there is little control over the process in management terms and this affirms that it is not enough to initiate a training strategy without following an elaborated project cycle for training. It is acknowledged that the quality and relevance of training in two provinces has been assessed with assistance from the manpower development department.

The Constraints

The main constraint is that:

- there are problems with the actual content based approach adopted during training. This strategy, built on the participatory tools provided to trained cadre, is proving to be constrained by the decision to only provide basic guidelines and advice for facilitators following the initial training stage.

Although all training sessions are supported by a cross section of facilitators, i.e. from different levels the above constraint is two fold. First it has led to somewhat stilted or insecure delivery and a lack of creativity or confidence to deviate from the "trained" or "learned" approach. Secondly the strategy relies wholly on the capacity and motivation of those who attend the initial training and their subsequent level of confidence. Basically it assumes that the training is effective first time round.

The Opportunities

The main opportunity is that:

- as the strategy avoids cascade training, preferring to train through vertically cross sectioned teams, it should be possible to build strong and unified teams. However, this will only happen when a supported environment exists where the responsibilities and functions of all the actors are clear.

Training content and approach

The approach to training is wholly participatory, advocating "hands on" experience to learning through workshop style sessions and field experience. The content of the training sessions is largely based on the participatory tools – their principles, application and potential.

The Achievements

The main achievements are that:

- currently a set of tools, a toolkit and a trainer's kit, that were intended to be and indeed have become, the mainstay of the Project's training strategy and subsequent facilitation, are complete. The actual development of these materials has taken an incalculable amount of time and effort representing a considerable achievement.
- the tools provide the content for the training but also the mechanism by which the PHE approach is facilitated. The enthusiasm shown for the tools is considerable.
- the training strategy coupled with the printed materials has given hygiene education a profile and credibility that was previously absent.
- the underpinning philosophy of PHE has been promoted through the training approach that is itself wholly participatory.
- the approach and content have been accepted and adopted in the main EHT training institutions where PHE is part of the curriculum and is examined.

The Strengths

The main strengths are that:

- the printed materials that act as the tools to enhance participation are the strongest component of the whole approach to training. The materials provide the basic content of the training sessions where they are used to encourage "learning by doing".
- the ten-day workshop training model (referred to as the Stage One Workshop) emphasises practical exercises that explain the use and application of the participatory tools. The exercises are put in to context through field visits and the hands on experience of live facilitation with communities. Wholly based on the Pilot Training Workshop held in March 1994, the ten-day model is reported to be aware of the need for team building and the sharing of experiences as it guides participants through the tools. It is vitally important to make sure that this stage of the training strategy is right as it represents the foundation upon which all subsequent delivery of training is based.

- the training sessions, if facilitated and interpreted as intended act as a role model for good practice in the field.

The Weaknesses

The main weaknesses are that:

- in terms of approach, each training stage can become a dilution of the previous one aiming to meet the perceived needs of different, yet not specifically defined target groups. Such dilution means that it is very difficult to monitor the quality and relevance of the training.
- conclusions drawn from discussions with trained cadre at district and field level suggests that the current ten-day model shortcuts in a number of critical areas. It is apparent that a greater importance needs to be placed on understanding how adults learn, the difference between the tool, method and the approach and the underpinning attitudes, skills and knowledge that impact upon the decision to change behaviour. (It is reported that this issue has been known to the project for some time and that is being addressed).
- a poor understanding exists of the fact that the expectations that govern communities are determined by the outcome of the interaction of individuals and their active participation in creating situation specific decision making criteria for change. As previously experienced in the execution of more traditional methods, communities do not passively accept and act on the expectations of others. To avoid this once again becoming an embedded weakness in the approach it is very important to affirm that behaviour change is reliant on the benefit having direct meaning or gain to the individual.
- the content in curriculum terms is derived from the need to apply and understand the participatory tools and as far as the depth of investigation and exposure is concerned is non-prescriptive from one stage of training to another. This is proving to be a weakness in that the quality of training received can not be determined from one trained cadre to the next and therefore all knowledge is assumed to be of a level, that in itself is undetermined.
- it is unclear to what extent the Stage Two training successfully emulates Stage One as the consequences of the possible dilution factor have to be taken in to account, something that is different from one training to the next.
- the continued reactive use of the application of the approach is threatening to weaken the philosophy of PHE. Currently there is evidence that a number of extension personnel apply the tools in mechanically rigid ways that unplanned have little regard for the wider development issues in the community. To curb this weakness there is a need to balance the understandable reactive use of the tools to address the prevalence of a particular disease and the use of the tools as part of a strategic approach to improved community health and well being. Unless the participants grasp these concepts during this first stage of training there is little chance that once the training is diluted to accommodate the remaining target groups that community level facilitation will be competent. In agreement with an earlier observation made by Wright, it is considered that the attitudes and actions of the facilitators are equally important as the content of the workshop.

The Constraints

The main constraint is that:

- the delayed but planned for distribution of the almost completed Field Guide is becoming a problem for both those cadre that are demanding it and the staff who are producing it. It is hoped that the Field Guide may help to address the issues of learning and motivation to change.
- the trainer's Tool Kit was developed and distributed without the appropriate training. It is not enough to simply distribute trainer's tools and advice or to include topic areas in a diluted, condensed or weakened sense without adequate support. The ability to facilitate a training process requires skill and it is accepted that this is developed over time. However, the

wisdom of releasing training kits without supervisory input beyond sometime exposure to the tools, and to a degree the concepts, is questionable. It would be regrettable if the kit aimed at unleashing the application of the approach became an actual constraint through default.

The Opportunities

Opportunity exists in the following ways:

- the approach to and content of the training could be strengthened by strategically linking it to the development of community based management and decentralisation initiatives.
- more emphasis could be placed on developing the approach with the training institutions, particularly those that train EHTs. At the moment the approach is integrated in to the curriculum but in an "accepted as correct and complete" manner.
- the approach is developmental and should allow for the facilitation of participatory research to inform future direction

Quality and relevance of training

The following comments are made about the quality and relevance of the training.
Below is a summary of the main points that describe the PHE training experience in Lupane District taken during a discussion with district level staff. Many issues are highlighted but in particular and a lot is implied about the ***perceived*** quality and relevance of PHE training. It is acknowledged that Lupane District may not be representative of the whole country but the evaluation team would like to state that many of the issues raised here were articulated elsewhere during our trip around the provinces.

Can you comment on the training?

Our main interest (in the training) was that we no longer would stand in front of people and talk, instead the people mattered - the process became theirs. We weren't talking to people we were talking with them. We would have preferred to pre-test in our own areas.

Who trained you?

The UNICEF team.

What was the training?

It was a 10 day introduction to the participatory tools with field trips to pre-test. We were trained in July 1995, the training was very valuable, we enjoyed it!

What did you do following the training?

We came back and organised training for EHTs and nurses. We became the trainers with the help of the Unicef programme assistant - we did the training in June 1996.We identified that the nurses who are with the community everyday should be trained, but this hasn't been done yet.

Why did the introduction of PHE to the EHTs take so long?

There were other things happening - Africa 2000 came along which meant that we used the tools ourselves but there wasn't time to train others. Although we didn't train the EHTs those in "the know" intensified the use of PHE and so malaria tools were developed at provincial level. We used the tools to train people in food handling.

What problems did you face as trainers?

We have been trainers for a long time - its only the approach that's different!
Its possible, and it happened that we got people who just won't shift from the lecture method. We had this problem and so we need to expose other extension cadre to the methods so that everyone is using the same and can be persuaded. The training must spill over to other sectors.

What is the difference between "exposure" and "training"?

We wanted everyone to know everything - that way they can work together but exposure is only showing an idea and training is showing how to do it.

Who should receive what in terms of training and materials?

Target Group	Should receive training only	Should receive exposure only	Should receive tool kit
EHTs	****		****
VCWs	****		****
HOs	****		****
Councilors		****	
AGRITEX		****	
DWSS Sub-coms	****		****
School Health Coms	****		****

What comment would you like to add about who receives what about the type of training?

We would like to continue to train teachers but they move on too fast and our time is wasted - we don't get the benefit in the district. The materials would be better belonging to the school not the teacher but we can't win. If the teacher has them they move with them and if the school keeps them the bag is used for other purposes, or the tools sits in the office.

We want the DWS Subcommittee to be trained so that they can all train at ward level - we go out as a district to troubleshoot and we should be able to use the tools then to solve problems in the community.

The councillors should help with mobilisation - it is political support.

The VCWs have to work with about one hundred households so its important they know everything.

We want the Agritex people to use a participatory approach - not necessarily our tools but appropriate ones to them.

Who do you think is the target groups are for PHE?

All the community - the adults and children but to date we have just looked to adults, that is why teachers should be involved. We need the adults to change the existing situation.

The Achievements

The main achievement is described as follows:

- as indicated the original intention of training in relation to PHE was to enable identified cadre to facilitate the use of the participatory tools at community level to influence key behaviour change. In these terms training is a means to an end and not an end in itself. However, the introduction of training in PHE is having another far-reaching effect that equally requires management if the benefits are to be realised. Beyond the stated intention the introduction of such training has activated a shift in the actual approach and delivery of vocational training for sub district personnel. Moving away from didactic teaching methods to an emphasis on learning through seeing and doing, the shift arguably represents the basis upon which acceptance of the PHE approach has been embraced by so many. In simple terms people have something tangible to talk about when they describe the implementation of hygiene education. Prior to the introduction of participatory approaches no method existed to conceptualise or demonstrate the application of hygiene education beyond vague budgetary line items. This outcome is significant and requires further examination as it impacts on the relevance of training in relation to the ability of the trainee to practise acquired skills.

