DRAFT

PARTICIPATORY HYGIENE EDUCATION

A PEOPLE CENTRED APPROACH TO BEHAVIOUR CHANGE IN HYGIENE

A Description of the First Three and a Half Years of the Development and Introduction of Participatory Hygiene Education Methods and Tool in Zimbabwe

UNICEF

DIRECTORATE OF ENVIRONMENTAL H[illegible]EALTH SERVICES
(Ministry of Health a[illegible]Child Welfare)

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Abbreviations:

CBM	Community Based Maintenance
CPT	Community Participation Trainer
DEHO	District Environment Health Officer
DEHS	Directorate of Environment Health Services
EHS	Environmental Health Services
EHT	Environment Health Technician
HEO	Health Education Officer
HEWASA	Hygiene Education Water & Sanitation
MNAECC	Ministry of National Affairs, Employment Creation and Cooperatives
MOHCW	Ministry of Health and Child Welfare
NAC	National Action Committee
NCU	National Coordinating Unit
PEHO	Provincial Environmental Health Officer
PHAST	Participatory Hygiene and Sanitation Transformation
PHE	Participatory Hygiene Education
PLA	Participatory Learning and Action
PRA	Participatory Rural Appraisal
PrEHO	Principal Environmental Health Officer
PROWWESS	Promotion of the Role of Women in Water and Environmental Sanitation Services
RDC	Rural District Council
RHC	Rural Health Centre
TBA	Traditional Birth Attendant
SARAR	Self Esteem, Associative Strengths, Resourcefulness, Action Planning and Responsibility
UNICEF	United Nations Children's Fund
VCW	Village Community Worker
VIDCO	Village Development Committee
WADCO	Ward Development Committee
WHO	World Health Organisation
UNDP	United Nations Development Programme

Introduction

The Participatory Hygiene Education Project (PHE) has been operating for three and a half years; one and a half years in development of the methods and tools in the field and two years in the promotion and dissemination of PHE. The Project is now embarking on a rapid scaling up of its dissemination work.

At this time of change it was considered important to document the experiences so far so that the significant experiences and learning can be carried forward. Also as the PHE work moves rapidly to many more people it is important to be sure that the basic concept remains well understood and intact.

Thus this document describes the concept, the experiences from an historical perspective and analyses the project approach, materials, training and impact in the light of the project's history and it's influence on community work.

A person with substantial experience in participatory approaches and methods in community work for health was given the task to research and write this document so that it would have a strong analytical nature.

In the spirit of the PHE Project that endeavours to work in a bottom-up people-centred way, this document was researched and written in the same manner. The information was gathered during a six week period in May/June 1996 from interviews with 37 extension staff and their superior officers and through observations of the training workshops and PHE work in communities. The information gained and the resulting analysis was shared with a wide variety of people working in PHE to verify its accuracy.

Keith Wright
June 1996

Summary

The Participatory Hygiene Education (PHE) Project has set out to facilitate the change of approach in hygiene education from a didactic technical model to a participatory social model.

The goal of the PHE Project is that all extension staff will be using participatory methods in their learning sessions with community groups and a participatory approach in their dealings with the community. The ultimate goal is that the approach and methods will be very influential in bringing about behaviour change in hygiene practices. The PHE Project is finally to be measured in terms of behaviour change.

Based in the Directorate of Environmental Health Services, the PHE Project has developed, through extensive field work, the methods and tools considered by the field staff to be appropriate and effective. The Project, using a bottom-up strategy, has successfully promoted this participatory approach for hygiene education which is now well known, acknowledged and appreciated. In its current stage the Project is disseminating the PHE skills through a decentralized system based at the provincial level and, at the same time expanding the scope of the tools into the community development process.

PHE is based on the principle that people will begin to change their behaviour practices when they have been able to analyze all aspects of their situation and the available options. The best way to create this analysis is to use people-centred methods that can create a non threatening, non imposing atmosphere and stimulate inquisitiveness. Interest and discussion is created through the use of visuals, mainly single line drawings of everyday events relating to hygiene.

These visuals and the method to facilitate a learning session using the visuals is termed a 'tool'. The tools have proved to be a mainstay of the Project. They have provided a mechanism by which the EHTs could apply the participatory methods; a means by which the hygiene education could have an identity and a means around which a tangible programme of activities for hygiene education could be built.

Although the tools have been central to the Project, the Project is not seen as a materials production project. The use of the tools and their influence in the community is the core of the PHE Project.

Similarly, the Project is not a training project although the training workshop is the main mechanism to disseminate the PHE knowledge and skills. With the rapid expansion of training in the last year there is a real danger that the training will dominate the time and project be judged on its training activities and not on the impact in the community.

Teams of officers are trained in each province and district. The team is a vertical cross section of staff from the province and district officers to the

extension workers. This gives the PHE a strong base and means that the extension workers do not operate in isolation. The teams are composed of different cadres and staff from a variety of ministries. PHE is inclusive rather than exclusive in who it trains.

The full training lasts 10 days but the trend is to shorten the duration and condense the content. Although understandable, this trend is liable to weaken the PHE. The most important part of the training are the field days. Normally, people are secptical of the methods and tools when they first see them but when they experience their power with community groups they become convinced of their appropriateness,

After training all the staff will have access to a Field Guide for reference and a Tool Kit of materials and visuals to use in the community session.

The PHE Project took a bottom-up strategy to develop the methods and the tools and to introduce them into the system. This strategy has proved to be very successful.

The greatest impact, in these early stages, can been seen within the institutions. There is a general acknowledgement of the appropriateness and effectiveness of the PHE approach, methods and tools. This acknowledgement is held by officers throughout the system from National Action Committee members, through the Directorate of Environmental Health to the Provincial and District Officers. It has also spread to other sections of the Ministry of Health and Child Welfare and to other projects such as Community Based Management (of water supply systems). The PHE has raised the profile of hygiene education and made hygiene education a tangible entity for which specific plans and targets can be made. As a result, the funding has increased and overall there is more specifically planned and prepared activities for hygiene education. Attitudes of staff at all levels has become increasingly positive towards the PHE approach, and its methods are being adopted by other projects.

It is too early to see significant changes in hygiene practices in communities but there are encouraging signs. All the districts which have established PHE work report an increase in latrine construction. There are reports of changes in hand washing practices at church meetings in Goromonzi District and at public meetings in Gwanda District where the run-to-waste method is now used. In Gutu Ward in Goromonzi District, using PHE in coordination with screening and treatment, the incidence of schistosomiasis in school children has fallen by 62%.

The PHE work is weakened by the lack of indicators for behaviour change that can be used as a sign post for the extension staff as well as a way to measure change.

The main challenge ahead is to turn the acknowledgement of PHE into commitment. This will include establishing a regular and reliable follow-up support system to the extension staff, making PHE a standard part of the basic training for Nurses and Environmental Health Technicians, including behaviour

change indicators into the reporting system and putting community capacity process indicators into extension staff performance appraisals. To strengthen the process of behaviour change and to sustain the process within the current trend of shrinking government resources for extension work, PHE will need to integrate into community based systems that can sustain activities that motivate behaviour change.

1. The Concept

1.1 Education and Understanding for Action:

Participatory Hygiene Education is based on the principle that people will begin to change their behaviour practices when they have been able to analyze all aspects of their situation and the available options. People do not respond positively to being forced to make behaviour changes and to being given pre-determined information without any opportunity to reflect on that information and combine it with their own experiences. To accept any new information and to put that information to use a person must be satisfied with the relevance, appropriateness and accuracy of that information. Questions such as 'Why?' 'What for?' 'Who says?' 'How?' have to be answered to the person's satisfaction before s/he will first confirm that the information is valid, and then make a decision to act on that information. Without this opportunity to analyse information that is calling for personal change a person will reject the call for change in behaviour practices.

Thus Participatory Hygiene Education is a method that:-

- Creates a non-threatening atmosphere in which people can feel free to ask questions and to challenge each other and outsiders,
- Transforms all learning sessions into sharing situations in which every one can participate equally learning from each other (group members and outsiders).
- Information is shared and analysed together.

The combination of these three features enables people to analyze the information that is presented to them. Analysed in terms of their own situation and needs, in terms of their own perceptions and in comparison with the perceptions of others. The learning is for understanding more than an accumulation of facts; an understanding that is the basis for action and a change in behaviour.

1.2 Action and Change as a Group Process:

Participatory Hygiene Education uses the SARAR philosophy which believes that:-

- people will best solve their own problems in a participatory group process, and
- within the group there will be sufficient understanding and experience to identify a course of action to begin addressing their own problems

SARAR stands for Self Esteem, Associative Strengths, Resourcefulness, Action Planning and Responsibility.

Self Esteem:

The self esteem of people rises when they realize that their ability to identify and solve their own problems is openly recognised and valued

Associative Strengths:

When people form and work in groups their capacity to act effectively grows and at the same time the individual gains personal support from being a member of the group

Resourcefulness:

The individual is a potential resource to the community that can be tapped to positive effect for the community

Action Planning:

Planning for action is central to enabling people to change behaviours. Change can only come about if individuals or groups plan and implement appropriate actions.

Responsibility:

The results of any actions are only meaningful if the groups take full responsibility for carrying out those actions

1.3 Action for Hygiene Practices:

The action from the behaviour change process is focused on hygiene practices

The major requirement for long term sustainable improvements in sanitation is personal behaviour change on hygiene practices and a positive attitude to sanitation as a whole. A change in attitudes and behaviour will have a positive impact on use, maintenance and repair of facilities as well as on personal hygiene practices.

It is widely accepted that the provision of sanitation facilities is relatively straight forward in comparison to behaviour change. Similarly, sanitation facilities without an accompanying appropriate hygiene practices will be of little impact.

Knowledge is not the problem. In Zimbabwe, knowledge on sanitation and hygiene practices is high. For example, a survey in Gwanda District showed that over 70% of people know the value of washing hands before handling food and over 50% know the importance of washing hands after visiting the latrine. Also 20-55% of people know the association between unwashed hands and disease. The need is to turn that knowledge into positive and sustained attitude and behaviour change.

1.4 Participatory Methods used by Extension Staff:

The participatory hygiene education tools and methods are designed so that they become common practice within the extension worker's programme of activities. The main user of these tools and methods is the Environmental Health Technician (EHT). It is envisaged that all extension staff will use these tools, or an adaption of the tools, so that the participatory method for education at the village level becomes an established practice.

1.5 New Attitudes and Approaches for Departments, Ministries and NGOs:

It is acknowledged that the process is larger than an educational session with a community group. For that community session to succeed it requires specific attitudes and approaches from Departments, Ministries and NGOs. These include:-

- community groups and individuals must be respected,
- the needs and concerns of the group need to be the guide for work, topics and objectives; bottom-up planning needs to be practiced,
- the timing and speed is determined by the community,
- all staff must have a positive attitude to building capacity of the community members and the community as a whole,
- institutions have to be able to be flexible so that they can respond to the requirements of the community,
- institutions will need to see the PHE as a process to change and not a product in itself, this requires a commitment to long term activities and sustained follow-up for the long term.

2. The Start

The Participatory Hygiene Education work arose out of a concern by the Directorate of Environmental Health Services (DEHS) about the limited behaviour change with regard to hygiene practices. Knowledge levels on hygiene and sanitation are high and material support for latrine construction are available but hygiene practices lag behind.

Studies showed that water is quickly contaminated during carrying and storage. Hand-washing with soap is not common although most families do have soap available in the compound. Children under five years rarely use the latrine even when they are available and this is not perceived by the parents to be a problem.

Hygiene and water related diseases rank in the top ten most common causes of out-patient attendances of children under five years old in the country. In particular, diarrhoea remains the leading cause of child mortality and morbidity for under five children.

The Directorate realised that work on hygiene needed a new impetus to make an impact on this disease pattern and to stop the fall in improvements. For example, the number of new latrines per year has fallen from a 47,088 in 1986, 15,000 in 1991 to 5,000 in 1992.

Hygiene education had been approached from the technical perspective whereby need for a change in hygiene and sanitation practices were described to people in terms of disease control and concentrated on sanitation structures. The Directorate could see that people commonly perceived hygiene and sanitation from a social perspective. For example, some people may wish to have a latrine so that they will be able to avoid the embarrassment of seeing relatives defecating rather than the advantages of reducing the incidence of diarrhoea in the household. Therefore, hygiene education did not appeal to the perceptions of the people.

At the same time it was seen that the skills of the Environmental Health Technician (EHT) in facilitating the communication process at the community level required strengthening. Little attention had been given to the process of learning, attitude and behaviour change. "We expected people to go from the bush system to the blair latrine in one move" described L. Nare the Principal EHO for Matabeleland South. "Looking back it was expecting too much".

Participatory methods were seen as the mechanism by which hygiene education could become more of a social process and to discuss the issues of hygiene behaviours in terms of social needs rather than a technical/medical perspective. At the same time the participatory methods would strengthen the EHT's communication skills and skills to facilitate the social process of behaviour change.

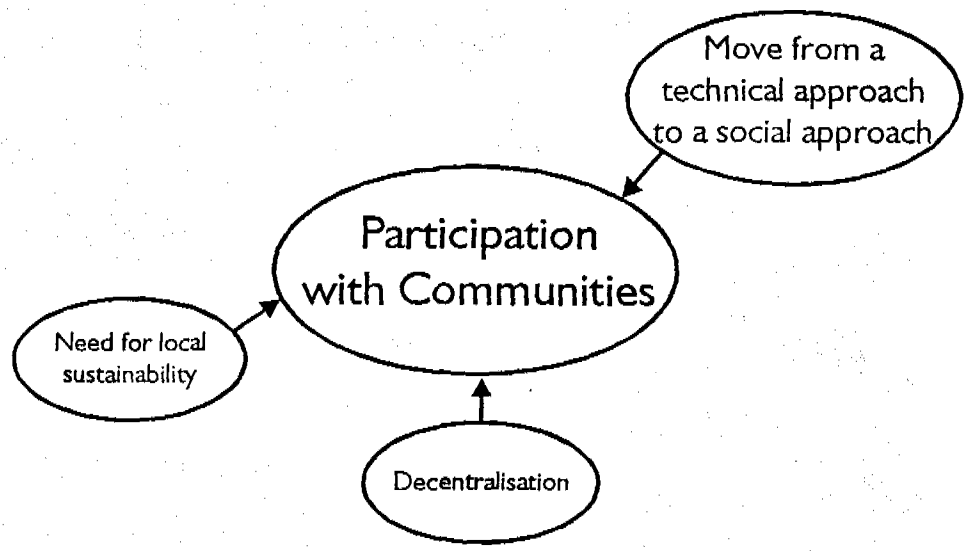
Concurrently, the organisation of hygiene education required some changes. Hygiene education had become seen as an 'on-going activity' that had no specific objectives or plans. It had become submerged by the hardware and construction aspects of water and sanitation. It received a small budget as a nominal amount (ie. Z$ 4,000 annually per district) with no breakdown of how it would be used. Hygiene education needed a clear sense of direction with indicators and objectives and a way to describe its work and impact.

The Participatory Hygiene Education was seen as a way to give hygiene education a role in the social process for change and tangible tools for extension staff to use. This clarity would enable hygiene education to identify indicators and targets that reflect the social nature of behaviour change for hygiene. All these factors combined would strengthen hygiene education and enable the work to have significant impact.

Participatory methods had been introduced some years earlier but the practice had not reached the EHT and had not become established as a common practice throughout the Environmental Health Services. An alternative method of introduction was required. The first reaction to the participatory methods by many staff in Environmental Health and Health Education was that the methods would not make much difference. At first they had to demonstrate that the participatory methods could be effective.

The National Action Committee for Water and Sanitation (NAC) was supportive of these changes. Some of the NAC members had participated in a workshop on participatory methods in 1990 and were familiar with the concept and the potential of the participatory methodology.

