Seminar for Practitioners Household and School Sanitation and Hygiene in East and Southern Africa

Uhuru Conference Centre, Moshi, Tanzania

19th – 21st November 2007

SUMMARY AND PROCEEDINGS REPORT

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NETWAS

Institute of Water and Sanitation Development

Abbreviations

CBOs	-	Community Based Organisation
CHC	-	Community Health Clubs
CLTS	-	Community Led Total Sanitation
CoP	-	Community of Practice
EA	-	East Africa
HH/PS	-	Household and Primary School Sanitation
HRD	-	Human Resources Development
HYSAN	-	Hygiene and sanitation
IRC	-	International Water and Sanitation Centre
IWSD	-	Institute of Water and Sanitation Development
KDS	-	Kampala Declaration on Sanitation
LGAs	-	Local Government Agencies
LNGO	-	Local Non-Governmental Organisation
MDGs	-	Millennium Development Goals
NETWAS	-	Network for Water and Sanitation
NGO	-	Non Governmental Organisation
PHAST	-	Participatory Hygiene and Sanitation Transformation
ToT	-	Training of Trainers
WASH	-	Water, Sanitation and Hygiene

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1. Introduction

1.1 Background

In the drive to achieve the Millennium Development Goals, the primary focus of many country programmes is to facilitate infrastructure provision for safe household and school sanitation. As a result, there is a growing knowledge gap in terms of learning and sharing lessons which would stimulate good practices towards ensuring the implementation of sustainable sanitation services, which are used effectively and hygienically towards improved health.

Programmes and projects claim to have good successful practices without indicating the real factors and drivers for success. Sometimes the reported success is less sustainable than claimed. A constructive analysis by practitioners using a neutral analytical framework will support the learning and subsequent uptake of approaches on good sanitation practices.

It is crucial that lessons and good practices in household and school sanitation and hygiene are shared and documented within and between regions in sub-Saharan Africa. This will enable the replication and up-scaling of good practices, counter-act the duplication of errors and wasted resources, and is needed for informing changes in policy and approach towards effective sanitation provision that achieves the intended benefits.

The East and Southern African Household and School Sanitation and Hygiene Community of Practice Seminar was a step towards enhancing information and lesson learning and sharing, encouraging practitioners to reflect critically on factors for improved impact, and to document these lessons and practices.

The two-day Seminar was also an opportunity to synthesise lessons and experiences for broader dissemination through a composite publication of similar Seminars to be held in South Asia and Latin America, and towards actions to be taken in the International Year of Sanitation (2008), and for political discussion and follow-up on regional/national actions at the AfricaSan+5 Conference to be held in February 2008.

1.2 Aims and objectives

1.2.1 Purpose

The seminar had a dual purpose:

- To create a conducive and catalytic learning and sharing environment for planners and practitioners specifically dealing with Household and School Sanitation and Hygiene.
- To contribute to a synthesis of the lessons learned on Household and School Sanitation and Hygiene (HH/PS San&Hyg) to be presented at the AfricaSan+5 Conference.

1.2.2 Objectives

The objectives of the seminar were the following:

1. To facilitate the sharing and learning of good practices on household and primary school sanitation and hygiene (HH/PS San&Hyg) from within the East and Southern African regions.
2. To encourage practitioners and planners to identify and document good practices and experiences on HH/PS San&Hyg.
3. To create opportunities to learn on good practices in HH/PS San&Hyg from other continents (through facilitators).
4. To synthesise both positive and negative lessons learnt on HH/PS San&Hyg and propose key policy and strategy messages for IYS and AfriSan+5.

5. To assess interest in regional Community-of-Practice on HH/PS San&Hyg in the regions, and if positive identify first process steps and means.

1.2.3 Envisaged Outputs

The seminar sought to have the following outputs.

1. Publication with papers presented giving an overview of good practices and outcomes of discussions and conclusions (hard, soft versions, and published on Internet).
2. Key messages and synthesis paper for regional/national inputs for IYS-2008 and AfricaSan+5.
3. Enhanced co-operative relationship among sanitation and hygiene practitioners and planners/ developers.
4. If interest exists, to take forward a Community of Practice in household and school sanitation and hygiene in East and Southern Africa.
5. Ensure links with other Community of Practice Seminars being held in Asia, West Africa, Latin America, through a joint publication and sharing of lessons and good practices.

1.3 Participants

A total of 40 participants attended the seminar. Most participants came from East Africa, 28% from Ethiopia, 20% from Uganda and 10% from Kenya. The remainder came from South Africa, the Netherlands, Malawi, Madagascar, Switzerland and Zimbabwe.

The organisations represented at the seminar also varied greatly in scope. Thirty six percent (36%) of organisations represented were Ministry of Health related agencies, 18% represented bi-lateral organisations (e.g. PLAN Int. and WaterAid), and 13% represented multi-lateral organisations (e.g. World Bank, UNICEF). The rest represented water and sanitation agencies, CBOs (5% each) and Resource Centres (18%).

1.4 Organisation

The seminar was facilitated by IRC International Water and Sanitation Centre, assisted by its Resource Centre partners, NETWAS Int. (Kenya), NETWAS Uganda and IWSD (Zimbabwe). Participants contributed through plenary, group discussions and the world café dialogues. Substantial financial support came from UNICEF ESARO, WSSCC and the IRC.

2. Summary of Seminar Outcomes

2.1 Main Outcomes

2.1.1 Overview of reported "best practices"

There is no absolute definition of a "best practice". What is important for a "best practice" is that the beneficiary community accepts it and that it has a significant impact. From the presentations and discussions "best practice" cases appears to have the following features:

i) Participatory community-based & -owned approach with clear and agreed arrangements between facilitators and community institutions
ii) primary responsibility is at household and school level
iii) a clear technical support base provided by health volunteers, government or NGO staff
iv) a recognised "champion" at the local level
v) political will/ support from local government

Also clear from the presentations and discussions was the view that success should not be measured only in terms of hardware (coverage) and how far project objectives have been achieved. Instead, there is need to consider the psychological impact on the beneficiary community e.g. attitude and behaviour change, sense of ownership, etc., as well as the impact on livelihoods and general welfare.

One of the presentations, showcasing the South African experience, showed that the availability of funds is not *the* solution. Software components, appropriate technology design, hygiene promotion and sustainability are equally important and must be addressed at the onset of a program.

2.1.2 Key drivers and motives for sanitation and hygiene change

The main drivers of change are often CBOs in the form of youth organisations and community health clubs, usually in partnership with development partners and government/community agencies. The cases presented at the seminar all show that projects strong on community-based ownership have greater impact.

The role of national sector reforms and policies, e.g. Mkukuta in Tanzania, cannot be ignored as a driver of change in sanitation and hygiene. Other overarching drivers of change include the MDGs, diseases outbreaks and the active participation of NGOs, CBOs and the private sector.

Factors for changing hygiene and sanitation behaviours are very psychological and therefore closely related to culture, religious and social values and norms. The factors that trigger or motivate behaviour change in households and individuals include gender, culture, age and peer group influences.

Key success factors emerged as follows:

- Local champions in sanitation and hygiene including local politicians who role model and set an example; "allies"; traditional leaders/ elderly; religious leaders; local 'heroes', etc
- Messages from all supporters (internal and external to the settlement or community) must be consistent
- Photographs (or illustrations) by local people or school children
- Local clubs/ committees have household and primary school sanitation and hygiene as a key (temporary or permanent) focus area

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- Clear local demand must exist, even if only among a few community members who will take a role as change agents
- Demand creation through social and commercial marketing approaches
- Local ownership is needed in process for improving sanitation and hygiene
- Community-based monitoring of progress and assessment of cleanliness and appreciation
- Competition on sanitation & hygiene between and within communities and schools
- Small, encouraging (replicable/sustainable) awards to communities or community groups with good achievement
- The combination of capacity building for both hardware (e.g. builders) and software (promoters, community groups, politicians)
- Pro-active linkages between household and primary school sanitation and hygiene initiatives and projects.

Negative motives include: shame; disgust; law enforcement; fines and by-laws; social exclusion; water supply only if sanitation is improved.

Positive motives include: privacy; get rid of smells; flies; pride; dignity; human respect (for neighbours and other community members); decomposed waste seen as a resource ('humanure'); no caving in of pits or collapsing of slabs; social pressure; lasting 'quality' facility using appropriate technology (low cost/ high quality), and competition between villages and inside villages.