The Strengths

The main strength in terms of quality and relevance is described as follows:

- prior to the introduction of PHE, health and hygiene messages were taught using a behaviourist approach to learning. Basically the mode of delivery was such that if a key

behaviour change was not observed following a lecture, the lecture could be repeated again and again until the desired behaviour was adopted. Teaching hygiene education in this way is a thankless and laborious task that may or may not make a measurable difference, at the very least it results in a demoralising work environment. The lack of alternative approaches further compounds the misconception that communities do not have the capacity to act upon often existing knowledge. It seems apparent that PHE has provided the key by no longer focusing on the preoccupation of identifying observable outcomes but by introducing activities that enhance cognitive capacities. Through the fostering of cognitive skills EHTs are now able to pass the stick and teaching becomes learning. The EHTs spoken to articulated this in terms of increased motivation, job satisfaction and evidence of qualitative indicators that determine impact.

The Weaknesses

The main areas of weakness in terms of quality and relevance of training are described below.

The term "training" is generically used to report all educational activities in relation to exposure to the participatory tools and the approach and learning how to facilitate them. In making no clear definition between exposure to the materials and the approach and the actual process of being taught how to apply them, little can be commented on in terms of the quality and relevance of specific training outputs.

The present reporting format does not make known what the term training specifically means in terms of reporting the progress of training in relation to the different target groups. For each reported training activity the content, duration and expected objectives are unclear as the implementation strategy is left to the district. For example, of the councillors trained does this mean a number of tools have been demonstrated in a participatory manner, or have the councillors been taught how to facilitate the use of tools with the community, or a mixture of both? What is the rationale behind training? Each interpretation of the approach may be valid but the intention remains unclear unless specified within the context of an overall PHE training and awareness strategy. Does the former scenario warrant being called training or is it something else? It is unhelpful to continue to base the make-up of specific training activities on assumptions rather than fact.

As stated earlier the original training model may have been diluted both in terms of time and content depending on the target group and this in itself has probably led in many situations to the delivery of awareness raising questions rather than the training of facilitators. The danger is the assumption that the total number of reported training outputs is the actual number of cadres with the necessary degree of competence to facilitate participatory hygiene education at any level. Clarification of the training aims and objectives for each target group is required before any meaningful evaluation of competence, quality and effectiveness can be carried out.

The issue of support is obviously concerning project personnel and certainly no evidence has been forthcoming to suggest that adequate and consistent structures exist. The absence of a defined support system creates a two-fold problem. First, weak support structures throw in to jeopardy the cost benefit and time spent on training and secondly, training in the context of enabling personnel to facilitate the use of the PHE tools becomes a means in itself, something that the project has rightly tried to avoid throughout. The continuation of training without the necessary support and follow up is highly questionable and risks undermining the enthusiasm that many extension personnel have in embracing the approach. Furthermore is the question of training to what end? To date an estimated minimum of 9,232 people have been trained but the number of distributed tool kits is only 798 which suggests that some 90% have limited or no access to the very materials they have been trained to use or understand. To continue training activities in this vein will inevitably lead to a further dilution of PHE delivery leading to dashed expectations, low morale, completely unknown coverage and a return to old methods. The

introduction of review meetings though commendable has limited scope in monitoring terms if the day to day back up and support is not forthcoming.

The Constraints

The main constraints are described below.

Demand for a field guide has further raised the issue of the difference between new and traditional learning boundaries and the relevance, content and scope of the current training model. There is emerging concern about the number of cadres, reported as a third of all trained EHTs, who are uncomfortable with the new approach and feel unable to put the method and tools in to practice. The result is a demand for explicit guidelines (elaborated in the Field Guide) to assist the delivery of PHE in addition to receiving initial training. This highlights the difficulty of introducing the approach against the background of how extension personnel were previously trained and their readiness and capacity to embrace new methods without careful preparation. As stated the introduction of PHE has impacted on the vocational training of EHTs and this non-rationalised step challenges the existing deterministic way of working that left little or no room for creativity on the part of individuals.

Beyond the mechanistic facilitation of PHE tools, facilitators require tacit knowledge perhaps best explained as intuitive knowledge that enables the transfer of learning to a variety of contexts. This tacit knowledge is difficult to conceptualise or verbalise and is unlikely to have featured in the past learning experience of EHTs receiving more traditional education. Education reliant on rote and didactic methods placed an emphasis on surface learning that manifested itself in specific situations and contexts. The approaches advocated in a participatory environment look towards deep learning that has application across any number of situations and contexts. In a situation where cadres are being trained to facilitate non-traditional approaches it is important to take in to account the effects of the existing training culture. Assumptions about the nature of knowledge and how knowledge is internalised have to be challenged as an integral component of all PHE training programmes. Wright's earlier observation in his June 1996 report that a dangerous assumption is being made that the training alone will be sufficient to bring about a change in practice by the extension worker is still a valid one. Addressing the issue presents an exciting challenge for the project and in part the field guide may do this however it is important to continue to exercise caution over the use of printed guidelines that could be applied too rigidly.

The Opportunities

It is considered that opportunities to improve the quality and relevance of training exist particular in the following areas.

The project has expanded its training activities at an alarming rate that on the surface may appear to be an indicator of success. Yet, unless the training can be measured in competency terms the quality elements built in to the original aims and objectives of the initiative will be lost. The potential of PHE rests in the people who facilitate it and the communities that embrace it and the role that training plays in this process should not be underestimated. The opportunity exists to develop meaningful indicators of success that can be used to assess, monitor and adapt the quality and relevance of the training strategy.

The suggestions made in Wright's report concerning the language used to express training should be considered without delay to avoid continued misunderstanding and confusion. The opportunity exists for this to be dealt with at the same time as the exercise to establish support mechanisms is undertaken.

Many lessons are to be learned from those that are facilitating PHE. An opportunity exists to formalise and make use of the feedback that is readily available in the field. For example, one of

the interviewed EHTs, previously was trained in Beitbridge, reiterated the importance of follow up by indicating that for him the most important aspect in understanding the tools was a refresher workshop. The first workshop exposed him to participatory tools and for a time he used the tools following the workshop process to the letter. It was only after a follow up process that he began to use his creativity. It was only then that he understood and realised that it is possible to utilise a participatory approach without the drawn pictures.

The issue of follow up and support is seen by the MOHCW as the cornerstone to the success of the project and various initiatives have been undertaken to overcome the personal limitations - for example some districts have appointed EHTs as PHE co-ordinators.

4.5 Printed Materials and Tools

The health education unit of the MOH&CW has been responsible for the development of health education materials, which have normally taken the form of posters. These posters have been geared to social marketing a solution to an identified problem. Traditionally posters have been used in a didactic manner assuming that there is a knowledge gap that needs to be filled. The centralisation of the development of materials has meant that often, the mass produced materials, while being appropriate for some areas were not for others. For example, whiles the areas with more rains and perennial rivers suffer from frequent bouts of water borne diseases, the areas from the drier regions suffer from water washed infections.

Since the approval (1994), to proceed with the development of participatory techniques for water supply and sanitation, and the subsequent development of participatory tools and techniques, a number of tool kits and associated materials have been developed, (not only by this project but also supported by the Belgian Government) and considerable progress has been made in this area.

The Achievements

To date the following tools have been developed:

- A standard tool kit comprising the following tools
- Task target analysis
- Flexi flans
- Nurse Tanaka
- Blocking the routes
- Story with a gap
- Diarrhoea child
- Unserialised posters
- Pocket charts
- Sanitation ladder
- Three pile sorting

These tools were developed pre 1997 with financial support from the Belgian government which was channelled through UNICEF and about 500 sets were subsequently produced as part of this process.

The above standard tool kit was subsequently complimented with additional tools that were developed as experience was gained in the use of the new participatory techniques. The additional tools are made up as follows:

- Blocking the routes, bilharzia
- Blocking the routes, malaria
- The Water Ladder

- VCW Mbuya
- EHT Moyo
- DDF pumpminder Mukoma
- Teacher Kanitza
- Animal crackers
- additional props such as A3 flexi flans or maxi flans

These tools were developed since the commencement of Irish Aid funding and 1,000 sets have been produced with an additional 500 sets of the standard tool kit referred to above. New tools are being developed continually, the latest, specifically for schools are:

- Spot the difference
- Snakes and ladders

In addition the health education unit of the MOH&CW has been instrumental in providing support for the development a series of 'A5 tools', (produced on A5 paper) as follows:

- Most common water sources
- Most hygienic water sources
- Most convenient water sources
- Most feasible water sources
- Taking drinking water
- Water storage

A diarrhoea doll (a doll used to physically demonstrate the effects of diarrhoea) made from plastic bottles has also been developed and is a great success in the field. These are made locally from plastic orange juice bottles and the production of 500 has been supported by Irish Aid.

