



The International Federation software tools for long-term water and sanitation programming



International Federation
of Red Cross and Red Crescent Societies

The International Federation's Global Agenda (2006–2010)

Over the next five years, the collective focus of the Federation will be on achieving the following goals and priorities:

Our goals

Goal 1: Reduce the number of deaths, injuries and impact from disasters.

Goal 2: Reduce the number of deaths, illnesses and impact from diseases and public health emergencies.

Goal 3: Increase local community, civil society and Red Cross Red Crescent capacity to address the most urgent situations of vulnerability.

Goal 4: Promote respect for diversity and human dignity, and reduce intolerance, discrimination and social exclusion.

Our priorities

Improving our local, regional and international capacity to respond to disasters and public health emergencies.

Scaling up our actions with vulnerable communities in health promotion, disease prevention and disaster risk reduction.

Increasing significantly our HIV/AIDS programming and advocacy.

Renewing our advocacy on priority humanitarian issues, especially fighting intolerance, stigma and discrimination, and promoting disaster risk reduction.

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Glossary

ARCHI	African Red Cross Health Initiative
CBFA	Community-Based First Aid
CBO	Community-Based Organization
DREF	Disaster Response Emergency Funding
GWSI	Global Water and Sanitation Initiative
GWA	Gender and Water Alliance
HQ	Headquarter
IDP	Internal displaced person
IEC	Information, Education and Communication
ME	Monitoring and Evaluation
NDRT	National Disaster Response Team
NGO	Non-Governmental Organization
OM	Operation and Maintenance
PHAST	Participatory Hygiene and Sanitation Transformation
PRA	Participatory Rural Appraisal
RDRT	Regional Disaster Response Team
ToT	Training of Trainers
UNDP	United Nations Development Programme
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Background

Hardware and software in water and sanitation programming

Lack of access to safe water, basic sanitation and poor hygiene practices are a major cause of disease and death among many of the world's poor. Recognizing this fact, the International Federation of Red Cross and Red Crescent Societies assists vulnerable communities to gain access to safe water supply and sanitation while encouraging improved hygiene practices, both in times of disaster and in the longer term developmental context. Since 1994, International Federation water and sanitation efforts have served over 9 million people worldwide, and during the period up to 2015, the Federation intends to increase this figure significantly.

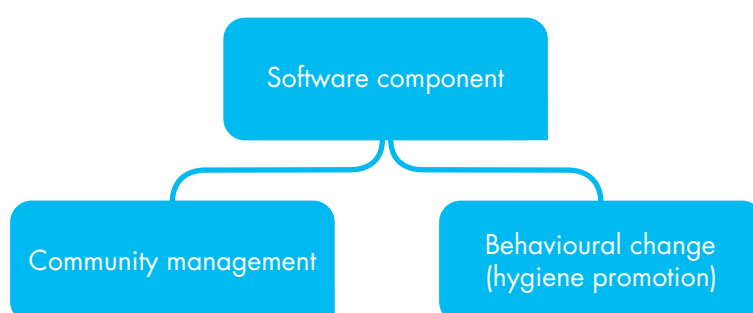
The International Federation advocates the integration of hardware and software for water and sanitation interventions. In this context, **"hardware"** is defined as the engineering inputs related to appropriate equipment and construction, such as tanks, pipes, pumps and latrines. **"Software"** can be defined through activities in the areas of hygiene promotion, local capacity-building, stakeholder involvement, monitoring and evaluation of impact and encouraging behavioural change, in order to ensure that water and sanitation systems deliver the optimum and most sustainable health and social benefits to the end users.

The 2003 water and sanitation policy states:

"The International Federation and each National Society shall realize that the hardware (e.g. pumps, pipes) aspects of water and sanitation interventions are easier to implement compared to the software aspects. Hygiene promotion (hygiene education, community participation and management etc.) must be established parallel to, if not, before introducing the hardware. Hardware installations need to be sustainable for the community with the ability to maintain them leading to long-term ownership. This will ensure best possible community ownership, management and commitment. In emergencies minimum aspects of hygiene promotion need to be established."

This integrated approach has been adopted by International Federation under the GWSI (Global Water and Sanitation Initiative 2005) establishing a set of criteria that should be met by all the Red Cross Red Crescent water and sanitation players.

Software component – This is an ‘**umbrella term**’ used within the GWSI framework to cover a range of strategies aimed at preventing water and sanitation-related diseases and optimizing the short-term effects of water and sanitation interventions. It includes the use of community participation methods and social marketing strategies to promote health and hygiene behaviour, and should also encompass the community management of engineering installations, which is important for effective buy-in and medium- to longer-term sustainability.



Community management refers to community control and ownership of water and sanitation systems. This is crucial since the aim is to make the community accept responsibility for maintaining their water systems. Community management covers two areas:

1. Community operation and maintenance (OM): Basic WASH (Water, Sanitation and Hygiene) knowledge and technical and managerial skills at Red Cross Red Crescent and community level should be established and, or improved. The training and expanding of community skills often increase levels of confidence and ownership within the community and ensure better delivery of services.
2. Community contribution to cost (operating and capital): Resource mobilization is vital to developing sense of ownership within the community and makes the water system durable since the community assumes responsibility for maintenance. A combination of legal ownership, work and economic contribution strengthen the identity that the community has with their water system. The community should establish the rules, regulations and sanctions and put such practices in place to ensure sustainability and scaling-up.

Behavioural change relates to **hygiene** and means not just having a sense of ownership for pipes and tanks, but also having a general view of the health problems in the community due to unsafe water, inappropriate sanitation and hygiene practices. According to UNICEF (1999), hygiene promotion consists of a planned approach to preventing diarrhoeal diseases through the widespread adoption of safe hygiene practices.

Experience has showed that **PHAST – Participatory hygiene and sanitation transformation**, acts as the backbone of software activities since, throughout the seven steps, the two core software elements, (hygiene promotion and community management), are widely addressed.

When implementing steps one and two, the community gains a basic understanding of the health implications of poor water supply and sanitation and learns to identify health problems, due to unsafe sanitation and hygiene practices. During steps three and four, the community develops a belief in their ability to solve their own problems and is empowered to make environmental improvements. All these elements provide the community with a very strong sense of ownership. During the next phase, the community is able to set up their own management system, select the principles for appropriate and suitable operation and maintenance practices, and commit towards behavioural change.

Depending on the scenario, PHAST should be used as a very dynamic and flexible methodology since the sessions might include more or less emphasis on community management or behavioural change. Moreover, additional activities might be implemented such as, large-scale hygiene promotion campaigns in those scenarios where illness and death are more often linked to poor sanitation and hygiene, than to inadequate water supply. In these cases, the software component should be strongly linked to the health sector. Water and sanitation should be clearly-defined within the health initiative, and treated as one of the most important aspects of preventive/public health. In fact, the International Federation's basic health policy has underlined the need for water and sanitation to be part of the public health structure within the National Societies, as part of their health and care agenda.

In those scenarios where there is no access to safe water and appropriate sanitation services due to a lack of management, the software component should be strongly linked to the hardware planning process, bringing together the community and engineering aspects of the project. The selection of appropriate technical options and management system should involve the community through a participatory process in which the community is an active partner and not simply a passive recipient. Partnership helps to sustain a project because it confers dignity and a sense of value on the vulnerable. When they realise that they can do, and achieve things for themselves, they learn how to replace wrong behaviours with right ones.

This guide

This water and sanitation software guide and the tools included in the CD-ROM, should be used in conjunction with a water and sanitation project in which the software component has to be developed. The package contains a technical **guide** which provides the basic and generic guidelines to implement the software programme and a **set of general references and tools** to better accomplish the different steps of the process. These tools are included in a separate CD-ROM to be used alongside these guidance notes.

This technical guidance does not contain theory and principles of hygiene promotion, community management, participatory processes and community mobilization, since there are many excellent manuals and guides which cover these aspects; (a broad representation of these is contained on the CD-ROM)

The Red Cross Red Crescent experience, particularly in the last decade, shows that most field workers address water and sanitation developmental interventions with an increasing degree of participatory approaches and methodologies, ensuring that the target communities determine their own health priorities and how they intend to tackle them.

The target audience of this manual is those Red Cross Red Crescent workers currently engaged in the water and sanitation or public health sector. Its aim is to give key guidelines on implementing the software component of water and sanitation programmes; to better reduce or contain water, sanitation and hygiene-related morbidity and mortality through participatory processes, as much as practicable; and to improve the community management system of the water and sanitation facilities.



Chapter 1

Hygiene promotion and behaviour change

What is hygiene?

Definition 1¹: outsider's view or scientific perception

It is the study of health and observance of health rules and measures of preserving health. Hygiene is the practice of keeping one's self and one's surroundings clean, especially to avoid illness and the spread of infection. It focuses on diseases which are spread by the faecal-oral route, particularly the diarrhoeal diseases which kill two to three million children under five each year. Research has shown that changes to a very few practices can have a huge impact.

Definition 2: insider's view or the perception of the actors themselves

Most people don't usually practise hygiene for health reasons. There are other motivations such as, a general dislike of dirt, an aesthetic preference for cleanliness, a desire to protect their children and themselves from dangerous, external influences, or, (most commonly of all), considerations of status, self-respect and social standing.

What is hygiene behaviour?

Boot and Cairncross (1993) defined hygiene behaviour as the wide range of actions associated with the prevention of water and sanitation-related diseases. Hygiene behaviour involves five areas of health, also known as the five hygiene domains. These are:

Elaborate table on the five hygiene domains

Cluster of hygiene practices	Relevant features and activities
Sanitation excreta disposal (Cluster A)	<ul style="list-style-type: none"> Location of defecation sites Latrine maintenance (structure and cleanliness) Disposal of children's faeces Hand washing at critical times (after cleaning children's bottoms; after handling children's faeces; after defecation) Use of cleansing materials
Water	Protecting of water source(s)
Water sources (Cluster B)	<ul style="list-style-type: none"> Location of latrines in relation to water source Maintenance of water source Water use at the source Other activities at the water source Water collection methods and utensils Water treatment at the source Methods of transporting water
Water Water uses (Cluster C)	<ul style="list-style-type: none"> Water-handling in the home Water storage and treatment in the home Water use (and reuse) in the home

1. Definition 1 and 2: Sandy Cairncross and Valerie Curti. *London School of Hygiene and Tropical Medicine.*

	<p>Hand washing at critical times (before or after certain activities, including religious rituals)</p> <p>Washing children's faces</p> <p>Bathing (children and adults)</p> <p>Washing clothes</p>
<p>Food</p> <p>Food hygiene</p> <p>(Cluster D)</p>	<p>Food handling or preparation</p> <p>Utensils used for cooking, serving food, feeding young children, and for storing left over food</p> <p>Hand washing at critical times (before handling food, eating, feeding young children)</p> <p>Reheating of stored food before serving</p> <p>Washing utensils and use of a dish rack</p>
<p>Domestic environment</p> <p>and environmental hygiene</p> <p>(Cluster E)</p>	<p>Sweeping of floors and courtyards</p> <p>Household refuse disposal</p> <p>Cleanliness of footpaths, play areas and roads</p> <p>Management of domestic animals (Cattle, dogs, pigs, chickens)</p> <p>Drainage of surrounding areas (location of stagnant water and other mosquito-breeding sites)</p> <p>Condition of housing</p>

What is hygiene promotion?

According to UNICEF (1999), hygiene promotion is a planned approach to preventing diarrhoeal diseases through the widespread adoption of safe hygiene practices. It begins with, and is built on, what local people know, do and want.