Doubtful drivers include mass campaigns, huge awards, model villages, demonstration latrines, dependence on community volunteering work, external subsidies, free slabs, etc.

Some of the key lessons learnt were that involving political leaders is key to success, starting from government policies is key to success, creating an ignition moment can mobilize the whole community, and that we should start with small 'do-ables'.

2.1.3 Promising ignition approaches

Approaches that build on and integrate with existing community and school structures and activities appear to be most successful and promising. Also use of locally available (or produced) materials in physical construction supports the successful ignition.

The key lesson learnt is that organised community groups act as entry points to the community and seem to provide the most effective way of engaging with the community. Involvement of the local leadership increases the chances of acceptance by the community. Some reported successful tactics include the use of membership cards as an incentive for community members to participate. On the other hand, community health clubs (CHCs) or similar community groups provide a unity of purpose. Organising beneficiaries in groups encourages members to be more analytical in terms of linking poor hygiene to poverty as members try to apply their acquired knowledge. Community members have control over their goals and activities as they can monitor their own progress, status, successes and problems.

Introducing projects to communities is not easy. In almost all the presented cases it was observed that projects need to use "allies" in the community to be accepted and be effective in the community. Besides having these allies, the sanitation and hygiene objectives must appeal to the community if uptake is to follow. In this regard, emphasis on health benefits alone is not a strong enough appeal! Project appeal can be enhanced by providing linkages to livelihoods and buttressed by "a lot of" awareness creation/raising. The use of demonstration also helps raise

interest, and by-laws and other regulatory instruments can cement the groups and encourage slow takers.

The presentation from Madagascar on school sanitation and hygiene showed that media technology in the form of photography is useful in influencing behaviour change when used as an advocacy tool focussing on schools. This approach can help to set up child to family learning and promotion.

In short, approaches that seem effective are those that encourage community ownership and use social marketing tools with some form of enforcement.

The most promising ignition approaches include Community Led Total Sanitation, PHAST, EcoSan, and approaches that are community-based and empowering. There were also positive results presented from government and health driven campaigns, from implementing a centrally co-ordinated sanitation and hygiene strategy, and short interventions: demonstrations, subsidy-based, focused on a few clusters of households.

2.1.4 Key challenges and constraints

At *national level*, the main challenges to sanitation and hygiene projects include inadequate financing; rapid population growth; poor data management; unclear reporting and feedback mechanisms; poor quality design and construction of latrines, and inappropriate technology (given soil, topography, groundwater level, weather, floods and culture).

Rapid population growth coupled with unplanned settlements creates problems in planning and provision .

At the *local level*, some of the main challenges noted include inconsistency in external support, sustainability issues of both hardware and behaviour, and community resistance.

With respect to information management, a key challenge is how to integrate adequate/ basic sanitation data in Local Government Information Management Systems, for example establishing sanitation and hygiene databases at district level. Such Systems could be fed with data from community-based monitoring.

In the rural areas, a key challenge is how to provide sustainable, affordable latrine technologies in general and how to cater for those communities that have no permanent settlements, e.g. the Maasai Sukuma livestock keepers.

2.1.5 Five key issues in sanitation and hygiene

The Seminar noted five key issues emerging in sanitation and hygiene:

(i) technology;

(ii) promotion/ initiation approaches;

(iii) the institutional framework;

(iv) school sanitation, and

(v) capacity building.

In technology, designs, their replicability and affordability are key. The ‘best’ approach to sanitation and hygiene improvement and behaviour change is yet to be defined but the most promising approaches are those that involve the community throughout the project cycle. Institutional frameworks are effective if they define clear roles and responsibilities for sector players, buttressed by strong co-ordination of the sector stakeholders and activities. School sanitation offers an opportunity to inculcate hygiene and sanitation practices in people at a tender

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age and effort should be made at all institutional levels to exploit this opportunity. Capacity building requires effective documentation and group learning.

2.1.6 Strategic orientations for the five key areas

The seminar identified some key strategic directions in each of these key issues:

With respect to technology..... there must be involvement and consultation of technology consumers, e.g. pupils in schools, vulnerable groups, families, etc. Only then innovative appropriate technology designs will be adopted and consumers are given a choice. The recommendations for technology adoption should be supported by research (evidence-based adoption). The procurement procedures for technology and technological support need to be improved to facilitate easy access and uptake.

With respect to approaches..., the participants noted the need for:

- inspired leadership in sanitation and hygiene at national and local levels
- approaches must target different gender and socio-economic groups differently
- target a few key behaviours at a time
- approaches and tools used should be outcome- rather than activity-oriented
- multi-sector forums need to be established at district level
- more information needs to be shared and efforts co-ordinated with other non-traditional hygiene and sanitation initiatives such as HIV/AIDS.

With respect to institutional arrangements... there is need for a clear national policy and implementation strategy on sanitation and hygiene aligned to other sector reforms. Sanitation and hygiene should be coordinated from a level not below a ministerial department.

With respect to school sanitation... sanitation and hygiene needs to be included in the school curriculum and teachers. There must be separate sanitation facilities for boys and girls and consideration given to different growth stages and needs, particularly of the girls at puberty.

With respect to learning and capacity building... learning and capacity building is best achieved through learning alliances that bring all sector players and stakeholders together at different levels (national, district, etc). Capacity builders themselves need to learn from the community so as to jointly define the most appropriate strategies, rather than teach the community alien methods that may have worked elsewhere but are not applicable to the local environment. Capacity building should start with where the community (beneficiaries) is and build from there using existing local frameworks and organisations.

2.1.7 Key messages for decision makers and policy makers

The Seminar resolved that policy- and decision-makers need to note of the following:

i) Decision-makers need to put sanitation higher on the agenda. It needs to get a higher priority.

ii) National and decentralised budgets should have a line item dedicated to hygiene and sanitation.

iii) The role of NGOS in hygiene and sanitation needs to be officially recognised and they need to be given representation at national and district level fora.

iv) The status of Department of Environmental Health needs to be elevated to the same level as the Department of Water.

v) Ministries of Health should be effectively involved in supporting and supervising/ approving rural household sanitation technologies before adoption.

vi) Government should organise technology shopping centres. These could be at higher levels but they are important for the community level to provide communities with available options.

vii) There is a need for consistent, regular inspection and enforcement by education & health officers towards improved hygiene and sanitation at schools and in committees.

viii) The Ministry of Education should institute routine personal hygiene inspections for school children and involve Parent-Teacher Associations and other community organisations in school sanitation activities (such as school open days).

ix) Government should reduce bureaucratic procedures in the construction and maintenance of sanitation facilities.

x) Hygiene and sanitation should become an examinable subject in schools.

xi) Governments and all responsible authorities to have a specific budget line item for school sanitation and hygiene.

xii) Data collection and storage should remain a mix of technologies (hard copies and software based) to cater for the different needs at the operational level, as well as take care of different technological competencies and resources.

2.1.8 Practitioners statement

Hygiene and sanitation…

- needs an institutional home and that home is the Ministry of Health
- needs a budget and the national fiscus must provide for this
- is not a paragraph in other sector policies - it needs its own policy.
- is everybody's business
- needs multi-sector forums for co-ordination, both at national and decentralised level
- is the responsibility of all – from government, NGOs, the private sector and the community itself. Households and communities need official recognition of that role.

2.1.9 A Community of Practice for rural household and school sanitation and hygiene

The Seminar agreed that there is a need for a platform (CoP) to discuss experiences in hygiene and sanitation, but the modalities of doing it still have to be worked out. The Seminar however, could not resolve what form or scope the CoP should take. One issue that should be addressed is whether a new network should be created or advantage taken of existing networks. The Seminar recommended that the resource centres (NETWAS Kenya in particular) prepare Terms of Reference (ToR) for the CoP and invite practitioners to join.

2.2 Main Conclusions

1. Its time to give sanitation and hygiene higher priority to water in WASH (water, sanitation and hygiene). Current WASH practices tend to favour water at the expense of sanitation and hygiene
2. Sanitation needs a lead ministry at the national level. It need not be housed in one ministry where it is pegged at department/ directorate level. The Ministry of Health (MoH) is the natural home for sanitation and hygiene.
3. Sanitation and hygiene initiatives should utilize existing local structures as much as possible to ensure uptake and contribute to sustainability.

