A REVIEW OF HEALTH AND HYGIENE PROMOTION AS PART OF SANITATION DELIVERY PROGRAMMES TO INFORMAL SETTLEMENTS IN THE CITY OF CAPE TOWN

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Faculty of Applied Sciences
Cape Peninsula University of Technology

Renay Van Wyk

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Supervisor: Professor Alvin Lagardien

STATEMENT OF DECLARATION

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I, Renay Van Wyk, declare that the content of this dissertation is my own work unless otherwise stated or acknowledged. Opinions contained herein are my own, and not necessarily those of the Cape Peninsula University of Technology. This document and/or part thereof have not been submitted to any other institution for fulfilment of a degree.

Student signature..... Date.....

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- local and provincial environmental health practitioners (Department of Health), officials from Water Services and Development Support Departments;
- community members and volunteers engaged in water and sanitation projects within each of the respective study sites;
- non-governmental organisations collaborating with communities and local authorities.

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ABSTRACT

Good sanitation includes appropriate health and hygiene promotion. This implies that proper health and hygiene promotion would have the desired effect as part of sanitation service delivery. However, lessons learnt worldwide show that in the promotion of health and hygiene, it is not enough simply to provide facilities, because if people do not use the available facilities properly, conditions do not improve or the system breaks down.

The 1986 Ottawa Charter of the World Health Organisation suggests that effective health and hygiene promotion requires the following key elements:

- the empowerment of local communities to take responsibility for promoting sanitation and environmental health
- collaborative partnerships of role-players across departments
- supportive policy environments.

Against this background, the focus of this study is the extent to which health and hygiene promotion forms part of sanitation delivery programmes to informal settlements in the City of Cape Town. The investigation was confined to a comparative review of approaches to health and hygiene promotion in four case study sites (Khayelitsha, Joe Slovo, Kayamandi and Imizamu Yetho) in the context of the following criteria:

- Community and household capacity to take responsibility for community-based health and hygiene promotion
- Role-players and collaborative partnerships across departments

- Implementation of health and hygiene promotion and alignment with national policy.

Analysis of the case studies highlights the ineffectiveness of once-off awareness campaigns and the need for a more comprehensive approach to health and hygiene promotion in line with the Ottawa Charter.

The push towards universal coverage of basic sanitation services will not bring the intended health benefits of delivery if, for instance, the provision of toilets is not complemented by appropriate health and hygiene promotion programmes.

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INTRODUCTION

1.1 Background

Rapid urbanization is a critical challenge for those charged with service provision to urban areas in developing countries. Unable to keep up with the rapid pace of population growth, many urban areas are experiencing a substantial increase in the number of people living below the poverty line in informal or unplanned settlements. Most informal settlements lack access to adequate and affordable basic services such as water supply and sanitation. Sanitation, health and hygiene promotion is a key aspect of sanitation service provision in conditions of urban poverty and dense informal settlements, as the aim of introducing sanitation systems is to ensure real health benefits.

Due to so many South Africans living under poor environmental conditions, our country is confronted by an enormous burden of disease. Providing adequate sanitation services to these poverty-stricken households continue to present many problems in South Africa. Unless communities perceive that they need to take responsibility for their own health, and are empowered to do so, these unacceptable conditions will remain.

The focus of this research emanated from the prioritisation of health and hygiene promotion as part of sanitation delivery to informal settlements by stakeholders serving on the Peri-Urban Core Group of the Provincial Sanitation Task Team, Western Cape.

1.2 Introduction to the problem

In order to understand the problems surrounding sanitation, one needs to know what the term "sanitation" refers to.

"Sanitation includes both the 'software' of understanding why water and excreta-related health problems exist and what steps people can take to address these problems, and 'hardware' such as toilets, sewers, water pipes and handwashing facilities" (DWAF, 2001: 14).

The White Paper on Basic Household Sanitation, 2001 suggests that good sanitation should include both appropriate facilities and appropriate health and hygiene promotion.

Sanitation systems fail because people do not use facilities properly therefore the mere provision of facilities to users is not enough.

The purpose of this research was therefore to review and compare health and hygiene promotion in the City of Cape Town and to highlight gaps in the sanitation delivery programmes.

1.3 Statement of the problem

Sanitation systems fail because people do not use facilities properly. This leads to poor sanitation and unhygienic practices that have an adverse effect on community and environmental health.

