Really making a difference:

Improving participation in delivering sanitation to poor communities

CSO preparatory meeting
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An outline

- What is preventing policy in delivery and participation from being translated into delivery?
- Poor municipal capacity, planning and budgeting
- Inadequate health and hygiene promotion
- Need for CSO's involvement in performance appraisal
- Community and HR dimension

High profile: high delivery?

- Sanitation no longer has a low profile
- There is now considerable policy on the question and well developed delivery strategies
- 2010 target to provide sanitation to all
- MDG target to halve backlog by 2015
- Sanitation latched on to high profile EPWP and ASGI-SA to create jobs
- Much greater general awareness in rural areas and high levels of demand in urban areas

The gap: output/target 2010

- Improved policy has somehow not had expected results
- Unofficial backlog of 3.9 million households not served.
- MIG allocation shows orientation toward allocation in urban centres (bucket eradication and waterborne sanitation projects)
- What relationship between planning, budgets and delivery?
- What role for rural communities, ISD?
- Review of existing technical, strategic, and financial approaches needed against *local* targets

Key issues

- Who actually is responsible for sanitation? How can communities initiate and manage sanitation projects?
- Generally poor representation of sanitation in IDPs/ WSDPs
- MIG funds allocated to sanitation are inadequate to achieve targets
- What are the cost/benefits involved over 20 years?
- Generally increasing emphasis on waterborne sanitation

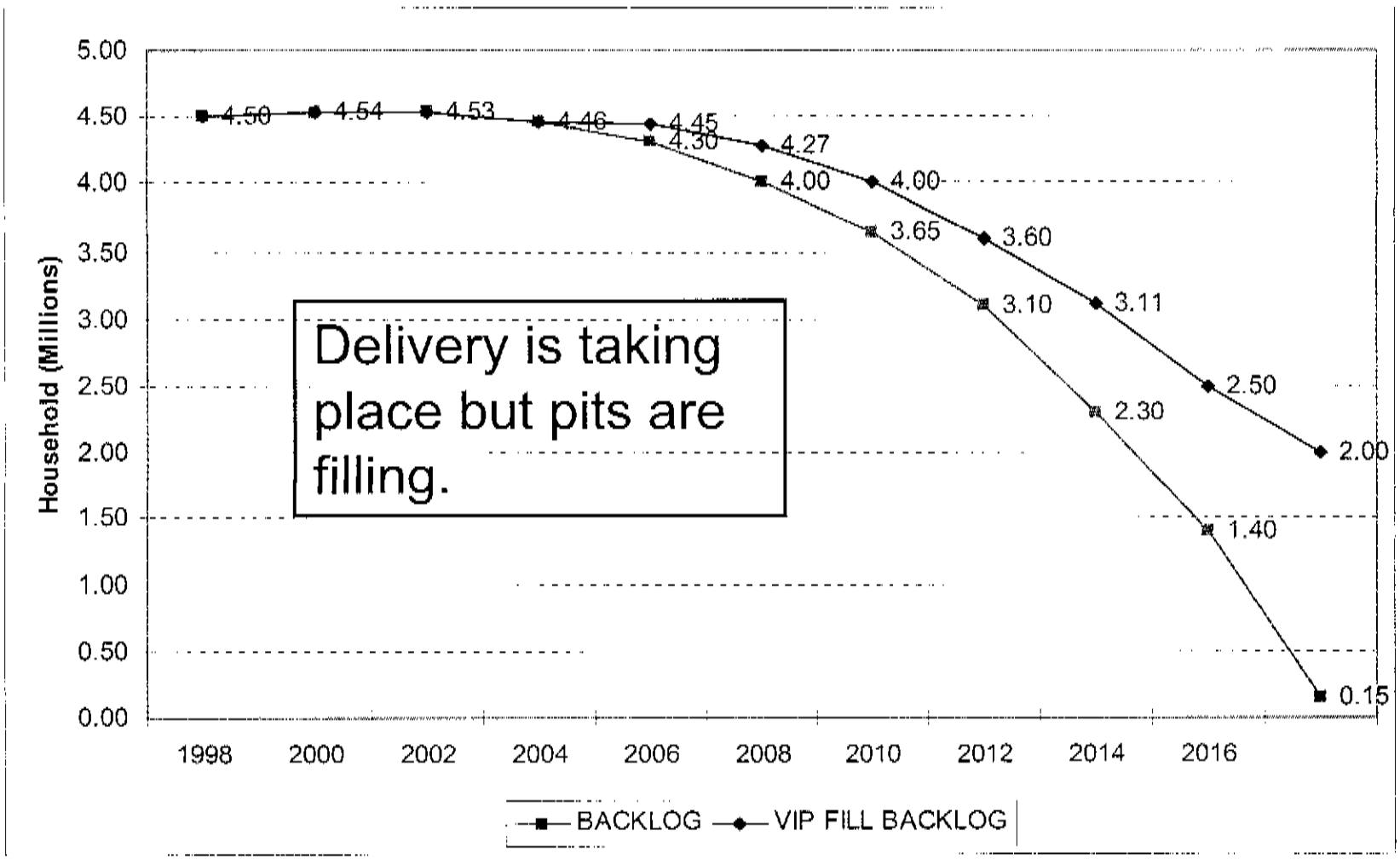
Will the MDG be met? (hhs)