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4. Sanitation and hygiene needs to ‘catch the children young’ and inculcate positive attitudes in school children. Hygiene should not be a punishment in schools.
5. The success of sanitation and hygiene initiatives need not be measured only in terms of physical outputs and software processes but should include impacts such as changes in behavioural attitudes and practices.
6. A key lesson from the implementation of sanitation and hygiene initiatives is that an approach can succeed if it focuses on district stakeholders; if it integrates sanitation and hygiene into other programmes such as malaria, child health and HIV/AIDS; if government support structures are established at village level, and if there is involvement and participation of the private sector, NGOs and CBOs.
7. The EcoSan approach can be a major promotion tool and is unique in the sense that many beneficiaries are motivated by the economic benefits of EcoSan and not links to death and doctors as is the case in most other sanitation promotion approaches. On the other hand, EcoSan as a technology may be a solution for high groundwater tables, flooding and loose soils.
8. The main problem in areas where there are no sanitation and hygiene projects is that there is usually no proper co-ordination of sanitation services, extension services are too weak to support rural sanitation, and even where communities have sanitation improvement, they lack appropriate low-cost sanitation technological options.
9. In some communities, meddling by politicians and negative cultural beliefs pose the greatest threats to project implementation.
10. A key lesson from implementing projects is that “no one-size fits all”. There is no one approach for all situations, no one technology for all conditions.
11. Sanitation and hygiene skills transfer through on the job training and mentorship program is preferable to deep studies and highly technical options.
12. For sanitation and hygiene initiatives to be successful at community level, organised community groups should be used as entry points, local leaders involved to increase acceptance, and the sanitation and hygiene project integrated with on-going activities.

2.3 Some Key Recommendations

1. Sanitation and hygiene initiatives should now focus on what beneficiaries want, not what options are available.
2. The Ministry of Health is the natural head and leader of sanitation and hygiene and this role must be recognized and resourced.
3. Establish multi-sector forums at decentralised levels to ensure harmonisation and co-ordination in planning and implementation of sanitation and hygiene initiatives.
4. The national fiscus should have a budget line item dedicated to hygiene and sanitation.
5. Sanitation and hygiene should not be a paragraph in the health or water policy! It must have its own stand alone policy.
6. Recognise the role of NGOs and the private sector in sanitation and hygiene.
7. Review health legislation to elevate the Department of Environmental Health to the same level as the Department of Water.
8. Develop technology centres that showcase available sanitation and hygiene options to communities.
9. Involve children in developing tools for sanitation and hygiene.

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3. Seminar Proceedings

3.1 Opening and Welcome

Opening remarks were given by Mr Jo Smet of IRC who stressed that the Seminar was for practitioners in the East and Southern Africa region to share experiences and ideas on hygiene and sanitation in the region.

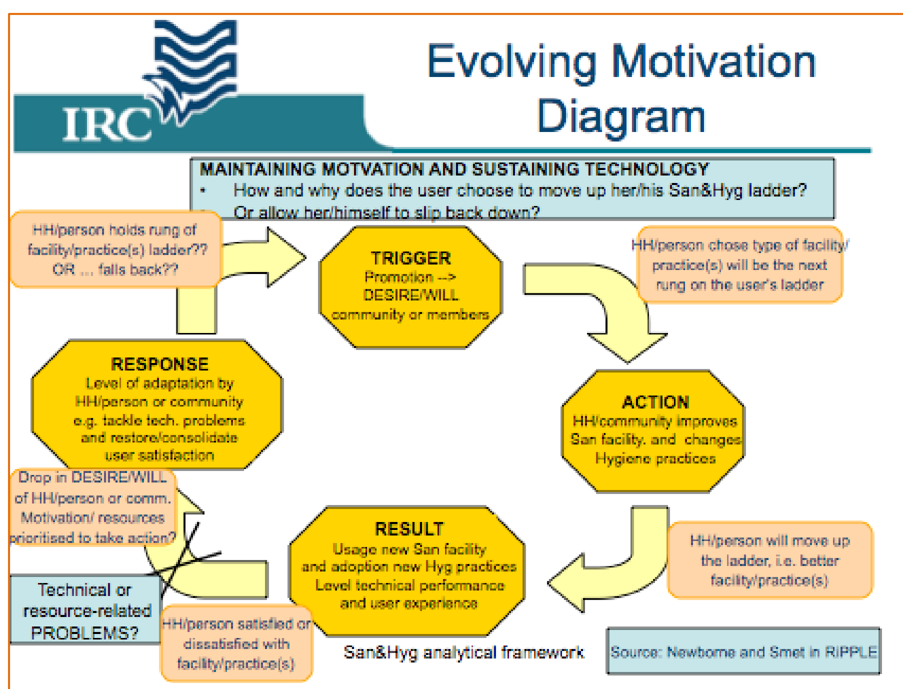
Participants then introduced themselves in pairs with each team member introducing the partner saying their name, the organisation, job and an incident they may have experienced regarding hygiene and sanitation.

A curious question was asked on when a participant last used a pit latrine for sanitation purposes. The answers were equally curious. About 60% of the participants had used a pit latrine within the last month!

3.2 Framework of analysis

Mr Smet outlined the framework for analysis to guide the deliberations during the seminar. The motivation diagram for the analysis is given in the figure below; the full presentation is on CDROM.

Figure 1: Motivation diagram for the framework of analysis used in the seminar



3.3 Case Studies and Discussions[1]

A total of 20 'good practice' case studies were presented and discussed following a broad outline:

1. Description of the case study (step by step activities)
2. Success factors (triggers/drivers for change)
3. Resources used (material, finance, labour, skills, etc.)
4. Main achievements (coverage, increased use, improved technology, etc.)
5. Challenges (and how they were overcome)
6. Lessons learnt

A few of the case presentations are summarised below. All are available on CD-Rom.

3.3.1 Nsumba Twezimbe Salaam Women's Club – Uganda

This project was **founded by** a club of six women in the Rakai district of Uganda with the initial goal of income generation in direct response to the HIV/AIDS scourge in the area. Sanitation and hygiene was integrated later and became the main goal. An Executive Committee of four runs the club supported by two committees, a Monitoring Committee and a Food Security Committee.

The project **aims** to integrate sanitation and hygiene with ongoing activities through home visits to its twenty member households, targeting disadvantaged widows, orphans and the elderly. Activities include education talks and demonstrations of systems such as latrines, hand washing facilities, drying rocks and bath shelters.

The identified **success factors** include organised women group, involvement of Health Extension Workers and the local leadership, as well as the integration of sanitation and hygiene with ongoing activities. Locally available materials were used in construction. Examples include the use of grass/ papyrus for roofing, cementing of floors using wam soil mixed with cow dung and the use of specific leaves for anal cleansing.

Pillars for continued participation have included issuing of certificates of recognition, a Constitution with rules and regulations and cash awards.

A noble observation is that neighbouring villages are adopting the initiative expecting to be funded. This development not only provides a challenge to the project funders but underlines an interesting motive for sanitation and hygiene improvement.

The **main achievements** of the project include 100% sanitation coverage in the project area, reduction in sanitation related disease prevalence, spill over effect to other villages, recognition country wide as the cleanest village and a cash award of UG Shilling 7.5m and 600m (equivalent to US$ 4,400 and 350).

The key **lessons learnt** are that organised community groups act as entry points, local leaders' involvement increases acceptance, and the integration of sanitation and hygiene in other community (income generating) activities increases the chances of success.

3.3.2 CLTS as a working approach: Experiences of Plan Ethiopia

Open defecation is common practice in many areas of Ethiopia resulting in high diarrhoeal incidence/ prevalence. An effective approach is needed for hygiene and sanitation development. Community Led Total Sanitation (CLTS) was introduced and is being implemented in Shebedino District and other Plan areas in Ethiopia including Lalibela in the North and Jimma in South West of the country.

Community members are involved and take the lead in all project phases from problem identification through to monitoring and evaluation.

The **major achievements** of the project are that (i) community members are empowered both mentally and psychologically, (ii) self initiative involvement and commitment made possible and feelings of self respect and self esteem cultivated, (iii) the golden rule “no to open defecation” has been inculcated into the minds of children, (iv) dramatic increase in sanitation coverage, a total of 2648 pit latrines constructed in 14 ‘kebeles’ communities of Shebedino, and (v) a strong sense of ownership created and community members became vanguards of sanitation.

