



## **New methodology for sanitation projects in the Northern Province**

*Limpko Klu and Kate Roper, South Africa*

IN THE NORTHERN PROVINCE of South Africa sanitation projects have been dependant on government subsidies for the last seven years. This dependency has resulted in projects being implemented in bits and pieces. The first stage of implementation (Phase A) comprised of training committee members, builders, a storekeeper, quality controller and bookkeeper. Three demonstration toilets would also be built at this stage. In most cases, the project would have to wait for a period of over twelve months before moving on to Phase B (due to government funding delays), which entails construction of household latrines. During this time lapse trained committee members would be expected to remain with the skills that they had received during Phase A. The actual fact of the matter would be that most committee members would be forced to go elsewhere to use the gained skills to look for better jobs. By the time the project would be ready to go to phase B there would not be any trained committee members. In cases where members would be available, they would no longer be interested in the project as the time lapse would have caused them to lose interest. The strong ones who chose to continue with the project would have to be trained afresh as they would never have had the opportunity to practice the skills they had gained.

### **The broad coverage methodology**

The given scenario shows that sanitation was not going anywhere in the Northern Province. A new concept was born where Mvula Trust, decided to try new avenues of a more sustainable way of implementing sanitation. The broad coverage methodology was then finalized in September 1999. The methodology encourages community participation and does not consider sanitation as a toilet building exercise but advocates for vigorous health and hygiene education and promotion in the community. The aims of the approach are to:

- Empower local municipalities to take on responsibilities as service providers as stipulated in the Water Service Act of 1994 and the Local Government Act of 1996;
- Encourage behaviour change in the community where the community reflect critically on their present hygiene practices and come up with means of adapting good health and hygiene behaviours;
- Discourage the use of the subsidy as the driving force for building toilets; and
- Encourage toilet upgrading where possible.

Throughout the project the local municipalities and environmental health officers (EHOs) are engaged. This is

to ensure that they will support the community even long after project implementation. Besides ensuring that integrated development takes place, the engagement of EHOs reduces the cost of conducting health and hygiene education in the community as such activities become the responsibility of the EHOs and the appointed community health worker.

### **Involvement of the Regional Sanitation Task Team (RSTT)**

The RSTT is comprised of members of the municipalities, different government departments (for example, water affairs and forestry (DWAF), health, education, local government, environmental affairs, agriculture), implementing agents and other relevant stakeholders. Each stakeholder is expected to contribute towards proper implementation of sanitation in that region. There are five RSTTs in the Northern Province, one in each region.

All the RSTTs were engaged during the development of the new methodology. They were also involved in prioritizing the communities where pilots would be implemented. Each RSTT came up with names of three villages where the project could be piloted. In most cases the names were suggested by the councilors since they are in close contact with the people. The names were then forwarded to the Provincial Sanitation Task Team (PSTT).

DWAF approved that a baseline study should be conducted in the fifteen suggested communities. Participatory methods like the use of Participatory Hygiene and Sanitation Transformation (PHAST) were used to collect initial information about the project. The sanitation ladder tool was used to find out the kind of sanitation the people wanted to have after the intervention. Different constraints were explored concerning different types of sanitation. In most cases the people wanted to have flush toilets but upon looking at the availability of water in their area and the cost to build and maintain such a system, they resorted to dry sanitation. A mapping exercise was also used to gather information about the village. This included the population and existing sanitation infrastructure. The contamination routes and barriers tool was used to establish people's beliefs about oral- faecal contamination.

The findings of the baseline study were then used to compile a specific project description (SPD). Each village had its own SPD that outlined the present situation in the community with recommendations of what needs to be done to improve the situation. Budgets were also included

in these documents. The SPDs had to be approved by DWAF before any implementation could take place.