Hygiene promotion encourages all the hygienic conditions and behaviours that can contribute towards good health. It aims to stimulate and facilitate the right behaviour change. Research has shown that hygiene-related practices such as safe disposal of faeces and hand washing after contact with faecal material can reduce the rates of intestinal infection considerably. Consider the following figures:

- There is now conclusive evidence that simple, acceptable, low-cost interventions at the household and community level are capable of dramatically improving the microbial quality of household stored water and reducing the attendant risks of diarrhoeal diseases and death.
- Hand washing with soap and water can reduce diarrhoeal disease by 35 per cent or more.
- Hand washing can also help to reduce the prevalence of eye infections such as conjunctivitis and trachoma.
- Pit latrines, when used by adults and for the disposal of young children's stools, can reduce diarrhoea by 36 per cent or more.
- Protection of water from faecal contamination can also reduce diarrhoea, because some diarrhoeal infections are water-borne. Improved water quality can be associated with up to a 20 per cent reduction in diarrhoea.
- Increased quantity of water used, which results from better access to water, can bring about a 20 per cent reduction in incidence of diarrhoeas.

Hygiene promotion vs. health promotion

Hygiene promotion is more specific and more targeted than health promotion. It focuses on the reduction and ultimately the elimination of diseases and deaths that originate from poor hygiene condi-

tions and practices. For example, good hygiene conditions and practices are enhanced when people can consume water that is safe, use sufficient amounts of water for personal and domestic cleanliness, and dispose of their solid and liquid wastes safely. However, a person may have good hygiene behaviour, but not be healthy for other reasons. Good or bad health is influenced by many factors, such as the environment (physical, social and economic).

Hygiene promotion vs. hygiene education

Education usually means ‘teaching people’, e.g., about what makes them ill and what they must or must not do. Often it is didactic (tending to lecture others excessively). In the case of hygiene education for example, the educators may want to teach people the germ theory of disease in order to discourage transmission through unhygienic practices. Such information has its place, e.g., when people themselves want to know how they can avoid getting a particular disease.

However, successful hygiene promotional programmes ‘do not instruct people’. They promote healthy conditions and practices in others, usually more effective ways than ‘teaching’, e.g., social marketing, participatory learning, and peer influence. In hygiene promotion, the individuals and communities themselves review their hygiene practices and develop ways of improving them. ‘Hygiene promotion begins with what people know and builds on their existing knowledge’. In other words, hygiene promotion includes strategies that encourage or facilitate a process whereby people assess, make considered choices, demand and sustain hygienic and healthy behaviours.

In hygiene promotion, there is always a hardware aspect to any promotional activity. This relates to improved water and sanitation facilities, such as:

- improved sanitation facilities, (latrines, garbage disposal pits, waste water drainage etc.);
- improved water facilities; and
- for environmental sanitation to be successful, vector control (techniques to enable individuals to take action against diseases carried by insects and other vectors) and eradication should also be undertaken.

On the other hand, hygiene promotion refers to the combination of, and linkages or relationship between the hygiene domains and the improved facilities. Without one, the other cannot succeed.

What is hygiene behaviour change?

Hygiene behaviour change is the action of replacing current unsafe hygiene practices with improved behaviour. Those who plan and manage hygiene promotion programmes often want to promote hygiene by educating people on the links between good hygiene and better health. However, local people themselves often do not see the health benefits as the primary reason to change their behaviours. There is the paradox that for the quickest and widest adoption of new behaviours, it is often better to rely on social ambitions than on health arguments to motivate people to adopt better hygiene practices. Convenience, status, esteem and financial gain are the stronger driving forces that affect people’s decisions on many aspects of their lives.

According to the BASNEF model², an individual will take up a new practice when he/she believes that the practice has sufficient benefits – beliefs: culture, values, traditions, mass media, education experiences, etc. – and then he/she will develop a positive attitude to the environment. Positive or negative influence from others – subjective norms: family, community, social network, culture, social change, power structure, peer pressure – who are important to that individual will also influence their decision to try the new practice. Skills, time and means – enabling factors: income, poverty, employment, inequalities, etc., – are also required to take up the new practices.

2. John Hubley (1993)

What is the approach to hygiene promotion?

There are basically two approaches to hygiene promotion or two methods to be used to promote behaviour change:

- **Directive approach:** The approach based on precepts developed by marketing specialists in the private sector. The marketing approach is typically implemented by the private sector at household level. A principle of the approach is to base hygiene promotion programmes on understanding of consumer behaviour. Once the formula is right, the marketing approach can be taken quickly and easily to scale.
- **Participatory approach:** A more flexible and participatory approach by which communities are empowered to decide for themselves which changes they should make. PHAST methodology is naturally related to this approach since it is a grass-roots process implemented at community level. These communities are more likely to achieve objectives which are theirs: people participate by consent and are not 'manipulated' by outsiders. Empowerment is part of a process of social change, one benefit of which is sustained and continued behaviour change.

The directive approach has been widely implemented in the water and sanitation sector with very good results in some cases, so it should not be underestimated when compared to participatory methodologies. The activities related to a social marketing approach might be an excellent opportunity to complement interventions based on participatory principles (such as PHAST) and increase the adherence to key hygiene messages.

Literature review

General references are included in the software water and sanitation CD-ROM:

General concepts: General hygiene promotion references

General concepts: Community participation

Implementation tools: Hygiene promotion campaigns

Implementation tools: Hygiene promotion training

Implementation tools: Hygiene and sanitation in schools



Chapter 2

Community participation and community management

What is community participation?

The concept of participation is concerned with the involvement of the local people (community), whether in rural or urban areas, in the management of issues and conditions affecting their lives. It empowers the local people by enabling them to analyse, make decisions, plan, and act on development activities that should improve the quality of their lives. Community participation is enhanced through participatory methodologies. The emphasis and strength of participatory methodologies are in facilitating or enabling the beneficiaries to make use of their knowledge and capabilities in order to institute sustainable local actions and institutions.

According to UNICEF, community participation is a development process based on dialogue, consultation with, and empowerment of, people in a community to identify their problems, decide how best to overcome them, and to make plans to seek appropriate solutions and assistance.

Nevertheless, because of the actions of international agencies and national governments who have tended to “*know what is best for the people, make decisions and plans for the people, and carry out actions that are meant to improve the life of the people*”, local people’s knowledge and capabilities have been suppressed over the years, to the extent that they do not see or feel themselves capable of acting for themselves. Instead, they have been reduced to perpetual dependence. The challenge is for development workers to facilitate the change of this attitude and belief, and enable the people to rediscover their innate strengths and capabilities and to redirect the same to their own development – hence, the concept of *community participation*. Participatory methodologies and tools are designed to enable development facilitators or workers to face and overcome this challenge. While using participatory tools, outsiders, (including employees of international or local agencies) should see themselves as facilitators or promoters of development and not as the main actors. They are challenged to explore the three essential elements:

- Consultation (which is usually passive and basically consists of informing or asking specific questions on interventions that have already been decided on);
- Contribution (of labour, locally available materials and even cash money when appropriate);
- Control (which consists of decisions on what people really require, e.g. decisions at the project identification stage, i.e. what to use donor funds on, forms of local and grass roots institutions that should be established for project management and even the right to say “no” to projects that people do not feel obliged to accept without the fear of losing donor support).

Most development agencies that try to embrace community participation often find themselves at the level of consultations only, while the more daring try to insist on contribution. Very few agencies are ready to embrace real participation by enabling people to take full control of the development process, which should be the ultimate aim in all cases.

What is community management?

Community management reflects the idea that communities should operate and maintain their own water and sanitation facilities. The community takes on the full range of management tasks related to maintaining a water and sanitation facility. The core of community management is making decisions: controlling the facilities and the decisions related to them.

Typical roles of a water and sanitation committee:

- Representing the community in contacts with government, support agencies and private sector.
- Coordinating roles with other community institutions or decision-making bodies.
- Ensuring efficient and effective overall management of the facilities
- Ensuring equity of water use and distribution
- Ensuring equity in decision making
- Financial planning, calculating and organizing contributions
- Organizing and supervising effective OM
- Enforcing rules and regulations
- Maintaining accurate records, including financial records, minute of meetings or other relevant information.
- Promoting hygienic behaviours and effective use of the facilities
- Holding and leading regular meetings.

OM responsibilities:

- Upkeep and repair of systems
- Monitoring system performance
- Problem analysis (when a problem can be fixed locally and when outside help is necessary)
- Collecting user fees
- Enforcing regulations and bylaws.

Community water, community management: from system to service in rural areas, ITDG.

Red Cross Red Crescent personnel involved in water and sanitation programming have the responsibility to support communities beyond helping them to install a system and then leaving them with the sole responsibility for managing it. In the Red Cross Red Crescent water and sanitation programmes the community management system usually relies on the community water and sanitation committees. Different factors need to be considered when establishing or strengthening water and sanitation committees at community level:

- 1. Community structures:** communities already have mechanisms for managing issues of common interest and for resolving disputes. Wherever possible we should respect their strengths and work with them. However, existing structures may become overwhelmed. In this case, an alternative needs to be explored with the community.
- 2. Clarifying roles:** how are the structures responsible for the management of the water and sanitation facilities linked to the community: Who does what? Who needs to be seen when something breaks down? What is expected from people? Who reports to whom? Who collects fees? Who audits? The roles and responsibilities of all actors should be clearly defined.
- 3. Representation:** Committees are the backbone to sustaining water and sanitation facilities. Usually, the control and decision-making process rests in their hands. However they can only function if their decisions are supported by the whole of the community. That is why representation of the community in its committee is crucial. Very often women are left out. However, it is not always possible to enforce gender representation on the committees and parallel structures of women and men need to be created.
- 4. Ownership:** Sense of ownership makes communities accept responsibility for maintaining their facilities. Sense of ownership might be created in different ways: (i) cost recovery or payment to strengthen the identity that the community has with the facility and (ii) legal ownership. These two factors allow the community to be perceived as an associate rather than a beneficiary.
- 5. Cost recovery:** To ensure sustainable water and sanitation intervention users must be willing to pay for water, both in times of limited cash income and in times of high water availability from alternative sources. People also have to trust in the system and its managers. Capacity, trust and willingness to pay, are essential to make cost recovery work. Inability to pay-issues should be addressed by the community (this can help decide who should be exempt from payment).

- 6. Rules, regulation and enforcement:** Rules and regulations are required to control both the behaviour of water users and that of committee members. Regulations should be enforced via a system of social sanctions. Additionally, the committee should be sufficiently respected within the community to ensure payment of fees. The power to enforce any type of control, other than social, should derive from a framework of laws and statutes, (through legalized registration with local government, registration of a constitution, etc.).
- 7. Training:** Separation of roles in the committees should be established: technical roles, (pump minders, caretakers, operators, engineers, etc.), and managerial roles, (members of the committee responsible for strategic decisions, such as tariffs, service level, etc.). Operation and maintenance training should be distinct from community management training.
- 8. Volunteer service:** In some complex water schemes, the caretaker position needs to be formalized and paid, but usually caretakers and committee members are volunteers. Those members need to be part of a larger support structure. Training and capacity building need to be conducted on a regular basis rather than a one-off occasion since training increases levels of confidence and ownership.
- 9. Monitoring:** Different systems for monitoring might be established by the committee and by the users. Committees should be able to visit households on a regular basis in small rural communities and users should be able to have access to financial accounts and minutes of meetings. Involvement of local water boards in monitoring or auditing activities is recommended.