The project gave advocacy workshops and conducted ToT for facilitators and basic CLTS training for community health workers (CHWs) after which the communities constructed their sanitation and hygiene facilities using local materials and their own labour. No subsidies were given for construction and direct promotion costs averaged 1$ per latrine (Plan project and overhead costs not included).

The project **success** is attributed to the “fear, shame and disgust” of the CLTS approach, total community involvement and commitment, proper facilitation and continuous follow up, and a joint venture of efforts by different actors.

Key **challenges** to the adopted project approach were identified as (i) subsidy orientation in subsidy areas left communities less keen to participate if no subsidy is given, (ii) limitedness of staff to follow up and replicate, (iii) inadequate facilitation skills of some facilitators, (iv) differences in commitment to and understanding of CLTS, and (v) potent backlash where follow up is deficient.

The main **lessons learnt** include that CLTS empowers and involves communities in development, continuous follow up and monitoring are key for success, joint venture highly demanded, the approach requires proper facilitation skills but bears a huge potential for application in another development sectors.

3.3.3 Community health club approach – Case study of Katakwi in Uganda

The approach relies entirely on community empowerment for health and development issues. There are four major components being implemented in phases.

The first component is the **Knowledge Base** focussing on (i) mobilising and sensitizing the community on hygiene and sanitation through participatory approaches – PHAST, (ii) organising communities into the ‘club’ arrangements based on voluntary basis, creating common unity and purpose of community health clubs (CHCs), (iii) conducting health/hygiene education through a card system and identifying practicable hygiene and sanitation interventions.

The second component is **Practical Skills Application** focussing on construction of hygiene and sanitation facilities identified through the knowledge base phase and improvement of existing infrastructure and behavioural change practices.

The third component is **Economic Empowerment** which focuses on promoting identified simple income generating activities, skills training in simple income generating activities, skills in improvement of financial management and environmental management skills / initiatives.

The fourth component is the **Social Activities / Initiatives** which looks at literacy training, care of HIV/AIDS victims/orphans and other relevant social community identified development activities promotion.

The **main activities** of the project include conducting community meetings/training, home visiting of fellow club members, drama activities rehearsals and performances (music, dance and drama), self-help in constructing necessary infrastructure, training pf local community artisans, conducting inter and intra community club visits to learn from each other and monitoring progress of CHC activities – participatory using household sanitation and hygiene monitoring forms.

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The **triggers for change** included the low levels of sanitation and hygiene in the district (43% latrine coverage, now at 55%), and the fact that the LWF as an NGO had worked in the district for over 5 years without realising/registering good progress. Success factors include the adoption of the 10 point KDS strategy for action (1997) and the direct support from the key lead ministries of health, water and environment.

The **resources** for the project are provided jointly by an NGO (Lutheran World Foundation), the district authorities and the central government. The LWF provides funding of relevant and related activities, human resource development and support, relevant provision development and dissemination of materials and labour by the target community (CHC members). The district provides human resources and communication materials whilst the Central Government offers resource persons and facilitators for capacity building.

The **main achievements** include increased latrine coverage from 44 to 55%, well organized non-government structures (CHC), ownership of the initiatives, increase in related hygiene infrastructure (e.g. tippy taps – a hand washing facility), increased collaboration between district and the NGOs.

Success factors include (i) effective triggers for change, (ii) the low levels of sanitation and hygiene in the district (43% latrine coverage, now at 55%), (iii) the LWF[2] as an NGO having worked in the district for over 5 years without realising/registering good progress, (iv) replication of the concept from CARE which had tried it out in IDP camps of Northern Uganda, (v) the 10 point KDS strategy for action (1997!!), and (vi) the improved sanitation and hygiene strategy (ISH) by key lead ministries (health, water and environment education).

Some of the **lessons learnt** are that (i) membership cards are powerful incentives, (ii) CHCs provide a unity of purpose, (iii) the approach encourages members to be more analytical in linking poor hygiene to poverty and try to apply acquired knowledge, (iv) strong exemplary leadership in CHC members is crucial, (v) use of demos raises a lot of interest, and (vi) by-laws cement the groups and encourage slow takers.

3.3.4 Youth spearheading hygiene and environmental awareness: Kiambu Experience

The project location is Kiambu Informal settlement, Pumwani Dirision, Nairobi, Kenya and the project initiator is Maji na Ufanisi and the Kiambu Youth Group.

The project involves the community in the development and operation of sanitation and hygiene facilities in the informal settlements and has been implemented through the following phases; organisation and mobilization, participatory urban appraisal (PUA), group formation – Constitution, leadership, Membership drive, hygiene and environmental activities and training.

The **trigger for change** was the poor and inadequate social infrastructures (Water, Sanitation, Drainage system and Waste management systems). The drivers for change included the Kiambio Youth group, Kiambio Youth Group children's club, Kiambio Community, Local Government, Maji na Ufanisi and other development partners.

Resource requirements included money /finance, construction materials, land/space, labour, technical expertise and time.

The **main achievements** include hygiene promotion – PHAST, promoting a cleaner environment, formation of a children's club, creation of strong partners with other developmental organizations, community policing in water, environment and sanitation (WES) and hygiene interventions.

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[2] LWF = Lutheran World Federation

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The main **lessons learnt** are that youth are important stakeholders in hygiene, water, sanitation and environmental interventions, the youth need to upscale their interventions to reach a larger population and that community participation is important in hygiene, water, sanitation and environment interventions sustainability.

The main project **challenges** were inadequate finances and lack of land /space.

3.3.5 Cluster approach - WaterAid Uganda

The project works with the community focussing on awareness creation and sensitisation on sanitation and hygiene through the formation of clusters of 10 households, promotion activities, Community Action Plans, mapping area and routes, LNGO, LG involvement and the provision of excavation tools.

The **success factors** and drivers for change have been identified as (i) the need for competition, (ii) hope and expectation for support in other interventions, (iii) liaison with community retired civil servants, (iv) involvement of the local leadership, (v) local non-governmental organisation (LNGO) staff support, (vi) external visitors, (vii) social benefits, (viii) community cohesion, (ix) publicity and (x) emphasis on behaviour.

Resources required for success included local materials, excavation tools, promotional tools, community human resources and LNGO staff time.

Main achievements of the project included 75% increase in HYSAN structures including 1.934 new latrines in 18 months resulting in 100% sanitation coverage in two communities and 90% coverage in 12 other communities. In addition the project managed to get whole households other than individual members involved and have the approach replicated by local government. The community and household elderly were supported.

The main **lessons** were that projects need to use “allies” in the community, start with issue appeal, emphasis on health benefits alone not strong enough, community members can monitor themselves, need to provide linkages towards livelihoods, and that a lot of awareness is still needed.

Some of the main **challenges** noted included insecurity of community regarding external support, sustainability because of domestic animals, livelihood approach and ‘difficult’ people who decampaign the project.

3.3.6 Ministry of Health and Social Welfare Tanzania: Roles and Responsibilities

The ministry defined its roles and responsibilities as policy formulation, legislation, guidelines, standards, supervision, monitoring and evaluation and research. Actual Implementation is done by the local authorities. Sanitation coverages (%) were given as below:

Type of Facility	Urban	Rural
Flush toilets	8.8	0.4
Traditional pit latrines	76.7	82.0
VIP	12.1	0.9
Total latrine coverage	97.6	83.3
No facilities	2.4	16.7

Source: DHS 2004 (TBS)

Among its achievements, the Ministry identifies the Sanitation and Hygiene Guidelines to be implemented at lower levels and the National Sanitation and Hygiene Strategy 2006 – 2015 which specified the strategy objectives, activities, defined roles of stakeholders, and set the sanitation standards.

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As part of the Strategy Public – Private Partnership (PPP) is promoted, a school health programme is implemented with the Ministry of Education, and decentralisation by devolution, (DD) in which local authorities are taken as focus of development with increased sources of funding, planning and budgeting and Implementation responsibility is followed. As a result of the Strategy villages implement their own plans with part funding from Central Government and Local Authorities.

What **triggered** the formulation of the strategy included national sector reforms and policies, Mkukuta (a poverty reduction and economic improvement strategy), the MDGs, disease outbreaks, active participation of NGOs, CBOs and private sector, as well as the application of participation approaches, PHAST, PRS, O and OD.