### **Management of subsidy**

During implementation the issue of talking about the subsidy was discouraged. Householders were given material assistance to help them build or upgrade their own toilets. The community was encouraged to practice good behaviours in order to receive material assistance for constructing new toilets, or upgrading existing toilets to ventilated improved pit latrines (VIP). Community health workers would go around the village conducting house to house visits to educate the community about health and hygiene. Several visits were done in the community. When the CHW noticed that there had been behaviour change, the household would be registered to receive material assistance for upgrading the toilet where possible, or building new ones. In some cases the householder was given material assistance of \$37.00 to build a toilet costing about \$147.00. The balance was then contributed by the householder in the form of material contribution, in kind or money. Material was purchased in bulk for a set of households that needed material assistance. Upon receipt of the material, the storekeeper would then distribute the appropriate material to the household, looking at the job card that was completed for each household. The job card would indicate clearly what the household is contributing and what has to be provided by the project. Because the use of local materials was encouraged, most people did not have to contribute any money, as they were able to collect local building materials for their toilets. This resulted in a large portion of the village being covered by the allocated funds. In cases of upgrading toilets, the figures were up to \$18.50 per upgrade. The most common upgrades were installing a vent pipe, a pedestal and a door to the existing toilets.

The project steering committee had been trained to manage the project on its own. Community health workers were trained on how to conduct health and hygiene education for the community. PHAST tools like three pile sorting were used to identify behaviours that were not good and action plans were made by the health workers on how they are going to ensure that behaviours would be changed. Time frames were indicated, as well as the personnel in the community who would be responsible for this. Mvula Trust work was mainly to monitor that activities on the action plans were followed. Assistance was also given in cases where the community needed it. Committee accounts have been opened for the community and the money for material assistance and to pay the bookkeeper, storekeeper, community health worker and quality controller was deposited into the committee's account. This money was managed by the committee. On average the sum of \$9,000.00 was deposited in the committee bank account. This money was deposited in three disbursements. At the beginning the sum of \$125.00 was used to open the account. Later on the sum of \$1,250.00 was deposited to help the committee purchase material for the toilets. When the amount was

exhausted, it had to be reconciled before the next disbursement of \$2,500.00 was made. The disbursement request had to include invoices for material purchased, wage registers to account for payment of wages and the job cards that indicated households where toilets had been constructed or upgraded. It was only when Mvula Trust was satisfied that the money was used for the purpose it was meant for that the disbursement was made. The same exercise was followed to receive the last disbursement of \$5,125.00. On completion of the project the committee had to reconcile and close their books. All the job cards have to be submitted and completion certificates are signed by householders, indicating that they are satisfied with the construction or upgrade made for them.

### **Problems encountered**

Even though this strategy is working well, there are still problems due to a lack of commitment from the municipalities and the Environmental Health Officers. Another dilemma that added to the problem were the local government elections in December 2000, where new municipalities were demarcated. Each municipality has its own councilors, which are mostly new or have been allocated new portfolios. However, this problem is being overcome by visiting all the new municipalities, introducing sanitation and how Mvula Trust operates.

We still have to get commitment from the Department of Health. The methodology indicated that Environmental Health Officers will be used. In most cases, joint ventures with clinic nurses were entered into, as they are also responsible for health issues in the communities. They have received the programme with open arms and are willing to work with the Community Health Workers.

When upgrading the toilets, it is a bit difficult to ensure safety of the slab, especially after a hole has been drilled through it to accommodate the vent pipe. Mvula Trust can only be held responsible for the interventions that they have engaged in even though other interventions might result in an imperfectly upgraded structure. For instance, when drilling a vent pipe in a slab, the slab might crack and become less stable. Such instances have to be monitored carefully by the technical consultants to ensure that they will not become safety hazards to the community.

### **Lessons learnt**

Community participation is the key to a successful project. The programme is managed by the committee with very little assistance from the project agents. Communities are capable of managing their own funds. In all the fifteen projects there has not been a single case of misappropriation of funds.

A lot of time needs to be allocated to the programme if better results are to be envisaged. A lot of time is needed to mobilize the community to buy into the programme. Communities still do not believe that a project can upgrade their toilets without expecting anything in return. The

programme is aimed at encouraging people to practice good health and hygiene so that their lives might be improved.

### **Conclusion**

Even though this strategy is working well the funding has not been enough to cover the whole community. It is only when continuous funding can be received that the momen-

tum that has already been initiated can be sustained. Municipalities need to be capacitated to be able to face the challenge of taking over sanitation as part of water services.

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LIMPHO KLU, Mvula Trust, South Africa.

KATE ROPER, Mvula Trust, South Africa.

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