Parallel to this desire to move from a technical to a social approach in Environmental Health Services there were changes of thinking with regard to the community's role in all of the water and sanitation sector. There was a growing realization that the community must be given the powers and responsibility to manage and sustain their own water and sanitation facilities and that the role of the Government and NGOs needs to move from an implementative approach to being facilitative and supportive. This shift in policy thinking was described in Vision 2000, which was first written in 1992 and refined and reaffirmed in 1995 (See Appendix 2). Vision 2000 calls for a bigger role for the water and sanitation sector in the social process. In turn the current Decentralization Policy is turning the attention to the community and the facilitative role for ministries. Thus the national policy and overall water and sanitation polices were supportive of the social policy and both see participatory methods as a major mechanism to facilitate the new role for the community in work at the Ward and Village level.



The DEHS found that UNICEF shared the same analysis of hygiene education and its relationship with the other components of the water and sanitation sector. Also both institutions shared the same understanding of the concept of participatory methods and approaches in hygiene education. Similarly, the Directorate and UNICEF agreed on the best way to introduce this new approach by working in a bottom-up process. UNICEF was able to offer funding support in a flexible manner that has proved to be very important factor in the success of the programme. To enable smooth coordination between UNICEF and the Directorate a UNICEF staff member who is a environmental health professional was based 75% of time in the Directorate and 25% in UNICEF.

The PHE Project began in 1993 with the objectives to :-

- promote the development of health life styles 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.

It is expected that the PHE project will be able to contribute significantly to :-

- enabling all people involved in issues of hygiene behaviours, such as the Village Community Workers (VCWs), Counsellors and Village Development Committees (VIDCO)s, at the village level to use participatory methods,
- enabling all officers working at the village level on issues of water, sanitation and hygiene behaviours to make participatory methods a natural part of their working practices.

3. The Origins of Participatory Methods

Participatory methods are not new in Zimbabwe. In the early 1980's the then Ministry of Community Development and Women's Affairs used participatory methods in the training of VIDCOs and WADCOs. Some NGOs such as Silveira House, Intermediate Technology Development Group and Save the Children Fund were also using such people centred methods in many sectors including health, agriculture and community development. Zimbabwe has long been at the forefront of the development of participatory methods for learning and action for development at the village level.

3.1 Participatory methods specifically for hygiene:

There were a number of initiatives that combined together to develop participatory methods for hygiene education. The tools have come from a wide variety of sources and development and adaption of tools is a on-going process.

In 1986 the Promotion of the Role of Women in Water and Environmental Sanitation Services (PROWWESS) initiative assisted the Save the Children Fund (UK) to introduce participatory methods into the training of Farm Health Workers. Later in 1990 through the Health Education Department participatory methods were introduced to environmental health senior staff and other health departments. However, there was no strategy for promoting the methods and tools and they did not spread far beyond the workshop participants.

Although the methods did not become common practice throughout the Health and Hygiene Education system they did become familiar to senior officers. It was on the basis of this exposure that the participatory methods were chosen to be the main mechanism to strengthen the Environmental Health Services' input into the behaviour change process for hygiene.

Since 1992 the Institute of Water and Sanitation Development, University of Zimbabwe has been promoting the use of participatory methods in water and sanitation activities. The institute includes participatory methods in its courses and promotes the use of participatory approaches in other areas eg. Cholera control in which the methods and tools are used in a strategic manner for community awareness and action rather than limited to education sessions.

The School Health Project run from the EHT Training School at Domboshawa developed visual materials to use as learning tools in its participatory approach to school health. This programme developed the pictures that are now used in several of the tools in the PHE programme (ie. the *Pocket Chart* and *Three Pile Sorting).*

By 1993 the PROWWESS initiative had evolved into the Participatory Hygiene and Sanitation Transformation (PHAST) that continued to train senior people in the East and Southern Africa Regions. The PHAST training concentrated on the development and use of specific tools that could be used in participatory learning situations. One person from IWSD was a facilitator in the PHAST workshops and became a resource person in Zimbabwe on the tools and methods used in the PHAST training through the IWSD. One UNICEF staff person and a trainer from the EHT training school at Domboshawa were trained in 1993 in a PHAST workshop, so that they could facilitate PHE training workshops.

Some countries, projects and NGOs have adopted PHAST as a programme approach as well as a methodology. In Zimbabwe other programme approaches were developing since 1990 using these methods and tools (or an adaption). PHAST is seen by the water and sanitation sector in Zimbabwe as a method rather than a programme in itself. In particular the workshop structure used in PHAST workshops was adopted in PHE together with a number of tools.

4. Difference in the Approach

A comparison of the implementation strategies to introduce participatory methods and tools for hygiene in the 1990 initiative and in the PHE Project shows the importance of the approach. Both projects have a very similar goal which is to have the participatory methods and tools for hygiene become common practice for extension staff. In the 1990 initiative senior staff were exposed to the method and tools in one workshop and were then expected to carry forward the training to the other staff in a cascade system. It was reported by several of the participants of that 1990 training that the cascade of trainings did not take place. The main reasons centred on five points;-

- there was no definite implementation strategy,
- there was no follow-up or expectation for reports,
- the tools that were used in the training were not available for use for further training or in the field work,
- there was no felt need to change the extension and education practices,
- there was no supportive policy that encouraged a participatory approach.

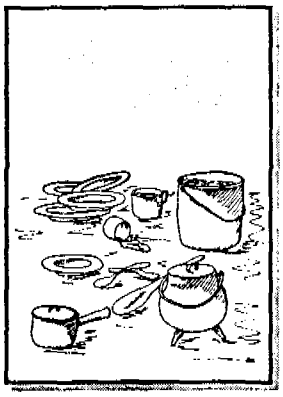
In contrast the PHE took a bottom-up approach. The project began with a long period of field development of the tools. When the extension workers involved in the development were satisfied with the tools and method, the project turned to introducing the methods into two more districts. In this way the new approach would grow gradually from the field.

The training was organized to train teams of staff that represented a cross section of relevant staff from provincial to ward level. This team would be able to implement the PHE work. The team, in some occasions, also included other cadres such as community nurses and Agritex extension workers. There followed an intricate programme of trainings for other health cadres so the methods and tools would not be restricted to environmental health.

The tools are a central part of the PHE Project and everyone trained has access to a set of tools. To further strengthen their usefulness, the tools have sufficient visuals to suit most cultural situations.

Significantly, the introduction of the methods and tools came at a time when the policy environment had become more supportive of the participatory approach. Likewise participatory approaches were increasingly seen as a useful mechanism to community work and no longer considered as fringe activities.

The combination of all these factors has meant that there has been widespread acceptance of the participatory approach for hygiene education. For example, at the 1995 annual planning meeting for Provincial Environmental Health Officers (EHOs) , the Provincial Officers insisted that PHE be introduced in many more districts than had been planned. The plan had to be changed from 6 to 28 districts to start PHE work in 1995/6.



5. Participatory Methods for all Extension Staff

The PHE methods and tools have not been seen as the sole preserve of the Environmental Health Services. It is planned that all the extension workers can make use of the participatory methods and adapt the tools, or make their own to fit their needs. The reasoning for this approach is that if all the extension staff use the same approach and the same methods in the community, the work of each officer will be supported by their colleagues. At the same time, it will need the concerted efforts of all the extension staff to bring about widespread behaviour change.

A participatory approach using participatory methods for learning and behaviour change was identified by the Environmental Health Services who now are the lead department for the PHE Project. The DEHS, with eight professional staff, based in the MOHCW headquarters in Harare, is the central office for the PHE Project, although they are not full time on PHE work.

The majority of the work is carried out by the environmental health staff with the EHO and the EHT as the main focus. The EHT is the natural choice because this is the only officer of the Ministry of Health and Child Welfare (MOHCW) who regularly works directly with communities and is based in the ward at the rural health centre. There are approximately 800 EHTs in the country distributed one officer per ward (although, the number of EHTs in post is falling). The EHT carries out the health education and the hygiene education work as well as a total of 40 other possible duties.

All the extension officers at the ward level will be trained in PHE methods and tools along with the councillors. At the district level Nurses, Rural District Council (RDC), District Development Fund (DDF) and MNAECC Officers are included in training workshops.

The funding for the PHE work within the district comes from the hygiene education vote as part of the district Integrated Rural Water Supply and Sanitation (IRWSS) projects or from the disease control vote.

Unfortunately, there has been little close coordination between the DEHS and the Health Education Department concerning the PHE work at the national level. They have been separated by their different perceptions of participatory education and its role in education for health. Also by the fact that Health

Education and Environmental Health have different roles. The former concentrates on the production of posters and support materials which does not require participatory methods in a hands on fashion. Whereas Environmental Health perceives its role as community work implementers where the participatory methods are a practical tool. Both departments do share a common desire to bring about behaviour change rather than just supplying information. The departments are working jointly on developing indicators and a reporting systems that can capture changes in behaviour and reflect the real nature of the process of community work for health. At the provincial level there is a close working relationship. The Provincial Health Education Officers (HEOs) help facilitate the training of field staff for PHE and give support to the EHTs.

There is a general attrition of EHT and EHO staff which is putting considerable strain on the system to maintain the services. It is now not uncommon for one EHT to cover two or even four wards. Many districts do not have a DEHO with as many as 40% of the environmental health posts vacant. Transport is a great limitation. Many EHTs have only bicycles to cover large distances. Coupled with this constraint, the financial constraints of government has severely limited the transport and subsistence allowance. This situation has created a dis-incentive to carry out frequent community work, particularly to the remoter communities.

6. Watershed Decisions

A number of watershed decisions have been made in the early period of the project. These decisions have had considerable influence on the character of the project.

- The project would start with the development of the method and tools at the village level with the EHTs 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 these 'new' districts);
- The project would not prescribe to the district how the PHE methods and tools would be introduced to the extension staff or how the PHE would be used in the village level work;
- The project would be based on bottom-up planning. Funding would be based on the plans made by the district/province. The funding decision would be made by the DEHS staff on a case by case basis per district;
- 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 to 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 of less durable materials 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 centered, 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 centered 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 on-going hygiene and sanitation work;

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

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

The project did not state 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 in 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.

7. Introduction of the concepts and methods

7.1 Development of the Appropriate Tools and Methods:

The first step was to develop the appropriate methods and tools for hygiene education with the EHTs in their normal community work activities. Beitbridge District was chosen as the field site because the District had an IRWSS project supported by UNICEF. The project at that time did not have specific funding. Under the umbrella of the IRWSS project the District EHO and the EHTs together with officers from the DEHS in Harare began the development.

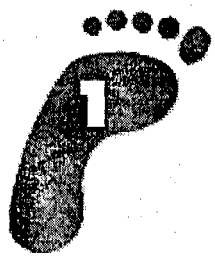
The work took place in Chipise Ward beginning in early 1993. The basis of the tools came from a variety of sources including PROWWESS and the book, *Helping Health Workers Learn* (Werner & Bower).

After considerable community work, 20 line drawing pictures were made specific to the needs and issues in Beitbridge District for use in the tools *Story with a Gap* and *Pocket Chart*. The tools were extensively field tested with communities, councillors and with the EHTs themselves. Along with the tools the field work showed the best methods to use eg. *mapping* is an excellent tool to use with the councillors; in the community the map is best drawn with men and women together.

Finally, five tools together with their associated participatory methods and community organisation approaches were prepared.

Story with a Gap (for hand pump maintenance)
Story with a Gap (for household hygiene)
Pocket Chart (for water use)
Pocket Chart (for defecation practices)
Mapping

At the same time, within the Integrated Rural Water and Sanitation Projects (IRWSS), a number of trainings were undertaken to explore the issue of community participation in activities for water and sanitation eg. workshop for councillors and a workshop for the District Water and Sanitation Sub Committee. These workshops used participatory methods for facilitation and illustrated the emerging participatory hygiene education tools. This helped to publicize the tools and demonstrate their effectiveness.



By the end of 1993 the EHTs and EHO in Beitbridge District and the Provincial Environmental Health Officers (PEHOs) appreciated the usefulness of the participatory approach and the tools. The first step towards the acceptance and adoption of a new approach in communication with the community for the EHT had been successfully taken.

7.2 Building Skills in Workshop Facilitation:

There was a need to have a group of people who could facilitate the initial workshops until PHE had developed its own momentum. In October 1993 one UNICEF staff from HEWASA Section and the Principal Tutor from the EHT Training School in Domboshawa were sponsored by UNICEF to participate in a workshop in Mukono, Uganda. This workshop was organized by the PHAST programme to enable people to learn skills in participatory hygiene and sanitation education. Later in the year, nine MOHCW staff were sponsored to participate in a similar workshop organized by the Training Centre for Water and Sanitation in Harare. Alongside this formal training UNICEF supported some adhoc opportunities for these people and other potential facilitators to practice their facilitating skills and gain confidence in the art.

7.3 Introduction to the Pilot Districts:

Now the time had come to integrate these new methods and tools in normal work situations so that they could become part of common practice in hygiene education. It was decided to work initially in two Wards in each of three Districts. The districts were chosen because they had funding for hygiene education work through the district IRWSS projects. Beitbridge with UNICEF funding and Mutasa and Goromonzi Districts with SIDA funding.

The training of the staff for this work was seen as a major moment for the PHE project and care was taken in its preparation. The main event was a workshop held in March 1994, here on referred to as the Pilot District Workshop.

7.4 Pilot District Workshop:

This workshop drew on the experience from Beitbridge and from the workshops held in the PHAST Programme. There were 6 tools prepared from the field development in Beitbridge District. In the pre-planning workshop some tools from PHAST were introduced and found to be worthwhile. These were:-

Blocking the Routes
Barrier Matrix
Three Pile Sorting
Gender Task Analysis
Sanitation Ladder
Dr Tanaka
Cup Exercise
Resistance to Change

Force Field Analysis
Health Pie
Attributes for Sustainable Hygiene Behaviour Change

Also, the workshop structure currently employed by PHAST was used as the basic structure for this workshop.

Twenty seven (27) officers participated in the workshop. The participants were deliberately chosen to be a cross section of the main people who would be involved in the PHE. Officers from the Provincial level (PEHO; EHO); officers from the District (DEHO, Projects Officer from the Rural District Council); officers from the Ward level (EHT, RHC Nurse) and NGO staff (AfriCare) all participated together.

The workshop objectives were:-

- to train and expose project implementors from districts and wards about the participatory approach,
- to establish a strategy for the implementation of participatory promotion at Ward Level,
- to strengthen hygiene promotion on the use of participatory methods and materials,
- to develop, pretest and adapt participatory hygiene education promotion tools,
- to design, monitor and document mechanisms for evaluation,

The workshop had three resident artists whose job was to draw the pictures devised by the participants. Many pictures were developed during the workshop and many more were identified to be drawn later. The tools were greatly strengthened by this injection of visual material.

Districts were requested to make their own implementation strategy. The project wanted to give the implementors the space to allow their implementation to have the flexibility that participatory work with communities and bottom-up planning requires. The strategies undertaken by the three districts are described in Appendix 3.

Eight months later a workshop was held with the same participants to review experiences. This workshop was both to share experiences and collectively find solutions to problems and by doing so, to continue to role model participatory attitudes and methods. The field reports showed that the tools were effective in creating interest and discussion in the communities and the EHTs enjoyed using them. Early indications were that they were helping to change behavior. The PHE methods and tools had received their second vote of confidence.

7.5 Teams within the Province:

These three Provinces now had the basis of a core of facilitators that could be used by the province to train other staff within the province as and when it wished. Now there would be no need for a national team to do all the work to extend the PHE approach throughout the system. The central based facilitators

could act in a supporting manner. Thus the further development in the three pilot provinces was decentralized to the province. This practice of decentralisation would continue with the other provinces.

At the same time there was a team of officers at all levels within the province who were familiar with the PHE methods and tools. The senior staff could support the field staff in their PHE work. The field staff were not isolated and without support in trying to implement new ways of working and planning with the communities.

7.6 Spreading the word:

At the same time as the development of the tools and the training workshops and their review, the staff at the head office were ready to take any opportunity to demonstrate the tools or to train people in the PHE methods and tools. This was to advocate for PHE and also to give others, who could use the methods and tools for their own work, a chance to gain the skills.

Some of these opportunities were predictable such as in workshops specially designed for senior staff. Others were more brave, using the participatory tools in situations where, traditionally, formal methods would be expected and participatory methods disapproved of.