Literature review

General references are included in the software water and sanitation CD-ROM:

General concepts:

Sustainability for water and sanitation projects

General concepts:

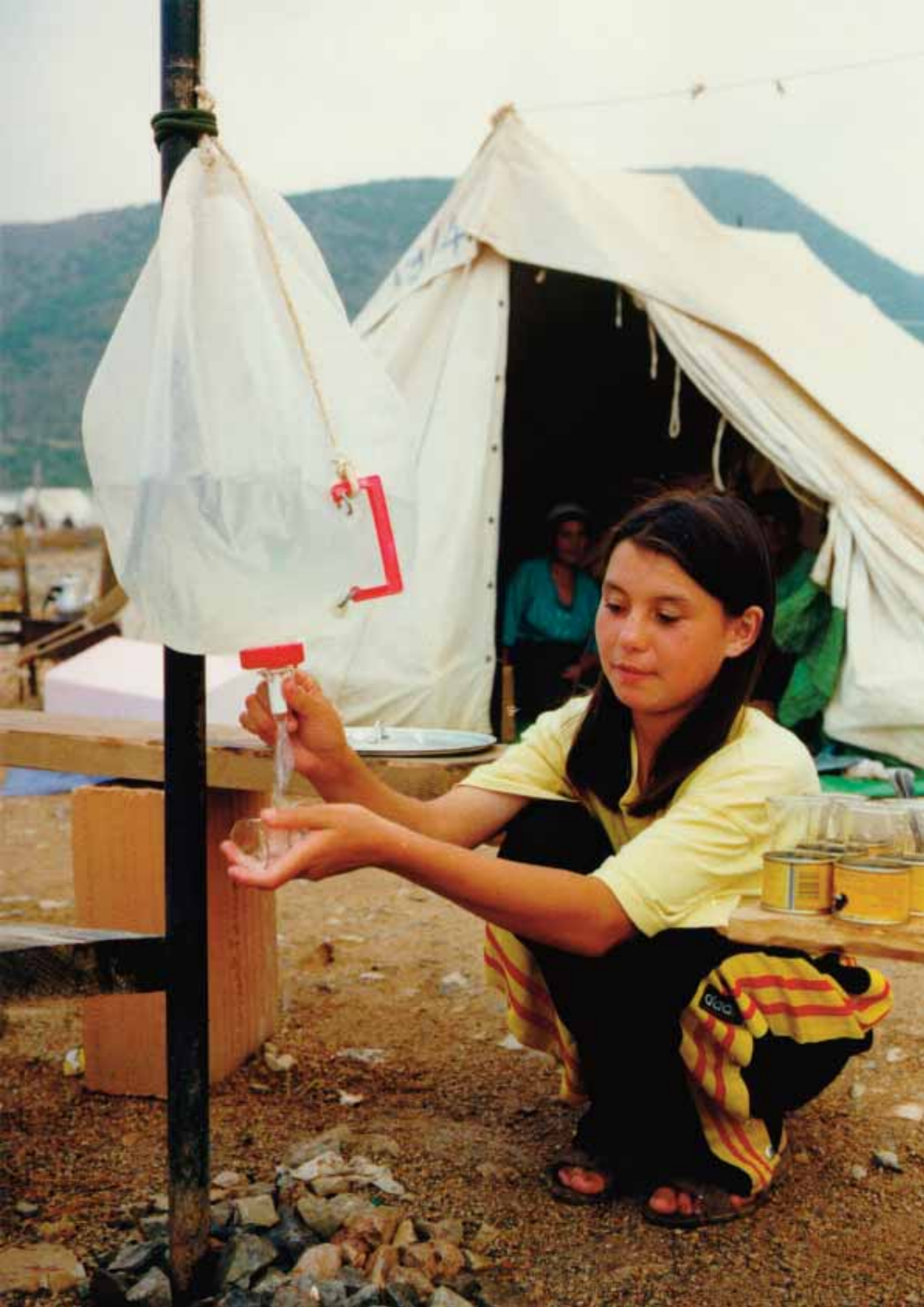
Community management

Implementation tools:

Community management system

Link between software and hardware

The project cycle (logical sequence of activities to accomplish the project's goal) has been used in the PHAST methodology as a basic structure to consolidate the process resulting in a seven step programme: (1) problem identification, (2) problem analysis, (3) planning for solutions, (4) selecting the technology options and, (5) the management system of those facilities, and (6) monitoring and (7) evaluation. The involvement of the community throughout the entire PHAST process ensures that behaviour change occurs not only towards health problems but also to community management. Using PHAST as an entry point at community level makes it possible to build trust, capacity and most importantly, establishing a dialogue between engineers and the community ensuring that all the above aspects are fully addressed.



Chapter 3

PHAST (Participatory hygiene and sanitation transformation)

3.1 – Introduction to PHAST

What is PHAST³?

Participatory hygiene and sanitation transformation is an innovative approach to promoting hygiene, sanitation and community management of water and sanitation facilities. It is an adaptation of the SARAR⁴ methodology of participatory learning, which builds on people's innate ability to address and resolve their own problems. It aims to empower communities to manage their water and control sanitation-related diseases. It does so by promoting health awareness and understanding which, in turn, lead to environmental and behaviour improvements.

PHAST brief history⁵

- **February 1993:** *PHAST initiative is born. Partners: WHO, UNDP, World Bank, PROWESS.*
- **August 1993:** *Selection of countries: Botswana, Kenya, Uganda and Zimbabwe.*
- **September 1993:** *One-week PHAST pre-planning workshop (Kenya).*
- **October 1993:** *Training of trainers (Uganda).*
- **November – December 1994:** *Country level field projects.*
- **December 1994:** *Review.*
- **November 1996:** *PHAST initiative report.*
- **1998:** *First edition of PHAST step-by-step guide.*

The PHAST initiative report contains the results and findings from four countries' field-level projects. The projects in Botswana, Kenya, Uganda and Zimbabwe shared a set of common results⁶:

- All the community members gained self-esteem. They started to believe in their ability to solve their own problems. They understood that what they could do with their own resources was enough to make a significant improvement to their health.
- They all had a basic understanding of the health implications of poor water supply and sanitation. They understood that the diseases they have experienced most frequently are linked to excreta.
- They all gained a sense of common purpose and an understanding of planning change in their communities.

3. WHO - <http://www.afro.who.int/wsh/pdf/phastinitiative/whatisphast.pdf>

4. SARAR: stands for Self-esteem, Associative strengths, Resourcefulness, Action Planning and Responsibility.

5. WHO - <http://www.afro.who.int/wsh/pdf/phastinitiative/howphastbegun.pdf>

6. WHO - <http://www.afro.who.int/wsh/pdf/phastinitiative/theimpactoncommunities.pdf>

PHAST seven step-by-step

Step	Activity	Tool
Step 1: Problem identification	Community stories Health problems in our community	Unserialised posters (2 hours) Nurse Tanaka (1.5 hours)
Step 2: Problem analysis	Community mapping Good and bad hygiene behaviours Investigating community practices How diseases spread	Community map (2.5 hours) 3-pile sorting (1.5 hours) Pocket chart (2 hours) Transmission routes (2 hours)
Step 3: Planning for solutions	Blocking the spread of disease Selecting the barriers Tasks for men and women	Blocking the routes (1 hour) Barriers chart (1 hour) Gender role analysis (1.5 hours)
Step 4: Selecting options	Choosing sanitation and water options Choosing improved behaviours Taking time for questions	Sanitation and water ladder (2 hours) Three pile sorting (2 hours) Question box (1 hour)
Step 5: Planning for new facilities and behaviour change	Planning for change Planning who does what Identifying what might go wrong	Planning posters (2.5 hours) Planning posters (2 hours) Problem box (1 hour)
Step 6: Preparing to check our progress	Preparing to check our progress	Monitoring chart (2 hours)
Step 7: Checking our progress	Checking our progress	Various tool options e.g. socio-drama and planning posters (2.5 hours)

For the purposes of this guide, the above PHAST process involving all seven steps shall be known as the 'standard PHAST process'.

Each of the PHAST steps is implemented using a tool kit (as indicated in the above table), most of which are comprised of a series of pictures. The manual followed is the PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal diseases, which takes the reader systematically through each of the steps, detailing how to undertake each activity, its purpose and the relevant materials to implement each step..

General readings (Introduction to PHAST) and the PHAST manual in English, French and Spanish can be found on the software water and sanitation CD-ROM: Implementation tools < PHAST.

The International Red Cross and Red Crescent Movement and PHAST

Hygiene promotion was highlighted in the International Federation water and sanitation policy. The policy acknowledged that participatory techniques such as PHAST are well established in International Federation water and sanitation health programmes. However, it stressed that hygiene promotion, (including hygiene education, community participation, management and sustainability), must be established parallel to, if not before the introduction of the water and sanitation hardware. The policy also emphasised that water and sanitation and health programmes should, where possible, be closely integrated. The PHAST step-by-step guide for the control of diarrhoeal diseases is the basis on which the International Federation implements its PHAST strategy.

Since 2000, PHAST has been undertaken by many Red Cross Red Crescent National Societies at community-level worldwide. The PHAST step-by-step guide has been translated into many different local languages. From 1993 to 1996, the International Federation Regional Delegations supported water and sanitation programmes in over 40 countries. They now advocate the use of this method to ensure that the installed water and sanitation facilities deliver optimum health and social benefits which can be sustained in the long term.

In 2003, a PHAST review⁷ workshop was undertaken. The 6-day event was attended by water and sanitation staff from eight National Societies in eastern Africa (Ethiopia, Kenya, Mozambique, Rwanda, Tanzania, Uganda, Zambia and Zimbabwe). A second PHAST review workshop was conducted in 2006, in Mombasa (Kenya) and it was attended by 11 National Societies (Ethiopia, Burundi, Kenya, Comoros, Uganda, Rwanda, Seychelles, Djibuti, Sudan, Tanzania and Somaliland).

The first review of PHAST undertaken in eastern Africa was followed by the PHAST draft Guidance Notes for the use of PHAST in Red Cross Red Crescent water and sanitation programming. This was produced by the International Federation PHAST group and included: a background to PHAST; the key lessons learned and remaining challenges; suggestions of how PHAST can be shortened and improved in both development and emergencies; its integration with ARCHI and CBFA; and a number of PHAST tools which are not included in the original PHAST manual, which are useful for monitoring and evaluation. Most of the contents in this guide are based on the original findings from that workshop.

In 2004, the International Federation launched its new Global Water and Sanitation Initiative (GWSI). It includes the number of past Red Cross Red Crescent water and sanitation beneficiaries, as well as those it aims to include from 2004 to 2015. The GWSI also outlines the type of response it delivers and methodologies used, including aspects of both software and hardware. The key factors of its success and International Federation partnerships are also outlined in the Initiative. The GWSI encourages National Societies to adopt a common approach, methodology, timescale and economy of scale. It also provides a framework within which National Societies can increase their contributions to meeting the water and sanitation and health components of the millennium development goals (MDGs). The GWSI is perceived as the way forward in its 10-year commitment to the International Federation's contribution to meeting water and sanitation MDGs.

⁷ The final reports and appendices are included in the software water and sanitation CD-ROM: Implementation < PHAST < PHAST Review.

Guiding principles for Red Cross Red Crescent PHAST programmes

Community-based Red Cross Red Crescent volunteers

Community-based Red Cross Red Crescent volunteers are the key to successful implementation of PHAST programmes. They are exclusively placed to mobilize their own communities and guide the population through the PHAST steps, whilst at the same time maintaining a strong link with their local Red Cross Red Crescent branch. PHAST takes from two to six months for implementation. During this time the volunteers provide services to their communities by contributing a few hours of their time each week. It is essential that volunteers are well-managed. This means supervising their recruitment, support training and refresher courses, and ensuring that they are closely monitored at all times. If PHAST volunteers remain involved with health and, or water and sanitation programs over a long period of time, it helps to increase their capacity and strengthen the community and its response system.

Emergencies including epidemic outbreaks

In times of disaster, Red Cross Red Crescent PHAST volunteers living in their own communities are well-placed to respond immediately to water, sanitation and hygiene needs. During an epidemic outbreak, it will be advantageous to call on networks of pre-trained, Red Cross Red Crescent volunteers already living in the communities. They can be mobilized quickly, and provided with key messages to help with disease prevention.