The above tools are now provided as a complete tool kit that includes a tool kit bag and additional stationary. In order to supplement the complete tool kit a field guide (discussed elsewhere) is currently being developed to help outline the methodologies in relation to the use of the tools.

A trainers tool kit to support the training at the lower levels has also been developed. 200 copies of this kit have been produced and they have been distributed to the districts via the province.

The existence of the tools mean that for the first time physical materials are available to facilitate hygiene education at field level. The fatigue experienced by those trying to implement hygiene education in more traditional ways is being alleviated and accompanying attitudes are finding themselves challenged. This is having a dramatic effect on the community who are increasingly becoming animated and more involved with "project type" activity.

From a production and distribution point of view a total of 1,000 complete tool kits have been produced and 798 distributed to eight provinces, forty four districts and the sub district levels. The size of the production effort is immense and has consequently demanded equally complex organisation and management.

The decision not to prescribe the format in which the tools are to be used has allowed for flexibility that has developed in few situations. This is to be encouraged as it is an essential element when facilitating activities that challenge the complexities of human behaviour that is neither universal or static.

The Weaknesses

The evolution of the use of the tools the central focus of the process (referred to earlier, see section 4.3 - Achievements) has limited the scope and breadth of participatory methods. While some EHTs have adapted the tools to suit the different situations, some have not been able to use the method to address their many duties. For example some EHTs indicated that the tool kit did not contain any pictures related to shop inspections and so they were therefore unable to utilise a participatory approach in that situation.

The project decided to train a cross-section of people involved in hygiene education and equips them with the tool kit. The evaluation team noted that there are a number of people who have been trained but have inadequate access to the tool kits that their training was so dependent on. For example a great emphasis is placed by many on the VCWs who are acknowledged as being important in awareness creation and community mobilisation. However it seems that many of those that have been trained do not yet have tool kits.

The sheer volume of materials required for each tool kit is huge - over 350 pictures per kit. Ideally all trained personnel should have access to a kit. While every effort is made to facilitate this (kits are provided to institutions rather than individuals), it is not always the case, Almost all field staff complained about not having access to the materials for one reason or another, predominantly because of the low coverage in terms of numbers of kits. It is estimated that there is only one tool kit for about every 12 trained cadre. This can have a significant negative impact on motivation among field staff in particular and put the whole process in danger.

The Constraints

The materials, in particular the drawings are printed on fairly thin card and are not laminated. While the logic behind developing less durable materials is understandable and justified in terms of cost per unit, it does mean that the tools do not last long. Some EHTs have tried to make their materials more durable by mounting them on hard cardboard. Not all of them however have the same creativity.

The Opportunities

Considerable opportunity exists in the area of materials development. It is already demonstrated that the use of the participatory techniques is widely accepted. Already a number of these techniques have been adopted to suit needs which were not originally considered in the first kit but have been articulated by the communities, i.e. blocking the routes for bilharzia and malaria. This development should be fostered as much as possible as it could have a significant impact in other sectors also.

4.6 The Degree of Completeness of the Project

In real terms the extent of completeness of the project should be measured against the impact it has on the quality of life and health standards of the rural communities the project was designed to support. However, as indicators to measure improvements in peoples health and well-being have not as yet been fully articulated it has become necessary to measure completeness in terms of the proposed outputs of the project rather that what impact it has had on health standards of the rural poor.

Project outputs have been divided in to the following categories:

- materials and tool development
- training in the application of participatory hygiene education

- provincial level training in PHE applications
- district level training in PHE applications
- sub-district level training in PHE applications
- ward level training in PHE applications
- builder training
- community builders
- VCWs
- EHTs
- participatory hygiene education sessions with
- VHPs
- health clubs
- communities
- construction of sanitation enabling facilities
- construction or rehabilitation of family wells

The Achievements

Materials and tool development:

The achievements in relation to the development of tools and materials has been discussed in detail in the previous section - 4.5 above.

Training in the application of participatory hygiene education:

- provincial level training of trainers teams; all eight provincial teams trained, one supported directly by Irish Aid
- district level personnel (i.e. trainers of trainers at the district level); 1,337 people trained, 652 supported by Irish Aid
- personnel employed by NGOs supporting PHE; 93 people trained, 16 supported by Irish Aid
- sub-district level personnel; VCWs, 841 (164 IA); FHWs, 838; Councillors, 157 (16 IA); Local Leaders, 649 (66 IA);
- Teachers, 507 (150 IA);
- VHPs, 120 (120 IA). In addition and estimated 4,690 ward level personnel (i.e. combinations of the individuals referred to above, for example councillors, VCWs and FHWs may have been trained as a group) have been trained.

It has been estimated that at least 9,232 people have been trained at the district and sub-district levels in participatory techniques. Of these over 1,184 have been supported directly by Irish Aid.

Builders Training

In order to support the PHE activities it was seen as appropriate to train builders in sanitation and family well upgrading techniques in an effort to support the development of demand driven latrine and improved water supply initiatives. Training is given in the standard latrine construction techniques using four bags of cement, in family well upgrading and in the construction of hand washing facilities. This training is sufficient to support the construction of water supply and sanitation enabling facilities to a minimum acceptable standard.

To date this has resulted in:

- 1,535 community selected builders trained. It has been estimated by UNICEF that perhaps twenty per cent of the total trained are women, all supported directly by Irish Aid.
- 111 VCWs have been trained as builders, again all supported by Irish Aid
- 142 EHTs have been given training to compliment the skills that they already gained as part of their training as EHTs, all Irish Aid supported.

Community Sessions:

Community sessions can be taken as meaning PHE sessions that were implemented at community level for the purpose s of hygiene education promotion. The lack of reporting mechanisms have meant that the actual number of sessions is not known but it certainly exceeds those expressed here. Community sessions do not infer cost for the project as community animators, for example VCWs, EHTs of VHPs etc, usually facilitate them. They are included here to provide an insight into what the actual training that was supported by Irish Aid has resulted in:

- over 327 sessions were facilitated by VHPs (no cost to the project)
- EHTs with Health Clubs facilitated more than 460 sessions. The Health Clubs are predominantly located in two wards of Makoni District
- over 3,288 sessions have bee facilitated in communities

Sanitation:

To support the construction of sanitation facilities, that is the VIP latrine (Ventilated Improved Pit), the project has supported the provision of a subsidy in the form of cement to the household level. Nationally the subsidy currently provided has been five bags of cement per household. Irish Aid funds used to support this subsidy have been channelled through Mvuramamzi Trust and Africare. In the case where Mvuramanzi Trust is operating the subsidy was three bags of cement per household as that is the level provided by the Trust. In a similar manner the subsidy supported by Africare was four bags consistent with their development strategy.

To date Irish Aid funding has supported the construction of 2,460 latrines (programme total 4,628), with 535 (total 5,373), under construction at present..

The project also supported the production of 10,000 copies of the Blair Latrine Construction Manual (4 bag model), the Family Well Upgrading Manual and the Construction of Hand Washing Facilities Manual. These have been distributed to trained builders through the MOH&CW.

Family well upgrading

In a similar manner to the subsidy for latrines a subsidy is provided for the upgrading of family wells. Again the subsidy is channelled through Mvuramanzi Trust they being the only organisation involved in the physical upgrading of these facilities, although GOZ supports the strategy.

- To date Irish Aid has supported the upgrading of 1,074 wells (programme total 5,373), with 715 (total 3,573), presently under construction.

The tables following in section 5 highlight the outputs achieved to date by district. Direct Irish Aid support is shown in italics. These tables are also complemented with a map showing the distribution of the various PHE activities in Zimbabwe.

The Weaknesses

Presently there is no clear evidence to suggest that a link exists between the facilitation of PHE activity and the emergence of a demand driven environment. However, it is fully accepted that for the Project it may be too early to draw conclusions as achieving the desired scenario is actually a long-term aim. Yet, where NGOs, namely AFRICARE and Mvaramanzi Trust are operating there is certainly a visible demand for hygiene enabling facilities, in particular latrines. What is not clear in Mashonaland East and Manicaland is whether PHE is influencing this or if it is the existence of a subsidy that generates active interest. It is also not known to what extent

other influencing factors effect demand, for example local political and peer pressure or the problems of drought and whether the presence of PHE makes a difference. In Goromonzi District the community indicated that during 1995/96 they suffered water shortages. The operating NGO is therefore addressing a practical demand driven need that was felt before the more recent introduction of PHE. Once again any attempts to indicate that there is a clear correlation between PHE and demand is difficult.

However, there are some isolated cases where PHE is considered to be having an impact and creating a demand for hygiene enabling facilities. These instances are thought to be more associated with individuals running the PHE and associated activities rather than the presence of PHE activities per se.

In Gwanda the RDC indicated that since PHE started communities have been constructing their own facilities without having to wait for a subsidy. The communities have on their own initiative built over 200 hundred VIP latrines. Most of the community initiated latrines are double compartment. Furthermore, communities have hired a private contractor who has been drilling boreholes on their behalf and 83 family boreholes have been drilled. While it can be argued that Gwanda is a dry area and therefore the demand for water is practical, the same cannot be said for latrines. In the past communities have also not felt the need to sell their animals for water development but have waited for solutions from government.