The following were some of the main events:-

- National Action Committee: Participatory Planning Workshop (1994); 5 day workshop
- MNAECC; Participatory methodologies and approaches (1995): 10 day workshop
- Africa 2000 Programme: Participatory Hygiene Education Methods in Tools (1996); 6 day workshop
- DDF (water) PFO/SFO workshops in (1994 & 1995): 5 day workshops

Opportunities were taken to include staff from other programmes that could make use of participatory methods in general as well as the PHE tools. For example, DDF staff working in the Community Based Maintenance Project (CBM); Agritex staff, Nurse tutors from Central Hospitals, MNAECC staff, Tutors at the EHT Training Schools.

By 1996 participatory methods were becoming well known and commonly used. People could receive input or participate in participatory methods from a number of different programmes and workshops eg. through the CBM in Mukoni District; in MOHCW staff development activities in Mutare & Chimanimani Districts, through the Manpower Department of the MOHCW.

7.7 Be bold, be brave, be convinced...

At the 1994 Annual WES Sector Review the Hygiene Education Report presented *Nr Tanaka* and got all the people present to participate. This was a brave move considering the meeting was composed of senior staff and donors

who could easily have disapproved of such a method in that situation. However, it made a positive impact and went a long way in showing that hygiene education now has something tangible to offer and something that has much more chance of influencing behavior change than the previous didactic methods.

The *Pocket Chart* on hand washing was used to assess the hand washing practices of those present at the Provincial Annual Conference in 1995. The Pocket Chart was used in the same way as it would be used in the village.

At the UNICEF Regional Sanitation Workshop in Zimbabwe in 1994 *Mapping, and Sanitation Ladder* were used. At first the tools were received with scepticism but by the end of the session had generated a positive response.

Blocking the Routes and *Nr Tanaka* were used at the UNICEF Programme meeting in 1994. There were to be three tools used but the discussion was so intense in the first two tools that there was no time to complete the third tool.

These sessions gave people who knew about participatory education only in theory a chance to experience it for themselves. The power of these participatory methods and tools can only be understood through personal experience.

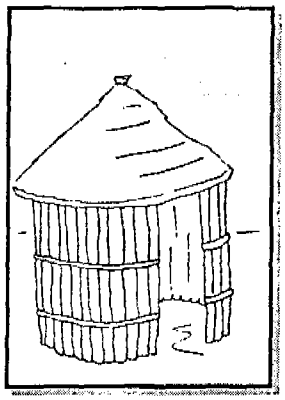
7.8 One cannot say 'no'....

An important character of the PHE project is that the project itself works as a role model in people centred attitudes and actions and therefore has an open, welcoming and supportive approach to everyone involved in participatory education and in water and sanitation. So when the demands from the districts were made there had to be a positive response.

The original plan was that in 1995 a further three districts in three new provinces would begin PHE work and in the existing provinces two or three more districts would start. In 1996 work would begin in 3 districts in 2 more provinces and more districts would start in the existing districts. However, when this was presented at the PEHOs Planning Meeting in 1995 it was rejected by the PEHOs. All the provinces wanted to start PHE work. The PHE approach, method and tools was showing that it had taken root. The third step in the acceptance and adoption of the participatory way of working had been taken.

As a result, teams from five provinces were trained in 1995 (2 in June; 2 in July and 1 in August). In 1996, 38 districts will have started PHE (UNICEF has agreed to financially support the PHE work in 19 districts and to provide tool kits to every district). In May 1996 alone there were 9 district training workshops.

This very rapid expansion shows great interest in PHE but it is also putting considerable strain on the follow-up support capacity. This issue will be described in Sections 13.6 and 13.7.



8. Establishment of PHE within the Provinces and Districts

The responsibility for the establishment of PHE in the hygiene and sanitation work in the provinces and districts is decentralized to each province. In this situation the DEHS plays a reactive role in support to the provinces and districts.

So far each district has used a similar pattern for introducing PHE.

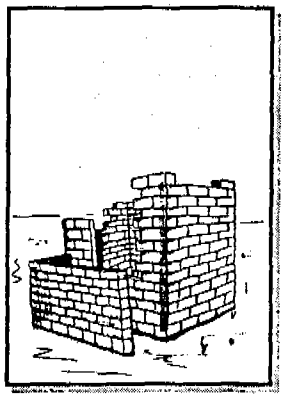
- briefing the District Health Executive,
- training all the EHTs and RHC nurses. In the same workshops the following cadres may also participate (varies from district to district). The Community Health Nurse, District Nursing Officer, RDC Projects Officers, DDF, MNAECC and Agritex staff,
- demonstrating the methods and tools to the District Water & Sanitation Sub Committee and some skills training in the use of the tools,
- training of all the extension staff in each ward (normally two EHTs working together to facilitate the workshop) in the use of the tools,
- enabling each Ward to make a plan for PHE and then to use those plans to form the district plan for PHE,
- training of councillors in the use of the tools (at district level),
- introduce PHE into the school's work on health and connecting it to child-to-child activities through training the school health masters (only in Goromonzi District so far).

Between districts there is some variation in the implementation, often created by the difference in interest by the EHOs and EHTs who receive the initial training. In some cases the delays in obtaining resources for activities that require resources eg. training of the EHTs and Nurses; training of the Ward Health Teams, has meant that plans have had to be changed. For example, in Beitbridge District some PHE work has begun in the communities where no extra resources are required before all Ward Training has taken place. Table 1 shows the differences in implementation steps taken by the three pilot districts.

The strategies to introduce PHE taken by the three provinces in which the three pilot districts are located are described in Appendix 3.

Table 1: Strategies taken by the pilot districts to introduce the concepts and practice of PHE

Beitbridge District	Goromonzi District	Mutasa District
Briefed the District Water & Sanitation Sub Committee	Briefed the District Health Executive	Briefed the District Health executive
Briefed the District Health Executive	Initial focus on bilharzia & dysentery	June'95 workshop for all EHTs and RHC Nurses (6 days)
Concentrated in 2 Wards (Siiyoka I and Siiyoka II)	Concentrated in Gutu Ward on bilharzia. Worked mainly through schools and VIDCOs	Trained Ward Health Teams in 7 Wards (2 days each) in the use of the methods & tools
Trained the Ward Health Team in the 2 Wards (3 days each)	Demonstrated the use of the tools at the WES Planning meeting in June '94	
Demonstrated the tools with village leaders in 11 villages (2 days each)	Feb'95 Workshop for all the EHTs & RHC nurses (6 days)	
March '95. Workshop for all EHTs, EHT for Beitbridge Urban, District Nursing Officer, Assistant DA & RDC Projects Officer (6 days)	All ward health teams given 1 day (each) demonstration of the PHE methods and tools	
Trained 3 groups of VCWs and 1 group of FHWs in the use of the tools (2 days each)	Included demonstration of the tools and methods in the FHWs training	
Note: Planned to train all the Ward Health Teams but unable local suppliers no longer accepted government requisition orders	May'95 Workshop for 25 School Health Masters (5 days)	
	Demonstrated the tools to community leaders (1 day in each village)	
	May '96 Trained District Water & Sanitation Sub Committee (5 days)	
	May'96 Workshop for 25 School Health Masters (5 days)	



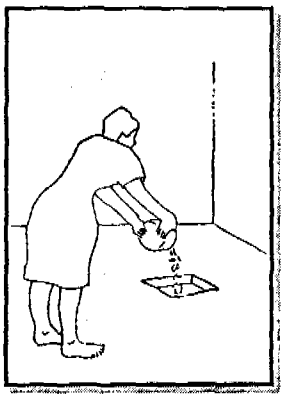
9. Making PHE Methods and Tools Common Practice

The main goal of the PHE project is for the participatory methods and tools to become common practice for the extension staff when working with communities.

This is the most difficult part of the project because it requires attitude and behaviour change by all the extension staff, especially the EHTs, as well as officers throughout the hierarchy. This will require considerable follow-up and support. Training organised as a one off cannot bring about a change on its own.

It is not possible to be exact about the how much the PHE methods and tools have become common practice. It is too early to expect widespread change and as yet there is no reporting system in place that can reflect the community work and education methodologies an EHT is using.

The DEHOs interviewed reported that not all the EHTs feel comfortable with the new methodology. On average about 33% of EHTs are confident and enjoy using the methods soon after the training. Considering that this change of working practice represents a considerable change for the EHTs, from the didactic to the participatory, this is a high percentage for an immediate change. The work to enable remaining EHTs to use the methods and tools is described in Section 14.4a.



10. PHE in the Community

There are five main ways in which the methods and tools are applied at the community level.

- as part of normal activities;
- as a one off event;
- as part of building community capacity;
- as part of a specific campaign;
- within a community based structure specific for hygiene and sanitation.

10.1 As Part of Normal Activities:

This appears to be the most common practice in this initial stage of the project. The EHT will use one (sometimes two) tools in one session with a community group. The participatory method is used only when a tool is used, and a tool is used only when the session topic is about hygiene. The session will last anything from 1.5 to 3 hours.

There is no specific follow-up for that particular group. The next session in that village may be with a different group of people. The sessions fit into the general workplan of the EHT that is based on his extensive knowledge of the locality and the community.

The tools are not used in any strategic manner. The session topic may not directly build on the topic from the previous session. The tools are not used to build a complete awareness of the hygiene situation in that village, with the aim of enabling the community to identify its own priorities and plans so as to take action on their own initiative.

10.2 As a One off Event:

A workshop of 2 days is run by the EHT with assistance from other ward extension staff in each community for village leaders and some community members. In the workshop all the tools are used to enable the participants to become more aware of their own personal hygiene behaviours and of the hygiene and sanitation situation within their village.

Such a system does not reach all the people in the village. Only 25-30 people have the benefit of the participatory sessions. It is assumed that the leaders will use the learning from the sessions in their work in their community, but, as yet, it is not known if that does happen.

10.3 As Part of Building Community Capacity:

The tools are used in two ways. Firstly the tools are demonstrated to the community leaders (Kraal Heads, VIDCO members and VCWs) so that these people can assist the EHT when there are sessions on hygiene in that community.

Secondly, the tools are worked through, in a similar pattern to that used in the training of the EHT, lasting one (sometimes two days). Through the training the leaders become more aware of the hygiene situation in their village, so that they can promote hygienic practices and encourage behaviour change. During the two days all the tools are used to assess the situation in sanitation and hygiene behaviours in that village. The workshop ends with a workplan for that village.

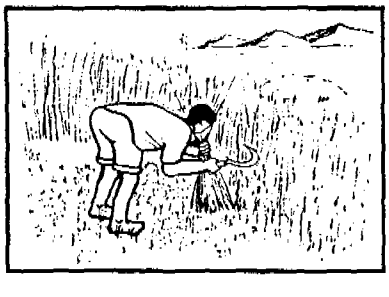
The responsibility for the further promotion of behaviour change is on the village leadership. The workshop does not cover management skills on how to promote behaviour change within the village.

This type of workshop would be strengthened if it were to use additional participatory methods for the community to collect their own information from the village. So far, mapping is the only tool that can be used in this way. Tools that would fit very easily in the PHE have been developed under the title Participatory Learning and Action (PLA) (formerly Participatory Rural Appraisal). PLA tools are further discussed in Section 16.1.

10.4 As Part of a Specific Campaign:

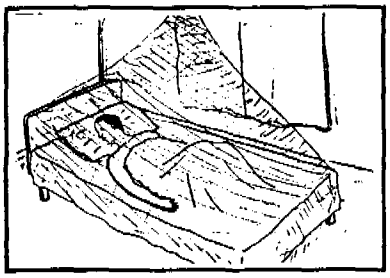
PHE methods and tools have been used as the main mechanism in the community organisation, awareness raising and education work in three campaigns. In the malaria campaign in Beitbridge, Gwanda, Bulilimamangwe and Lupane Districts. In a dysentery control campaign in Umzingwane District (carried out by two EHTs from Beitbridge District). In a bilharzia campaign in Goromonzi District.

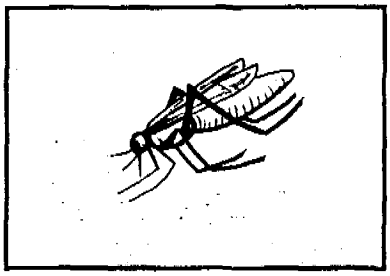
10.4a Malaria Campaign:

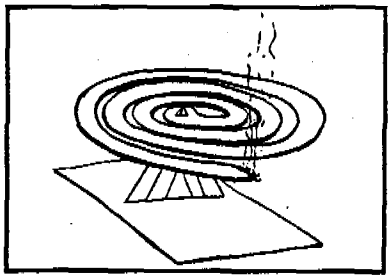


The malaria period of 1995/6 was particularly severe. In Lupane Districts, one of the worst affected districts, two EHTs adapted some of the tools to use in an intensive way with communities.

Blocking the Routes was the first tool that was adapted. The tool is used in the same way as for faecal-oral transmission. The differences were the drawings. Drawings such as the mosquito, mosquito breeding







sites, spraying and sleeping under a mosquito net, replaced those for faecal-oral transmission. Most of the drawings came from the DEHS and some were drawn by an EHT in Lupane.

The tool is used with community groups and with clinic patients waiting for treatment. Although it is difficult for the ill patients to concentrate, the tool always captures the people's interest. This is helped by the fact that everyone feels that malaria is a real problem for them and they wanted to find solutions.

In the community meetings the tool concludes with plans on how to remove or spray the breeding sites. Communities have organized to buy the chemicals and spray the sites and the EHTs provided the sprayer.

The tool, *Story with a Gap*, in which the story begins with an healthy person who was bitten by a mosquito and ends with that person with a high fever, did not create interest or much participation and was soon abandoned.

At the Malaria Treatment Centre set up at Ngcono Primary School, Beven Senda, the EHT, uses a number of methods in an integrated way to stimulate action for prevention. Senda's strategy includes the use of PHE tools and also an application of the people centred methods associated with the tools outside of the learning sessions. For example, he visits men at their evening social gatherings to discuss issues in an informal way as and when they arise.

Each day Senda gathers all the people who have escorted the patients to the Centre in one of the classrooms. He facilitates a session that uses the same methodology as in the district trainings for PHE. To create a good learning atmosphere the workshop tool *Animal Crackers* is used. The main learning tool is *Blocking the Routes* that identifies the spread of malaria and what can be done to stop further infection. The discussion on the issues that the participants identified themselves concentrates on how the community can do something itself to prevent malaria.

This session raises the issue of the community acting alone and not waiting for the government services and ends with a verbal commitment from the participants to carry out prevention measures in their own homes.

To follow through from these awareness sessions Senda carried out the same session with the village leaders and concluded with a discussion on prevention measures that the community can do. The main resulting action was to spray the breeding sites.

First, the community mapped the location of the breeding sites from which the calculations for chemicals and action plans were made. So far, six villages have sprayed all the breeding sites in their locality.

Another part of the strategy is to meet the men at evening social gatherings. Commonly the men do not attend the village meetings on health issues. These social gatherings allows Senda an opportunity to discuss the issues and answer questions such as "will the chemical spray kill our animals?"

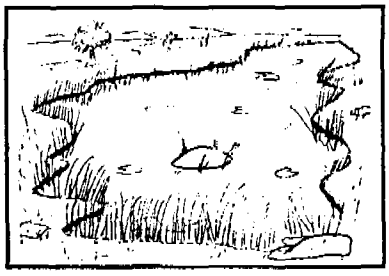
In the classroom sessions back at the Treatment Centre Senda uses a second tool that has been adapted from the PHE tool kit to gather information. The *Pocket Chart* is used with four pictures - a traditional healer, drug shop, health centre, steaming/smoking (a traditional practice of burning herbs and inhaling the smoke). The participants are asked to place a piece of paper in the pocket which contains the picture of the practice that they first use when ill with malaria. This 'voting' is done in secret.

The results are then shared with the VCWs and the village leaders when they visit the Centre. This information helps to identify appropriate messages to give to the people.