The problem statement is supported by the Ottawa Charter (WHO, 1986) which suggests that effective health and hygiene promotion programmes require supportive environments, which can only be established if communities are empowered to join other role-players across departments in taking responsibility for promoting sanitation and environmental health.

1.4 Significance of the study

The importance of this study is clearly stated in the following extract from the White Paper on Basic Household Sanitation, 2001: "When sanitation systems fail, or are inadequate, the impact on the health of the community, on the health of others and the negative impact on the environment can be extremely serious ..."

This study, to compare and review health and hygiene promotion programmes, is important to such role-players as municipalities, communities and households involved in the implementation of appropriate health and hygiene promotion to assist local authorities in sanitation service delivery.

The need for a more a comprehensive approach to health and hygiene promotion is in line with aims as set out in the Ottawa Charter (WHO, 1986), namely to:

- strengthen action through the empowerment of local communities in taking responsibility for promoting sanitation and environmental health;
- assist in reorienting health services through collaborative partnerships of role-players across departments; and
- suggest creating enabling and supportive policy environments.

The qualitative approach and action research methodology applied in this research engaged the stakeholders in reflecting on the outputs of research to encourage their own learning and ensure their ownership of the knowledge products.

1.5 Delimitations of the study

The investigation is confined to a comparative review of local authority approaches to sanitation and health promotion in four case study sites (Khayelitsha, Joe Slovo, Kayamandi and Imizamu Yetho) in the City of Cape Town. The research did not investigate the provision of acceptable, affordable and sustainable 'hardware' such as toilets, sewers, water pipes and handwashing facilities.

1.6 Aims of the study

The purpose of the investigation of approaches to health and hygiene promotion in four case study sites in the City of Cape Town was to:

- identify targets and find out if they have the capacity to execute community-based approaches in health and hygiene promotion;
- clarify the involvement of and relationships between role-players across departments in health and hygiene promotion as part of sanitation service delivery to promote collaborative partnerships;
- determine the extent to which the implementation of appropriate health and hygiene promotion is aligned with national policy to improve health and hygiene promotion programmes.

1.7 Research questions

The research is framed through the following questions:

- Who are the targets and is their capacity being built through health and hygiene promotion programmes?
- Have role-players from the different departments been involved in programmes and how are these relationships manifested?
- To what extent is the implementation of health and hygiene promotion programmes aligned with national policy and what do these entail?

1.8 Assumptions of the study

- It is essential that every individual should understand exactly what is meant by "hygienic conditions", including the ways in which these conditions can be improved and maintained.
- Local authorities can deliver appropriate health and hygiene promotion by empowering local communities with the knowledge and skills to interpret and apply sanitation and health information, which will facilitate the improvement of sanitary and healthy conditions.
- The improvement in health is the direct result of improved standards of hygiene as well as the provision of sanitation services

1.9 Definition of terms

This section aims to define key terms related to sanitation, health and hygiene education.

1.9.1 The White Paper on Basic Household Sanitation (2001) refers to **sanitation** as the principles and practices relating to the collection, removal or disposal of human excreta, household waste water and refuse as they impact upon people and the environment. Good sanitation includes appropriate health and hygiene promotion, and acceptable, affordable and sustainable sanitation services.

According to the World Health Organisation (WHO) **sanitation** relates to:

> ... interventions to reduce people's exposure to diseases by providing a clean environment in which to live; measures to break the cycle of disease. This usually

includes disposing of, or hygienic management of, human and animal excreta, refuse, and wastewater, the control of disease vectors and the provision of washing facilities for personal and domestic hygiene. Sanitation involves both behaviours and facilities which work together to form a hygienic environment (WHO, 1998).

Both these definitions highlight the importance of access to facilities and good sanitation, as well as proper hygiene and related practices.

1.9.2 **Sanitation promotion** is defined by the WHO (1988) as:

> ... an initiative to advance sanitation, raise the profile and status of sanitation, and further the growth and expansion of sanitation and to enhance awareness around it. In the public health sense of the world, it also involves providing the enabling mechanisms to others so that they make up the sanitation promotion armed with effective tools.

This definition is in line with the Ottawa Charter that suggests creating supportive environments and empowering local communities to take responsibility for promoting sanitation and environmental health.

1.9.3 **Health** is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO, 1946).