This however is not to negate the influence that hygiene education seems to have had on the re-prioritisation by the communities. Even where NGOs are visible like in Mashonaland Provinces, the family wells and latrines demand a lager input from each household than it places on the project. The evaluation team was told that the estimate input by the community is at over US $ 100 per household. If the community is willing to invest this much amount in these facilities then it has to be more than just the subsidy inducement.

In Matabelalend it was noted that PHE has helped in creating the demand for hygiene enabling facilities. The evidence was found in Lupane district, implementing the WHO Africa 2000 initiative. At the start of the initiative communities were utilising the cement subsidy for plastering their own homes, or would leave the cement unused or loan it out to other members. With the advent of PHE, the programme can no longer cope with the demand for cement. The EHTs seemed to be interested in promoting the hygiene not because of a linkage to some subsidy, but because they believe the methodology is bringing about change.

An enabling facility that seems to be supply driven more than being demand driven is the wash hand facility. The current standard latrines is constructed with a hand-washing facility. During the evaluation mission , most of the latrines visited in Goromonzi, Makoni and Mutasa hand washing facilities that are not being utilised. The facilities visited had no water in the tanks, no evidence of water in the ground and the few that had water in the tanks the water had scum ,evidence that the water had been in the tank for long. This does not mean to indicate that hand-washing patterns have not changed. Communities are using "run-to waste" method when there are gatherings, they wash before eating but there is no tangible evidence that they wash after using the latrine.

It may be that PHE can only be successful if contributing to an overall development approach but in the absence of its proven strategic use this is impossible to tell.

The Constraints

The term "completeness of the project" presents a problem when considering the operational effectiveness of PHE activity. The underlying assumption within PHE is that the use of the methodology and materials will induce behaviour change at a household level. So, once awareness exists individuals begin to internalise messages and so change or adapt certain behaviour or practice. As part of this process it is hoped that a demand is created to sustain the

positive change in behaviour or practice that results. This demand usually manifests as an enabling facility and in the case of the Project it is met through provision for latrine construction and family well upgrading. In a truly "demand driven environment" interventions are only made at the request of the community or individual. These points are extremely important when considering issues of scale and coverage because, as indicated, the actual range of it is relevant to the real demand that is being created as a result. So for example the Project is very widely spread but it is not known if the originally stated desired outputs are being realised.

The issues of scale and coverage are tightly bound to those of subsidies, motivation and perceptions of need as seen by the community on the one hand and the Project on the other. The basic question is twofold. First, does the actual presence of PHE activity prove to be beneficial in terms of the overall objectives and secondly is presence in itself a measure of coverage? These questions and factors are considered below.

National coverage, contrary to the intentions of the planned implementation strategy, has taken off at a far greater pace than anticipated. The dissemination of the process has out-paced early expectation and consequently the quality of its growth is constrained by insufficiently dedicated capacity to monitor progress and offer adequate support. Quality assurance simply is not in place and this undermines the wealth of progress that has no doubt taken place.

A major concern regarding the wisdom and cost benefit of going to scale is to do with the benefits to health. Again not enough is known within the Project to be able to conclude that PHE has an eventual health benefit to the community and further research is required.

The opportunities

A wealth of opportunity exists to research the implications and effect of introducing PHE on a wide scale. For example - Why is it that the very presence of an NGO leads to demand? Would the same demand exist in a wholly GOZ supported community? Should resources be continually pumped into PHE and can it survive as a programme without subsidies and NGO support? These questions in themselves present a real need and indeed an opportunity for further research.

4.7 Gender

The Project is following a "low key" approach in relation to gender issues. This is a deliberate strategy claiming to be borne of experience where the overt promotion of women in particular has sometimes led to the reinforcement of negative attitudes about the roles and responsibilities of women.

The Project has adopted the following principle to describe gender although this is not formally articulated; that gender means the context and reality of both women's and men's lives that can together affect self determined change. Gender is not solely about women's issues.

The Achievements

It is claimed that some indicators are beginning to emerge to confirm that women are becoming involved in water and sanitation issues beyond the role of principle user. For example women are cited as being increasingly active in health clubs and village health promotion initiatives.

It is believed that the Project is having some success in the area of advocacy, particularly in relation to challenging the attitudes of EHTs, the majority of which are male.

The Strengths

The participatory tools and materials coupled with the overall approach have noticeably facilitated an increase in the number of women who actively participate in hygiene education sessions. It is repeatedly commented that women have a voice where before they were either silent or ready to comply with the domineering views of men. It is thought that the drawings are largely responsible this shift in the willingness to participate.

The fact that the Unicef Project Officer is a woman has proved to be very important in raising the issue of the presence and subsequent roles and responsibilities of women in the Sector even though this was not initially seen as an affirmative action.

The Weaknesses

The project had hoped to recruit a high percentage of women to train as builders but for largely undocumented reasons this has not happened. The number of women trained is said to be about 20% of the total but the absence of follow-up and monitoring means that little is known about the productivity patterns of them once they are trained.

The constraints

Efforts to rationalise and balance the roles and responsibilities of men and women in at all levels of the Sector are probably constrained by the negative attitudes of some of the actors.

The opportunities

There is clearly an opportunity to investigate the nature of women's involvement in water and sanitation programmes particularly where NGOs and similar agencies can support the development and facilitation of participatory research activity.

5 SUMMARY OF ACHIEVEMENTS

This section presents a summary of the achievements of the PHE project in map and tabular format. The critique in relation to each of the achievements has been provided in the previous section. Further discussions regarding qualitative and quantitative achievements are given in the next section,- Section 6.

The tables show what has been achieved in total since the PHE project started and this is indicated by district. Those elements that have been supported directly by Irish Aid are shown in italics. Form the point of view of the "community sessions" numbers of are thought to be significantly higher as present reporting formats do not allow for the presentation of detailed returns indicating total numbers present at these community sessions.

MASH CENTRAL
MASH WEST
MIDLANDS
MATEBELELAND NORTH
BULAWAYO
MATEBELELAND SOUTH
MANICALAND
MASVINGO

LEGEND

PHE Irish Aid
PHE Partial
PHE Other Donors
Sanitation
Family Wells

The above map indicates the distribution of present PHE initiatives .

	Reporting Perion August 1995 to July 1997										
			PHE Training Activities								
	Province/ District	Tool	District		Extension Level						Ward
		Kits	Dist	Ngo	VCW	FHW	Cncl	Lead	Teach	VHP	Trng
	Matebeleland North	10	40								
1	*Binga*	*19*	*24*								
3	*Bubi*	*16*	*27*								
3	*Hwangi*	*10*	*18*		72	30		74			135
4	*Lupane*	*13*	*25*								
5	Nkayi	-	-								
6	Tsholothso	-	-								
7	Umguza	-	-								
	Matebeleland South	9	11								
8	Beitbridge	15	18		102	20		7	2		300
9	*Bulalimamangwe*	23	*35*		*19*						45
10	*Gwanda ** (0, 20)*	17	35		*69*				*27*	*18*	270
11	*Insiza*	20	26	2							
12	*Matobo*	*16*	*16*								
13	*Umzingwane*	*17*	*35*								
	Midlands	8	7								
14	*Chirumhanzu*	*16*	17								
15	*Gokwe North*	*20*	27								
16	*Gokwe South*	*21*	25								
17	Gweru	-	-								
18	Kwekwe	-	-								
19	Mberangwa	30	45								1,080
20	*Shirugwi*	*24*	32		76		16		33		195
21	*Zvishavane*	*10*	15								
	Mashvingo (P/Trng)	5	5								
22	*Bikita ** (3, 5)*	11	25								
23	*Cheredzi ** (2, 2)*	2	3								
24	*Chivi*	2	2								
25	*Gutu ** (4, 4)*	*4*	*36*				8				
26	*Masvingo*	*3*	*3*		4						
27	*Mwenzi*	3	3								
28	*Zaka*	2	2								
	Mashonaland West	8	8								
29	*Chegutu*	*3*	*3*								
30	Hurungwe	-	-								
31	Kadoma	25	50								
32	Kariba	-	-								
33	Makonde	-	-								
34	*Zvimba ** (4, 4)*	*4*	*15*		40	60					
	Mashonaland Central	5	6								
35	*Bindura*	*15*	*18*								
36	Centenary	-	-								
37	*Guruve*	*24*	*42*								
38	Mazowe	18	24	1			20				
39	*Mt. Darwin*	*15*	*32*								
40	*Rushinga*	*1*		1							
41	*Shamva*	*8*	*15*								
	Mashonaland East	11	9								
42	Chikomba	12	37	6			3	3			225
43	*Goromonzi ** (0, 25)*	78	48	4	58	181	5	33	82		255
44	*Hwedza*	*11*	40	26	106		10	67	73		195
45	Marondera	12	18	7	52	380	11	32	34		345
46	*Mudzi*	15	*42*	6	10		7	7			240
47	*Murewa*	*14*	*23*	15	22		30	30	40		450
48	*Mutoko*	*16*	*37*	5	4		2	8			210
49	*Seke*	*19*	*50*	3	*18*	151	*16*	*33*	*41*		315
50	*U.M.P*	*12*	42	12	12		10	80	150		225
	Manicaland	4	6								
51	Buhera	-	-								
52	*Chimanimani*	*14*	-		6	6					
53	*Chipenge*	*30*	35		65	8	7	70	25		90
54	*Makoni*	*5*	*6*		18		2	10			
55	Mutare	-	-			2					
56	Mutasa	14	14	1	56		4	80		*64*	
57	Nyanga	16	16	2	32		6	95		*38*	
	Gwands MDS	*5*	*76*								
	Gweru MDS	*3*	*25*								
	*Man Devt ** (30, 43)*	*35*	*43*								
	Totals	798	1,337	93	841	838	157	649	507	120	4,690
	Irish Aid Supported:	*496*	*652*	*16*	*164*		*16*	*66*	*150*	*120*	