In the campaign in Gwanda the four EHTs involved used similar tools and adaptions to those in Lupane. The EHTs were given the malaria drawings by the DEHS in October 1995 and with these they made their own adaptions. The two main tools were *Blocking the Routes* and *Signs and Symptoms.* The latter tool is a picture of a sick person from which the participants gave their ideas on the signs and symptoms of malaria. Any inaccuracies or omissions are corrected by the EHT at the end of the session. These two tools were used with 11 groups as part of the malaria campaign.

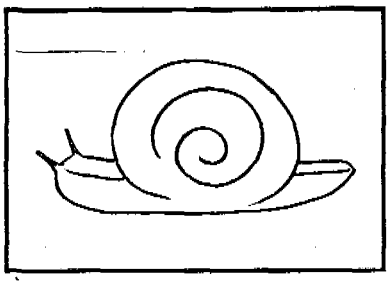
In Bulilimamangwe District the EHTs used a series of tools in their malaria campaign. Not all the tools are used together. There is a selection of the following used based on the situation in any one community. *Mapping* by the community identified the mosquito breeding sites and the location of the malaria cases. A drawing of a person lying in bed leads to a discussion on the signs and symptoms of malaria. This tool may be combined with making the knowledge of malaria more enjoyable by making the questions and answers into a quiz game format. *Blocking the Routes* enabled the participants to identify the way malaria is spread and how it can be reduced/prevented. This tool is facilitated together with the *Pocket Chart* to decide on the most feasible methods for reduction/prevention.

10.4b Target on Schistosomiasis:



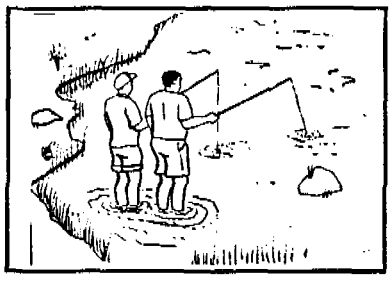
Gutu Ward in Goromonzi District has one of the highest incidences of schistosomiasis in the country. In one school 48% of the children were infected. An area containing nine villages with a total of 346 households was to be the focus of the intervention. The work was carried out by the EHTs who had participated in the Pilot District Training Workshop.

The work was to combine participatory education with screening, treatment, environmental control of the snails and building latrines. The participatory education would include awareness raising to motivate the communities to play the leading role in the organisation of implementation of

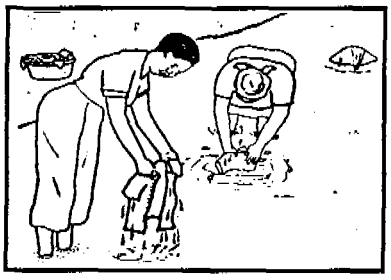


these interventions. The tools were to be used in a strategic way. Work began in April 1994.

Step one was to gain the support and interest of the village leadership. Sessions were held with the VIDCOs and VCWs using *Blocking the Routes, Pocket Chart and Nurse Tanaka.* Information from the clinic records was given to the group when they had understood the basic issues regarding the disease. The leaders agreed on specific changes that needed to be made and pledged the support of the community.



At the same time the EHTs worked with the school teachers in two schools. It was agreed with the School Development Authority to meet with the teachers in the afternoon after classes. In these meetings the tools *Blocking the Routes, Three Pile Sorting, Story with a Gap, Nurse Tanaka, Pocket Chart, Healthy Pictures and Johari's Window* were used to share information on schistosomiasis in the locality and train the teachers in the use of the tools. In turn, the teachers used the tools in lessons on schistosomiasis.



A meeting with the Parents Association followed in which *Blocking the Routes* and *Three Pile Sorting* were used. The pictures for these two tools had been drawn by a health orderly locally or obtained through UNICEF on request from the Goromonzi team. The main conclusion from the meeting was to screen the children, which was carried out in July 1994.

Two surveys were then carried out. Both surveys were made by community members, and recorded by the VCWs, as a way to raise interest and awareness on schistosomiasis and as a way to re-enforce the role and responsibility of the community to eradicate the disease.

The first, a 'behaviour survey', lasted two days in which the *Pocket Chart* was used to identify the water and sanitation infrastructure and the common hygiene practices related to these structures. This was followed by a Survey of all the snail sites.

Meanwhile sessions were held with all the Kraals. 20-30 people would participate and the tools *Blocking the Routes, Nurse Tanaka and Diarrhoea Child* were used. These meetings covered schistosomiasis and dysentery with the aim to further increase motivation to participate in the communal activities concerning schistosomiasis and to change behaviours.

The community began their communal and individual activities. They cleared the snail sites in the locality and, in total, built 450 latrines and upgraded 180 family wells, which included new latrines and hand washing facilities at the schools. Once these activities were underway the children were treated.

One year later the children were screened again. It was found that the incidence had fallen by 62%.

10.5 Within a Community Based Structure Specific for Hygiene and Sanitation:

Commonly the EHTs work within the established system for village leadership and organisation. These do not have the responsibility or organisation for carrying forward hygiene behaviour changes. Currently it is seen that the EHT is the only one who carries out hygiene education and promotion. There is no structure with the role to provide on-going motivation for behaviour change.

There are two examples of where such structures have been created. One which has made a structure of committees to manage the latrine materials together with a group of volunteer hygiene promoters. The other system is based on women's groups set up as health clubs.

10.5a A Structure of Hygiene Promoters and Sanitation Committees:

In three wards in Nyanga and three wards in Mutasa Districts AfriCare has organized a project that focuses on the promotion of blair latrines and the associated hygiene practices. The work is organized through a local structure. In each village there is a committee (Sanitation Committee) with the responsibility for storage and distribution of the materials for blair latrines. Each village also has a number of volunteer Village Hygiene Promoters (VHPs) and commercial latrine builders.

The VHPs are trained for 3 days on how to use the PHE tools to promote hygiene and the need to have a blair latrine. So far 56 people who range from school leavers, women with a family to latrine builders have been trained. Each VHP has been given a set of PHE tools. The drawings in the tools appear to be an important symbol of their position as VHPs. Care is taken of the drawings; some VHPs have even colored the PHE pictures and made a card backing for re-enforcement.

The VHPs meet with groups and individual households within their village. They also give hygiene information when the household collect their latrine materials. In all, 301 formal sessions have been held by the VHPs.

The emphasis of the project is on blair latrine construction and it would appear that the VHPs concentrate on promoting the need for a blair latrine and put less emphasis on the hygiene behaviours. The tools are used for promotion of one technology and intervention with less emphasis on education for personal behaviour change.

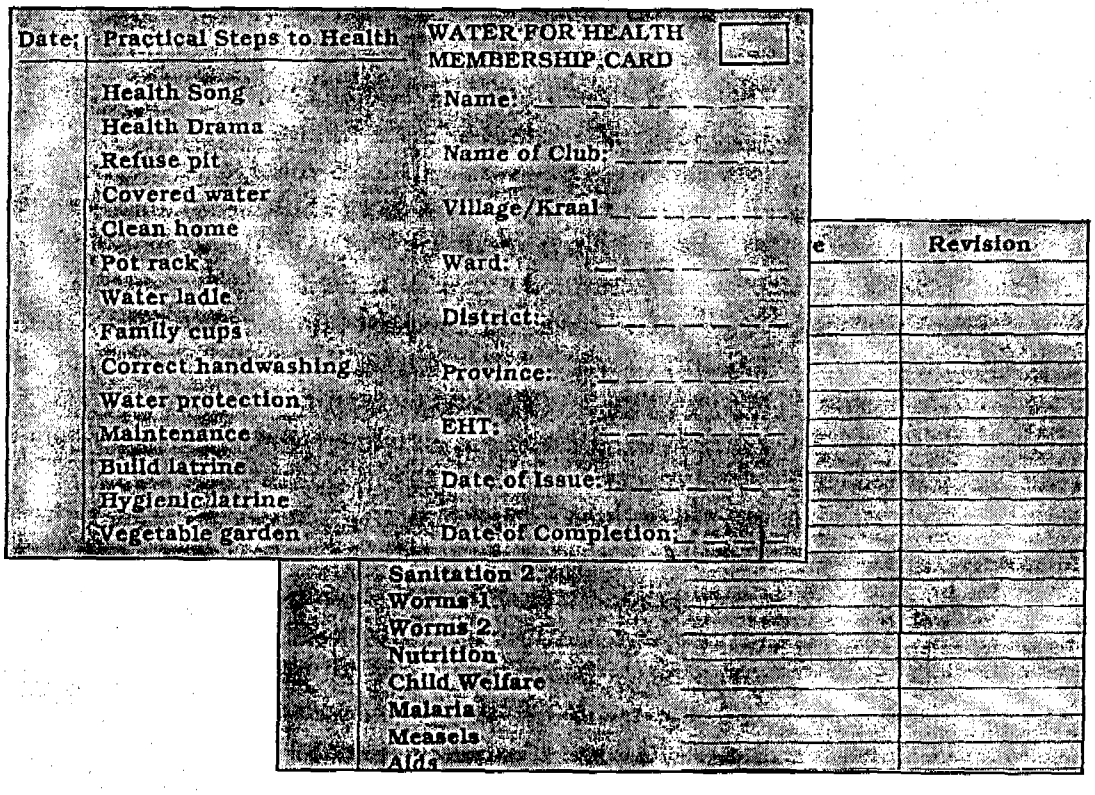
The VHPs do provide a structure that can maintain the continuous promotion of hygiene practices that is required for significant behaviour change. However, the chances are, with the current emphasis on blair latrine construction, that when the latrines have been built the activities of the VHPs will fade away.

This system which involves the community in much of the implementation has achieved impressive construction rates. For example, in Nyangwe Village 42 latrines have been built in the last 5 weeks. In 1.5 years a total of 2.610 latrines have been built in the 6 wards.

Although there is good structure for the promotion and construction there still remains a dependency attitude within the community and the programme staff. Both groups depend on the supply of cement, reinforcing wire and the fly screen. The general attitude is that no one will dig the pit and collect the local materials unless the supply of other materials is guaranteed.

10.5b A Health Club Structure:

In two wards in Mukoni District work on hygiene behaviour operates through womens' groups organized as health clubs, called Move Ahead Clubs. The work is based on the principle that people are motivated to change if they are part of a group of people all trying to make the same changes. The project, which is run by Studio Ahead, uses people-centred, participatory methods to form the clubs and raise the initial interest, and uses the participatory methods and tools in the learning sessions.



The membership of the Club is very significant. A new member is given a card which signifies a commitment of that person to undertake an education programme and to make hygiene changes in their household. On the card the health sessions the person has attended is signed off and the changes to their home is also dated by the EHT.

There are 18 sessions which range from 'Our Environment' to 'Personal Hygiene' and 'AIDS'. The actions, called 'Practical Steps to Health, include physical systems such as 'covered water', 'latrine', and 'pot rack'. Behaviour practices make up the other steps, including 'correct hand washing', 'clean home' and 'hygienic latrine'.

There are several activities to build group cohesion and peer group pressure to adopt hygienic practices. The Club meets once per week for 6 months for the learning sessions. When a person completes all the learning sessions she will receive a certificate. Having completed all the practical water sanitation and hygiene improvements in her home the member receives a T-Shirt with the Move Ahead Club Logo. These are given out at presentation ceremonies. The members wear the T-shirts with pride as it is open statement that they have made their hygiene improvements.

After the learning stage, the Club continues to meet once per week to review progress of activities at the member's homes and cover other issues of interest and concern. After all the members have completed all the 'Practical Steps to Health' the group will continue with income generating activities.

The role of the EHT, who is a government officer, is to organise formation of the Clubs, facilitate the learning sessions and attend some of the monthly meetings and organise for the supply of materials for latrine construction.

In Ruwombe Ward there are 10 Clubs formed from 2 villages with a total membership of 661 people. The Club size varies from 21 members to 133. These 661 come from a total population of 3,000 people.

In Mayo Ward there are 8 Clubs formed in 4 villages. Four of the Clubs are composed of village groups and 4 Clubs are school health clubs. The total of 170 members come from a population of 480 people.

There has been great enthusiasm to join the Clubs, especially in Ruwombe Ward. The original plan was to have one Club of about 30 people from each village. The demand was so great that there are now over 600 people in 10 Clubs. The members are all women with a few older men.

Membership of a Club appears to have a very big influence on the people. They have wanted to be members, feel support from the group and feel encouraged to attend, to learn and to put the learning into action. The Club membership card and the T-shirt have also been a big motivational force. The group meets once a week. These meetings cover a number of topics from learning sewing skills to savings and credit and agriculture. Hygiene is not the only topic. This avoids overdosing on hygiene which runs the risk of creating negativeness. The VCWs have played a very central part in the formation and continuing support and motivation of the groups. The group meetings and activities keep up the interest and maintain motivation in between the visits of the EHT. There has been a very high attendance rate even during the busy planting season.

The EHT uses the PHE methods and tools in these sessions and the VCWs and group members report that they find the methodology very enjoyable and that it enables everyone to take part and to learn. Significantly, the issues raised during the sessions are discussed within the community weeks after the sessions.

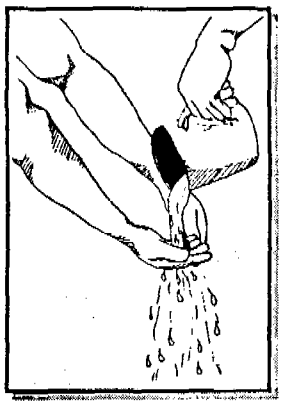
From the EHT's perspective, the close interaction with the group of motivated people who are organized into groups has enabled the EHT to :-

- understand the people's problems,
- plan with the people for water and sanitation activities because the EHT is able to connect with a large and organized group which has a high attendance rate, and because the members are motivated to take actions,
- remove the barrier of fear and suspicion that is often present between a community and the EHT,
- easily prioritise the order of who should receive cement for the family well or latrine,
- work within a clear structure within the schools (for school health clubs).

There have been a number of changes in daily practices.

- the run-to-waste method for hand washing is now the common practice,
- members have agreed not to shake hands in the morning until they have washed their hands,
- all members have got ladles so as to hygienically remove drinking water from the home container,
- all the members cover their water containers,
- many members have made bricks and dug pits in preparation for the cement and construction of the latrines,
- every member wants to have a blair latrine in her home.

Working with one group for one day per week for 6 months and then monthly visits thereafter represents a considerable time investment by the EHT. It has the advantage that the tools can be used in a concentrated way to overcome the initial reluctance in behaviour change. This concentration, together with the continuing motivation created by the groups, has brought dividends. This experience does raise the question of just how much concentrated time is required in any one community to enable that community to start the process of behaviour change. The extension worker cannot provide continuous support. Therefore, a system within the community that can maintain the motivation for behaviour change is important, if not essential.



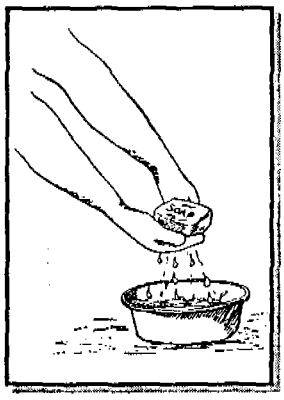
11. Educational, Promotional or Motivational:

These five approaches can be classified into three types, educational, promotional or motivational.

PHE in normal activities and as a one off event are working for behaviour change by using the PHE in a primarily educational way. There is no frequent and regular follow-up related to that PHE session to encourage that learning to be put into action. The learning is expected to be the main influence to stimulate the behaviour change.

The campaigns and work with local leaders allows the PHE methods and tools to be applied in a promotional way. The leaders pass on information that they learnt in the sessions to inform people of the need to change some behaviours.

The approach using community groups dedicated to hygiene issues enables the PHE methods and tools to operate in system that can provide the continuous motivation to make changes in hygiene practices. In this way the PHE can be used in a motivational manner.



12. The Printed Materials

At the beginning of the project it was planned that the tools would be the central mainstay to enable the participatory methods to become common practice. In addition other materials, the Trainers Guide, Field Guide and VCW Guide, would be required as further support.

At the same time it was stressed that the project is not a materials development project. The materials are seen as a means to an end. The development of the materials has taken a great deal of work from the development in the field to mass production. However, it has been seen as an invaluable investment in time and effort. The acceptance of the materials has been a function of the way in which they were developed and introduced and of the applicability of the materials themselves.