Links with other programmes

It is important for PHAST programmes to collaborate with other Red Cross Red Crescent community-based initiatives, especially where there is overlap. The integration of PHAST with other Red Cross Red Crescent programmes at the community level must be examined more closely in order to maximise resources. Some systems have been developed integrating PHAST and CBFA (Community-Based First Aid) programmes. The ARCHI toolkit, used in Malaria and HIV and AIDS prevention components of community-based health programmes, has also been integrated in PHAST activities. Community-based tools used by the Red Cross Red Crescent have been harmonized recently to produce a simplified tool box to promote a more integrated approach to community programming.

This tool box, CBFA and ARCHI toolkit, are included on the software water and sanitation CD-ROM: Implementation < PHAST < Link with other Red Cross Red Crescent programmes.

Integrating hygiene promotion and community management systems.



Through steps one, two and three, communities can determine their own priorities for disease prevention and come to a consensus regarding the hygiene behaviours and sanitation systems most suited to their specific environment. People within the community possess an enormous health-related experience and knowledge. With the appropriate support, all people, regardless of their educational background, are capable of understanding that faeces carry disease and can be harmful. They can learn to trace the faecal-oral route of disease-transmission within their own environment and further, identify appropriate barriers accordingly.

Through steps four, five, six and seven, the community gains enough information and experience to begin to address its own problems. Communities will be able to assess their current circumstances accurately and devise a plan for future improvements. Moreover when people know that they are responsible for finding a solution they start to demand information.

The involvement of the community will result in a higher level of effectiveness and sustainability than could be expected from externally-imposed solutions. Those that create decisions within the community will be committed to following them through, thereby creating sustainability. Through this creative learning approach, based on real experience, individuals can evaluate and change their own behaviour.

Core activities for implementing a PHAST programme

Core activities	Resources	Outputs
Identification of gaps and areas for intervention		
WASH literature review	WASH documents to review	Literature review report
Institutional mapping of other stakeholders	Stakeholder analysis and Venn diagram	Stakeholder analysis report
Baseline survey focusing on water, hygiene and sanitation	PHAST baseline survey	Baseline survey report
Gender analysis	Gender checklist	Gender analysis report
PHAST programme		
Design of selection criteria for PHAST trainers, PHAST volunteers and community mobilizers to be involved in the PHAST programme.	Selection checklist	PHAST implementers identified
Simplification of the PHAST WHO manual and translation into the local language	PHAST WHO Manual	Adapted PHAST manual for ToT and volunteers
PHAST training (trainers and volunteers) and development of action plan	PHAST Manual for ToT and volunteers	Register of PHAST trainers 2 ToT and 30 volunteers PHAST training report
Adaptation, testing and development of PHAST toolkit	IEC material database Local artist	PHAST toolkit adapted to the target community
PHAST deployment at community level	PHAST kit for volunteers	Register of PHAST implementers 1 implementer and 25 households PHAST ME report
Linking with the hardware component		
Mapping of water and sanitation facilities	PHAST step two	Map of water and sanitation facilities
Participatory selection of technical options	PHAST (steps four and five) Engineer and local water board	Hardware component Community management component (water and sanitation committee)
Planning for new facilities	Manual for community water and sanitation committees	
Technical and managerial training of community water and sanitation committees	Engineer and local water board	

Hygiene social marketing – Mass campaign design		
Hygiene practices assessment	Baseline survey report PHAST (steps one and two) Literature review report	Hygiene education Communication plan
Identification of target audience		
Identification of key communication messages		
Identification of channels of communication		
Design and production of IEC materials	IEC material database	
Participatory monitoring and evaluation		
Impact survey	PHAST baseline survey	Impact survey report
Developing a set of SMART indicators	Diagram of indicators	Diagram of indicators
Establishing a monitoring system based in coaching groups	Quarterly HH monitoring sheet	Quarterly monitoring reports
Establishing community-based monitoring and evaluation	PHAST (steps six and seven)	PHAST implementation report



Benefits and constraint of Red Cross Red Crescent PHAST programmes

Benefits

- PHAST has helped the community to identify its own problems, understand what they can do, and has motivated them to plan and seek their own viable solutions.
- PHAST has helped the community to become self-reliant, with a common purpose, which results in a sense of ownership of facilities.
- PHAST has encouraged the community to plan for preventive activities and the community management of water supplies.
- Communities can better understand the issues of poor sanitation, how latrines can help reduce diseases, the importance of keeping water safe and hand washing.
- PHAST involves both men and women who should be represented at all stages of its implementation. In some refugee situations PHAST has encouraged women to be water pump technicians, and PHAST has been shown to empower women.
- The methodology used in PHAST can conceivably be used in the training of other topics such as HIV and AIDS and malaria (by modifying the tools).
- PHAST has raised the profile of the Red Cross.
- Some PHAST groups have reported that they have begun to undertake income generating projects.
- PHAST groups can work closely with water committees and neighbourhood health committees where they already exist, rather than developing parallel structures. Where these committees exist, members can join PHAST groups.
- There has been some success when using PHAST tools with children; hence it is good to involve schools in PHAST especially because children are powerful agents for behaviour change.

Constraints

- There is a risk of overlapping and duplication between the roles of the PHAST groups, water and sanitation committees and neighbourhood health committees. Where present in communities, these groups should link up to avoid this.
- Long-term refugees or IDP can be harder to motivate to take part in PHAST as they have more of a dependency mentality.
- There are usually not enough tool kits for each volunteer.
- The time period over which PHAST is undertaken is sometimes too long and communities lose concentration and interest and attendance falls off (it can be difficult to keep the same groups consistently).
- Sometimes it is not possible to hold PHAST meetings with communities for a whole day as they are busy working. It is recommended to meet the community for no more than two hours per day and extend the period of implementation.
- PHAST and CBFA can take a different and contradictory approach by not using the same methodologies. CBFA is often taught in a didactic fashion.
- Some National Societies in conflict areas or urban areas find it difficult to recruit volunteers. Communities in these areas may still be traumatised and difficult to work with. They may have high expectations of receiving aid, which may weaken community participation and increase expectations on National Societies.
- PHAST is difficult to implement in National Societies which are in the process of restructuring.
- There is still a need to convince donors to incorporate PHAST into ongoing water and sanitation Red Cross Red Crescent projects, which often have a greater focus on hardware.
- Not all National Societies have a water and sanitation strategy which advocates that hardware and software are complementary.
- Reluctance from some to use PHAST as they feel that in asking the communities about their health concerns, the community will request interventions that the National Society cannot deliver.

Red Cross Red Crescent National Societies with experience in PHAST methodology			
Americas	Asia and Pacific	Europe	Africa
Guatemalan Red Cross Honduran Red Cross Salvadorian Red Cross Society Peruvian Red Cross Venezuelan Red Cross Paraguayan Red Cross	Indonesian Red Cross Society The Thai Red Cross Society Cambodian Red Cross Society Myanmar Red Cross Society	Red Crescent Society of Tajikistan	Zambia Red Cross Society Mozambique Red Cross Society Zimbabwe Red Cross Society Malawi Red Cross Society Burundi Red Cross Ethiopian Red Cross Society Red Cross Society of Eritrea Red Crescent Society of Djibouti Kenya Red Cross Society Rwandan Red Cross Somali Red Crescent Society Tanzania Red Cross National Society The Uganda Red Cross Society

Level three: Coaches

A coach can be defined as someone who ensures that networks of community volunteers are recruited, trained, motivated, supervised and monitored on a continual basis. Coaches might be recruited from the pool of experienced and skilled volunteers involved in community health programmes. The key qualities of a coach are likely to be: organization, administration, commitment and flexibility, and an empowering approach to hygiene promotion.

Why coaching groups?

It is possible to manage only a maximum of 20 volunteers effectively, in an area where their work locations are close together and distance between work sites are short. Where distances are greater, fewer vol-

unteers can be managed. The suggested ratio of coaches to volunteers is: 1 coach to 6-7 volunteers. In a large project, these coaching groups at branch or sub-branch level might require a branch coordinator to report to the headquarter.

Coaches should be part of the PHAST volunteer group⁸, receiving the same training and carrying out the same activities at community level, but also assisting and supervising the less-experienced volunteers during the implementation activities at community level. They will be responsible for the weekly group meetings during the six-month programme period. The role of the coaches is to lead the PHAST group through the PHAST seven-step process over six months and, in particular, to encourage people to attend the weekly group meetings.

They should have good facilitation skills and strong links with the local Red Cross Red Crescent branch staff. They should also be able to produce regular reports on the progress of the groups for the branch. When they have completed the PHAST training, they may have a role in overseeing the collection of baseline data and help with its analysis. Where group members need to write regular monitoring reports, coaches may well be able to help them with this. Coaches gaining experience might be considered for future training of trainers.

Level four: Community-based volunteers

Volunteers should be recruited to work in the community where they live. They will be able to contribute to the PHAST programme on a regular basis and as much as they can. For the implementation of a standard PHAST programme it is expected that they contribute five hours a week, (depending on the national volunteers policy), though this varies within different communities. Volunteers will mobilize their communities to undertake the step-by-step PHAST activities and will maintain an active link between their communities and local Red Cross Red Crescent branches, reporting back to their coaches regularly on activities undertaken. Volunteers should be equipped with a PHAST tool kit, a loudspeaker, monitoring sheets and a T-shirt and cap.

During the review workshops, volunteers' retention was raised as a key issue in implementation of PHAST. Experience has shown that existing volunteers policies might be very helpful in implementing PHAST programmes. The following chart outlines examples of how PHAST volunteers are managed in PHAST programmes:

	Contribution	Allowance	Equipment
Kenya Red Cross Society	1-2 hours / day 2 days / week	Transport and lunch allowance	T-shirts, caps, bags, stationary
The Uganda Red Cross Society	1-2 hours / day 2 days / week	Lunch allowance and transport refunds	Gumboots, raincoats, badges, T-shirts, caps, stationary, bicycles for coaches
Ethiopian Red Cross Society	2 hours / day 2 days / week	Lunch allowance at the time of training	Shoes, T-shirts and caps
Rwandan Red Cross	2 hours / week	Transport and lunch allowance	Bicycles, (one per pair), T-shirts and stationary
Somali Red Crescent Society	2 hours / week	Transport and lunch allowance	T-shirts
Tanzania Red Cross National Society	2 hours / day	Monthly allowance	Gumboots and raincoats

8. This position could be a full-time, contracted staff as some sub-branches are nearly as strong as their branch offices and have large programme areas. If this is the case, then some sub-branches could fall into level two. The role described below can vary from one National Society to another since a coach's working hours cannot be restricted to only 12 hours per month, (e.g., Human resources volunteer policy for Cambodian Red Cross Society).