Resources for strategy implementation come from central government, local government, basket funding from donors (in a Sector Wide Approach/ SWaP), the community itself and the private sector.

Achievements to date include high latrine coverage, community ownership and commitment to community projects – sustainability, increased funding to districts and formulation of a national sanitation and hygiene steering committee.

The **lessons learnt** are that the strategy can succeed if it focuses on districts of stakeholders, if it integrates sanitation and hygiene into other programmes school health programme such as malaria, child health, if government structures are established at village level and if there is involvement and participation of the private sector, NGOs and CBOs.

As a national level project, its main **challenges** include rapid population growth versus sanitation and hygiene infrastructure development, growth of squatters, slums, LDW coverage in hand washing, data management, reporting and feedback mechanisms, quality of latrines despite the high coverage rates, technology (soil topography, weather etc) and slow behavioural change.

A **way forward** with the strategy hinges on more vigorous implementation of the sanitation and hygiene strategy, strengthening collaboration among sector players and improvement of data collection at community level.

3.3.7 Impact of ecological sanitation on households and schools in Northern Malawi

This is a sanitation programme being implemented by the CCAP Synod of Livingstonia Development Department in Northern Malawi since year 2002. The programme offers sanitation and hygiene options using a marketing approach to households. So far Ecological sanitation has proven to be an option that has increasingly become popular among households and schools in the impact areas. Furthermore, EcoSan has triggered a massive change in behaviours of households and school pupils.

The programme promotes three types of eco-toilets. The Arborloo is the simplest and cheapest form where a pit is dug, used as a toilet and a tree is planted after the pit is full. In the program fruit trees have been grown by beneficiaries. These include bananas, granadillas, paws paws, citrus fruits, mangoes etc. The Fossa Alterna consists of two permanently sited shallow pits used alternatively. Once pit one is full, usually after 8 months, the contents are excavated and used as manure. The decomposed pit contents after maturity are popularly known as Humanure in the project areas and may be sold for as much as US$2 per 50kg. This increases the uptake and sustainability of the technology. The Skyloo does not require digging as vaults are built above ground level. Skyloos have served well schools built in high water table areas and in areas with sandy soils causing pits to collapse. The table below shows the distribution of the different EcoSan technologies in the project area.

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TYPE OF LATRINE	PERCENTAGE
Arborloo	41%
Fossa alterna	39%
Skyloo	2%
Children's latrine	15%
Improved tradition latrine	3%

Introduction of children's latrine in the programme is an innovation that has achieved good results for women as women have been relieved from carrying their kids' waste for safe disposal into the latrine and kids are now able to learn how to use a latrine at a tender age.

Several promotion methods used including small-scale entrepreneurs, sanitation promoters and sanitation clubs.

The **achievements** of the programme have been that:

i) The EcoSan approach has been a major promotion tool, many are motivated by the economic benefits and promotion is not linked to death and doctors as many professionals do in promoting sanitation.

ii) Both in villages and schools in the project areas, EcoSan has had a massive impact in turning around behaviours including hand washing after visiting a toilet among household members and school pupils in targeted areas.

iii) EcoSan has had an interesting effect on the gender roles associated with latrine construction: In the past it was unheard of to see women digging and constructing a latrine.

iv) Women are now a winning group in EcoSan activities as they are active masons and sanitation and hygiene promoters.

3.3.8 Madagascar – School friends of WASH in Madagascar

The WASH National Committee promoted sanitation and hygiene in the neighbourhoods through a photo competition in primary schools.

The main activities of the project were selection of schools and photographers, having photos taken by pupils, selecting the 12 best photos and photo exhibition in 6 regions. This approach was taken because the WASH national committee believed that photos report the real situation of sanitation and hygiene in the community.

The **main achievements** are that the 12 best photos were used for advocacy throughout the country and the photos also helped the community to understand their situation with respect to sanitation.

The **resources** required for the project were human skills/labour, camera, some finance and basic knowledge. The lessons learnt are that photos can influence behaviour change, that photos can be used as an advocacy tool and that the type of approach adopted in this project can help to set up child to family approach.

The **lessons learnt** are that photos can influence behaviour change, that photos can be used as an advocacy tool, and that the type of approach adopted in this project can help to set up a child to family approach.

3.3.9 Adequate Sanitation - Tanzania

In Tanzania, WaterAid has been supporting its partners (LGAs, LNGOs) to improve living standards of rural and per-urban communities through WATSAN projects since the 1980s. Sanitation services have been noted to have low priority at different administrative levels especially at district councils

and villages. Government and village data show that sanitation coverage is very high in most areas of Tanzania. However, quality of sanitation facilities (latrines) in most households is not adequate enough to provide protection of diseases spreading. WA-Tz has been working in 11 with districts Rural LGAs.

The success of the project has been attributed to stakeholder partnerships namely local NGOs as partners of WaterAid Tanzania, Water User Groups and hygiene promoters at village level.

In terms of **resources** financial support came from WA, other NGOs provided stationery, transport and allowances.

Some of the main **achievements** of the project are that it designed adequate sanitation checklist that was pre-tested and used for baseline data of sanitation in rural areas and that sanitation coverage improved from between 25% - 45% to 80% - 98% (as reported from LGAs data).

The main **lessons** were that before the project there was no proper co-ordinating of sanitation services in LGAs, extension services to support rural sanitation were weak to support rural sanitation and that communities have a great level of sanitation improvement BUT are lacking appropriate technological options of low-cost sanitation.

Challenges were identified include the need to integrate adequate/ basic sanitation data in local Government Management Information System, need to establish database of sanitation at district level, introduction of sustainable latrine technologies in rural areas, and how to provide sanitation facilities for those communities that have no permanent settlements (e.g Maasai, Sukuma – all livestock keepers).

3.3.10 At scale hygiene and sanitation in Amhara Region CLTS - Ethiopia

The project aimed at creating common ground among stakeholders, signing memoranda of understanding among WASH sectors and organising for sustainable hygiene and sanitation.

A **step-by-step** approach was followed. First the problem context was mapped, then the partnership was leveraged, followed by the development of a strategy with a common goal and lastly implement the strategised hygiene and sanitation activities in the districts.

For success, two facilitation levels were required: External facilitation focused on pre-planning meeting with political leaders and sectors, training human resources for behaviour change, data collection and analysis including conducting baseline surveys and WSR. Internal facilitation focussed on community mobilization (ActionPlan), “do-able” actions, latrine construction and the sanitation campaign.

Among the key **success factors** were evidence based advocacy, creating common ground, multi level, multi sectoral and multi-communication approach and the CLTS approach.

Financial **resources** were required only for software activities and no subsidy was given for construction.

The main **achievements** were that (i) a sustainable organization at all level was created, (ii) inspired leadership emerged, (iii) well-trained motivators at grass roots level were established, (iv) well-thought out monitoring and evaluation indicators developed and used, and (v) a follow up mechanism established.

Some of the key **lessons learnt** were that involving political leaders is key to success - starting from government policies - is key to success, creating an ignition moment can mobilize the whole community and that we should start with small do-ables.

The main challenge for the project was to get steering committee functioning effectively.

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3.3.11 Rolling –up HH sanitation and hygiene using the KDS model approach – Uganda

The Department of Environmental Health implemented a three year household sanitation and hygiene project in the three districts of Nebbi, Masindi and Hoima in Uganda. Five sub-counties were covered in each district. These districts are prone to cholera outbreaks as they border L. Albert and the River Nile. The areas are associated with poor sanitation & hygiene and low latrine coverages. Water-Aid Uganda funded the project.

The project was based on the Kampala Declaration on Sanitation (KDS 1997), whose main strategy for implementation focusses on exemplary Leadership, full community mobilization, focus on schools, focus on districts and lower levels of LGs, recognition of the central role of women.

Latrine coverage changed noticeably during the project. The table below shows the figures before and after intervention.