The materials consist of :-

A set of Tools
A Tool Kit
A Trainers Guide
A Trainers Kit
A Field Guide for Extension Staff
A Field Guide for VCWs

12.1 The Tools:

A tool is a instrument that is used in a learning session. It is specifically designed to attract people to participate in the session and to focus on a specific hygiene topic. The tool is composed of an explanation note that describes the steps to facilitate the session together with a set of drawings.

The explanation note describes how to use the drawings to create participatory learning. The description is divided under the headings: Purpose, Target Group, Materials, Method and Discussion Points. See Appendix 4 for the explanation note for the *Sanitation Ladder.*

Initially there was reluctance to include the explanation note for the tools. It was felt that if the steps of how to facilitate the session is written the facilitator will follow the steps as they are written and not according the response of the learners. As a result, it would turn a process into a procedure. This reluctance lasted 6 months before the DEHS staff gave into pressure by the field staff.

One tool can take from 30 minutes to 2 hours to complete depending on the amount of discussion the tool generates. To be used properly there should be no time limit on the session.

The Tools:
Three Pile Sorting, Sanitation Ladder, Pocket Chart, Drama, Songs, Blocking the Routes, Task/Target Analysis, Nurse Tanaka, Story with a Gap, Mapping, Unserialised Pictures, Diarrhoea Child, Diarrhoea Doll, Picture Analysis, Flexi Flans.

15 Tools with 357 drawings

12.2 Drawings:

The use of visual images is the basis for generating interest and participation in the topic and enabling self discovery learning. These have proved to be successful with a high degree of accurate interpretation when given time to 'read the drawings'.

All the tools (except the song and drama) use visualization as the basic mechanism to catch people's attention, stimulate ideas and enable manipulation and analysis of the information. Therefore each tool is composed of a number of line drawings. To be sure to have drawings to cover almost all circumstances, physical conditions and cultural practices the tools contain very many drawings. Three Pile Sorting has 94 drawings and there are a total of 357 drawings for all the tools (see Appendix 5).

Initially there was some debate about the visuals as to whether they should be simple line drawings or pictorial and/or with color. The pressure for colored pictorial drawings was on the basis that they will be more attractive and have a high prestige for all involved with the tools. It was finally decided that such detail was not required.

The experience so far shows that the drawings are well accepted by the learners and extension workers alike. Their attraction appears to be in the fact that they really do create interest and participation and that they are enjoyable to use.

By using complex pictorial drawings and an expensive tool kit would have run the risk of the tools dominating the project and the project becoming a materials production and supply project.

12.3 File of Tools:

The tools are packaged in plastic holders housed in a sturdy ring file. New tools, as they are developed, can be added to the file. The tool consists of a cover page which describes how to use the tool together with the drawings.

At this time the File of Tools does not include a description of the participatory methods that are common to all the tools, such has how to create a good learning atmosphere, how to be sure that everyone in the group participates. A description of this sort will be included in the Field Guide, but would act as a reminder to the user about the importance of the method and about the difference between the tool and the method.

12.4 Tool Kit:

The file of tools is provided in a kit which contains the basic stationery to begin using PHE methods and tools. Also included is the File of Tools and, when produced, the Field Guide. The colored crayons and extra plastic folders is available to color the pictures and provide protection to the pictures when in use. The plastic pocket chart was made by a womens group as an income generating activity. All the contents are kept in a standard holdall bag. Appendix 6 gives the complete list of contents.

12.5 Distribution:

Tool kits are not provided before training in their use. The Kits are not given to individuals. They are provided to the institution in which the person is based. The main location is the Rural Health Centre but that varies according to circumstances. In one district the kit is kept by the councillors.. The Kit is available for use by the EHT and all the other extension workers who have been trained, based in that Ward.

It is planned to distribute 800 Tool Kits and have available a further 300 of the Files of Tools.

12.6 Influence of the Tools:

The tools have proved to be very successful. They are the main mechanism by which to introduce participatory methods. Although it must not be forgotten that the bottom-up field based process by which the tools were developed has had a very big influence on their acceptability.

The tools have provided:-

- a mechanism by which the EHTs could apply the participatory methods;
- a means by which the hygiene education could have an identity;
- a means around which a tangible programme of activities for hygiene education could be built;

However, there is a trend to only associate the participatory methods with the tools. Some extension workers use participatory methods when using the tool but return to the lecture method when covering topics for which there is no tool. This is not a serious problem and can be overcome by including this

issue in the training and demonstrating clearly the difference between tool, method and approach.

The fact that the tools were not available to use (only the knowledge of the tools) was identified by PHAST to be one of the main reasons why the PHAST initiative did not become well established in working practices.

It is clear that the comprehensive tools and support materials has created a firm base for PHE methods to become common practice for ward extension staff.

12.7 Trainers Guide:

It is planned that the Trainers Guide will be a reference to assist the DEHOs and PREHOs when facilitating a training workshop for the field staff. The Guide will be produced during the second half of 1996 and currently is at the pre-writing stage. The content is expected to cover the areas of :-

- creating a good learning atmosphere in the workshop;
- team building within the workshop;
- personal awareness with regard to working in a participatory way with communities;
- principles to participatory methods and approaches;

12.8 Trainers Kit:

The Kit is a resource of visual materials for the workshop to train extension workers. The Kit is composed of the tools to use during the workshop. These are SARAR Explanation, Johari's Window, Resistance to Change Continuum, Animal Crackers, Energizers, Photo Parade, Cup Exercise, 9 Dot Straight Line, Pocket Chart Personal Behaviours, 8 Square Exercise, Field Visit Preparation and Evaluation and Reporting Format.

Johari's Window, Cup Exercise and Photo Parade focus on interpersonal communications. The Resistance to Change Continuum and Pocket Chart on Personal Behaviours introduce the sessions on behaviour change. Animal Crackers, Energizers, 9 Dot Straight Line, 8 Square Exercise help to create a good participatory learning atmosphere that also have a learning element as a conclusion to the tool.

The workshop tools are kept in a plastic folder with 12 pockets. There are no vacant pockets available for new workshop tools when they are developed although the pockets are large enough to store several workshop tools.

It is planned to distribute up to 200 Trainers Guides and Trainers Kits so that they are a reference resource at every District and Province.

12.9 Field Guide:

The Field Guide is designed to be a reference for the Ward extension officers, in particular the EHTs. The Guide describes how the tools can be used for a number of different topics. For example, *Blocking the Routes* can be used for scabies, malaria and bilharzia; *Three Pile Sorting* can be used for male and female workload and responsibilities, general hygiene and water storage. A full list can be found in Appendix 7.

This Guide describes in detail how the tools can be used for a variety of topics and objectives. It is designed for people who have undergone the training. The tools are divided into five groups - Community Participation, Hygiene, Water, Diseases and Sanitation.

The Guide is still in production. Progress has been slow because a long block of time has not been devoted solely to the writing and production. It has been made as an addition to other duties. After an initial meeting to plan out the general content work groups were formed to carry the work forward. However, the work groups have not met and most of the work for the drafting and editing and sending it to district officers for comment has fallen on the UNICEF seconded staff. Studio Ahead was contracted for six weeks to make the layout and scan in the drawings. Nonetheless, all the editorial work had to fall on busy people.

The Guide describes the use of the tools in isolation with little reference to community process within which behaviour change takes place. There is no reference to the use of the tools in a mini programme that can turn the tools from educational sessions into a motivational process, or to their use in the process of community development and within the social dynamics of a community.

The Guide would be greatly strengthened if these areas were included. Although the Guide would be strengthened by the inclusion of these areas it also is not fatally weakened by their exclusion. Their inclusion can come as the project develops and turns its attention from the introduction of the methods and tools to their use in the community.

12.10 Distribution:

The final decision concerning the distribution has yet to be made. The options are to have the Guide in the three main languages - Shona, Ndebele and English - or to use only English and make a VCW version in Shona and Ndebele. It is planned to have a total of 800 produced so that they can be added to the Tool Kit, although the final number will depend on the printing cost. It is hoped that it will be a high quality production to further motivate the use of the tools

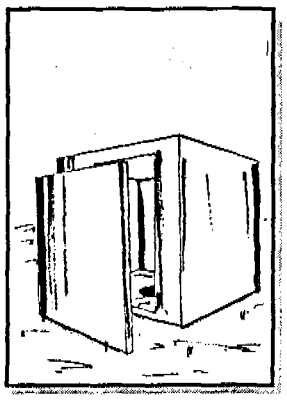
12.11 Guide for VCWs:

It is perceived that there is a need for resource material for the VCWs. The current thinking is to produce the material as a number of booklets. One

booklet would describe two tools for one topic area ie. hygiene, water or community participation. The booklet will contain a pictorial detailed description of how to facilitate the tools and be written in Shona and Ndebele.

12.12 Costing:

File of Tools...	US$19 each
Tool Kit...	US$57 each
Trainers Guide...	at the pre-writing stage
Field Guide...	not yet at printing stage
VCW Guides...	currently in the conceptual stage



13. The Training

Training in a workshop setting is the main mechanism to pass on the knowledge and skills for PHE. However, although training is the main mechanism, and a great deal of time is absorbed in training workshops and its associated activities, the PHE Project is not a training project. The training is a means to an end - that of making PHE methods and tools common practice for extension workers - and is not an end in itself.

There is a danger that there is so much demand for training that there will be no time to provide the support and confidence building that will turn the knowledge obtained in the workshop into daily practices. The project would then become a training project.

There is an assumption that the training alone will be sufficient to bring about a change in practice by the extension worker. This is a dangerous assumption. It is reported that one third of the EHTs are confident enough to put PHE methods and tools into practice after the workshops. Further, there are few of these EHTs who use these tools strategically to bring sufficient concentration to influence behaviour change. The training must be accompanied with long term and frequent follow-up support. There is some concern in the DEHS that the provinces and districts, in general, currently are not providing the required follow-up support.

13.1 The Training System:

The training is not organized in a cascade manner. It has a team training approach. Teams that represent a vertical cross section of officers within the province are trained together so that they can start the implementation. In this system the field staff are trained with their district and provincial heads. These senior officers provide the support for the field staff who, as a result, do not operate in isolation.

Similarly the ward extension workers are trained as a team (sometimes together with the councillor) so that they are all familiar with the methods and tools and all have the opportunity to use them.

This creates the opportunity for all the extension staff to use the same approach and methods in the community thus avoiding giving confusing messages to

the community by using different approaches and also avoiding the work of one extension worker undermining the work of her colleague.

The training is organized to be in three stages. In Stage One a team from one province consisting of officers from the provincial office together with officers from a number of districts and extension workers are trained. The workshop is facilitated by central DEHS staff and one or two people from the province or district who have some field experience in PHE.

This cross section team are expected to be able to start the district and ward training within one district and begin the community work. This provides the practical implementation experience which will be used in the trainings for Stage Two.

Stage Two is managed by the PEHO. In this stage the original team facilitates the training of staff from the remaining districts in the province. This is carried out with one or two districts per workshop. In the early trainings a person from the DEHS often assists with the facilitation until the team from within that province has the skills and confidence to continue alone.

The participants from a district are, again, a cross section. District officers are together with ward extension workers, MOHCW staff combine with staff from DDF, the RDC, MNAECC and Agritex. Deliberately, there is no set pattern to the participants. It is left to the district to decide on its own strategy. One common pattern is that the training is not for environmental health staff only. All staff who work with communities are welcomed.

The Third Stage happens within one district. As described in Appendix 3, the steps that the district takes to train the appropriate people takes many different paths. Commonly there is training for the councillors and for the remaining ward extension staff who did not attend the Stage Two workshop.

13.2 The Training Workshop:

The training workshops are a 'photocopy' of the Pilot District Training Workshop held in March 1994. The difference is in the number of days. The original workshop was 10 days and the Stage One workshops maintain that duration. The Stage Two workshops are normally 6 days in length and the Stage Three workshops are 2 or 3 days in duration.

The 10 day workshop is scheduled in the following way:-

Day 1	Introductions, Sharing Experience in Participatory work, PHE Project Objectives, Health Pictures, Health & Hygiene
Day 2	Theory on personal communication using the *Photo Parade, the Cup Exercise, Johari's Window*, Role Play and Drama Work through 2 tools - *Nr Tanaka* and *Pocket Chart* Preparation for the Community Visit
Day 3	Community visit - a look and listen visit to make a quick assessment

of the situation and arrange the time and venue for the second visit. The participants are divided into 3 groups to visit one of three communities

Day 4 Community Visit Report
Work through 6 tools - *Mapping, Faecal-Oral Routes, Blocking the Routes, Barrier Matrix, Sanitation Ladder, Pocket Chart* (group behaviour) and *Three Pile Sorting*

Day 5 Behaviour change theory using the *Resistance to Change Continuum*
Work through 7 tools - *Task Target Analysis, Story with a Gap, Drama, Force Field Analysis, Unserialised Posters, Diarrhoea Child, and Diarrhoea Treatment.*

Day 6 Theory of working in a project with hardware and software components using the *Integration of Hardware and Software* exercise.
Preparation for the community visit. To prepare 1 or 2 tools to use on the visit. The choice of tools is based on the assessment made on the first visit. The same groups visit the same communities.

Day 7 Preparation for the community visit
Half day free

Day 8 Community Visit

Day 9 Reports on the Community Visit and the use of the tools
Theory on behaviour change from a personal viewpoint
Action Planning
Implementation Plans

Day 10 Presentation of the Implementation Plans
Review of Issues Arising
Workshop Evaluation

13.3 Content:

The main part of the content is the practical exercises with the tools and the field work practice. Analysis of inter-personal communication and behaviour change as background to the use of the tools.

The use of the tools is frequently (at least 3 times per day) interspersed with energizers such as the 9 Dot Line and Lifeboat that all illustrate a point that is relevant to PHE.

Team building for the cross section teams is an important part of the workshop although it is not stated in the workshop objectives.

The workshop content does not include detailed discussion on topics that can illustrate the community dynamics context for the tools and their use for behaviour change:

- how adults receive information and learn;
- a practical model for behaviour change;
- the difference between the tool, method and approach;
- using the tools in a strategic way and how it can fit into the existing work pattern;
- using the tools to fit into the process of community participation;

- current feeling of dependency and self reliance;
- decentralisation and community management;
- systems/structures that can carry on the motivation for behaviour changes eg. womens groups, health clubs, volunteer promoters;
- systems to ensure that the PHE becomes motivational and not remain as education.

13.4 Workshop as a Role Model:

It is considered that the attitudes and actions of the facilitators are equally important as the content of the workshop. The organisation and facilitation of the Stage One workshops are a role model for attitudes and participation methodology for the stage two and three workshops and for the community work. The importance of group work is stressed throughout the workshop with group work a common arrangement for the workshop activities.

13.5 To Cut or to Condense:

When the workshops are repeated at the district and the ward there is a problem if the duration is reduced. The dilemma becomes to cut the content or be less detailed with each topic. Generally, all the content is included but each topic receives less detail. This tends to weaken the training.

The most vital part of the workshop is the community visits. Commonly, the participants are sceptical of the methods and tools when they are presented in the first three days. "I thought they were child's play" remembers C. Musara the Principal EHO for Goromonzi District. It is the second community visits in which the tools are used in a real situation that the scepticism changes to belief. "They really work!" is a frequent evaluation after the experience in the community. If the workshop structure is to the changed the community work must remain.

13.6 Facilitation Skills:

At this time there are relatively few people (about 30) with sufficient experience with the tools and have good facilitation skills. These people facilitate well in terms of facilitating participatory sessions and in providing a role model. However, all these people have full time jobs which limits their availability. Additionally, due to the nature of the workshops more than one facilitator is needed to organise and facilitate a 6-10 day workshop.

13.7 Rapid Expansion:

Since mid 1995 there has been an explosion in the scale of the training programme. Instead of training for 12 districts in 1996 there will be training for 35 districts. Although this expansion reflects an interest and enthusiasm in PHE it also puts the training system under great strain.

This has overtaken the development of experienced facilitators , as described above. Training with less experienced facilitators will reduce the quality of the training. This in turn will create more demand for follow-up support to the trainees in community situations.