Access to flush toilet or Ventilated Improved Privy

	1995	2003
All households	8,802,344	12,546,104
Basic sanitation	5,851,027	7,911,933
Below standard or none	[illegible]	[illegible]
Without access	34%	37%

Source: OHS 1995 and GHS 2003

Measuring progress



The problem with VIPs

- The “Fill Up” issue a major question:
- Many VIPs in rural areas are filling up. In many cases it is not possible or affordable to empty or move them.
- So as progress is being made toward the target, the backlog is being renewed.
- Should we build on what is working-progress in policy, Mvula community level, innovations?

Inadequate expenditure

- The final 'real' costs must be known;
- VIPs have to factor in replacement over 10-12 years or even sooner.
- Key issues are re-involving community: PSCs would increase delivery;
- To provide 3.9 million toilets in 3 years, need to deliver 1 million per year;
- Present delivery rate is less than 300,000 per year;
- It is suggested that, at R3000 per toilet with 40% water borne solution, need R21.3 billion to complete or R5.3 billion per year.

Competing models?

- Possible confusion because of the wide variety of mechanisms of delivery;
- Involvement of Local Municipalities?
- New integrated model needed around the key objectives:
- Highest level of direct beneficiaries: suppliers, builders and HHs
- High levels of capacity building through project roles;
- Labour intensity
- *Accredited* training in skills: building, PM, health promotion,
- Use of local suppliers as far as possible,
- Minimize unnecessary transportation,
- Involvement of householders and individuals
- Technology which is cost effective over time

CSO's and municipal performance

- Municipalities must "involve the local community in the development, implementation and review of the municipality's performance management system, and in particular, allow the community to participate in the setting of appropriate key performance indicators and performance targets".
- Section 42 of the Municipal Systems Act.

CSO inspection and standards

- Many complaints from HHs about VIPs especially over time;
- Availability of hand washing facilities?
- What depth and life of VIPs e.g. Blair toilets set at 3m;
- Are the pits lined?
- Doors able to be repaired?
- Are HHs trained to 'sign off' on the completion of VIPs?
- What check on the Quality Assessors?
- Adequate quality of materials?

Key issues ISD and HR

- Not sufficient priority given to advocacy, social mobilisation and institutional issues;
- Need to link to movement for social upliftment cf PSCs, local economic development, etc.
- Insufficient attention to training: where is training up to ABET1 level available? Which SETA?
- Training should not be narrowly technical; importance of ***Development Practice*** in Sanitation, ABET1, 2, 3, and 4
- Need for project manager training locally
- Greater possibilities in local networking: to provide leadership across water and sanitation, local suppliers, etc

‘Solutions’ emerging on the ground

- New combination of social and institutional arrangements and community control e.g. MT in Ozwathini appear effective;
- eThekwini Municipality urinary diversion provided to rural communities;
- Everywhere there is a turn towards waterborne sewerage;
- What new ISD and HR approaches can involve the community and vastly accelerate implementation?

Three proposals for CSOs:

1 Civil society should take the initiative in terms of undertaking quality assurance of the VIPs built especially where there are questions of poor construction through public works;

2 CSOs should set out the norms and standards for sanitation delivery in different contexts to ensure they meet citizen needs; with VIPs these must set out who will take responsibility when the pits are full;

3 These standards and measures as assessed by CSOs and households should be set out in a **single "signing-off" document** which should be widely distributed and set out in IDPs and WSDPs to meet constitutional requirements.