1.9.4 **Hygiene** relates to a set of principles and practices, such as cleanliness, to maintain good health. In the context of sanitation, health and hygiene education is defined as all activities, like monitoring their facilities and increasing hygienic practices, aimed at encouraging the behaviour and conditions that help to prevent contamination and the spread of diseases related to poor sanitation.

1.9.5 **Hygiene education** entails all activities aimed at encouraging behaviour and conditions which prevent diseases related to water and poor sanitation (Boot, 1991).

From the abovementioned definitions it is clear that health and hygiene education relates to activities including monitoring facilities and hygienic practices for communities and households, based on the context.

1.9.6 **Appropriate** programmes should be suitable to the context, consistent with prevailing or accepted standards according to the Minimum Standards in the Health and Hygiene Education Strategy (DWAF and DoH, 2005)

1.9.7 **Capacity** is the ability to understand and utilise the necessary knowledge and skills to inform hygiene practices.

1.10 Summary

This chapter introduced the context of the study. It explained the significance of the study by identifying the need to review health and hygiene promotion approaches though a comparative framework to assist local authorities in the delivery of appropriate sanitation programmes to informal settlements.

In Chapter 2 a literature review of the global and regional sanitation delivery context; national sanitation polices and strategies that create an enabling environment; and local government approaches to sanitation service delivery provides the starting point for the study.

Chapter 3 sets out the qualitative approach applied in this research that engaged the stakeholders in reflecting on the outputs of research in order to encourage their own learning and ensure their ownership of the knowledge products. It provides the reason for each step in the study and clearly describes how rigour is achieved.

Chapter 4 documents the results of the field-based investigation and the comparative review of approaches to health and hygiene promotion in four case study sites (Khayelitsha, Joe Slovo, Kayamandi and Imizamu Yetho) in respect of role-players and relationships, community and household responsibilities, and implementation.

Chapter 5, the concluding chapter of the thesis, presents the findings of the study. Recommendations are made regarding implementation and possible policy implications.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter consists of a literature review that:

- outlines the global and regional context and emphasises the importance of implementing sustainable services and promoting sanitation and hygiene promotion as necessary development interventions;
- highlights key policies and strategies that create an enabling policy environment for the delivery of health and hygiene promotion. It includes the South African national sanitation policy environment and local government approaches to sanitation service delivery, which provided the starting point for investigation;
- discusses concepts like empowerment, literacy and promotion and shows how they fit into health promotion approaches.

2.2 The global context of health and hygiene promotion

The following statement by the then Secretary-General of the United Nations, Kofi Annan, to the fifty-fourth World Health Assembly held in Geneva on World Water Day 2001 highlights the global challenge to implement sustainable water services including both technical and health and hygiene promotion components:

> We shall not finally defeat AIDS, tuberculosis, malaria, or any of the other infectious diseases that plague the developing world until we have also won the battle for safe drinking water, sanitation and basic health care (Special Features Edition, March 2001).

A global perspective, highlighting the burden of disease that is related to poor sanitation and poor hygiene practices, is described as follows:

> Nearly 40% of the world's population (2.4 billion) have no access to hygienic means of personal sanitation. Globally, WHO estimates that 1.8 million people die each year from diarrhoeal diseases, 200 million people are infected with schistosomiasis and more than 1 billion people suffer from soil-transmitted helminth infections. A Special Session on Children of the United Nations General Assembly (2002) reported that nearly 5 500 children die every day from diseases caused by contaminated food and water (WHO, 2004: 13).

It is clear that the provision of sanitation is a key development intervention – without it, ill-health entails a life without dignity. Simply having access to sanitation increases health, well-being and economic productivity. Inadequate sanitation affects individuals, households, communities and countries.

2.2.1 The adoption of the Millennium Development Goals

The adoption of a number of Millennium Development Goals (MDGs) by the United Nations General Assembly in September 2000 was a significant event that challenged the global community to reduce this burden of disease and increase the health and well-being of all peoples.

These goals were reaffirmed in 2002 at the World Summit on Sustainable Development in Johannesburg, thus acknowledging the importance of promoting sanitation and

hygiene as necessary development interventions. In addition, specific targets on sanitation and hygiene were added.