	Reporting Perion August 1995 to July 1997										
		Bulders Training			Community sessions			Sanitation		Family wells	
	Province/ District				VHP	Health	Comm	new	under	new	under
		Builders	VCW	EHT	sess	clubs	sess	lats	cons	comp	cons
	Matebeleland North										
1	*Binga*										
3	*Bubi*						45				
3	*Hwangi*										
4	*Lupane*						172				
5	Nkayi										
6	Tsholothso										
7	Umguza										
	Matebeleland South			2							
8	Beitbridge			2			132				
9	*Bulalimamangwe*						22				
10	*Gwanda*			4			284				
11	*Insiza*						42				
12	*Matobo*						37				
13	*Umzingwane*						25				
	Midlands										
14	*Chirumhanzu*							6	89	160	140
15	*Gokwe North*	63	12	8				17	72	27	16
16	*Gokwe South*	26	3	1				17	12	238	42
17	Gweru	7		1				218	518	62	153
18	Kwekwe										
19	Mberangwa									5	
20	*Shirugwi*	73	9	9				49	27	373	285
21	*Zvishavane*	40	5	3						5	
	Mashvingo (P/Trng)			8							
22	*Bikita*									4	
23	*Cheredzi*									18	32
24	*Chivi*										
25	*Gutu*	219	3	36				140	5	1,067	1,029
26	*Masvingo*	50	3	1			25	281	265	194	219
27	*Mwenzi*										
28	*Zaka*										
	Mashonaland West										
29	*Chegutu*							13		13	
30	Hurungwe										
31	Kadoma	47	6	6			85			206	274
32	Kariba									3	1
33	Makonde										
34	*Zvimba*										
	Mashonaland Central										
35	*Bindura*	35	5	5				173	36	87	42
36	Centenary										
37	*Guruve*	273	15	10				36	232	161	212
38	Mazowe	8	2							68	
39	*Mt. Darwin*										
40	*Rushinga*										
41	*Shamva*	8	1								
	Mashonaland East			2							
42	Chikomba	91	8	5			14			287	
43	*Goromonzi*	58	13	6			578	84	59	497	267
44	*Hwedza*						447				
45	Marondera						43				
46	*Mudzi*						15				
47	*Murewa*						200	322	145	174	70
48	*Mutoko*						37	20		34	
49	*Seke*	5		17			67			15	
50	*U.M.P*						138				
	Manicaland										
51	Buhera								20		
52	*Chimanimani*										
53	*Chipenge*	56	5	8			220			287	95
54	*Makoni*	62	1	5			250	1,334	1,213	1,368	696
55	Mutare					460					
56	Mutasa	277		1	253		150	1,443			
57	Nyanga	137		2	74		160	475			
	Gwands MDS										
	Gweru MDS										
	Man Devt										
	Totals	1,535	111	142	327	460	3,118	4,628	2,673	5,373	3,573
	Irish Aid Supported:	*1,535*	*111*	*142*				*2,460*		*1,074*	

6 MEETING THE PROJECT OBJECTIVES

6.1 The Indicator and Impact Debate

To determine the extent to which the objectives are being met the rationale used to interpret the difference between output and objective must be explained.

By the term project objectives we mean:

the original people orientated improvements that were stated in the project proposal document as the overall project objective to:

- improve the quality of life and health standards of the poorest sectors of Zimbabwe's population, through an intensive programme of participatory hygiene education, supported by the construction of hygiene enabling facilities.

All other objectives for the purpose of the evaluation have been differentiated in terms of hardware and software outputs. Therefore, the immediate objectives as stated in the project proposal document are split in to their hardware and software component parts. The immediate stated objectives were to: -

- maximise the health impact of water and sanitation improvements and
- increase the rate of latrine construction and associated works (hand-washing facilities and upgrading of unprotected village wells) in order to contribute to the achievement of the national goal of 50% coverage by the year 2000.

Output is considered to be any productivity that in isolation will not necessarily lead to people orientated improvement. Output tends to be hardware related but here also refers to training activity and material distribution.

This interpretation has been reached in an effort to deal with the complex issue of determining indicators for success and measuring impact. The project stresses that it is neither a training project nor a materials project, in fact it is a people orientated project and its impact is solely reliant on the motivation and willingness of individuals to change circumstance and practice. In simple terms the project is about the desire to make choices and take action based on the ability to make informed decisions.

There is considerable debate in the project about how to best measure success and impact. To date despite a number of attempts to establish reliable indicators have been being made, although no final agreement has as yet been reached. In management terms this means that key project areas continue to receive inadequate attention. The key areas are: -

- reporting systems
- monitoring and adjustment
- proactive planning
- the development of a relevant training strategy
- follow-up and support
- the strategic use of PHE by all trained cadre
- the integration of PHE and CBM
- the role of PHE in decentralised districts
- intersectoral collaboration, co-ordination and partnership
- research and development

It is fully acknowledged that a considerable amount of effort has already been put into the development of indicators and reporting systems for monitoring purposes. The challenge now is

to operationalise these. It is further acknowledged that this area is highly problematic but at some point the suggested, and in part developed, indicators have to be accepted as being better than no indicators and these should be immediately researched and applied. It is also further noted that there are staff shortages at various critical levels in government which further hampers the follow up and support activities.

That a certain level of confidence exists in the PHE process is evident from the many conversations held with those involved but at present it is not formally articulated. This position if left risks having an affect on both the commitment of funding agencies who increasingly want to see hard proof of the approach, and the motivation levels of those implementing the programme. The project, through the MOH is developing and co-ordinating a network system to maintain and encourage confidence amongst its trained cadre and the initiative if managed efficiently and effectively will help enormously.

The key behaviour changes are given, having been in place as targets for change since before the project started. A significant indicator of the level of confidence in PHE is that other health issues outside the identified hygiene practices have emerged as focus topics for new participatory tools. The impetus to develop these topic areas, notably malaria and bilharzia, is surely borne of enthusiasm and the belief that the application of PHE is proven as far as it works better than that which existed previously! In fact it has been reported that many EHTs have articulated plans which reflect that PHE is applied in a proactive manner. A tremendous amount of time and effort is spent in drawing, testing and adapting tools and it is unlikely that extension personnel would go to such lengths if they did not believe in the benefits and value added. Is the motivation to create new tools based on the fact it makes an EHTs job easier, a valid enough secondary reason, or primarily is there proof that the cases of disease is actually reduced?

6.2 The use of Existing MOH Monitoring Systems

This evaluation exercise has investigated the options for assessing the impact of PHE on the health and well being of the community. Remaining cautious about the problems and validity of using clinic returns particularly in relation to diarrhoeal disease, the investigation focused on the existing national monitoring system for disease prevalence.

The MOH uses a monthly return form called the "T5" to monitor the pattern of reported diseases from a national perspective. The figures are gained from clinic outpatients department records at ward level and are compiled by each district. The form lists the general diseases and conditions that are reported most frequently and also allow for the monitoring of location specific diseases. The main water and sanitation related diseases are reported as are the diseases that are being introduced in to the PHE effectiveness debate, for example malaria and scabies.

The Team looked at the returns from two districts, Gwanda and Makoni tabulating the figures in an attempt to plot prevailing trends. Where as the trends seem to back up the evidence that the pattern of disease is perhaps changing an analysis has not been conducted given the constraints upon time faced by the Team. Therefore at present a verified conclusion as to why reported cases of specific diseases should be falling in some wards and not others cannot be offered. Nevertheless given the right research environment it is the opinion of the Team that the information represents a real opportunity for impact monitoring. Used in conjunction with the qualitative indicators that are already in part developed and the utilisation of the control areas that readily exist where PHE is not conducted, it is thought that a correlation between the facilitation of PHE activities and the reduction of reported diseases would probably be revealed.

Such research should also consider the inputs in terms of training, subsidy and other human and physical resources. Effective quantitative and qualitative monitoring necessitates an understanding of the value-added nature of any given input in relation to the anticipated and actual output. So for example, does the number of community based PHE sessions held over a period have an affect on the numbers of reported cases of disease? If fewer sessions are held is

there a knock on effect? Does the strategic use of PHE result in greater measurable impact than ad hoc or occasional use of the tools and approach?
Such research, that is urgently required, will hopefully qualify the enthusiasm that is felt throughout Zimbabwe that PHE actually makes a difference to the health and well being of the community.

Discussions in Rusape, Lupane and Gwanda indicated that there would be support for this method of monitoring, and possibly reporting through the T5 format.

6.3 Observations from the field

The experiences and opinions of district trainers and implementers in Lupane District are representative of the many comments gathered from the field. A tremendous opportunity exists to use such qualitative indicators to measure the level of effectiveness of the PHE initiative.