13.8 Follow-up Support:

Field experience has shown that the training alone will not bring about a change in working practices. Long term follow-up support after the training is essential. Currently the DEHS is trying to act as a role model to the provinces and districts in the way that they carry out frequent follow-up work. However, due to the heavy workload on the DEHS staff it has not been possible to provide sufficiently frequent follow-up and be that ideal role model.

However, the people who are in a position to provide follow-up support are caught in a vicious cycle. On the one hand they need to provide facilitation assistance to the many trainings, which takes time away from the follow-up work. At the same time, the many trainings are creating new and more follow-up work.

The DEHS staff and the two UNICEF seconded staff provide the follow-up support in the field. They have divided the work so that each person has two provinces to support. They visit the province once per 3 months. In one visit they may visit 2 or 3 districts. So it can be 9 months or more before a district will receive more than one support visit. The exception is Matabeleland North and Matabeleland South Provinces which have full time support from one of UNICEF seconded staff. This support work needs to be increasingly provided by the province, and this support work needs to be seen as a major and essential part of the PHE work for the next few years.

13.9 District Review Workshops:

One useful form of support will come through the proposed review workshops. These are likely to be 5 days in which all the extension staff using PHE can share experiences, devise new strategies, find solutions to problems and receive adaptions of the tools and new tools. At the same time, the effectiveness of the training workshops can be reviewed and improvements identified. It is expected that these review workshops will be the mainstay of the follow-up support and the main mechanism to identify areas for improvement within the PHE work.

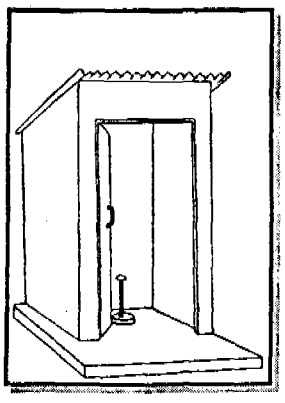
13.10 Over Use of the Term 'training':

The term 'training' is used for all the main events in PHE. Workshops at national and provincial level are referred to as 'training' and also sessions at the community level are also called 'training'. By using the term 'training' for the community sessions gives the impression that the sessions should be carried out in the same way as the other training workshops. This can lead to the PHE work being organized

at the community level as one workshop per village. In this way the PHE becomes a one off event instead of being a part of a long term process. The following are possible suggestions for alternative terms:

Learning about the PHE Methods & Tools:	
Provincial Officers learn the PHE methods & tools	training
District Officers learn the PHE methods & tools	training
Ward Extension Staff & councillors learn the PHE methods & tools	training

Extension Staff using the PHE Methods & Tools:	
Sessions (or groups of sessions) in which the village leaders analyze their local situation & make community plans	Possible terms:- - community management sessions - leaders planning sessions - planning sessions - community mobilization & organization - awareness & planning
Sessions (or groups of sessions) in which the villagers learn more about the hygiene, water, sanitation & health	Possible terms:- - village learning sessions - village awareness sessions - village sessions - village learning - village awareness & learning



14. Use of the Tools

The proof of the value of the tools is in their use. The tools have shown that they have had an impact within the institutions which is described in Section 15. The following concentrates on the use of the tools in the community work.

14.1 A Good Tool:

A tool is considered by the EHTs to be good when :-

- the facilitator and the participants realised that they both have a lot of knowledge with which to share with each other;
- the people start to teach each other;
- the facilitator needs to give only a little input and the people take over the discussions and identify the learning points;
- it enables the people to come up with solutions;
- it brings people together;
- it makes people want to take action on the issue;
- it brings the people to make a resolution for action relating to the topic under discussion;

The EHTs consider the method and tool together to be effective if :-

- people are taking action on hygiene;
- when the people realize the negative effect of depending on outside assistance;
- the community has a plan of actions;
- households have a commitment to take certain actions;
- people feel a sense of ownership of the actions and the sanitation and hygiene enabling structures;
- when the community organise actions themselves and make requests on the authorities to work together;

The use of the tool is to work toward behaviour change and needs to be evaluated in that light. C. Musara, the Principal EHO for Goromonzi District described it thus "If the tool does not motivate people to make a resolution for some kind of positive action the activity is a game not a tool"

14.2 The Popular and Unpopular Tools:

There are definite favorite tools. These tools are used the most and are the ones commonly adapted.

Popular	Unpopular
Story with a Gap	Task Target Analysis
Nurse Tanaka	Unserialised Posters
Three Pile Sorting	Drama
Sanitation Ladder	
Mapping	

14.3 Participation:

The 'participation' in Participatory Hygiene Education refers to the participation in the learning session. The project, in this early stage, has concentrated on the learning session. It is planned to expand the participation into playing a part in the community development process once the methods and tools have become established.

The three pilot districts all had specific issues that would be the target of the PHE which pre-determined many of the sessions. Bilharzia and dysentery in Goromonzi; latrine construction in Mutasa; hand washing in Beitbridge. Even so there has been room for covering other areas, such as constructing a dip tank or building a creche, if they arise during the sessions.

14.4 The Tools as the Message:

In the beginning there was a tendency by some extension workers to train in how to use the tools with community members in the same way that they were trained. In this case the message of PHE had become the tools.

Such a misinterpretation is possible when the training and most of the PHE work concentrates on the tools. This situation was short lived but could re-emerge with the rapid expansion of the training which may use the original training workshop format and not be conscious of this possible misinterpretation.

14.5 Main Issues:

Currently the main issues in the use of the tools fall into the following groupings:-

a. Difficulties in the up take of the tools:
   - there is considerable differences in the up take of the methods and tools;
   - other cadres than the EHT are not commonly using the tools;
   - fear of spoiling the drawings;

b. Strategic use of the tools:
   - the tools are not commonly used in a strategic way to make a concentrated input and turn the tools from education to motivation.

c. Tool-Method-Approach:
   - the participatory methods are commonly only associated with the tools.

d. Adapting the Tools:
   - although there are several adaptions of the tools many staff require ideas for expansion of the methods and tools.

14.6 Difficulties in the Up Take of the Tools

It is estimated that about one third of the EHTs feel comfortable with the methods and tools and immediately make use of the tools. The majority of the remainder do not yet feel confident to use the participatory methods. It appears to be a matter of confidence rather than resistance. This difference is to be expected in the early stages and it emphasizes the need to have a comprehensive and supportive follow-up system.

A number of measures have been taken that will be beneficial in the long term. At the ward level all the extension workers are trained in PHE and are encouraged to work together in PHE activities. The EHTs from neighbouring wards are encouraged to work together until they are confident to continue alone. The first year EHT students have been trained in the PHE methods and tools so that they will be familiar with the methodology when they start work.

Similarly, a number of cadres other than the EHTs have been trained, particularly the Nurses from the rural health centres and the District Community Nurses and District Nursing Officer, the RDC Projects Officer, MNAECC Officers and School Health Masters. This has been a definite policy decision to make the PHE methods and tools become well known and common practice within all community work for health. The policy has been successful in making the practice acknowledged as a viable approach. K. Nlovu, the Acting Community Sister in Bulilimamangwe District reflects the sentiments of many with his observation "The tools actually work".

However, in general, these other cadres have not started using the tools. In the case of the Community Nurses it appears to be a combination of two factors. Firstly, the health education sessions at clinics are not long enough for participatory tools to take their full course. Secondly, the nurses need tools that are specific to the common topics they cover. Generally, people feel that they need tools specific to their need before they will embark on the new method. This raises the issue of whether the PHE Project has the mandate to make tools on topics that are beyond hygiene.

A policy decision was made to produce the drawings on normal thickness A4 paper to keep the costs down and allow for many drawings to be included in many kits. Currently there are 357 drawings in the kit. Given that everyone

stated that they need to have many options provided for them to use, believing that they do not have yet the experience to create a new tool and prepare the visuals, this remains a valid decision.

The downside is that there is a general concern that the drawings will be spoilt if they are used. Solutions to this situation are easily found by those EHTs who want to use the tools. Some have made photocopies so as to keep a set of originals, others put the drawings in the plastic file holders, others have backed the drawings with cardboard and a few Districts are paying for the commonly used drawings to be laminated.

14.7. Strategic Use of the Tools:

There appears to be little appreciation for the need to use these tools in combinations and to use these combinations in a strategic way to make a concentrated input. Without this type of input it is unlikely that there will be significant change of behaviour.

Commonly the tools are used individually or sometimes two in one session. There is also considerable time lag between sessions which does not enable the people to make direct links between the lessons learnt from each tool. This is partly due to the fact that the EHTs have a wide variety of duties and that they have to cover large areas (two wards is common) with little transport available.

Also, the issue of the strategic use of the tools in the community process for behaviour change is not stressed in the workshops. (The training in PHE is described in Section 13). There are good examples of the strategic use of the tools in the bilharzia campaign in Goromonzi District, the malaria work in Lupane District and in the community awareness sessions for CBM. These examples could be used as case studies in the PHE training of the extension staff.

14.8 Tool-method-approach

It was widely reported that there is a tendency to use participatory methods when using the tools and return to the didactic method when not using the tools. For example, the topic of hand washing would be covered using the participatory methods; and immediately after, the topic on (say) immunisation would be covered using the lecture method.

The EHTs have not fully appreciated the difference between tool, participatory methods and the participatory approach. They have not seen the behavior change value in participatory methods for awareness, learning and understanding. Similarly, these methods can be used in very many circumstances and do not require a tool. See Table 2.

Table 2

TOOLS	METHODS	APPROACH
- an instrument for a specific learning activity (that is participatory)	- a friendly & non-threatening atmosphere is created	- policy to use participatory methods whenever possible
- the basis of a tools is commonly a set of pictures	- facilitator talks little	- policy to encourage the learning to be based on the facts that come from the community & later added to by the facilitator
- a tool is a mechanism to enable learning through self discovery		
- a tool does not have to be based on a set of pictures	- facilitator encourages the people to talk & to discuss between themselves	- policy that the plans of the district are based on the plans made by the villages
- instruments such as role plays and social dramas are also useful tools	- takes time and does not rush the session	- all the district and extension staff have a positive attitude to using the participatory methods
	- uses ways that enable the people to realise that they have knowledge & ability	- work is reactive to the requests by the villages
	- everyone has an equal chance to speak & give input	- the work is organised in a way that is convenient to the villagers
	- people sit in a circle	- all community work contains the objective to help build the confidence & determination of the community
	- uses ways to enable people to analyse the facts that have emerged during the session	
	- no person is to dominate the session	

14.9 Adapting the Tools:

There have been a number of adaptions of the tools. *Nurse Tanaka* has been the mother of many tools including Mukoma DDF (DDF), Mbuya Chipangamazano (MNAECC), Teacher Kanitza (School Health Masters).

Nurse Tanaka is a nurse at an RHC and there is a long line of people waiting for treatment. The participants decide the condition of each of the people in the line. The participants then go through each one identifying whether the condition is preventable. These people are then removed from the line and

put on one side. This leaves in the line only those people who are suffering from non preventable conditions. Always the remaining line is very much shorter than the original line. The resulting discussion brings up common problems and concerns experienced by the community. The conclusion of the session normally focuses on prevention and self reliance.

In Mbuya Chipangamazano the central person is now a VCW. The queue of people are coming to the VCWs for assistance. The resulting discussion concentrate on the issue of self reliance.

For Mukoma DDF the queue of people are now hoping that the DDF officer will assist them. The problems that the people bring are divided into those which the community can solve or prevent and those which require DDF assistance. The resulting discussion focuses on self reliance and the concept of community based management of the water systems.

The other adaptions include:-

- *Blocking the Routes* for malaria
- *Blocking the Routes* for bilharzia
- *Barrier Matrix* for planning skills for councillors
- *Task Target Analysis* where the male and female categories are replaced by the councillor and the people
- *Three Pile Sorting* for teachers for hygiene practices within schools
- *Snakes and Ladders* for hygiene facts for school children
- *Kitchen Mapping*
- *Household Mapping*

The Community Based Maintenance Project has adapted a number of the tools for use in its awareness sessions with communities. Here the emphasis is on self reliance and building the interest and skills for community management. The tools used are *Sanitation Ladder, Three Pile Sorting* (using pictures of handpumps in various states of repair and disrepair), *Mapping* (in which there is no map but the groups visit the pumps and consider why they are in the condition that they are and what can be done about the situation).

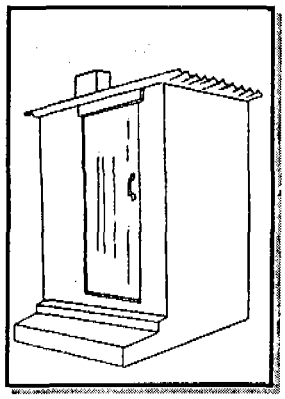
The MNAECC in Gwanda in their training of extension workers and VIDCOs as part of the IRWSS project uses a number of tools. *Story with a Gap* is used for the topic of composition, roles and responsibilities of the Water Point Committee. Seven tools (*Sanitation Ladder, Blocking the Routes, Task Target Analysis, Story with a Gap, Pocket Chart, Unserialised Posters, Mapping)* are used to cover the issue of community participation with the VIDCOs.

14.10 Networking:

The current challenge is to network all these ideas. One group of EHTs may have devised an adaption for bilharzia but not yet thought of one for malaria. While in other districts tools for malaria have been developed. Experience has shown that having adapted one tool does not mean that more ideas will flow. A network to share ideas and stimulate creativity is required.

A newsletter that describes adaptions and different strategies is being considered. A newsletter represents a great deal of work if it is to have good quality content and be issued frequently. At this time there appears to be no spare capacity in the DEHS to maintain a regular newsletter production.

The other possibility for networking is to hold annual or bi-annual review workshop in each district in which new tools are introduced. At the same time practical issues can be discussed and the areas of the strategic use of the tools and the difference between tool, method and approach can be covered in detail. The first of these review meetings will start in mid 1996 and hopefully will become established practice for all provinces and districts.



15. Impact

There have been a number of significant achievements in this initial period of the project. These achievements are centred on the institutional area. It is too early to see widespread changes in the field work and community actions. However, there are encouraging signs that show the potential of the PHE methods and tools on community actions and behaviour change. The description of the impact is divided into three areas, institutional, attitudes and community

15.1 Institutional:

The PHE work has:-

- raised the profile of hygiene education ;
- provided appropriate practical methods for behaviour change;
- brought new practical ideas into an area in which there were few ideas for different approaches;
- made hygiene education a tangible entity; now definite plans with specific targets are being made;
- enabled planners to have a recognizable target to fund;
- created an increase in specific funding; from a nominal amount of Z$4,000 per year to, in some cases, Z$150,000 eg. in Hwange District for 1996, all the vote for education in the IRWSS project was allocated for PHE;
- enabled all the senior officers in the water and sanitation sector including the NAC members to understand the process of the PHE and be supportive of the methods and approach;
- built up a team of people in each province who can further develop PHE in their province;
- spread to other projects eg. the methods and tools have been seen to be effective in the field and have been included (sometimes with adaptions) in other projects, notably Africa 2000 and Community Based Management;
- encouraged the Human Resources Department, MOHCW, to run PHE workshops.

All these together have made participatory methods and approaches commonly acknowledged and valued. This has been one factor in the high level of interest in PHE and the demand for training in the methods.

For the first time UNICEF has obtained funding which is specific and secure for hygiene education. Previously hygiene education was a small part buried in the funding for water and sanitation.

15.2 Attitudes:

Following on from the changes within the institutional framework there are considerable changes in attitudes towards participatory methods and approaches. Officers who have used the PHE tools in real community situations testify to their effectiveness is capturing people's interest and creating a foundation for behaviour change. This observation is held also by those people who have not yet found a way to use the tools in their own professional role such a Nurse in an RHC.

The following are typical statements. Significantly these attitudes can be found throughout the hierarchy and are not limited to the field workers.

"Before I used the PHE methods I didn't believe that people had that knowledge" *L. Nare Principal EHO Matabeleland South Province*

"I am now seeing the people with different eyes" *C. Musara Principal EHO, Goromonzi District*

"Three pile sorting is a real eye opener for the community" *E. Mudzingwa EHT Rusike*

The challenge is now to turn these positive attitudes, and the acknowledgment that the participatory approach and methods has a major role to play in behavior change for health, into strong commitment.