District	Before	After
Nebbi	52.6% (2005)	58% (current)
Masindi	39.3%	48%
Hoima	65%	68%

The main **achievements** of the project were that women in the model villages can express themselves in public without hindrance, home improvement competitions launched in each of three districts, a study tour to learn and share experiences undertaken, all the five sub-countries in the project area have been supplied with sanitation implements and 10 bicycles, a computer and a printer per district, monitoring and support supervision mechanisms have been established, and model villages with total sanitation and hygiene, and some of the model villages have achieved 100% latrine coverage e.g. Mambi Village in Nebbi District,

The project **challenges** included (i) a lack of effective District Water and Sanitation Co-ordination Committees in the districts, (ii) a lack of grassroots structures like Village Health Teams (VHTs), (iii) fear of losing votes by politicians, (iv) poor physical environmental factors, (v) uncontrolled immigration from neighbouring countries, and (vi) negative cultural beliefs that still prevail in some communities.

The main **achievements** of the project were that the capacity of district leaders with focus at sub-country was built and the action plans produced are being implemented. Now there is a presence of sanitation & hygiene budgets at some of the sub-country level, technical staff is trained in the use of PHAST tools and Step Approach for sanitation mobilization and development of a monitoring tool has been developed. Model villages with total sanitation and hygiene have been established and there is a spill over effect to neighbouring villages. An improved Management Institutional System (MIS) and skills have been achieved at district level through the provision of computer and printer.

The **motivating factors**/ driving force for community participation included the idea of integrating income – generating activities with sanitation, self motivation, monitoring, women and husbands involvement, dignity were key in their success, team work of PHAST club members and other sanitation and hygiene related groups made it a reality and things happened, political will support and involvement at various levels of LGs, commitment of extension workers who were always in the community mobilizing, guiding, sensitising, monitoring and supervising the processes made it possible, motivation and facilitation of extension workers in terms of transport and mobilization allowances, cleanliness with disease prevention and their privacy not being evaded.

The main **lessons learnt** are that the political leaders and technical staff can now plan and budget together and agree on activities to be implemented as per resource envelope; PHAST tools and a step-by-step approach is regarded as useful and recommended for sensitization, planning and

budgeting; local community groups/ clubs have a self motivated commitment to achieve their set goals/ targets if guided by technical people and leaders; exemplary leadership is a motivating factor, and sanitation and hygiene facilities can be provided by using locally available materials.

3.3.12 Mpumalanga - South Africa

The project was run by local municipal sanitation working groups, supporting Provincial Local Government Delivery Projects (LGDP). The key players included local village leaders, political representation, officials, emerging contractors and ministry officials of health and water.

The Working Groups monitor resources, assess the best technologies to be used, ensure skills development and job creation, and account to the people at village level.

The technical components and social user and health education is government funded according to specific criteria which are monitored. The main resources are the time and dedication of the role players to participate in the Working Groups.

The main **achievements** are that the provincial programme has been able to be accelerate by five times over the past 4 years and has attracted interest from other provinces and national government to help other provinces to duplicate the approach. Also, accountability and improved monitoring and effectiveness has been achieved to ensure more people have access to basic sanitation.

Key **lessons**/ challenges are that no one size fits all; rather standardize and duplicate the approach of working groups than the technology used. Also, transfer of skills is needed through on the job mentorship rather than deep studies and highly technical options, and lastly monitoring funding and scaling up the program to meet government objectives remains a challenge.

3.4 Group Analysis

Participants were divided into five groups and requested to analyse the provision of household and school sanitation in keeping with the following framework of analysis:

- What are key factors for success?
- What are key factors for improvement, challenging factors? (learning from challenges)
- What is the major specific approach or combination of approaches to pull trigger?
- What are the key drivers for change? (which institutions, actions, transformation)
- What is/are main motive(s) or drive(s) that ignites individual/HH/community to change behaviour? (social, cultural, economic, psychological, enforcing, etc.)
- What is relative importance for support by relevant institutions?
- How to make it resource-effective and replicable?

Table 1: Group responses to the key analytical questions on household and school sanitation.

QUESTIONS	KEY GROUP RESPONSES
Key factors for success?	At agency level: Correct problem identification; proper planning; commitment of all role players; availability of resources; readiness of the enabling environment, accessing indigenous knowledge; community empowerment; co-ordination between stakeholders; political will; understanding local needs; learning and sharing information; inclusive of different target groups (women, men and children); multi-lateral

QUESTIONS	KEY GROUP RESPONSES
	support; institutional support; appropriate trained human resources. At community level: Community empowerment; indigenous knowledge; flexibility in implementation; communication (attitude and facilitation skills); use of existing clubs and groups, ownership of project by community; inspired leadership; continued motivation of the local champions; competitions and awards
Key factors needing improvement?	Lesson learning, sharing information on successes and failures and lessons learnt Government policy and leadership; addressing capacity and skills gaps, timeous release of funds Collaboration and co-operation at all levels; sharing information on successes and failures; working with the private sector and scaling up. Technology issues (solved by proper planning and lesson learning from similar organizations) Culture (training, community exchange visits, change cultural leaders) Prioritisation of sanitation Proper institutional set up and home for sanitation and hygiene
Major specific approaches or combination of approaches to 'pull the trigger'?	Household centred; participatory; decisions should be made by the community; PHAST approaches; identify the right gate-keepers and change agents; diffusion of replicable innovations; marketing approach; institutionalization at community level.
Key drivers for change?	Visionary leadership; political commitment; self respect and dignity; disease prevention; overcoming calamities; loss of prestige due to problems; the community itself (their own leaders) Affordability and accessibility Right perspective of costs and appropriate technology (realistic/ applicable) Promotion from different angles
Ignitions for individuals/ households/ communities to change behaviour?	Modelling and mimicking others; financial, status and other benefits; health benefits; fear of by-laws; peer pressure Understand what the community wants: Different strategies for different types of people (recognize those that make things happen, make those who see things happen participate, shame/punish those that let things happen). Different social aspects: development, modernity, dignity.
Importance for support by relevant institutions?	Issue of ownership; capacity building; sustainability; quality assurance, Promotion by different professionals

QUESTIONS	KEY GROUP RESPONSES
	Co-ordination and integration.
How to make it resource-effective and replicable?	Affordability; joint planning and implementation; history of technology, Proven impacts and demonstration Affordability, use of available resources, locally financed.
Challenges	Limited financial resources; bureaucracy; resistance to change; institutional set-ups (sanitation has no parent ministry).

3.5 Identification of key issues

The participants deliberated on the issues identified from the group work and came up with a list of key issues pertaining to household and school sanitation and hygiene. Several issues where raised in the brainstorm and then grouped by consensus into five categories of technology, approaches, institutional framework, school sanitation and capacity building.

Table 2 summarises the five categories and their component issues.

Table 2: Key issues in household and school sanitation as identified by Eastern and Southern African practitioners.

KEY ISSUE	COMPONENT ISSUES
Technology	Research, designs, appropriate technology, replicability, affordability,
Approaches	Social marketing, advocacy, enforcement, community ownership, ignition, empowerment
Institutional framework	Co-ordination, leadership, enabling environment, advocacy, investment, networking, clear roles and responsibilities,
School sanitation	Affordability, empowerment, behaviour change, community involvement
Learning and capacity **building**	Learning, capacity building, documentation, research.

The key issues identified in the plenary were put up for “world café” deliberations. Five people volunteered to be the café owners, each handling one key issue. Each café owner prepared his/her approach to handling the group visits to their café.

3.6 World Café Strategies

The key strategies in each area were:

3.6.1 Approaches

1. A home exists for sanitation; it is normally the Ministry of Health. What is lacking is the leadership for sanitation.
2. Donors do not strongly influence the development of sanitation and hygiene; they merely give funds for WASH. Governments should be more serious about financing sanitation and hygiene. Practitioners should do more to influence the budgeting process for both donors and governments.
3. Community participation should be guided by evidence-based advocacy.