Why has the District adopted PHE?

The old lecture method didn't bear fruit - impact just wasn't there, even with the subsidy we saw nothing tangible, the cement was often used to plaster houses instead of building the latrine!

The lecture method began and ended in the session, there was no follow up. No emphasis on community empowerment - we didn't believe people had the knowledge to change.

PHE is a conspicuous method - we see it and we see the fruit it bears.

What do you think about the issue of ownership?

Look at the Africa 2000 programme where the community is wholly responsible. The use of PHE has promoted community responsibility and the desire to change (behaviour) beyond water and sanitation. The community on behalf of the community is managing the subsidies.
Before it was our (the districts) responsibility to police the use of cement, now the community does it. I don't know if this is what is officially meant by community management, but here it is! A major problem in the past was sanitation, everyone would talk about water, and thats easy to solve with boreholes and so on but nobody wanted to know about sanitation. Now we can discuss it freely. The people are proud to have a toilet.

In relation to the tools what comment can you make?

We have confidence in the tools - they work!

How do you (as implementers) decide how and when to use the tools?

We hear there is a problem and we react - the problem exists and so form the EHTs we find out what it is and then we take action.

What is the impact of PHE from the district's perspective?

It is too early to tell. The extra time that PHE takes to in working with the community pays off. The work load of the EHT has increased and this is how it should be.

How does the district monitor the work of the EHT?

We do spot visits by district teams going out and we can identify the weaknesses, we also discuss with the facilitator if they have enough confidence with the tools. We can only do a spot check once every three months as the scope for environmental health is so wide - it is more than just PHE.

What indicators does the district have in place?

We get information from the EHT and give it to the district office for a three monthly report that goes to the province.

What evidence have you, either as implementers or from the district perspective seen to suggest there is an impact?

Refuse pits - there are more in the district, also pot racks and both of these are subsidy free. Latrines but with the subsidy by Africa 2000. We have no proof of the hand-washing at the Blair latrine.

What would help the district to monitor work on the ground?

We need the VCWs to be on the spot looking for impact at the most bottom level because EHTs can't do it so effectively, they haven't the time.

Have you adapted the tools?

Yes, for plague - we use the old transmission route poster in a participatory way instead of a lecture.

6.4 Qualitative Indications of Change

There is no shortage of indication, that PHE is playing a role in the way that the community and its animators report key behaviour change. Although as already stated, this is not reported in a measurable way examples of the experiences are worth including as they expose the range of the changes that people perceive as happening. Included in the experiences are the reasons for adopting PHE, perhaps a possible indicator of change in itself, and how PHE is seen in relation to qualitative issues of ownership, key behaviour change, attitudes and use of knowledge. Questions were also asked about monitoring and reporting. The discussions held during the evaluation indicate that there is sufficient opinion in the field to conduct a future qualitative survey and analysis that could be linked to the quantitative indicators through the T5 exercise.

Some initial areas to highlight and concerns expressed from the information gathered include that: -

- there is a lot of valuable experience and information in the minds of those implementing PHE that risks being lost if not captured in a systematic way
- there is little taking place in the key areas of monitoring, reporting and supervision
- PHE is often applied in the occasional sense and rarely in a strategic manner
- the competency of those facilitating PHE activity is not known and therefore quality in relation to training and delivery is difficult to measure
- there are a number of articulate "champions" who could be used to assist the process of research in to impact monitoring
- some cadre are "running with" the concepts while others clearly do not understand it beyond a basic mechanical application of the tools
- there appears to be a feel for change and an excitement related to the use of PHE and the sense of there being an outcome
- EHTs may be relying on PHE for reasons of job satisfaction at the expense of other duties and tasks, the effect of which is not known

6.5 Quantitative Indication of Change

The quantitative indicators that contribute to an assessment of meeting the objectives relate to either the training and material distribution elements of the project or support through the subsidy of sanitation and protected water facilities - the inputs in relation to the outputs. In isolation the building of latrines, hand-washing and pot storing facilities and the protection of family water points does not prove that behaviour change was induced by the fact that PHE sessions have been conducted. The whole area of using quantitative indicators to measure PHE success is fraught with issues of subsidy inducement to act, unknown behaviour patterns in relation to the facility, the effects of culturally bound norms, tradition and the pressure of peer groups that influence the decision to "follow the crowd".

It is very clear that in the wards visited there are a huge number of completed latrines, the majority of which meet the minimum standards set for latrine construction in Zimbabwe. A percentage of the latrines have double units, some have single units and many have hand-washing facilities although certainly not all. Pot racks and water storage and water use systems (covered pots and the use of ladles and/or individual cups for drinking) are evident. Linked to the issue of water hygiene and storage is the noticeable trend towards the "pour to waste" method of

hand washing. Reports suggest that the method is widely used at public gatherings, for example funerals, and this is regarded as tangible evidence of both a key behaviour change and a significant cultural shift as hand-washing is usually linked to ritual and belief in this context. The latter example highlights the complexity of the indicator debate. A change in previously culturally-bound rather than heath related behaviour falls somewhere "betwixt and between" qualitative and quantitative measures, however in real terms no more than a general trend can probably be observed.

An under-exposed indicator yet one that emerged repeatedly throughout the evaluation is that of the recognition of the significance of incremental steps towards minimum sanitation standards and practised behaviour levels. Without compromising the national goals for standards and coverage, the Team believes it is important to take full account of the steps a community or household can take to improve their health and well being. For example, the functionality or standard of a VIP latrine is not compromised by the fact that it is built of local or traditional materials. A grass roof should be no less acceptable than a roof constructed from cement slabs or roofing sheet if the owner has chosen it. Countenance should be given to the acceptability of such structures and importantly to the actual value of the positive action that the owner is taking. (These ideas are not only the view of the Team but were also debated at the annual sector review in 1996). Hence, the behaviour change is greater and of more measurable significance than the perceived dropping of standards. Similarly recognition should be given to the change in behaviour that is directly related to circumstance. For example, where the disposal of excreta is limited to the bush, when the person is away from his/her homestead, practise of the "cat-method" is an acceptable behaviour compared to defecating in an open space and leaving the excreta on the ground, either exposed or covered by leaves. The issue here is about how impact is to be measured and the danger of undermining the individual's empowerment to make decisions and basic community management principles.

The meeting of the Project's objectives is dependent on a number of complex concepts and factors that require further research. A period of reflection and research will ensure that the wealth of learning that is felt at every level of operation, surely the Project's underlying objective, will not be marginalised by the pace at which the Project is currently reporting unmeasured outputs.

7. SUSTAINABILITY

7.1 The Context

Sustainability is a wide and often complex issue within any given project. In recent years the sustainability of the water programme has become a topical issue in Zimbabwe. The policy initiatives summarised in Vision 2000 sought to map out the way forward for sustainability in Zimbabwe. Some of the principles of the Vision have been operationalised through recent decentralisation and community based management (CBM) initiatives.

Decentralisation as indicated is seen as key to addressing the issue of sustainability within the water and sanitation sector. The Rural District Council Act of 1988, as already described, gives the overall mandate of development to Rural Local Authorities. To support the initiatives the Rural District Capacity Building Programme [RDCBP] is seeking to strengthen the capacity and capability of RDCs to empower them to take new roles and responsibilities.

Increasingly, evidence points to the fact that central agencies can not adequately cope with the operations, management and maintenance of water facilities. It is also increasingly felt that only through a community managed system will there be effective and efficient operations and maintenance leading to sustainability.

The issue of sustainability so far has not been of central concern within the PHE Project. Initially the Project understandably focused on creating awareness about the methodology and process, promoting acceptance, developing skills in the use of the approach and developing and adapting materials for use at field level. Although not consciously addressed, some of the adopted strategies and approaches have contributed to the partial targeting of a sustainable programme. The evaluation team therefore did not actively seek to evaluate measures that have been taken to address sustainability but rather attempted to initiate a debate on the way forward.

The discussion about sustainability focuses on the following areas:

- sustainability of PHE without the external support
- funding
- skills and capacity and
- institutional sustainability at the: national, district, sub - district and community level

In the past IRWSS projects had very little in terms of budget allocation for hygiene education. The activity itself had a very low profile with personnel in the Ministry unable to quantify or qualify their strategic and operational plans. As discussed earlier, the past strategy had no defined outputs and generally hygiene education was carried out in an ad hoc manner. Since the introduction of PHE, hygiene education has gained visibility within the Sector. The use of participatory approaches has had backing at a policy level within the Sector, and the approach is now institutionalised within the Ministry of Health. In the immediate term this has strengthened the PHE process and allowed it to grow. If the support of policy makers persists this will strengthen the future progression of PHE.

Generally the environment within community development is conducive to the continuation of the use and development of participatory approaches. There are positive moves to empower and strengthen locally based structures particularly through the decentralisation and the CBM pilot programme. The current environment can then allow for the promotion of the philosophy of PHE that steers away from top down approaches to facilitate bottom up development strategies. However, it should be emphasised that an environment conducive to change and a supportive yet informal policy, alone will not lead to a sustainable process. Other issues such as funding and the capacity of the institution must be taken in to consideration.