Phast trainings	Trainers – level 1 (Branch level)	Sub-branch field officer or trainer – level 3 (Branch level)	Community-based volunteer - level 4
Purpose of the training course	To develop a pool of trainers within the National Society that will train PHAST volunteer groups at branch level.	To develop a pool of PHAST volunteers within the National Society that will implement the PHAST process at community level.	To develop skills that allow the volunteers to teach friends and neighbours about hygiene and health promotion.
Educational objectives	<ul style="list-style-type: none"> ■ Principles of hygiene promotion. ■ Methods for community participation, especially in PHAST. ■ Adult learning techniques. ■ Volunteer management. ■ Monitoring and evaluation tools for behaviour change in hygiene, sanitation and water interventions using participatory methods. 	<ul style="list-style-type: none"> ■ Principles of hygiene promotion. ■ Methods for community participation, especially in PHAST. ■ Community mobilization techniques. ■ Monitoring tools. 	<ul style="list-style-type: none"> ■ Principles of hygiene promotion. ■ Methods for community participation, especially in PHAST. ■ Community mobilization techniques. ■ Monitoring tools.
Selection criteria	<ul style="list-style-type: none"> ■ Strong commitment and ability to facilitate participatory learning. ■ Broad experience in a variety of health and environmental programmes, preferably in Red Cross Red Crescent programmes at branch level. PHAST trainer can be recruited from the existing pool of trainers and volunteers of community-based health care (CBFA) or water and sanitation programmes. ■ Logistics and training organization (venue, transport, materials, etc.). ■ Experience in effective community action planning. ■ Participatory monitoring. ■ Strong problem analysis and logical planning framework skills. ■ Resource management. 	<ul style="list-style-type: none"> ■ Willingness to volunteer. ■ Ability to train others, since after the workshop they will be expected to train either at the branch or community level. ■ Ability to disseminate health messages. Experience in Red Cross Red Crescent community health programmes is an asset. ■ Literate - can read and write in local language. ■ The participants must come from the project area. Branch representation in order to ensure branch level buy-in of the process. ■ Gender and age equity. 	<ul style="list-style-type: none"> ■ Willingness to volunteer up to 12 hours per month. ■ Be a peer to the target group (i.e., mother, youth, etc.). ■ Be respected by the community. ■ Must live in the village. ■ Have enough time to commit to the programme. ■ Willing to adapt to new ideas. ■ Strong belief in the programme's aims and objectives. ■ Good negotiator. ■ Limited writing skills may be necessary, but not for everyone. ■ Ability to use PHAST tools and other information, education, communication (IEC) materials.

Lessons learned and good practices regarding PHAST training:

1. Red Cross Red Crescent volunteers already involved in other projects with a water and sanitation component, (e.g., food security), can become PHAST volunteers.
2. In the debate about whether PHAST volunteers should be Red Cross Red Crescent members first, it was considered a priority to recruit good leaders to PHAST groups and to have members who are already active in their communities and are able to undertake community mobilization. Ideally, these may be Red Cross Red Crescent volunteers, but this is not essential. PHAST groups are ideal recruiting ground for Red Cross Red Crescent volunteers.
3. National Societies implement PHAST in different ways, e.g., the training of Red Cross Red Crescent volunteers is not always undertaken sequentially from steps one to seven. In some instances, volunteers are trained initially in steps one and two, after which they go directly into the field to practise the skills they have learned.
4. The PHAST master trainers should be experienced enough to allow the introduction of the PHAST steps in a flexible manner, i.e., not necessarily sticking rigidly to the PHAST step-by-step guide. For this reason, master trainers should have enough experience and flexibility to be able to adapt, or even replace a tool, (as suggested in the guide), if one is found to be inappropriate.
5. While standard PHAST training assumes that participants already have knowledge and experience in the use of SARAR and PRA, upon which PHAST is anchored, and that such participants are already experienced facilitators, this is not always the case. For this reason, trainers should try to include sessions geared towards strengthening the facilitation skills of participants, such as dry-runs or simulation and role play exercises, and video feedback sessions.
6. The best way to develop participants' confidence, self-esteem and capacity building, is to use real-life examples for training, i.e., what they already know and have experience of. This can also help identify participants who can provide assistance during the actual training course.
7. Literacy is a basic criterion for a PHAST group member, Red Cross Red Crescent volunteer, as they need to be able to document and fill in reporting forms. However, other ways of reporting can be explored in order to reach the widest range of community representation, (especially in the community-based PHAST groups).
8. PHAST group leaders who become coaches should be better qualified than the PHAST group members, Red Cross Red Crescent volunteers. Leaders need to have the skills which will enable them to coordinate volunteer activities: make regular visits to discuss reports, and coordinate their work with the branch level water and sanitation programme coordinator.
9. PHAST training materials can be improved by adapting and translating them into local languages to make them more relevant to the local context.
10. To exchange experiences, review PHAST progress and strengthen the skills and knowledge of the volunteers, a refresher course should be factored in every two years when designing a PHAST programme.
11. Certificates to be given at the end of the first cycle.
12. Special attention should be paid to the concept of 'participation' during training, as in many National Societies, this term is widely taken to mean "cheap village labour".

Day	Module	Activity	Tool
1	Module 1 Introduction Definitions	<ul style="list-style-type: none"> - Introduction, expectations - Ground rules - Introductory talk - Principles of hygiene promotion and sanitation 	<ul style="list-style-type: none"> - Presentation - Group dynamics - Brainstorming
2	Module 2 How people learn Working with people Communication skills PHAST introduction	<ul style="list-style-type: none"> - Adult learning process - Participation and experience-based learning - Methods on community participation - Communication skills - Introduction to PHAST and PHAST tool kit 	<ul style="list-style-type: none"> - Comparative pictures - Role play - 3-pile sorting - Group dynamics - Brainstorming
2	Module 3 PHAST methodology step 1: Problem identification	<ul style="list-style-type: none"> - Community stories - Health problems of the community - Baseline survey 	<ul style="list-style-type: none"> - Unserialized posters - Nurse Tanaka
3	Module 3 PHAST methodology step 2: Problem analysis	<ul style="list-style-type: none"> - Mapping water and sanitation in our community - Good and bad hygiene behaviours - Investigating community practices - How diseases spread 	<ul style="list-style-type: none"> - Community mapping - 3-pile sorting - Pocket chart - Transmission routes
4	Module 3 PHAST methodology step 3: Planning for solutions	<ul style="list-style-type: none"> - Blocking the spread of diseases - Selecting the barriers - Tasks for men and women in the community 	<ul style="list-style-type: none"> - Blocking the routes - Barriers chart - Gender role analysis
5	Module 3 PHAST methodology step 4: Selecting options	<ul style="list-style-type: none"> - Choosing sanitation improvements - Choosing improved hygiene behaviours - Taking time for questions - Linking with the engineer 	<ul style="list-style-type: none"> - Sanitation options/ladder - Three pile sorting - Question box
6	Module 3 PHAST methodology step 5: Planning new facilities and behaviour change	<ul style="list-style-type: none"> - Planning for change - Planning who does what - Identifying what might go wrong 	<ul style="list-style-type: none"> - Planning posters - Story with a gap - Problem box - Resistance to change continuum
7	Module 3 PHAST methodology step 6: Planning for monitoring and evaluation	<ul style="list-style-type: none"> - Preparing to check our progress - Coaching system 	<ul style="list-style-type: none"> - Monitoring checking chart - Developing participatory indicators - Household quarterly monitoring sheet
8	Module 3 PHAST methodology step 7: Participatory evaluation	<ul style="list-style-type: none"> - Checking our progress - Baseline survey 	<ul style="list-style-type: none"> - Various tool options
9	Module 4 PHAST review Development of Plan of Action	<ul style="list-style-type: none"> - Constraints of using PHAST - Lessons learnt - Volunteers' recruitment and management - Plan of action 	<ul style="list-style-type: none"> - Dynamic group - Brainstorming
10	Module 5 Mass hygiene education campaign Three steps PHAST	<ul style="list-style-type: none"> - Channels of communication (folk media) - IEC materials - Activities with children 	<ul style="list-style-type: none"> - Dynamic group - Role play - Photo parade
11	Field visit	Visit to a project site	
12	Evaluation workshop	Feedback	Chart



This 12-day programme is only a standard guide. Some of the activities can be done in the same day and the programme reduced to a 10-day training session. Also note that module five might be interesting only for those National Societies that seek to increase capacities in the hygiene promotion sector during times of emergency.

Further to PHAST ToT, a “Plan of Action” should be developed by the participants for their respective branches. This should include a definition of the roles of those involved, including volunteers, coaches and branches. It should also define how the programme will be implemented, by whom, in which areas, who and what are the links with the community, and ways to mobilize them. An exit strategy and monitoring indicators should be developed from the outset.

General references to PHAST training can be found on the software water and sanitation CD-ROM: Implementation tools < PHAST < PHAST training.

Chapter 3.3 – PHAST implementation

PHAST consists of 17 activities organized in seven main steps. One activity is usually carried out each week and the whole programme, typically, lasts from four months to six months. The first five steps are about helping the group to develop a plan to improve water supply, sanitation and hygiene behaviour, while steps six and seven consist of monitoring and evaluation.

Members of PHAST groups are encouraged to share what they learn with their neighbours and the rest of their community. Since they are volunteers, it is often difficult for group members to meet more than once a week. The core group of community volunteers trained at sub-branch level will be expected to form, and train, in a cyclical manner, PHAST groups (15 – 25 households) within the targeted villages during the “action” period. An initial community level training will cover an average of four months depending on availability of the villagers and seasonality.

The activities use pictures, drawings and charts as tools to help kick-start discussions at the weekly meetings. Talking about sanitation and hygiene can be difficult for many people.

Shortening PHAST

There does not appear to be a clear way of shortening the PHAST process in a development context without interfering with the natural progression of activities and, thereby losing its impact. Where PHAST is a burden on the community, (as identified by some community members and Red Cross Red Crescent trainers), it may be necessary to change the programming of PHAST, in which case, the following issues should be taken into consideration:

1. Facilitating more sessions per week at community level. (E.g., activities one and two of step five i.e., ‘planning for change’ and ‘planning who does what’, might be merged into one activity, since they are inter-related). This presents several dilemmas:
 - Overwhelming communities with PHAST activities in the face of competing community needs in terms of time. The involvement of urban populations may be very difficult to sustain.
 - Going through the PHAST process too quickly and not having real impact or community buy-in.
 - Volunteer fatigue. A programme would require more volunteers so that volunteers are not required to work more than four hours a week. The alternative is to remunerate the volunteers and risk losing the spirit of volunteerism and its sustainability. In some cases, large numbers of volunteers are required to facilitate the PHAST groups (as the PHAST process aims to include 5 per cent of the target population as members of PHAST groups).
2. Leave the shortening of the PHAST process to the discretion of the programme manager based on the baseline survey findings, particularly where hardware already exists and there is no need for technology choice.

During the developmental phase, where water and sanitation hardware facilities are necessary, the PHAST process should be undertaken as set out in the original standard guidelines for PHAST, produced by the World Bank/UNDP. There might be a need, however, to change the programming and facilitation of the PHAST process, rather than the content, as it is important to keep the tools themselves intact, and the order in which they are implemented.

PHAST implementation – lessons learned

1. Steps one and two can be integrated as part of the activities needed to carry out the baseline survey. The implementation of these two initial steps can be supported by externally-trained Red

Cross Red Crescent facilitators from either the branch or sub-branch (district) offices, using a range of methods: key informant interviews, mapping, focus group discussions, household interviews, etc.