4. People within the communities should help (or be used) to ignite/ lead sanitation and hygiene initiatives in their communities.
5. Competition among communities can help drive the sanitation and hygiene uptake and speed up scaling of initiatives. For example successful villages can be declared the Healthiest Village in the district (or even country). This will inspire the village to maintain its standards whilst encouraging others to emulate (or aim to surpass) it.
6. Inspired leadership is required at the national level. The leadership should focus on new approaches to get financial, material and human resources for sanitation and hygiene.
7. Community engagement by agencies. Agencies are different, push different agendas and use different approaches. There is need to harmonise and co-ordinate the approaches of government, NGOs, private sector and other players at all operational levels starting with the national level down to the district level. For example the approach of all inclusive District WASH Committees should be promoted.
8. Motivation and volunteering at community level is key to success at the local level and needs to be encouraged but with the realization that the contributions by individuals are part-time and often also short time. Incentives for volunteering should include training and setting up village funds to help fund the activities of volunteers such as attendance at far away meetings.
9. There is need to monitor the work of health extension workers at all levels.
10. There is need to plan for health and hygiene. Planning remains the responsibility of government but must be supported by the donors who fund the ground activities.
11. Government to provide basic information and support in baselines upon which the donor agencies can base their actions and interventions.
12. Need for child-centred approaches.
13. Use approaches that target different groups – men, women and children as well as the different socio-economic groups. The approaches and tools should be outcome-oriented.
14. Target a few behaviours at a time, share information and co-ordinate efforts with other non-hygiene/sanitation initiatives such as HIV/AIDS (which is largely a health, hygiene and sanitation issue).
15. Use the opportunity offered by special days/ events such as sanitation week, presidential speeches, etc., to spread hygiene and sanitation messages.
16. Identify champions to lead the cause of hygiene and sanitation.
17. Pre-test approaches – don't just assume that they work because they have worked elsewhere. Document, monitor and evaluate processes (not just successes) as references for decision making.
18. Scaling up should not just be coverage but advocate for adoption.

3.6.2 The Institutional Framework

1. Multi-sector forums need to be established at district level to ensure co-ordination in planning and implementation.
2. The national fiscus should have a budget line dedicated to hygiene and sanitation with clearly specified expenditure activities, clear success indicators and comprehensive reporting guidelines.
3. There is need for a clear national policy and implementation strategy on sanitation and hygiene aligned to other sector reforms (such as water and environment). Sanitation and hygiene should not be a paragraph in the health or water policy!
4. Government must allocate adequate financial resources to retain professional staff in the sector.

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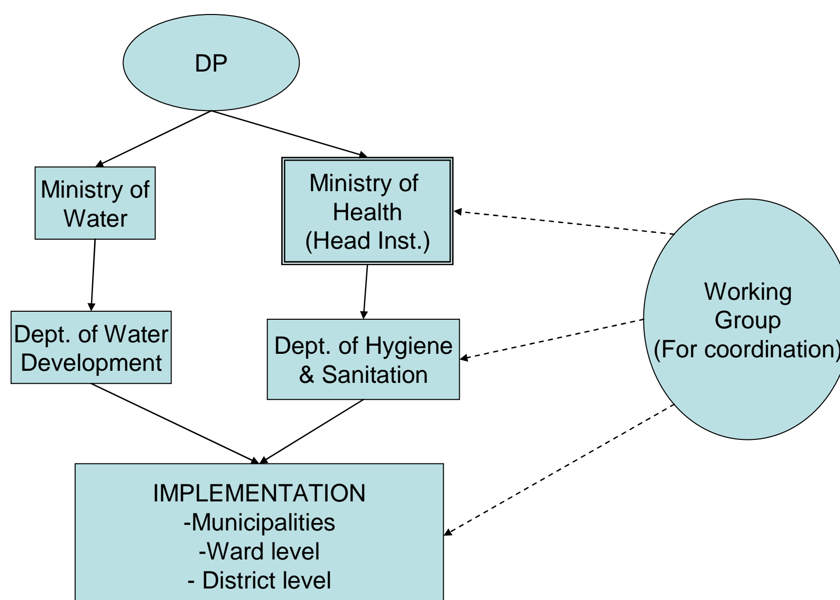
5. The role of NGOs in sanitation and hygiene needs to be officially recognized and NGOs be given representation at national and district level in Working Groups on hygiene and sanitation. The involvement of the private sector needs to be encouraged.
6. The review of health legislation (e.g. the Health Act) is long overdue. In the review there is need to elevate the Departments of Environmental Health to the same level as the Departments of Water Development.



3.6.3 Technology

1. Involvement and consultation of technology consumers, e.g. pupils in schools, is essential if appropriate technologies are to be adopted
2. The technology needs to be user friendly and recognize the different needs of different users e.g., the elderly, sick, children, disabled, etc.
3. Ministry of Health should be effectively involved in supporting and supervising/ approving technologies before adoption.
4. Sanitation standards in technology construction need to be enforced.
5. Technology information should be packaged targeting both the designer and the consumer.
6. Quality control of technology is very important.
7. Recommendations for technology adoption should be buttressed by research (evidence based adoption).
8. New technology should be tested before scaling up. Need to set-up technology forums to avail information to consumers as well as advise on appropriateness of technology.
9. Look at how to promote local promoters from the host community to design technologies. This could help the community to have suitable/appropriate technologies.
10. Affordability of technology is important. The initial costs should be known and the O&M cost implications clarified.

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11. The sustainability implications of various technology options must be considered.
12. Organize technology shopping centres. These could be at higher levels but they are important at the community level to accord communities with available options.
13. The technology ladder systems should be considered but should have sanitation considerations. Technology ladders should not be linear from first to last step but should be modified to suit prevailing local conditions.
14. There is need for clear design and construction guidelines and these must be enforced.
15. User education for technology use remains essential (e.g. materials for anal cleaning).

3.6.4 Strategies for School Sanitation

1. Hygiene and sanitation to be included in school curriculum, and teachers trained to enhance their participation in hygiene and sanitation promotion.
2. New school construction to include appropriate facilities and experts to be involved in the selection of sanitation plots to avoid inconvenient sitting such as school ablutions at market place (in which it becomes public toilets not school facilities). Every school to have WASH clubs and also work within existing clubs, head teachers, parents teachers' associations, etc. Establish functional clubs where they do not exist.
3. Build the capacity of science teachers and senior teacher champions.
4. Make separate sanitation facilities for boys and girls and consider the growth stages and needs, particularly of girl children at puberty.
5. Need for consistent, regular inspection and enforcement by education and health officers for improved hygiene and sanitation.
6. Organize hygiene and sanitation competitions and involve the media.
7. Institute routine personal hygiene inspection for school children and involve the parents' teachers associations and other community organizations in school sanitation activities (such as the school Open Day).
8. Cultivate strong linkages between the teacher-child-parent regarding hygiene and sanitation practices.
9. Reduce bureaucratic procedures in the improvement/maintenance and construction of sanitation facilities.
10. Develop methodology and tools involving children to reinforce positive hygiene and sanitation practices (e.g. use of local language, sanitation design games, etc.)
11. Hygiene and sanitation should become an examinable subject in schools.
12. Both quantitative and qualitative data/information on school hygiene and sanitation to be included in education monitoring information.
13. Need for strong coordination of school hygiene and sanitation efforts among focal ministries (education, health, water, culture, etc.) at all levels.
14. Improve procurement procedures for technology and technological support.
15. Have outreach programs from schools to communities.
16. Review school building rules and regulations to increase profile of hygiene and sanitation, make them available and enforce them.
17. Beyond construction increase the software component (training).
18. Governments and all responsible authorities to have a specific budget line for schools hygiene and sanitation.

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19. The practice of children cleaning toilets should be encouraged but should not be taken as punishment so as to inculcate positive attitudes in school children towards hygiene and sanitation.
20. Location and use of toilets by pupils should be monitored by teachers/health clubs members to avoid child to child abuse.