7.3 Funding

Where IRWSS projects operate there is scope to secure sufficient funding for the continuation of PHE activities. For example Lupane District in Matabeleland North, earmarked to commence an integrated project with the support of the ODA, indicated that they have already budgeted over Z$ 75 000 for hygiene education and the production of hygiene education materials. The project will also seek to have a hygiene education officer as an advisor to council.

In Gwanda District where a IRWSS project is being implemented with UNICEF support, the RDC indicated that the budget allocations for hygiene education has been rising. Therefore in many of the areas that already have some form of supported PHE, or who are about to become involved, funding may not be an immediate issue of concern. However currently PHE funding for those districts, which have no IRWSS project, remains uncertain.

The national budget for the environmental health department is limited and so this suggests that PHE activity in such areas will, in the short and medium terms, still require external funding. However such funding need not necessarily be targeted for training new districts but rather focused at the support of a consolidation phase.

7.4 Skills and Capacity

Evidence for the need to consolidate all PHE activities is to be found throughout the Report and the need is no less crucial in the area of skills and capacity. The sustainability of the process beyond the life of the Project is dependent on the strength of its foundations. Each of the areas that require consolidation also calls for competent, knowledgeable and skilled personnel to facilitate and support the process of taking stock in order to move ahead confidently. At most levels capacity exists albeit in varying levels of competence but very often either an individual or a group is unable to dedicate sufficient quality time to PHE related tasks.

It is believed that the presence of externally recruited technical advice (TA) has proved to be effective in promoting the use of the participatory approach and has indeed been instrumental in ensuring the initial launch and current security of the Project. While this advice continues to be valid and necessary it is perhaps better utilised not in the present project framework but in securing mechanisms for sustainability.

7.5 Institutional Sustainability

National level

PHE is not seen as a separate project but rather as a process that falls within the overall operational framework of the Environmental Health Department. Against this principle, PHE is perceived not only as belonging to the MOH&CW but to the Sector. In taking this view an attempt is being made to ensure sustainability of the process. At the national level the Health Education Unit is tasked with materials development however for purposes of expediency and logistical ease, the PHE project has been developing materials through the Environmental Health Department. Ideally, Environmental Health Department and Health Education Unit should be working closer together and complimenting each other. However, realistically the Health Education Unit that prioritises according to epidemiology statistics does not always place hygiene promotion at the top of the list. In the past the NORAD funded consultant for hygiene education used to be placed within the Unit but tended to focus on health and not on hygiene education. This necessitated the change of placement from the Unit to the Environmental Health Department. Within the 1997 priority list for the Unit, hygiene education does not feature in the top 5. Areas of priority include among other issues AIDS and STDs. Clearly a mutually supportive arrangement between the agencies at National level is desirable for long term sustainability.

7.3 Funding

Where IRWSS projects operate there is scope to secure sufficient funding for the continuation of PHE activities. For example Lupane District in Matabeleland North, earmarked to commence an integrated project with the support of the ODA, indicated that they have already budgeted over Z$ 75 000 for hygiene education and the production of hygiene education materials. The project will also seek to have a hygiene education officer as an advisor to council.

In Gwanda District where a IRWSS project is being implemented with UNICEF support, the RDC indicated that the budget allocations for hygiene education has been rising. Therefore in many of the areas that already have some form of supported PHE, or who are about to become involved, funding may not be an immediate issue of concern. However currently PHE funding for those districts, which have no IRWSS project, remains uncertain.

The national budget for the environmental health department is limited and so this suggests that PHE activity in such areas will, in the short and medium terms, still require external funding. However such funding need not necessarily be targeted for training new districts but rather focused at the support of a consolidation phase.

7.4 Skills and Capacity

Evidence for the need to consolidate all PHE activities is to be found throughout the Report and the need is no less crucial in the area of skills and capacity. The sustainability of the process beyond the life of the Project is dependent on the strength of its foundations. Each of the areas that require consolidation also calls for competent, knowledgeable and skilled personnel to facilitate and support the process of taking stock in order to move ahead confidently. At most levels capacity exists albeit in varying levels of competence but very often either an individual or a group is unable to dedicate sufficient quality time to PHE related tasks.

It is believed that the presence of externally recruited technical advice (TA) has proved to be effective in promoting the use of the participatory approach and has indeed been instrumental in ensuring the initial launch and current security of the Project. While this advice continues to be valid and necessary it is perhaps better utilised not in the present project framework but in securing mechanisms for sustainability.

7.5 Institutional Sustainability

National level

PHE is not seen as a separate project but rather as a process that falls within the overall operational framework of the Environmental Health Department. Against this principle, PHE is perceived not only as belonging to the MOH&CW but to the Sector. In taking this view an attempt is being made to ensure sustainability of the process. At the national level the Health Education Unit is tasked with materials development however for purposes of expediency and logistical ease, the PHE project has been developing materials through the Environmental Health Department. Ideally, Environmental Health Department and Health Education Unit should be working closer together and complimenting each other. However, realistically the Health Education Unit that prioritises according to epidemiology statistics does not always place hygiene promotion at the top of the list. In the past the NORAD funded consultant for hygiene education used to be placed within the Unit but tended to focus on health and not on hygiene education. This necessitated the change of placement from the Unit to the Environmental Health Department. Within the 1997 priority list for the Unit, hygiene education does not feature in the top 5. Areas of priority include among other issues AIDS and STDs. Clearly a mutually supportive arrangement between the agencies at National level is desirable for long term sustainability.

Currently the professionals involved in the Project seem to be overwhelmed by the programme. The rapid expansion of the PHE activity means that capacity exists only to ensure the day to day running of the programme with no time being dedicated to the monitoring and evaluation of the Project. The professional staff are simply under-utilised as far as their skills and knowledge is concerned by the fact they are tied to necessary but nevertheless menial tasks. If the current "fire-fighting" pace is maintained the approach will no doubt continue but the value of it in development and sustainability terms will be severely undermined. There is an urgent need to refocus the job descriptions and tasks of key personnel to ensure that the vast amount of credible work that has been undertaken is not wasted. It was commented on more than once during the Review that the underlying feeling is that unless the human resources are allowed to concentrate on research and development issues, coupled with management, that the Project runs the risk of becoming self defeating by its very success.

Provincial level

Presently it is unclear how effectively the province is undertaking its roles and responsibilities in relation to PHE. This situation is not helpful and puts additional pressure on the national level that is carrying a huge managerial responsibility.

Within the framework of IRWSS projects, there are provincial water and sanitation sub-committees whose task is to give guidance to districts and provide both technical and professional support. The Provincial Water and Sanitation Sub-Committee is not meant to oversee the duties of the district but works with them to co-ordinate activities. This structure is key to the sustainability of the approach and its capacity should be harnessed to the full to release the national level of some of the duties. Within the Ministry of Health the PEHOs have also been involved in the process and are tasked with the planning of PHE activity including giving professional, administrative and logistical support to the districts.

The identified and acknowledged weakness of no system being in place for monitoring the quality of implementation at the district level must be dealt with and the province is key to the success of any effort to undertake this task. Provincial support is necessary not only in terms of quality checks but in terms of building the confidence and skill at the district level and this requires urgent attention.

The suggestion that the province assumes more meaningful roles especially in terms of support for strategic planning and training should be explored so that their roles and responsibilities can be clarified.

District level

There is huge potential to be found at district level where evidence is beginning to emerge of the existence of a belief in decentralisation and the will to implement intersectoral programmes. The growth of the decentralisation programme and interest in the principles of community management provide the forum for PHE to develop within a carefully managed environment. The need for strategic planning and application of the approach is acute and the district is central to this process.

As with its equivalent at provincial level, the district water and sanitation sub-committee if given the necessary support, is set to manage all water and sanitation activity in the district and PHE should be encouraged to maintain a high and valued profile within this system. There is a need to concentrate efforts and resources at district level to build capacity and strengthen the ability to functionally manage project cycles of which PHE is seen to be an integral part.

Community Level

At community level the PHE Project has not yet comprehensively addressed the complex issues of sustainability. A number of areas require urgent attention if the approach is to be truly embedded as an integral part of promoting community development initiative.

The first area of concern is the issue of personnel and who is responsible for what in terms of facilitation, management and extent. There is a great need for the acceleration of work to promote community management of the PHE process so that the limit to what an over tasked EHT should be doing is clear. Added to this is the use of VHWs and the extent to which these people can be involved in PHE. There are many arguments to support the training of VCWs but in reality their effectiveness is not yet known. What is clear is that the roles and responsibilities of the village institutions needs to rationalised and then fully understood by all the actors so that the most appropriate support can be made available.

Linked directly to the above cadre is the issue of resources and in particular access to the participatory tools and materials. This area has been dealt with earlier in the report and is crucial to any hopes to ensure local sustainability of the approach is realised.

The Project realises the need to understand the community management process and the link with community based management initiatives is very important. What does need to develop is the understanding of the project cycle approach and how the processes used in PHE can be woven in to it in a strategic manner.

Throughout the Country a number of strategies are being used to implement water and sanitation programmes. Some of these are described in the Report, for example the introduction of the health clubs, the IRWSSP and the work of the NGOs, yet others, notably Africa 2000 and the mounting experience of the community based management initiatives, require further analysis in relation to PHE involvement. It is clear that PHE is operating in a number of different environments and as part of the over riding need to research the impact of PHE is the need to rationalise the range of learning experience and advice.