2. In steps three, four and five community leaders and key informants should be involved in the sessions. At this stage, the PHAST group should link with the water and sanitation community committee and the engineers. Furthermore, the community might select a group of volunteers to be trained specifically in health and hygiene issues. Additional hygiene-related topics that the community is interested in should be added, i.e., prevention of malaria, dengue, worms, skin disease, etc. Also, depending on National Society health policy, first-aid training and key health messages, especially mother-child topics such as, immunization, breast feeding, nutrition, etc.
3. Hardware activities should begin once step five is complete and especially after the community have agreed to their roles and responsibilities in community management. Starting some basic construction activities after step five, based on the community's demands, help to create trust and reliance on Red Cross Red Crescent, as the community realises that "talk is finally translated into action".
4. PHAST groups have been motivated by holding competitions between different PHAST groups in the same and different areas and by distributing T-shirts and badges. These competitions have attracted crowds and served to disseminate information.
5. There is a risk of overlapping and duplication between the roles of the PHAST groups, water and sanitation committees and community health committees. Where present in communities, these groups should link up to avoid this. In Somalia, integrating PHAST groups in the already existing community water and sanitation committees has been seen as a valuable resource developed by the project.
6. It is important to forge strong links between PHAST programmes and National Society headquarters staff, especially where National Societies are running large programmes. Projects which are in remote regions require structured visits as part of the process of monitoring and evaluation.
7. It is important that National Society Branch Secretaries strengthen their links with water and sanitation projects which includes giving them more support. It is also important that branch secretaries are fully up to date with the PHAST process and its activities.
8. PHAST should involve both men and women who should be represented at all stages of its implementation. For example, in some PHAST projects, women have been encouraged to be water pump technicians.
9. It is useful to involve children as beneficiaries in water and sanitation projects, especially in PHAST activities in particular schools. In Somalia a project called 'CHAST' has been developed which is an adaptation of both PHAST and child to child methodologies.
10. Red Cross National Societies implement PHAST in different ways, e.g., the training of PHAST group members and Red Cross Red Crescent volunteers is not always undertaken sequentially from steps one to seven. In some instances, Red Cross Red Crescent volunteers are trained initially in steps one and two, after which they go to the field directly and practice the skills they have learned before progressing to the following steps.
11. It is crucial for the correct deployment of PHAST to have a pre-developed volunteer policy within the National Society since this is what will guide the National Society on how to motivate and retain PHAST volunteers. The policy should outline the roles and expectations of volunteers, as

well as the upgrading process. Institutional strengthening under the Organizational Development sector is recommended.

- 12.** A system of rewarding and upgrading volunteers through the coaching system has to be mainstreamed in the volunteer policy.
- 13.** The average working hours for volunteers is up to a maximum of two hours per week, depending on the activity. Volunteers must not volunteer for more than two hours in a week, except in exceptional cases.
- 14.** PHAST sessions can be run targeting special vulnerable groups i.e., mothers with children under five that subsequently might form a group responsible for passing on information to other mothers at household level.



3.4 – PHAST in emergencies

Community participation in emergencies

The Red Cross Red Crescent experience, particularly in the last decade, shows that most field workers address water and sanitation developmental interventions with an increasing degree of participatory approaches and methodologies, ensuring that the target communities determine their own health priorities and how they intend to tackle them. However, in emergency situations, it is widely assumed that this approach is not appropriate as the target groups are often unable to make decisions or assume control, especially in the most immediate post-emergency scenario.

In an emergency, when rapid action is needed, it is too easy for the relief workers to make assumptions about people's needs and priorities. It may be actually very difficult to set up an effective mechanism for consultation and participation in the early phase of the emergency. However, a special effort should be made to at least establish the principles of consultation and participation, which can be developed over time. Past experience has shown that community participation in the response phase and, in the communication of specific hygiene messages in the immediate aftermath of a disaster, ensures sustainable and incremental improvements in environmental health.

In disaster response, community cohesion is usually affected, family units are split and individuals are involved in search and rescue or distribution of vital relief items. At this stage, the identification of needs relies on volunteers, trained professionals and the availability of community members for assessment. Therefore, definition of response is limited. In recovery, community leadership may be stronger since the situation may be more stable as the vital needs of families and community members are met.

Defining the stage at which relief workers should introduce participatory methodologies varies from one scenario to another. Over the years, the International Federation has implemented water and sanitation programs with National Societies as a response to emergencies and as a strategy towards disaster preparedness. Introducing PHAST in eastern Africa in 1999 as a community management disaster tool has shown that when a disaster occurs those Red Cross Red Crescent National Societies that have been working on participatory methodologies as part of emergency prevention and preparedness, are better able to introduce the participative elements in the response efficiently from the outset. Uganda Red Cross society was one of the pioneer organizations to implement Primary Health Care, including PHAST in 1981, within a total of four pilot branches and later expanding to 17, (in Kampala, north and south western parts of the country). The target groups were peri-urban and rural communities, refugees and internal displaced persons.

In May 2002, in response to a growing concern about the implementation of PHAST by National Societies in the east Africa region, the International Federation Regional Delegation in Nairobi produced a concept paper for hygiene promotion in emergencies, "*When PHAST needs to be FAST*".

In 2003, the first PHAST review in Kampala, Uganda, examined whether PHAST could successfully be shortened in emergency without losing its impact and the community 'buy-in' seen to be so essential to its successful implementation. New guidelines were produced for shortening the PHAST process during an emergency and also specifically during a *cholera epidemic*.

PHAST in refugee or displaced camps

Assumptions: The National Society has been implementing PHAST before the onset of an emergency and has trained volunteers in PHAST methodology and has already developed PHAST toolkits.

Timeframe: PHAST should be initiated within two weeks of the arrival of refugees or IDP for a period of implementation of eight weeks. A PHAST session might be undertaken in a period of one week depending on the nature of each emergency and access to the affected population. Following the implementation of PHAST sessions, the team might focus on community management of facilities and dissemination of hygiene messages.

During the acute phase of an emergency, the PHAST process should be shortened as follows:

Step	Activities	Tools	Purpose	Timeframe
1	Health problems in our community	Nurse Tanaka	To identify possible health risks posed by displaced status.	Day 1: 1-1 ½ hours session
2	Good and bad hygiene behaviour	3-pile sorting	To allow for in-depth analysis of problems and their causes.	Day 2: 1-1 ½ hours session
	Investigating community practices	Pocket chart		Day 2: 1-2 hours sessions / group.
	How disease spreads	Transmission routes		Day 2: 1-1 ½ hours session
3	Blocking the spread of disease	Blocking the routes	To analyse possible solutions to identified causes of problems.	Day 3: 30 min – 1 hour
4	Choosing improved hygiene behaviours	3-pile sorting	To identify key messages for improved hygiene.	Day 3: 1 hour
5	Who does what	Planning posters	To distribute roles and responsibilities with regard to management of communal facilities for both men and women, including management of water points, ensuring latrine cleanliness and vector control activities.	Day 4: 1-2 hours
6	Preparing to check our progress	Monitoring chart	To monitor change in the displaced population.	Day 4: 2 hours

Activities which may be removed from the standard PHAST process during emergencies:

- Community stories
- Community mapping
- Tasks for men and women
- Choosing improved water and sanitation facilities
- Taking time for questions
- Planning for change
- Identifying what may go wrong
- Checking our progress

Tips

We might develop some cross-checking mechanisms to ensure consistency and that the information communicated in step one. We can conduct interviews with key personnel such as, health staff and community leaders, for example.

A rapid hygiene and sanitation appraisal should be undertaken as part of the ongoing assessment.

Step four can include a presentation about the different sanitation and water supply options that might be implemented in the camp quickly - design principles, maintenance requirements, etc. The PHAST groups might be a good entry point for community consultation.

The hygiene key messages identified through step four might be used to develop a massive hygiene education campaign. Some of the PHAST members might be involved in the dissemination activities.

Step five might be linked to the establishment of community committees and technical training. Some of the PHAST members might be involved in the committees.

In Step six, the role of the Red Cross Red Crescent volunteers in the monitoring system and the specific activities that will be carried out, (e.g., household visits), should be explained to the community.

In some cases, (population displacement across the border), it will be necessary to use interpreters to talk to the target beneficiaries. Interpreter should be native speaker, preferably from the same social group as the target community. It is also preferable to start training community-based volunteers in order to avoid the need for interpreters.

The PHAST toolkit should be adapted to the community as soon as possible, especially in those cases where there are differences in dress, physical features or community customs of the target community.

PHAST for in-country disease outbreaks like cholera

A rapid appraisal should be undertaken as outlined above. During an outbreak, the PHAST process should be shortened as follows:

Step	Activity	Tool(s)	Purpose	Timeframe
2	Community mapping	Community mapping	In-depth analysis of the disease outbreak and its cause	Day 1: 1-1 ½ hours session
	Good and bad hygiene behaviour	3-pile sorting		Day 1: 1-2 hours sessions/group
	How disease spreads	Transmission routes		Day 1: 1-1 ½ hours session
3	Blocking the spread of disease	Blocking the routes	To analyse possible solutions to identified causes of problems	Day 2: 30 min – 1 hour
	Selecting the barriers	Barriers matrix		Day 2: 30 min – 1 hour
4	Choosing improved hygiene behaviour	3-pile sorting	To identify key messages for improved hygiene	Day 3: 1 hour
6	Preparing to check our progress	Monitoring chart	To monitor according to agreed standards	Day 4: 2 hours

Activities that may be removed from the standard PHAST process:

- Community stories
- Health problems in our community
- Investigating community practices
- Tasks for men and women
- Choosing improved water and sanitation activities
- Taking time for questions
- Planning for change
- Planning who does what
- Identifying what may go wrong
- Checking our progress

After the emergency phase of the disease outbreak, the community can be taken through the PHAST process as a developmental or post relief phase.

Tips

Specific sessions might be designed for cholera transmission routes and prevention measures. General references about cholera are included on the software water and sanitation CD-ROM: General concepts < WASH related diseases < Cholera.

Uganda

Red Cross emergency response during the cholera outbreak

Since 1979, there has been a chronic outbreak of cholera in the Hoima, Bundibugyo and Kibale Districts in western Uganda. The situation is aggravated by a lack of sanitation facilities and safe water, unsafe cultural beliefs of these communities and cross border population movement. All these areas are landing sites, and depending on the fishing season, each of these areas is subject to continuous rotational movement. The source of water for these communities is Lake Albert. The commonly-used methods for water treatment are chlorination and boiling.

In 2006, there were 98 reported cases and 33 deaths. Since this was a situation beyond the ability of Uganda Red Cross they applied for Disaster Response Emergency Funding (DREF), in which the Uganda Red Cross Society disaster management programme became the focal point for the implementation of the cholera DREF response. The programme had NDRT, (National Disaster Response Team), members who were based all over the country. There were also Red Cross Action Teams in 33 of the 49 branches with 15 radio-based stations.

The Programme dealt with both preparedness and response activities. These include:

1. Setting out response mechanisms at community level, (community-based action teams).
2. Equipping warehouse with emergency stocks, (non-food items).
3. Awareness, education and development of IEC materials on common disasters.

As part of activity three, 'Shortened PHAST' trainings were conducted targeting at least 100 volunteers. They were deployed in the affected communities and conducted one week – hygiene-promotion sessions with the community action teams. The methodology used was three step PHAST with focus areas in first aid, cholera prevention, control and basic hygiene and sanitation promotion:

Step one – Problem identification

Step two – Design of immediate response

Step three – Activity design and monitoring and evaluation

As a result of the response the Uganda Red Cross Society contributed to contain the outbreak in the affected area through increasing awareness of safe hygiene practices using a community-based action approach.

Lessons learned

Volunteers' fatigue. Volunteers had to carry out intensive door-to-door sensitization for a considerable time.

Equipment for volunteers should be available since they were frequently involved in burying activities.

A cholera kit should be considered when outbreaks occur in extended geographical areas with lack of health facilities, personnel and other actors. Training volunteers to use the cholera kit is essential.

Accessibility was a problem due to the landscape

Sustainability of interventions is a real problem in those areas with very low water and sanitation coverage.

These areas should be a priority for future water and sanitation interventions.

Migration is a key element: continual hygiene promotion of activities should be carried out in these communities.

South Asia

Earthquake – Pakistan:

ensuring gender equity and community participation in the water and sanitation programme is included in the software water and sanitation CD-ROM: Implementation < PHAST < PHAST in emergency.

The case study reveals the findings of the implementation of PHAST activities during the transition between the onset of the emergency and the recovery phase.