3.6.5 Capacity Building and Learning Strategies

1. Whilst human resources development (HRD) remains the core of CB the other aspects of organizational development (OD) and institutional arrangements (IA) should receive attention.
2. It should be noted that whilst CB is required at all levels in the sector the operational level and the opinion shapers at this level such as traditional & religious leadership, NGOs, private sector should be targeted.
3. CB is best achieved through learning alliance sessions that bring all together at different levels (national, district, etc). However targeted CB for the different sector players remains relevant.
4. Practitioners (ourselves) should move away from seminars and refresher courses as a form of CB and focus more on exchange visits as well as living with the community.
5. CB should start with where the Community (Beneficiaries) is and – build from there using existing local frameworks and organizations.
6. Capacity builders need to learn from community not teach the community. They must speak the community's language and simplify guidelines (local language) as well as harmonise their messages to avoid/limit confusing the community.
7. CB should be evidence based and demand driven informed by clear capacity need assessments. Supply driven training should be avoided at all costs.
8. The objective for CB in hygiene and sanitation CB should remain accelerating access to sanitation. All CB initiatives should be designed with this in mind.
9. With respect to information it is important to document experiences so as to learn from each other, e.g. 2 page summaries of important events or publications should be shared through current information networks, purpose organized learning events, etc.
   Information sharing should start with the individual self and be led by the resource centres. However there is need for regional repository of information with national nodes. Such a repository should use existing regional initiatives for information sharing.
10. The key CB issue that remains is how to transform experiences to practical action. To resolve this, learners are encouraged to draw-up action plans for post training activities which should be monitored and follow-up by training facilitators and learner superiors.
11. The second issue is the high staff turnover at higher levels and practitioners.
12. Data collection and storage should remain a mix of technologies (hard copies and software based) to cater for the different needs at the operational levels as well as take care of the different technological competencies. Guiding formats harmonized standards, e.g. sanitation coverage must be developed.
13. Decision-makers need to put sanitation higher on the agenda. For example practitioners should give facts at council/parliament inductions to highlight the importance of hygiene and sanitation.
14. Since politicians listen to themselves, one of their own should be used as champions for hygiene and sanitation promotion.
15. We should note that learning alliances are for those in but what about those outside the sector.
16. There is need to influence the curriculum of formal training institutions to highlight importance of hygiene and sanitation.

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17. Local and national governments do not appreciate CB so there is need to package CB in a manner that is recognized as useful by the authorities.
18. Who pays for CB? If it is truly need based then the beneficiaries should.

3.7 Key Recommendations to AfricaSan +5 Conference

From the strategy deliberations and the ensuing plenary the key recommendations that can be deduced for the AfricaSan +5 Conference are the following:

1. Hygiene and sanitation initiatives should now focus on what beneficiaries want not what options are available.
2. The MoH is the natural head and leader of hygiene and sanitation and this role must be recognized and resourced.
3. Establish multi-sector forums to ensure coordination in planning and implementation of hygiene and sanitation initiatives.
4. The national fiscus should have a budget line dedicated to hygiene and sanitation.
5. Hygiene and sanitation should not be a paragraph in the health or water policy! It must have its own stand alone policy.
6. Recognise the role of NGOs and the private sector in hygiene and sanitation.
7. Review health legislation to elevate the Department of Environmental Health to the same level as the Department of Water Development.
8. Develop technology centers that showcase the available hygiene and sanitation options to communities.
9. Involve children in developing tools for hygiene and sanitation.

3.8 Next Steps

The issue of a establishing a Community of Practice (CoP) for household and school sanitation and hygiene in East and Southern Africa was discussed in the plenary. This discussion was combined with thoughts on how to take the Seminar and its recommendations forward.

The participants unanimously agreed that there is a need for a platform (CoP) to discuss experiences in hygiene and sanitation but what has to be worked out are the modalities of doing it. The Seminar could not resolve whether practitioners should physically meet at prescribed times, or have a virtual home with moderation from one of the lead institutions in household and school sanitation. Neither could the Seminar resolve the question of what should be the scope of the CoP: should be CLTS, rural household sanitation or just household and schools sanitation and hygiene in the broadest sense possible?

The participants noted that the logistics of organizing the CoP are high and stressed the need to make the CoP structure feasible and sustainable. One issue that should be addressed is whether a new network should be created or advantage should be taken of existing networks.

Recommended actions for follow up:

The Seminar recommended the following immediate actions in relation to the establishment of a CoP in household and schools sanitation.

1. Resource Centres to prepare summary of proceedings.
2. WSCC to start dialogue for presentation of Seminar deliberations at AfricaSan+5.
3. Resource Centres to prepare terms of reference (ToR) for the CoP and invite practitioners to join.

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Some of the key points raised in this session include the following:

1. NGOs have been taking the lead in hygiene and sanitation in districts in which they work independently of other stakeholders (e.g. government and the private sector), and when they leave the project stops. There is a need to involve local government for continuity and sustainability. Adequate government representation is needed in national and local hygiene and sanitation forums.
2. Share the success of case studies presented here with in-country networks e.g. in Uganda, the WASH Resource Centre and UWASNET.
3. There appear to be common issues in all the countries. Let us have a joint resolution e.g. on sanitation financing.
4. Ensure the seminar key messages reach AfricaSan+5 based on the institutional framework presentation. The Moshi Seminar results need to be given a slot in the Conference. A short summary is needed of the key issues and recommendations from the practitioners' perspective.
5. As a suggestion for the CoP: Remember the HRD Club of East Africa with thematic areas and informal meetings; meet once year with no formal membership. Form a Club of Practitioners.
6. Why was there was no media coverage – need to start working with media.
7. As practitioners we should change our working approach to think also of the community level and share information with them.
8. UNICEF is willing to co-ordinate a CLTS e-group.
9. Southern Africa should learn from the co-operation demonstrated by East Africa.

3.9 Closing Remarks

3.9.1 Final comments

Mr Smet of IRC gave the closing remarks and called on all practitioners to take heed of the following points about hygiene and sanitation in the East and Southern Africa Region.

i) What is the progress after 20 yrs? Where are we going? Are we progressing or we are just standing still? Have we not talked for too long?

ii) There is devotion to success from the practitioners. This devotion needs to be converted to practical results.

iii) Hygiene and sanitation initiatives should now focus on what beneficiaries want out of the options that are available.

iv) As practitioners we have to make decision-makers realize that they need our field experiences.

3.9.2 Some general comments on logistics

The participants recommended and requested the following:

i) Improvement on logistical support e.g. a driver to pick people from the airport.

ii) That the sanitation marketing presentation be put up on internet and on CD Rom.

iii) The organisers should share the Amara project and if possible organize workshop in the field in Ethiopia in June 2008.

Appendix 1.Workshop Program

DATE and TIME	PROGRAMME COMPONENT
Monday 19 Nov 07	**DAY 1**
11:00-14:00	Registration
13:00-14:00	Lunch
14:00-14:30	Welcome, Introduction
14:30-15:00	Programme, objectives, outputs, structure, logistics, inventory of cases/posters
15:00-15:30	Framework of analysis
15:30-16:00	Tea/coffee
16:00-17:30	Case studies/Best Practice Household Sanitation and Hygiene: Ethiopia (1), Kenya (1), South Africa (1), Tanzania (1), Uganda (1), Malawi (1)
17:30-18:00	Posters' session
18:30-21:00	Drinks and snacks – Park View Inn or other place
Tuesday 20 Nov 07	**DAY 2**
08:30-10:30	Case studies/Best Practice Household Sanitation and Hygiene: Madagascar, Uganda (2), Zimbabwe, Ethiopia (2); Tanzania (2), Uganda (3); Ethiopia (3); South Africa (2)
10:30-11:00	Tea/coffee
11:00-11:30	Poster discussions on presented cases/best practices on Household Sanitation and Hygiene
11:30-13:00	Case studies/Best Practice Primary School Sanitation and Hygiene: Uganda, Kenya, case …
13:00-14:00	Lunch
14:00-14:30	Poster discussions on remaining presented cases/ best practices on Household /School Sanitation and Hygiene
14:30-14:45	Structure of Group analysis and synthesis; Group formation
14:45-15:30	Parallel analysis groups: 3-4 on Household and 1 on School Sanitation and Hygiene
15:30-16:00	Tea/Coffee

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16:00-17:30	Parallel analysis in groups: 3-4 on Household and 1 on School Sanitation and Hygiene
17:30-18:30	Presentations from groups (4-5 groups)
18:30-19:00	Prioritisation of 5 key issues on Household Sanitation and Hygiene; 3 key issues on School Sanitation and Hygiene. Identification of 8 Issue 'Owners'
Evening	'Owners' prepare for World Café
Wednesday 21 Nov 07	**DAY 3**
08:30-08:45	Recap of day 1 &2
08:45-09:00	Intro to World Café
09:00-10:30	Analysis of factors for success and hindrances, and key strategies
10:30-11:00	Tea/coffee
11:00-12:15	Presentation of World Café outcomes
12:15-12:30	Summary synthesis
12:30-12:50	Follow-up; possible Community of Practice on Household/ School Sanitation and Hygiene: interest and feasibility, suggestions, to be followed up by facilitators
12:50-13:00	Evaluation
13:00	Closing and farewell
13:00-14:00	Lunch and departure

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Appendix 2.Attendance list

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