15.3 Community:

A number of districts and EHTs have begun to apply the PHE methods in an effective way. The following are some of the reported changes that have taken place since PHE methods and tools have been used.

- Beitbridge District reports that PHE methods have become standard practice for the EHTs.
- In Gutu Ward, Goromonzi District, the PHE in combination with other intervention, brought a 62% reduction in schistosomiasis infection in school children.
- In Gwanda and Lupane the methods have been used in malaria campaigns and in Umzingwane District the PHE methods were used in a dysentery control campaign.
- Gwanda District reports that the run-to-waste system for hand washing is now used at public gatherings, particularly, at funerals, and in Goromonzi the same method is now used at church meetings.
- Beitbridge District reports an increase in the demand to construct hand

washing facilities, more hygienic water collection practices, more hygienic use and maintenance of latrines.

- In Goromonzi District there is an increase demand for cement to upgrade family wells.
- In Mutasa District there is an increased demand for materials for latrines.
- PHE methods and tools have been the main promotional mechanism for latrine construction in six wards in Mutasa and Nyanga Districts. In the six wards 2,610 blair latrines have been constructed in 1.5 years.
- 850 women are members of Move Ahead Health Clubs in two wards in Mukoni District. Each member is committed to adopting a set of hygiene practices and building a latrine in their household. Hygienic hand washing practices are already widespread throughout the members.

However, it is not possible to be exact on impact at the community level until appropriate indicators for behaviour change and a reporting system, that clearly describes the process of participatory education and behaviour changes, is devised and in operation.

15.4 Disappointments:

Although there is overall satisfaction about the progress the project is making there are some concerns over the following areas:-

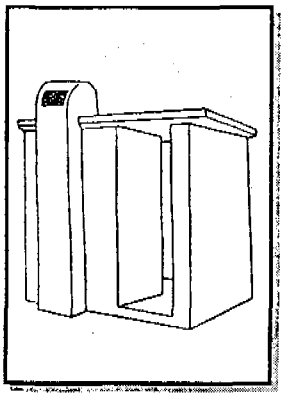
- the indicators specific for PHE have not yet been developed and as a result, specific community process or behaviour change targets for the PHE work are not yet in place;
- similarly, the current reporting system does not capture the activities that are carried out at the community level, both in terms of the EHTs work and in terms of the community actions and the individual behaviour changes;
- there is insufficient follow-up support both from the central level and from the province and district staff to facilitate the further development of the methods and tools, and to provide the confidence to the extension staff to use the tools;
- with the increase demand for training the project will become a training project and there will be no time to ensure that the PHE is being used effectively in communities;
- in general, few cadres other than the EHTs have started to use the tools in more than an occasional manner;
- there is no strategic thinking about the use of the methods and tools.

15.5 Indicators and Reporting:

This has been a particularly difficult area to negotiate. From the beginning of the project there has been a desire to develop indicators that accurately reflect behaviour change and the social processes that bring about behaviour change.

The standard indicators measure the numbers of structures - blair latrines is the most common - and the number of people attending hygiene education sessions. These measurements do not indicate any change in hygiene practices

This need has been recognised right from the beginning of the project. There have been a number of meetings, beginning in mid 1994, followed by two more workshops in 1995 and 1996. The difficulty has been to create indicators that measure behaviour change that are, in themselves, measurable. In May 1996 the provincial and headquarters officers for Environmental Health and Health Education in a three day meeting were unanimous in their desire for behaviour change indicators. A number of possible indicators were identified and a report format was designed (see Appendix 8) and will be field tested in three districts in all the provinces for two months. It is recognised that these indicators are not complete and that they are the first step in a long process of refinement.



16. Local Sustainability

The issue of local sustainability has not yet be addressed in PHE. In this first part of the project the emphasis has been on establishing the PHE methodology in the common practices of the extension staff. The training programme reflects this emphasis. However, behaviour change does not happen overnight, it requires long term motivation. The EHTs are not able to make frequent visits to all villages. If an EHT covers two wards, which is a common situation, he may well visit the same village only twice in one year. There is a need for communities to maintain their own motivational activities.

There are many examples that have emerged through the work of the EHTs of communities who are willing to organize their own action once they are fully understanding of the situation. In Ngoco, Lupane District, 6 villages were willing to carry out the spraying of mosquito breeding sites once they were aware of the situation and the difficulties the ministry had in carrying out the spraying. The same action was taken by Gatho Village in Bulilimamangwe District. Mangala Village in Kezi District organized itself to pay for diesel for their water system when they heard that DDF was unable to continue supplies. Each household pays Z$5 per month and no 'free riders' are allowed. The village leadership agreed with DDF that the village would pay for the diesel and DDF would provide the transport.

The PHE tools are not in themselves sufficient to cover the areas of community management. They have not been designed to do so. However, the PHE methods are an appropriate methodology of communication with which to raise awareness about self reliance and build an interest in community management.

The Community Based Management Project (CBM) has taken the methods and adapted many of the PHE tools to use when raising awareness and in the training of water source communities. The adaptions made by CBM are described in Section 14.9.

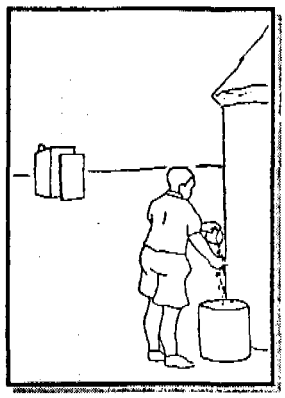
The Africa 2000 Project which has the emphasis on local management and will now use the PHE methodology in its community work and the PHE tools for its hygiene education. Similarly, the MNAECC programme of training VIDCOs to build community capacity in the IRWSS project in Gwanda will use many of the PHE tools (see Section 14.9).

By using similar methods and tools projects can be mutually supportive. Appendix 9 shows a conceptual model of how CBM and PHE has the potential to be mutually supportive.

It is recognised that some form of local sustainability is required to bring about behaviour change. Currently, the project is observing the relative impact of the different ways that the PHE is being carried out in communities (as described in Section 10) to try to identify the best mechanism for local sustainability. The next step is to expand the tools to include how the community can sustain activities that motivate behaviour change.

Community Planning and Monitoring:

The foundation for local sustained activities is a comprehensive understanding by the community of their own situation. The PHE methods are ideally suited to create this understanding. Firstly, the tools can be organized in combinations that can enable leaders to become aware of the situation in their community and enable the community itself to measure change. Secondly, other tools that use the same method as the PHE method can be added. These include time lines that show how the community has or has not worked well together, transect walks, institutional relationship mapping, wealth ranking and trend analysis for hygiene related diseases.



17. UNICEF Support

A number of donors have supported the PHE Project. SIDA, DANIDA and NORAD fund staff in the DEHS Harare, whose duties include support to the PHE Project; a number of donors have supported the Government of Zimbabwe to jointly fund the field work of the EHTs within the IRWSS projects (NORAD 12 districts, Dutch Government 11 districts, DANIDA 3 districts, SIDA 3 districts, ODA 2 districts, UNICEF 2 districts).

UNICEF's support has been both facilitative and financial. In the view of the Director of the DEHS, Mr. S. S. Musingarabwi, UNICEF was asked to give close assistance because, UNICEF :-

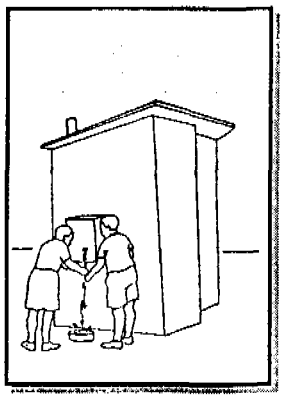
- and the DEHS shared the same interpretation of the concept of the project, the need and the solutions;
- was willing to start small and grow slowly;
- could provide financial support in a flexible manner;
- was willing to play a facilitative role and be a part of the development of the concept, the methodologies and of the tools;
- was able to support in many small areas that could keep the project active eg. printing materials developed by the DEHS rather than waiting for many months to go through the Government printing service.

UNICEF's support consists of :-

- a seconded UNICEF staff person to the DEHS Harare, who is a environmental health professional with specific skills in participatory approaches and methods (75% time for the DEHS);
- a seconded UNICEF staff person who is an environmental health professional to support the PHE work for Matabeleland North and South Provinces (100% time), since mid 1995;
- working with the DEHS to, and provide funding for, the development of the participatory tools;
- working with EHTs and DEHO in Beitbridge District in community work to develop and field test the initial tools;
- assisting (co-writing, proof reading, lay-out, printing, compilation of the hard copy) with the production of the Tool Kit, the Trainers Guide and the Field Guide;
- funding of the production and printing of all the printed materials
- funding the supply of 800 Tool Kits, 800 Field Guides and 200 Trainer Guides;

- supply stationary for training workshops;
- direct funding for workshops (pay directly to the hotel for food and accommodation; pay per diem directly to the participants; supply stationary & tool kits);
- funding for PHE activities in 19 districts (in 1996) and willing to provide funding for specific activities in other districts if other funding is unavailable. The funding amount is determined from proposals submitted by the districts to the DEHS and approved by the DEHS.

This type of support, which is a combination of facilitative and financial, has proved to be very staff intensive for UNICEF. However, it is this type of support that the DEHS has valued. The facilitative nature of the work has been the more useful in the development of the project and building its momentum than providing funds alone.



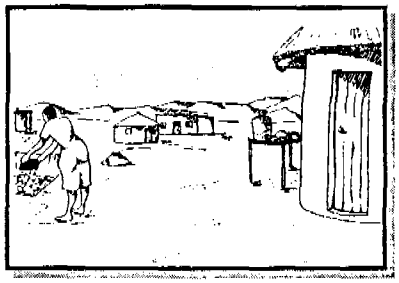
18. Contradictions During Transition

There are number of contradictions during the period of transition from a technical approach to a social approach, from a didactic methodology to a participatory methodology. These contradictions have been recognised and will be addressed.

The main contradiction at this time, is that the EHTs feel that they must promote a blair latrine. The blair is the only acceptable latrine design and the number of blairs built is a main measurement of their work. This perceived need to have blair latrines undermines the participatory process. For example, a group have used all the participatory tools to decide that they do need latrines. The EHT has let them consider all the options but when they come to finally decide on their next step in sanitation improvement, the EHT insists that they build blair latrines. The people have considered the sanitation ladder and agree that there is a gradation of improvements, but finally they are stopped from making incremental improvements, which may be their preferred choice, and persuaded to go from the bush to the blair. This type of persuasion undermines all the previous participatory process and does not engender behaviour change.

The EHT feels that he can only suggest the standard methods for sanitation and water supply. If, for example, a borehole is not possible the EHT feels that he cannot suggest locally made water collection systems. Again this limits the participation.

At this time the reporting systems concentrate on numbers of water and sanitation structures. This keeps the emphasis on the technical approach rather than the participatory social approach.



19. Looking Forward

Although there is now widespread acknowledgement of the effectiveness of the methods and tools and a generally positive attitude to the participatory approach, there still some way to go to turn that positiveness into commitment throughout the environmental health staff.

Creating an Enabling and Supportive Environment:

Looking forward there is a need to create an enabling and supportive environment for the PHE methods and tools to develop and prosper. These areas include:-

i. Performance Appraisal

The performance appraisal of the EHTs needs to reflect the type of work now required of him in PHE. So that the appraisal will not be based so much on physical structures but include such process indicators as the number of communities who have a plan made by themselves for hygiene behaviour change.

ii. Indicators and Reporting

Appropriate indicators and reporting systems are essential for the next stage in the development and in the creation of an appropriate performance appraisal system. The development of appropriate measuring and recording instruments is well underway.

iii. Contradictions

By removing the contradictions (as described in the previous section) that currently exist will avoid giving the EHT conflicting messages.

iv. PHE in basic training

A major support to the move from a technical to a social approach will be the inclusion of the PHE methods and tools in the basic training of Nurses, EHTs and other extension staff. This has already been recognised and a number of opportunities taken. Nurse Tutors and EHT Tutors have participated in the training workshops and their training schools provided with tool kits. All First Year EHT students were trained in PHE and provided with a two tools prior to their field attachment in 1995/96.

As well as including the methods and tools as a topic the training will require the tutors to be a role model for the participatory approach as the PHE Project itself has endeavored to do.

Province and District:

Looking forward for the provincial and district level there will be a continuing requirement to keep the focus of the work on making the application of the tools to be effective and resisting the pressure to allow the project become a training project. Follow-up support and a continuous process of networking new ideas on methods and tools is vital.

Furthermore the PHE work will need direction to move it from educational in its organisation to being motivational. This will require more strategic use of the tools and incorporating them into the process that strengthens the community capacity and interest to sustain systems that stimulate behaviour change.

Looking Back and Looking Forward

The PHE Project can be seen as having two parts (and more may follow). The first part concentrated on the community work skills and on gaining institutional acceptance of the participatory approach to hygiene education. This included;-

- development of appropriate methods and tools;
- introduction of the methods and tools to the national, provincial and district and to the extension staff and demonstrating their usefulness;
- enabling the extension staff to use the tools;
- enabling staff from other ministries to learn the methods and skills;
- starting the process of behaviour change in hygiene practices in communities.

The second part will concentrate on sustainability through building the enabling environment and blending the PHE approach into community based structures and systems. This will include:-

- establish a strong system of follow-up support and periodic review by field staff;
- adding concepts of local sustainability and the strategic use of the tools into the training;
- adding tools that can be used by the community to get a comprehensive understanding of their own situation;
- develop some tools that are relevant to other cadres that will enable them to use the methods and tools;
- use indicators and reports that reflect the community process and measure behaviour change;
- creating an enabling environment at the national level.

Appendix I

People Interviewed

Matabeleland South Province:

I. Dube	Provincial Environmental Health Officer
O. Dube	Chairman, Water & Sanitation Committee, Beitbridge District
Dr Labode	District Medical Officer, Beitbridge District
L. Nare	Principal Environmental Health Officer
D. Ncube	District Environmental Health Officer, Beitbridge District
B. Ndou	Projects Officer, Rural District Council, Beitbridge District
L. Ndlovu	Environmental Health Technician, Dite I Ward, Beitbridge District
K. Ndlovu	Acting Community Health Sister, Bulilimamangwe District
C. Mabenda	Community Participation Trainer, Gwanda
A. Maboyi	Chief Exective, Rural District Council, Beitbridge District
G. Mugwagwa	Principal Envrionemntal Health Technician, Beitbridge District
B. Mkhweli	Principal Environmental Health Officer, Bulilimamangwe District
E. Mpofu	Environmental Health Technician, Manama Ward, Gwanda District
S. Sibanda	Environmental Health Technician, Kufusi & Hulisupi Wards, Gwanda District

Matabeleland North Province:

S. Maphosa	Provincial Environmental Health Officer
T. Mpofu	Principal Environmental Health Officer
J. Ndebele	Senior Environmental Technician, Lupane District
B. Senda	Principal Environmental Health Technician, Lupane District

Mashonaland East Province:

M. Chizunza	Health & Hygiene Education Officer, Mashonaland East Province
C. Musara	Principal Environmental Health Officer, Goromonzi District

Ministry of Health and Child Welfare, Harare:

S. Musingarabwi	The Director, Directorate of Environmental Health
M. Chibanda	WHO/CRS Advisor, Directorate of Environmental Health
M. Jeranyama	Programme Officer, DANIDA, Directorate of Environmental Health
M. Massunda	Projects Officer Health Education & Hygiene Education, Directorate of Evironmental Health
F. Mukonowatsauka	Training Officer, Human Resources Dept Planning & Management Unit
J. Mutaurwa	Project Officer, Finance & Administration, Directorate of Evironmental Health

Ministry of Local Government, Rural & Urban Development, Harare:

N. Chimucheka	Training Officer, Community Based Management Programme, District Development Fund
B. Majaya	Montioring Officer, National Coordinating Unit

Non Government Organisations:

J. Hampson	Silveira House, Research Dept
W. Mantanganyidze	Silveira House, Nutrition Improvement Programme
Ms Ncube	Matabeleland Development Foundation, Bulawayo
J. Waterkeyn	Studio A.H.E.A.D., Harare

UNICEF:

T. Dooley	Project Officer, HEWASA Section
S. Kupe	Assistant Project Officer, UNICEF, Bulawayo
S. Mawungandize	Project Officer HEWASA Section
L. Munro	Project Officer, Monitoring & Evaluation Section
B. Rajbhadari	Senior Project Officer, HEWASA Section

Appendix 2

Vision 2000 - the main points

Produced in 1992, refined and reaffirmed in 1995

1. **Institutional:**

   a. Organized Communities - aware, active and self organized communities with strong participation of women, able to influence local authorities, playing a central role in planning and setting priorities, and managing some local services.

   b. Rural District Councils - accountable and responsible for :-
      - development of strategic rural development plans including management of land;
      - ensuring the delivery of primary services, including water and sanitation;
      - supporting community initiatives, including community management of Rural Water Supply and Sanitation (RWSS);

   c. Streamlined Central Government:
      Streamlined but crucial roles, including national planning and budgeting, finance policy formulation and resources eg. water and trunk services, bulk water supplies, research and information exchange.

   d. Private Sector:
      A widespread, small and large scale private sector (both formal and informal) including community business, delivery goods and services in rural areas.