3.5 – PHAST tool kit

The PHAST tool kit consists of drawings made by a local artist reflecting the local culture and conditions. A set of drawings should be developed specifically for every activity in each step. The set should be composed of the following tools:

Step	Tool	Set of drawings
Step 1: Problem identification	Unserialized posters	Set 1: 10-15 drawings (A4 size) showing scenes of everyday community life.
	Nurse Tanaka	Set 2: 30 drawings (A4 size) of people in the community.
Step 2: Problem analysis	Community map 3-pile sorting	- Set 3: 30 drawings (1/4 of A4 size) of everyday hygiene practices, both good and bad in the local culture.
	Pocket chart from set three can be used.	Some of the drawings
	Transmission routes from set three can be used.	Some of the drawings
Step 3: Planning for solutions	Blocking the routes	Some of the drawings from set three can be used.
	Barriers' chart	-
	Gender role analysis	Set 4: Three drawings (A4 or larger) of a man, woman, man and woman together, boy, girl and boy and girl together. 12 drawings of daily household and community tasks related to water, sanitation and hygiene practices.
Step 4: Selecting options	Sanitationwater ladder	Set 5: From 2 to 10 drawings (A4 size) of different human excreta disposal methods, both hygienic and unhygienic.
	3-pile sorting	-
	Question box	-
Step 5: Planning for new facilities and behaviour change	Planning posters	Set 6: 2 large drawings, one showing a problem situation and another showing a greatly improved situation or solution to the problem.
	Problem box	-
Step 6: Preparing to check our progress	Monitoring chart	-
Step 7: Checking our progress	Various tool options e.g. socio-drama and planning posters	-
Total		6 sets – 100 drawings

Prototype tool kit

Standard drawings: Different sets of standard drawings in black and white have been developed and can be applied modifying those aspects, (custom, housing, clothing, etc.), that need to be adapted to the target area. These drawings can be found on the CD-ROM: International Federation IEC materials database. The modifications can be made by tracing or photocopying the original and using colour to show the local variations.

Using photographs or existing materials: Photographs showing scenes of everyday community life might be useful to develop drawings and or, they can be used directly for certain tools, e.g., sanitation options and the planning process. Existing posters, leaflets, etc., might contain drawings that can be used in three-pile sorting, for example. Technical and project manuals can also be a good source of pictures and drawings.

It is recommended to develop the tool kit containing all the required materials for a group or community of 20-25 households, as follows:

- Box or bag for the whole tool kit.
- One folder for each step, complete with brief instructions in local language.
- One folder for each activity, (each packaged separately within the steps' folders), the associated tool and any other required materials for the activity, complete with brief instructions in the local language. Laminating the game cards for each activity in a different colour, is recommended.
- The “Seven steps of PHAST” outline and chart in the local language.
- Extra materials such as paper, markers, tokens, sticky tape. The monitoring tools, (templates, sheets, checklists, etc.), should be printed and bound and included in the toolbox or bag.

All game cards and instructions should be laminated on both sides to protect them against weather, dirt and frequent handling. Game cards will also have serial numbers printed on the reverse in, to make them easily identifiable.

Adapting the prototype tool kit – steps

Step one: Find an artist. The ideal artist is someone who has artistic skills, takes part in Red Cross Red Crescent activities at community level and lives in, or close to, the target communities.

Step two: The artist should attend a complete PHAST training workshop and should be briefed initially in PHAST methodology and given a set of standard drawings. Moreover, the artist should attend field visits with participants to make initial sketches. Then, while the workshop is taking place, the artist should develop the sets that can be used and discussed in the training sessions. This is a practical and participatory form of pre-testing.

Step three: The artist should produce a complete set of drawings to be pre-tested in the target community. This can be done by taking the drawings to the community and asking people if what they see correctly portrays their local environment and cultural features. Drawings should be modified according to the feedback received.

Step four: A master set of drawings, in black and white, should be kept so that they can be photocopied. A tool kit should be produced for every PHAST team.

Examples of pre-adapted toolkits can be found on the software water and sanitation CD-ROM: Implementation < PHAST < PHAST tool kit adaptation (Niger and Somalia).



Chapter 4

Additional PHAST tools for Red Cross Red Crescent water and sanitation programming

4.1 – Gender checklist

Gender refers to the different roles, rights and responsibilities of men and women, and the relationship between them. Gender does not simply refer to women or men, but to the way their qualities, behaviours and identities are determined through the process of socialization. Gender is generally associated with unequal power, freedom of choice and access to resources. The different roles of women and men are influenced by historical, religious, economic and cultural realities. These roles and responsibilities can, and do, change over time.

The term “gender”, as recognized by the Gender and Water Alliance, also considers the intersection of women’s experience of discrimination and human rights’ violations not just on the basis of their gender but also on the basis of race, ethnicity, caste, class, age, ability or disability, religion, and a host of other factors.

Women and men are defined in different ways in different societies; the relations they share constitute what is known as gender relations. Gender relations constitute, and are constructed by, a range of institutions such as the family, legal systems, or the market. Gender relations are hierarchical relationships of power between women and men and tend to disadvantage women. These hierarchies are often accepted as ‘natural’ but are, in fact, socially-determined relationships, culturally-based, and subject to change over time. Gender relations are dynamic, characterized by both conflict and co-operation, and mediated by other factors, including caste, class, age, marital status or position in the family.

Differences between the sexes, such as the ability to give birth, are biologically-determined and are different from socially-prescribed gender roles.

Recognizing the above, a gender analysis refers to a systematic way of looking at the different effects of development on women and men. Gender analysis requires separating data by sex and understanding how labour is divided and valued. Gender analysis should be conducted at all stages of the development process; one must always ask how a particular activity, decision or plan will affect women differently from men.

Gender, water, sanitation and hygiene⁹

A focus on gender differences is of particular importance with regard to hygiene and sanitation initiatives. Gender-balanced approaches should be encouraged in plans and structures for implementation. Access to adequate and sanitary latrines is a matter of security, privacy and human dignity, particularly for women. However, even in places with adequate latrine coverage, the availability of sanitation facilities does not necessarily translate into effective use. This is due to taboo, cultural norms and beliefs.

Women are acutely affected by the absence of sanitary latrines:

- When women have to wait until dark to defecate and urinate in the open, they tend to drink less during the day, which causes all kinds of health problems, e.g., urinary tract infections.

⁹ Mainstreaming gender in water management – A practical journey to sustainability: A resource guide (UNDP).

- Women can be sexually assaulted or attacked by wild animals when they go into the open for defecation and urination.
- Hygienic conditions are often lacking at public defecation areas, leading to worms and other water-borne diseases.
- Girls, particularly after puberty, miss school due to lack of proper sanitary facilities.

At the community level, hygiene and sanitation are considered a women's issue, but they impact on both genders. Yet societal barriers continually restrict women's involvement in decisions regarding sanitation improvement programmes. Thus, it is important that sanitation and hygiene promotion and education are perceived as a concern of women, men and children, and not just of women.

The drinking water supply sector has a long history of examining the roles of women, due to the high visibility of women carrying water over long distances in many countries. The effort to expand access to water supply has also led the way in evolving a gender-based approach that takes account of changing social structures, and their effects on the way that women and men use and manage water resources. Considerable achievements have been made in incorporating a gender analysis into local drinking water supply programmes.

Gender is a critical factor in ensuring sustainability and hence, the overall success of water projects. Gender mainstreaming is a way to ensure that there is adequate representation of men and women in operation, maintenance and management of programmes projects.

General references about how to integrate gender needs in WASH (Water, Sanitation and Hygiene) programming are included on the software water and sanitation CD-ROM: General concepts < Gender.





Gender checklist for water and sanitation programming

General data

.....
Total number of family's data disaggregated by age and sex.
.....

.....
Number of families headed by females, and number by males.
.....

.....
Child-headed families.
.....

.....
Number of unaccompanied boys and girls, elderly, disabled.
.....

Water collection, transportation and allocation at HH level

.....
Patterns of water collection, (water fetching and carrying): Time spent (hours per day).
.....

.....
Relationship between water collection and girl child school attendance.
.....

.....
Gendered division of access to means of water transportation. When the family has access to private transport, (bicycle, donkey, motorbike, etc.), do men retain the priority in its use leaving women to travel by foot?
.....

.....
Patterns of water allocation among the family members: sharing, quantity, quality.
.....

Access to and control over water sources

.....
The different uses and responsibilities for water by men, women and children, (e.g., cooking, sanitation, gardens, livestock, etc.).
.....

.....
Who makes the decisions about water use in the community: (water irrigation, domestic use, watering livestock, selling water, brick-making, etc?) Do women have access to income-generating activities related to water?
.....

Gender division of time-use in the household

Who makes the decisions about time spent at household level?

Normal means of handling, storing and treating water at household level.

Who is responsible for household hygiene? Who is responsible for hygiene and sanitation practices at community level? If women are responsible for the hygiene status of themselves and their families, what level of knowledge and skills do women have?

Technical option or OM

Gendered division of responsibilities for maintenance and management of water and sanitation facilities. Are women equally represented on community development committees, water committees, community associations, etc? Which roles do women represent in those associations? Do they have access to the treasury?

Who maintains the latrines and water points?

Does the community need technical training on latrine use for operation and maintenance and hygiene and or, managerial training for maintenance?

Options for convenient, user-friendly designs, low cost and affordable facilities.

Physical designs for water points and latrines appropriate to water source, number and needs of users.

Does the community need facilities adapted for the disabled and elderly, (especially female)?

Privacy and security

Location and design for privacy and security of water points and latrines, and bathing facilities.

Safety around water sources, especially if women and children are primary users. Do women feel constrained to travel alone in public to the water point or sanitation facilities because of real danger of aggression or social disapproval?

Sanitary habits of women and girls

What is appropriate to discuss? What types of materials are appropriate to distribute? How are children's faeces treated? What are the cultural issues with regard to water and sanitation activities during pregnancy, menstruation, anal cleansing, etc?

Cultural issues

What are the main cultural issues which impact upon women's and men's access to water? What can be reinforced and introduced?

Traditional gender roles and power structure

How do women perceive themselves in traditional roles and active participation? How much of this can be changed and how much is it not possible to change?

Who decides how much money should be spent on water?

If programmes are based on demand-responsiveness: there needs to be an awareness of the possible exclusion of women-headed households that are unable to make contributions.

4.2 – Monitoring and evaluation tools

Monitoring is the day-to-day management task of collecting and reviewing information that reveals how an operation is proceeding and what aspects of it, if any, need correcting. Monitoring in hygiene promotion is a continuing function that uses the systematic collection of data on specified indicators to inform management and the main stakeholders of the extent of progress and achievement of hygiene improvement.

Evaluation is the objective assessment of an ongoing or completed water and sanitation operation, programme or policy, or its design implementation and results. The aim is to assess the project's, relevance, whether it is sustainable and if the objectives and overall goals have been met. An evaluation should provide information that is credible and useful, so that lessons can be used in management decision-making for the next part of the project cycle.

The PHAST programme contains a number of monitoring and evaluation tools which can be used by facilitators and or, volunteers:- Examples of monitoring charts: Community stories (unserialized posters), Health problems in our community (nurse Tanaka), Good and bad hygiene behaviour (three pile sorting), Investigating community practices (pocket chart), How disease spreads (Transmission routes), Selecting the barriers (barriers chart), Tasks of men and women in the community (gender role analysis), Choosing sanitation and water options or improvement (sanitation and water ladder), Choosing improved hygiene behaviours (three pile sorting), Planning for change (planning posters), etc.

Although the standard PHAST process covers monitoring and evaluation, it could still benefit from additional tools. These were developed during the Review of PHAST in east Africa at the end of 2003 and at other regional and International water and sanitation follow-up meetings. They include, (1) baseline survey tools, (2) essential indicators and (3) quarterly monitoring tools.