Arguably the most important factor in ensuring community sustainability is the overall understanding of how the community perceives its own future. This requires far reaching research in to the use and impact of PHE and also systems for the regular monitoring and evaluation of community based development activity. There are many opportunities to develop PHE within the expanding participatory learning for action field and these should be explored.

8 PROJECT EXPENDITURE

The table below presents an analysis of project expenditure for the period August 1995 to July 1997. At this stage it is extremely difficult to conduct a cost benefit analysis in relation to project objectives as the impact of the interventions are not as yet known or the indicators by which to measure such impacts agreed and finalised as discussed in the previous sections of this report. Therefore what is presented below is a brief analysis of expenditure against planned budgeted amounts.

Budget Line	Code	1995	1996	1997	Total Budget	Expend to date	Balance	%
PERSONNEL								
Recruitment	011	3,175	-	3,160	6,335	-	6,335	
PRSI	021	2,140	4,285	4,266	10,691	-	10,691	
Superannuation	022	2,140	4,285	4,266	10,691	-	10,691	
FSA	031	21,420	42,850	42,660	106,930	160,000	- 53,070	
Int. Proj Travel	041	3,175	-	3,950	7,125	-	7,125	
Child Travel	042	3,175	-	3,950	7,125	-	7,125	
Baggage Claim	043	3,175	-	3,950	7,125	-	7,125	
Subsistence	044	3,175	6,350	6,320	15,845	-	15,845	
Hotel Costs	045	3,175	6,350	6,320	15,845	-	15,845	
Education fees	061	4,000	8,000	7,900	19,900	-	19,900	
Insurance	081	800	1,600	1,580	3,980	-	3,980	
Medical Checks	082	635	-	632	1,267	-	1,267	
Rent	092	2,380	5,550	5,530	13,460	-	13,460	
Sub Total		52,565	79,270	94,484	226,319	160,000	66,319	**71**
ADMINISTRATION								
Local Salaries	141	11,100	22,200	22,120	55,420	119,679	- 64,259	
Misc. Admin	143	11,100	20,600	20,540	52,240	11,491	40,749	
Sub Total		22,200	42,800	42,660	107,660	131,170	- 23,510	**122**
TRAINING COSTS								
Training Personnel	502	27,000	76,000	94,800	197,800	184,674	13,126	
Sub Total		27,000	76,000	94,800	197,800	184,674	13,126	**93**
CAPITAL COSTS								
Vehicles	151	23,800	-	-	23,800	34,568	- 10,768	
Construction	154	35,000	75,000	83,740	193,740	234,943	- 41,203	
Education Mats	166	38,000	90,000	97,960	225,960	80,064	145,896	
Sub Total		96,800	165,000	181,700	443,500	358,575	84,925	**81**
CONSULTANCY	108	4,000	8,000	7,900	19,900	35,000	- 15,100	
Sub Total		4,000	8,000	7,900	19,900	35,000	- 15,100	**176**
GRAND TOTALS		**202,565**	**371,070**	**421,544**	**995,179**	**869,432**	**125,747**	**87**

Personnel

In this context the personnel costs refer to expatriate personnel recruited by UNICEF but supported by this budget line. The positive balance is due to the fact that the project officer was not in position for the first six months. The project started in August 1995 and the present incumbent was not in post until January 1996. To date about 71% of the budget allocated for personnel has been utilised.

Administration

Included in this budget line are costs associated with the salaries and administrative for locally recruited project staff which are supported directly by the project. The negative balance is due to the salary adjustments made in 1996 for the project officer (47%) and the driver (42%) which had not been anticipated when the project proposal was finalised and this has resulted in an over expenditure of 21%

Training costs

Training costs are those costs associated with the running of training workshops and sessions to train extension personnel in PHE methodologies and their application. The positive balance is due to the temporary suspension of advances by UNICEF (not only for this particular project but all UNICEF supported projects), to GOZ due to non accountability of money advanced by UNICEF in 95/96 to government departments. The suspension period was from February to August 1997. However, even allowing for this, 93% of the funds have been utilised to date.

Capital costs

Capital costs include all those costs associated with the purchase of project vehicles and construction materials used to support the construction of latrines and improve family wells. It also includes for the production of hygiene education materials.

Almost 81% of the funds earmarked for capital costs have been utilised to date. There remains some US $ 145,00 to be spent in relation to education materials although two tenders are currently out for printing new tools and three planned tools/guides are in the finalisation stage and payment will be made upon completion of the work

On construction there is a negative balance due to the increases in the price of cement.

Consultancy

The negative balance is due to the study on the declining trend in latrine construction launched by the NAC and supported by UNICEF. This item overshot the budget by 75%.

Grand totals (overall comment)

Overall, the project is within the global budget allocation and has to date US$ 869,432 of US$995,179 (87%) has been utilised.

UNICEF is channelling funds through the NDF in the Ministry of Finance then to the MOHCW and eventually to the appropriate district . This system is obviously very bureaucratic and normally results in long delays before the money reaches the project levels. For example, in one instance it took almost nine months for the funds to reach Matebeleland South and this has implications on the achievement of targets. Channelling funds through NDF has also resulted in the rejection of requisition for materials at the local level to delays in processing cheques by the Central Payment Office (CPO). The problem is further compounded by the stop payment system that has led the private sector to prefer cash as opposed to government requisitions.

To minimise the level of bureaucracy, UNICEF has been paying directly for items like workshops but they have since been instructed by the MOF to stop this system and ensure that funds come through NDF. NGOs have been used in the provision of enabling facilities and this cuts the bureaucracy but it has the disadvantage that NGOs are target focused and may miss the software component of the programme. It is very difficult for PHE to be done through NGOs as it is a socially and community driven process and they do not have the necessary institutional structures to implement PHE in a sustainable manner.

In an effort to alleviate the situation, after funds are in the MOHCW they can be deposited in the Provincial Medical Director's account which allows direct payments as compared to requisitions, However, for some provinces PMD's do not operate accounts.

Also one problem is the general lack of accountability of funds disbursed and this caused UNICEF to temporarily suspend disbursements from February to August 1997 and this partly explains why some funds have to date not been utilised. However, this problem has now been resolved.

9. RECOMMENDATIONS

The recommendations are made in light of considerable thought with regard to the most appropriate way to move forward given the sheer complexity of the Project.

The recommendations are intended to allow the Project to capitalise on the wealth of enthusiasm, dedication and support that is evident for the continuation of the development of participatory hygiene education. The recommendations should be considered against the following statement.

It is believed that the value and significance of the participatory hygiene education experience in Zimbabwe should not be underestimated. From the point of view of development per se both regionally and locally, the importance of the lessons learned by the Project is tremendous. The PHE initiative places Zimbabwe at the forefront of development in the area of research into the sustainability of the approach; the foundations are relatively secure and the programme sufficiently advanced to enable meaningful evaluation of the impact of PHE to begin. The Project is operating within a dynamic research and development environment where the very practise of the approach is resulting in an incredibly steep learning curve. This fact should be recognised and capital made of its potential.

Establishing the context for the recommendations is very important and it is suggested that:

All the recommendations work within an integrated community based management framework that internalises the project cycle approach.

This means that it is essential that the project cycle concept is fully understood. By this we mean that basically the project cycle should allow for two things to happen:

- that the actual process approach to PHE develops and grows, and that
- the effectiveness of the process approach is maximised through the application of functional management systems designed specifically to support it.

Essentially the process approach is based on a non prescriptive, non directive and developmental philosophy while functional management is specific, measurable, achievable, realistic and time-bound (SMART). In a project cycle approach to community based development the process can never reasonably exist if it is not managed in a strategically functional manner.

In light of this the recommendations are that:

- the Project must urgently facilitate a process within the Ministry of Health that focuses on consolidation at all levels of the Project's sphere of influence and operation.

This should be done through:

- immediate consultation involving all the actors to determine the most appropriate way forward and the subsequent swift implementation of agreed action that considers;
- revising, if necessary the aims and objectives of the Project;
- clarifying the understanding of terms, objectives and the overall intentions of PHE in relation to impact;
- the undertaking of analysis and assessment to inform the elaboration of the PHE project cycle and the articulation of a logical framework;

- research into, the agreement of, and the immediate monitored application of qualitative and quantitative indicators of success;
- review and the subsequent action of an effective reporting mechanism;
- agreed and standardised terminology and language;
- the facilitation of a comprehensive training needs analysis to inform future direction and training strategy;
- agreement of need, standards and application of performance appraisal for all actors with responsibility for the facilitation of the process;
- development of a system of professional support for cadre that includes the elements of management, supervision, education, support and training;
- the most efficient way of releasing the relevant professionals, particularly at national level to facilitate the consolidation phase.

Finally it is recommended that Irish Aid continue its support for this very important project. The focus of future support should be in the areas of consolidation of the existing activities with a strong emphasis on research to inform future development. The process of introducing PHE to the remaining districts will be carried forward given that expectations have been raised and this should be supported for the remainder of the present phase of funding. However, plans for future activities, that is, beyond the current phase of funding must be time bound and have measurable outputs and clear indicators for success. Therefore the recommendations outlined above should be addressed during this present phase.