2. **NGOs:**
   Active NGOs supporting community initiatives within the RDC Development Plans and national policies.

3. **Financing of RWSS:**
   RDC capital investments financed by a mix of Central Government allocation (form revenues & coordinated donors funds) and local revenues, with the mix determined by type and level of service. Most recurrent costs for RWSS raised locally, with the community managing funds for basic services. RDCs allocating special grants for operation and maintenance to disadvantages communities to ensure equitable and sustainable basic services.

4. **Manpower Development:**
   RDCs should have trained and experienced management and technical teams with access to component advisory services of central government, and a qualified private sector capability at national and community levels. Community members and especially women having social organizational and technical skills.

Appendix 3

Strategy for the Introduction of PHE in the first three provinces

Matabeleland South Province:

Work on PHE had already started in Beitbridge District before the main training programme began in the Province. Beitbridge District had an IRWSS project which included some funding for hygiene education.

The EHO, Principal EHT and two EHTs from Beitbridge were trained in the Pilot District Training in March 1994. The steps they took on return from the workshop were:-

- briefed the District Heads of Departments;
- the two EHTs worked together. They trained the Ward Health Team in Siyoka I and Siyoka II Wards. The Health Team included all the extension staff at ward level. The training took three days and was a compressed version of the Pilot District training without the field work.
- in the next 11 months the two EHTs held two day workshops in 11 villages for the village leaders and others (ranging from 22 to 48 participants) using a selection of the nine tools *(Picture Analysis, Three Pile Sorting, Diarrhoea child, Nurse Ndou, Blocking the Routes, Story with a Gap, Mapping, Socio Drama and Pocket Chart).*
- the same two EHTs facilitated a 7 day training for the first year students in the Gwanda EHT Training School.

In March 1995 Beitbridge District team facilitated a training for all the EHTs in the district, the EHT for Beitbridge Town and the District Nursing Officer. After the workshop, all the EHTs prepared plans for hygiene education in their wards.

Training of the remaining Wards was the next target but there was a problem with the obtaining resources for the workshops because local suppliers would not accept a Government Requisition Order. This has been a constant difficulty for the project. The EHTs continued with the work that did not require extra funding.

22 Village Community Workers and Farm Health Workers were trained in how to use the methods. 38 sessions were held in villages in 8 wards throughout the District between January to March 1996.

Meanwhile the Provincial Officers were preparing to spread the knowledge and skills and promote the use of the method and tools. Organized through the Provincial Environmental Health Office, the staff who were trained in the Pilot District Training in March 1994 and the Provincial Health Education Officer, facilitated a workshop that had the same structure, content and character as the Pilot District Workshop. The participants were the members of the Water and Sanitation Sub Committee from each of the districts together with one Nurse from the Central Hospital, the EHT for Bulawayo City Council, the

District Community Nurse and RDC Projects Officer from each district and the MNAECC Provincial Officer.

The first outcome of the workshop were plans from all the districts (except from Beitbridge and Gwanda that had funding through their IRWSS projects). From these plans a Provincial plan was made and a proposal was submitted to the DEHS. The EHT for Bulawayo City made a separate plan and was allocated specific funding from the City Council.

Funding was granted to the Province in November 1995. Since then Bulilimamangwe District has trained all the EHTs and the nurses from all the rural health centres. The training has covered how to use the tools in a similar pattern to the original workshop for the pilot districts. Matobo, Insiza and Umzingwani Districts will do the same by the end of June 1996.

Gwanda District took a slightly different route. First the EHTs, the EHT from Gwanda Town and the health orderlies from the rural health centres were trained in the tools. The same type of workshop was held for the nurses in the rural health centres and the District Community Nurse. There then followed three workshops in which a total of 75 VCWs were trained in the use of the tools. The final training so far was for all the councillors and the School Development Association for seven wards.

The EHT for Gwanda Town submitted a proposal which was funded through the IRWSS project. A Knowledge, Attitude Practices study on water, sanitation, and hygiene was carried in 30 villages and fedback to the WADCOs in a pictorial format that provided a village by village profile.

Mashonaland East Province:

The PHE work began in Goromonzi District being one of the pilot districts. The staff were enthused by what they had learnt at the Pilot District Workshop. They began with a feedback to the District Health Executive who agreed that all EHTs and RHC nurses should be trained. This took place in February 1995.

Meanwhile the Goromonzi team wanted to use the tools on two main problems - bilharzia and dysentery. The first target was bilharzia working through the schools. They had no funding at this time so they met with the teachers after classes in two schools and with the children during classes. Details of this initiative is detailed in Section 14.9.

The Principal EHO of Goromonzi was able to gain Provincial interest by first briefing the PREHO who then invited him to demonstrate one of the tools at the SIDA planning meeting in June 1994. The tool, *Three Pile Sorting,* was well received and sparked interest across the Province.

On the request of the DEHO of Murewa District, the Goromonzi team trained the EHTs of the District. The Provincial HHEO has organized training

(facilitated by the HHEO and members of the Goromonzi team) for the EHTs and RHC nurses in all the other districts in the province.

Significantly, Mashonaland East environmental health and health education officers have insititutionalised the participatory methods and apply them in many different circumstances and meetings.

Back in Goromonzi District, all the EHTs and RHC nurses were trained in early 1995. From the plans the EHTs made following the training, a District plan and proposal was made to the DEHS. There then following the training of all the extension workers at the ward level. The training lasted 2 days for each ward and concentrated on the use of the tools. Also one day sessions on hygiene issues have been held in all the villages. The sessions are open to everyone, but the Kraal heads, VIDCO members, VCWs and TBAs are the main targets. The remaining activity is to hold a special training on the use of the methods for the councillors.

Two groups of 25 School Health Masters (April 1995 and May 1996) were trained for 6 days using the same workshop format as the Pilot District Workshop. The District Water & Sanitation Sub-Committee were trained for 6 days in Participatory Approaches for HHE in May 1996.

Manicaland Province:

Mutasa District, one of the pilot districts, had the DEHO, 2 EHTs, the EHT based at the Province, the Provincial HHEO and the Project Officer working for AfriCare trained in the Pilot District Training in March 1994.

The first step after the training was a briefing of the Provincial Health Executive. Progress from then on was slow. It was more than one year before a workshop was held to train all the other EHTs in Mutasa District together with the RDC Projects Officer and the Nurses at the RHCs. Up to mid 1996 seven ward health executives have received 2 days training in the use of the tools and seven villages in these wards have had one session (normally half a day in length) on hygiene issues using the tools.

Activities to spread the PHE to other districts in the Province were started by Provincial Officers. The District Heath Executive in Chipinge and Nyanga Districts were briefed on the PHE approach and methods. The EHTs in these districts, together with the RDC Projects Officer and the MNAECC Provincial Officers, were trained in how to use the tools. All the Ward Health Executives in Nyanga District have been trained and eight villages in Chipinge District were reported to have had sessions on hygiene using the tools. As yet there has been no ward level training in Chipinge District.

Meanwhile a separate project was now using the PHE methods and tools. In 3 wards in Nyanga and 3 wards Mutasa, AfriCare were using the tools in the promotion of blair latrines and associated hygiene practices.

Appendix 4

Sanitation Ladder Explanation Note

Sanitation Ladder

Purpose

The purpose of the exercise is to help communities determine where they are in terms of hygiene behaviour in general and sanitation progress in particular. It assists communities and health workers to reach a consensus on the direction and steps needed for making progress. This exercise is used to show the progression from the undesirable to desirable sanitation practices. To look at where we are and where we want to be.

Target Group

Community Groups and particularly household heads/decision makers.

Materials

Pictures depicting various methods of human excreta disposal including the following:-

1. Open defecation close to the house
2. Bush defecation
3. Covering faeces with leaves
4. Burying faeces
5. Traditional pit latrine
6. Blair latrine
7. Blair latrine with hand washing facilities

Method

1. In groups give the participants the pictures depicting the various methods of excreta disposal and ask them to sort out them into 'steps' according to improvements in sanitation practices.
2. Identify the local existing behaviour.
3. Identify improvements in behavioral terms.
4. Request the participants to sort out the pictures of different behaviours into what they consider to be happening now in the area (place at the bottom of the ladder) and what is the ideal behaviour at the top.

Discussion Points

1. In general, at which step in the community?
2. Why have the people not moved from one step to the other along the ladder?
3. Why are the people not constructing latrines?
4. Is it difficult to construct a latrine?
5. What barriers are encountered in constructing latrines?
6. Is it necessary to move directly from bush defecation to the construction of latrines, or are there any other steeps we can take to improve sanitation practices?

Appendix 5

Tools and Drawings

Original Drawings:

Unserialised Posters	-13	
Nurse Tanaka	-23	
Sanitation Ladder	-21	
Three Pile Sorting	-70	(now replaced by the drawings on A5 cards
Task target Analysis	-15	
Diarrhoea Child & Treatment	-17	
Blocking the Route (faecal-Oral)	-10	
Flexi Flans	-22	
Story with a Gap	- 8	
Pocket Chart	-25	

Additional Drawings:

Three Pile Sorting	-94	
Animal Pictures	-19	
General	-18	
Maxi Flans	-17	

Adaptions of the Tools:

Water Ladder	-11	
Blocking the Routes - malaria	-12	
Blocking the routes - Bilharzia	-13	
Blocking the Routes - Scabies	-14	
Pocket Chart - water storage	-15	
Pictures of officers eg EHT,VCW	-16	

Total Drawings ...	357

Appendix 6

Contents of the Tool Kits

The tool kits are not supplied to individuals. The kits are issued to institutions and registered at the district and provincial environmental health offices. For the Environmental Health Technicians (EHTs) the tool kits are issued to the Rural Health Centre in which the EHT is based.

The kit comprises of one holdall bag in which are the following items:-

- PHE Tool Kit file (containing 15 hygiene education tools)
- 1 x diarrhoea child model
- 1 x pocket chart
- 20 x plastic file inserts
- 40 x manila files
- 1 x bottle of glue
- 1 x roll of masking tape
- 1 x pad of flip chart paper (A1 size)
- 4 x large markers (variety of colours)
- 6 x thin markers (variety of colours)
- 1 x packet of coloured crayons
- 1 x A4 notebook
- 2 x A5 notebooks
- 2 x ballpoint pens
- 1 x ruler
- 1 x scissors
- 2 x pencils
- 1 x pencil sharpener
- 2 x erasers
- 1 x A4 size clipboard

The replenishment of the materials is the responsibility of the district environmental health services paid for from the Hygiene Education budget line item.

Appendix 7

Tools and their Applications as described in the Field Guide

Community Participation:

1. Community Knowledge	Mapping
2. Needs Assessment	Unserialised Posters
3. Gender Issues	Three Pile Sorting
4. Equity Issues	Pocket Chart Voting
5. Hygiene Solidarity	Song
6. Hygiene Awareness	Drama

Hygiene:

1. General Hygiene	Three Pile Sorting; Sanitation Ladder
2. Kitchen Hygiene	Story with a Gap
3. Refuse Disposal	Story with a Gap
4. Household Hygiene	Story with a Gap
5. Hand Washing Methods	Voting-Pocket Chart
6. Hand Washing Times	Voting-Pocket Chart
7. Personal Hygiene	Focus Group Discussion

Water:

1. Most Common Water Sources	Line Up
2. Most Hygienic Water Sources	Line Up
3. Most Convenient Water Sources	Priority Ladder
4. Most feasible Water Source	Priority Ladder
5. Water Use Practices	Voting-Pocket Chart
6. Taking Drinking Water	Three Pile Sorting
7. Water Storage	Three Pile Sorting
8. Water Point rehabilitation	Story with a Gap

Diseases:

1. Preventable Diseases	Nurse Tanaka
2. Diarrhoea	Diarrhoea Child
3. Oral rehydration	Diarrhoea Doll
4. Bilhazaria	Mapping/Identifying and Blocking the route Signs & Symptoms (Combination of Tools)
5. Malaria	
6. Scabies	
7. Worms	
8. Eye Diseases	

Sanitation:

1. Defecation Practices	Voting
2. The Germ Theory	Making a Story
3. Oral-Faecal Transmission Route	Blocking the Routes
4. Sanitation Priorities	Priority Ladder
5. Care of Latrines	Group Discussion

Appendix 8

Indicators for Hygiene and Health Education

Community Level Indicators

- community activities and household behaviour
- community management
- number of hand washing facilities provided
- existence of litter bags in schools
- number of people using water from protected sources
- % of households with refuse pits
- number of protected water sources
- number of decisions concerning water that satisfy the needs of women
- number and type of health education methods used
- number of people not using a sanitary facility
- evidence of waste water on the ground and clean water in the tank
- number of diarrhoea cases in the community
- number of facilities functioning at any given time
- presence of anal cleansing materials
- number of people using a hand washing facility
- number of hygiene and health education sessions held
- number of meetings held by women to discuss water issues

Implementation Level Indicators

- reports received of activities done
- % of households that have made a positive behaviour change in sanitation
- number of times the community has called the extension worker to help them in their education activities
- usage and maintenance of water and sanitation facilities
- number of community sessions held by the extension worker
- number of communities that have made their own plans
- number of self sponsored projects
- number of villages with active project management committees
- number of communities that have achieved more than 50% of their plans
- number of requests made by the community to the extension worker
- water and sanitation disease trend
- number of latrines with wash hand facilities
- down time of water pumps
- homesteads with refuse pits and pot racks
- number of communities trained in PM
- number of trained extension workers
- number of provincial support visits to the district
- number of national support visits to the province
- quality of water and sanitation structures
- number of support visits to the extension personnel by district
- number of people who have met their EHT in the last 6 months

National Level Indicators

- availability of social behaviour research directory in HHE
- availability of resources to support programmes
- number of staff development programmes initiated
- provincial plans submitted
- number of review meetings held between sector ministries and/or departments
- expenditure rates by each province
- number of studies commissioned and results shared
- number of feedback reports submitted to each province
- availability of monitoring tools and indicators
- % of plans approved and funded
- number of support visits to each province
- number of problems created through lack of coordination
- % of issues adequately followed-up
- audit reports submitted for each financial year
- number of posts created
- % of meetings properly concluded
- fewer complaints on funds released

Appendix 9

MINISTRY OF HEALTH AND CHILD WELFARE ZIMBABWE: HYGIENE AND HEALTH EDUCATION

National/Province/City: . . . . . **District:** . . . . .

Ward: . . . . . **RHC/Clinic:** . . . . .

Month: . . . . . **Quarter:** . . . . .

Date	Venue/Village	Topic	Method	Learning Materials			Target Group	Participants		Facilitator	Outcomes
				Used	Distributed	Received		No	F/M	Title	

General Comments:

. . . . . .

. . . . . .

Name of Reporting Officer: . . . . .

Signature . . . . .

Appendix I

Common Ground for CBM and PHE