General references to monitoring and evaluation can be found on the software water and sanitation CD-ROM: Monitoring and evaluation tools < General readings.

1. Baseline survey

A survey is a useful tool for assessing programme needs and evaluating programme achievements and progress. A survey is conducted to collect additional data from a population. Its purpose is to gather information that is not routinely collected by existing information systems.

The baseline study is the analysis and description of a situation prior to the programme against which assessments or comparisons can be made. The baseline study provides a benchmark for our programme objectives, focusing mainly on water, sanitation and recommended hygiene behaviour. The baseline provides the framework for monitoring and evaluation, with a follow-up study, (typically mid-way through the operation), to facilitate final analysis and overall impact of the programme.

Principles to be applied to the PHAST baseline study:

- Baseline data is always required.
- Baseline studies can be time-consuming and expensive. If possible, existing secondary sources should be used to collect data.
- A baseline study should be followed by an impact study which should use the same methodology and study the same samples or sites to generate comparative data.
- A baseline survey should ideally be conducted before implementation of PHAST activities at community level.

General references about how to implement a survey are included on the software water and sanitation CD-ROM: Assessment tools < Survey < How to conduct a survey (manuals) including short guidance notes for survey (International Federation).

Different examples of questionnaires are included on the software water and sanitation CD-ROM: Assessment tools < Survey < Examples of questionnaires, (including PHAST baseline survey – International Federation). The PHAST baseline survey questionnaire does not have to be used uniformly by all Red Cross Red Crescent National Societies. It can be used as a template and adapted accordingly. Here are some suggestions for using this questionnaire:

- The questionnaire is aimed at mothers and female caretakers.
- Each questionnaire should take approximately 30 – 40 minutes to complete.
- The questionnaire will be completed by a volunteer. It is often better for volunteers to work in pairs, especially if they are women.
- The questionnaire will be analysed at Red Cross Red Crescent branch and or, headquarters level.
- It should take at least two days to train a volunteer to complete the questionnaire.
- Where possible, volunteers who undertake to complete the questionnaire will have undergone previous PHAST or CBFA training.
- As it is rarely possible to include the entire target group in a survey, a limited number of respondents should be selected. This is known as the sample. The characteristics of the sample should be similar to the total population so it is as representative as possible. Different ways of obtaining a sample include: random sampling (picking names from a hat or at random from a list; interval sampling: (selecting persons from a list at regular intervals); or cluster sampling: (where groups of people, rather than individuals, are selected to comprise the sample).
- The baseline survey should take no longer than 1-2 weeks to complete. One way to calculate the total time needed to conduct a baseline survey is to take a sample size of 100 households, for example, hence 100 questionnaires. If one person or a team of two, can complete six questionnaires in a day, it will, therefore, take one person 17 days to complete all 100 questionnaires, or two people 8.5 days. (Note: time should be allowed for travelling to the community, walking between houses and introductions).
- The baseline survey should not be followed up more than once a year.

2. 5 Essential indicators¹⁰ for PHAST activities

A list of key hygiene indicators for monitoring PHAST was identified during the PHAST review workshop held in Uganda in 2003.

Sanitation

- Use of latrines.
- Presence of children's faeces in courtyard.
- Presence of animals in the house.
- Presence of refuse pit.
- Cleanliness of latrine.
- Presence of bathing facilities in the household.
- Number of bed nets, (ITN), or vector control initiatives.
- Hand washing at key times, (after contact with faecal matter and before handling food).
- Presence of hand washing facility, (sign of use, location of facility, presence of soap or other cleaning agent).

Safe water

- Use of safe drinking water, (from safe source or disinfection of water),
- Clean drinking water is stored in covered container.
- Water supply system functional.

¹⁰ Based on assessing hygiene improvement – Guidelines for household and community levels (EHP - USAID)

- Quantity and quality of water, (refugees only).
- Household management of diarrhoea.
- Knowledge of ORT, (use of salt and sugar or ORS).

There are four indicators in the above list which are shown to have a proven impact on decreasing diarrhoeal diseases. They should always be included when monitoring PHAST activities.



Percentage of caretakers with appropriate hand washing behaviour

Note: In case hand washing practice cannot be verified by observation, this alternative indicator might be used: Percentage of caretakers who report having used soap for hand washing at least at two critical times during past 24 hours.

Definition: Appropriate hand washing behaviour includes three elements: (1) hand washing supplies, (2) hand washing at critical times and (2) hand washing technique:

(1) Hand washing supplies: water, soap, ash or other detergent, a device that facilitates hand washing at a basin, sink, bucket or tippy tap, and a clean towel or cloth (optional).

(2) Critical times for hand washing (WHO):

- After defecation
- After cleaning babies' bottoms
- Before food preparation
- Before eating
- Before feeding children

(3) Hand washing technique:

- Uses water
- Uses soap ash or other detergent
- Washes both hands
- Rubs hands together at least three times
- Dries hands hygienically by air drying or using a clean cloth

Calculation: [Number of caretakers in the sample who demonstrate appropriate hand washing] vs. [Total number of caretakers interviewed in the sample].

Source of information: Hand washing can be measured by self-reporting of critical times and demonstration of technique in a household survey. Data on hand washing behaviour can also be obtained through direct observation in the household. This is recommended since there is the interviewee's tendency to over-report desirable behaviours.

Target values: Hygiene promotion programmes have demonstrated significant increases in improved hand washing behaviours. Targets aimed at increasing hand washing by 50 per cent over the baseline, are realistic and attainable.

PHAST monitoring activities and tools related to this indicator:

Activity: Good and bad hygiene behaviour (Tool: Three pile sorting). This tool may help to monitor the level of adherence to specific hygiene and sanitation practices within the community.

Activity: How disease spreads (Tool: Transmission routes). Activity: Selecting the barriers (Tool: Barriers chart). These tools may help to analyse the level of knowledge gained by the community about how diarrhoeal diseases can be spread through the environment.

Model questions for the questionnaire:

- Can you show me how you wash your hands?
- Does the person use water? Determine whether washing hands is practiced using recycled water and whether it constitutes a considerable risk of faecal contamination.
- Does the person use soap (or alternative)?
- Are both hands washed?
- Does he or she rub hands together, three times or more?
- How does the person dry their hands?
- Does the towel or cloth appear to be clean?

Percentage of households with access to an improved and hygienic sanitation facility

Definition: Access means that any member of the household should be allowed to use the facility at any time, day or night. The facility should be located within a convenient distance from the user's dwelling, (30 metres or less). An improved facility means that the toilet design is culturally acceptable and safe. Hygienic means that there are no faeces on the floor, seat or walls and there are few flies. Using sanitation facilities means that a sanitation facility is the predominant means of excreta disposal for household members >12 months of age.

Calculation: [Number of households in the sample with an improved and hygienic sanitation facility] vs. [Total number of households in the sample].

Sources of information: Information concerning usage of sanitation facilities can be obtained through a household survey in which the surveyor asks the mother or household head about the family latrine and then inspects the latrine to see if it is, (1) functioning, (2) hygienic and (3) shows signs of use.

Note: *For children, the question should not be whether they use the toilet themselves, but rather if their faeces are disposed of at the toilet.*

Target values: To ensure health impact within the community, at least 75 per cent of households in that community should have access to, and use of, latrines. (Bateman and Smith 1990)

PHAST monitoring activities and tools related to this indicator:

Activity: Investigating community practices (Tool: Pocket chart). This tool may help to monitor the level of adherence of specific hygiene and sanitation practices within the community.

Model questions for the questionnaire:

- What kind of toilet facility does this household use?
- Where is the latrine located?
- How many households share this latrine?
- May I see the latrine? (Observation: Is there faecal matter present inside?)
- Where do you usually wash your hands?

Percentage of households with access to improved

Definition: Access to the water supply means it should be available within 30 minutes, or a 1km radius of the household in rural areas, and 5 minutes, or 200 metres in urban areas, (includes travelling there and back, waiting and collecting). The total time to fetch water, including time travelling to and from the source, queuing, and filling containers, should be as short as possible.

Calculation: [Number of households in the sample with access to an improved water source] vs. [Total number of households in the sample]

Source of information: Data are collected from a survey of a random sample of households. A cluster survey should not be used because water sources may be location-related. The survey should be carried out at the time of the year when water supply is lowest or when most sources have run dry. The surveyor should visit each house or compound and verify access to a water supply as defined above. In some cases, the distance to the water supply might be measured to ensure it falls within the prescribed 1km radius.

Target Values: Based on available research, an acceptable maximum time and distance is estimated as follows: access should be within 30 minutes or 1km of the household in rural areas, and 5 minutes or 200 metres in urban areas, (including time to travel there and back, wait for and collect water).

PHAST monitoring activities and tools related to this indicator:

Activity: Investigating community practices (Tool: Pocket chart). This tool may help to monitor the level of adherence of specific hygiene and sanitation practices within the community.

Model questions for questionnaires:

- What is the main source of drinking water for members of this household?
- How long does it take you to go to your main water source, get water, and come back?

Percentage of households that have access to water treatment

Definition: Water treatment supplies would include one of the following: (1) Hypochlorite solution, (2) Water filter and (3) Bottles for solar disinfection.

Calculation: Number of households with water treatment supplies divided by the total sample size.

PHAST monitoring activities and tools related to this indicator:

Activity: Investigating community practices (Tool: Pocket chart). This tool may help to monitor the level of adherence to specific hygiene and sanitation practices within the community.

Model questions for questionnaires:

- Do you treat your water in any way to make it safer to drink? If yes, what do you usually do to the water to make it safer to drink? (Only check more than one response if several methods are usually used together, for example, cloth filtration and chlorine.)
- When did you last treat your drinking water using this method?
- If water is treated by a method other than boiling, may I see the product or device?

General references for WASH Indicators can be found on the software water and sanitation CD- ROM: Monitoring and evaluation tools < WASH indicators.

3. Quarterly monitoring tools: PHAST monitoring sheets

In addition to undertaking a baseline survey and following it up on a regular basis, additional regular monitoring of the impact of PHAST can also be undertaken on a quarterly basis. This can be done by PHAST facilitators in their own communities. Results can then be compared and used to track changes related to each intervention.

A PHAST monitoring sheet should be created containing the five essential indicators using the corresponding tools as PHAST activities: (investigating community practices; good and bad behaviours; blocking the routes and selecting the barriers) and the questions related to the PHAST questionnaire. This sheet can be filled in for the first time during the initial implementation of the PHAST steps by the PHAST facilitator and then subsequently with the same PHAST group members once every quarter.

An example of a PHAST quarterly monitoring sheet format for household general observation is included in the software water and sanitation CD-ROM: Monitoring and evaluation < Training module PHAST monitoring and evaluation (International Federation). It is not necessarily intended that this be used uniformly by all Red Cross Red Crescent National Societies, but rather as a template and adapted accordingly.

Both the completed monitoring sheets, along with observation sheets, can then be given to the local Red Cross Red Crescent coaches to check that all key indicators for PHAST have been measured. PHAST facilitators may need to be paid per diem for work undertaken during these quarterly one-day meetings.

During the quarterly meetings, PHAST facilitators should ensure that all the key indicators selected for the PHAST programme are measured and recorded. This can be achieved by way of information gathered during discussions with PHAST group members and the completion of PHAST monitoring sheets, as well as through observation of households. The PHAST step-by-step guide contains all the activities and tools which should be used to complete the PHAST programme.

The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality

In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence

The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service

It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity

There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality

The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.



The International Federation of Red Cross and Red Crescent Societies promotes the humanitarian activities of National Societies among vulnerable people.

By coordinating international disaster relief and encouraging development support it seeks to prevent and alleviate human suffering.

The International Federation, the National Societies and the International Committee of the Red Cross together constitute the International Red Cross and Red Crescent Movement.

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