The following goals that were articulated are most relevant to the focus of this study of the health promotion aspect of sanitation:

- Halve, by 2015, the proportion of people without access to basic sanitation.
- Promote safe hygiene practices.
- Promote affordable and socially and culturally acceptable technologies and practices.
- Build institutional capacity and develop programmes for waste collection and disposal and services for unserved populations.

By setting a series of goals and targets including water supply, sanitation and hygiene in the MDGs, the world community has acknowledged the importance of their promotion as development interventions. International experience clearly states that sanitation facilities alone do not guarantee the improvement of health, thus emphasising the need for a broader approach to sanitation implementation where health and hygiene promotion is included as an integral part of sanitation delivery programmes.

2.2.2 Community involvement

Lessons from a global perspective have affirmed that communities are involved by taking responsibility and ownership of facilities. Communities have been recognised and promoted as an important element in sustainable sanitation solutions.

Global recognition that the responsibility for sustainable sanitation interventions must be located within the user community is contained in VISION 21: a shared vision for hygiene, sanitation and water supply as expressed within the Iguagu Action Programme (WSSCC, 2001).

Global sanitation advocates a community-based approach, described as a "commitment to building on people's energy and creativity" and an approach in which "households and communities take the important decisions and actions" (WSSCC, 2001: 12).

The responsibility of making choices that are conducive to health and facilitating the improvement of sanitary and healthy conditions lies with the household or local community.

Empowering these households and local communities with appropriate sanitation, health and hygiene education would create a supportive environment and strengthen action in the promotion of sanitation and environmental health.

Global sanitation advocates a community-based approach through which the empowerment of communities by means of health and hygiene education would create supportive environments in sanitation delivery.

2.3. The regional context of health and hygiene promotion

2.3.1 The adoption of the NEPAD Health Strategy

An important achievement of NEPAD was the adoption of the NEPAD Health Strategy at the first AU Conference held in Tripoli in April 2003 (SARPN, 2003). The strategy highlights the strengthening of commitment, securing health systems and the empowerment of people to improve their health.

All these objectives enhance the aim of implementing effective and sustainable health and hygiene education. The World Health Organisation - Africa Region has identified the following health promotion interventions as priorities:

- Advocacy for health promotion
- Capacity building, particularly of people skills and knowledge
- Individual countries to develop plans of action integrating them into their respective health systems
- Inclusion of non health sectors in health promotion actions
- Use of health promotion methods to strengthen priority health programmes.

These priorities are pertinent to planning and implementing sanitation and health promotion as part of sanitation delivery programmes in South Africa.

2.3.2 The health focus of the Southern African Development Community Directorate for Social and Human Development

The health focus of the Southern African Development Community (SADC) Directorate for Social and Human Development has a strong emphasis on HIV/AIDS and malaria with little emphasis on sanitation and health promotion related to water and sanitation services. However, key South African stakeholders in the sector should promote sanitation and health in the SADC Directorate for Social and Human Development Encouraging the development and integration of services related to water and health and hygiene aspects is pertinent to the advancement of healthy and sustainable livelihoods which is dependent on effective health and hygiene promotion.

2.4 The national context of health and hygiene promotion

2.4.1 The South African National Sanitation Policy environment and local government approaches

This section highlights key policies and strategies that create an enabling policy environment for the delivery of health and hygiene promotion.

The Bill of Rights contained in the South African Constitution (South African Constitution, 1996: 6) and the Water Services Act No.108 of 1997 provide a legislative framework for the rights of access to basic water supply and basic sanitation (DWAF, 1997).

In addition, the Strategic Framework for Water Services defined *Basic sanitation services* as "The provision of a basic sanitation facility which is easily accessible to a household ... and the communication of good sanitation, hygiene and related practices" (Strategic Framework for Water Services, Section 6.3, 2003: 45). The Strategic Framework for Water Services sets out a national framework for the water services sector (water and sanitation) in South Africa.

The White Paper on Basic Household Sanitation (2001) supports that definition by stating that good sanitation includes appropriate health and hygiene awareness and behaviour, and acceptable, affordable and sustainable sanitation services. The National Health Bill provides a framework for a structured uniform health system within South Africa and in particular provides for the establishment of Municipal Health Services at District Municipality Level (Group C municipalities). This relates to the study in terms of identifying institutional responsibility for sanitation and health promotion at local government level and particularly the role of the environmental health department in the provision of sanitation services.

The Draft Health Promotion Policy for South Africa provides a framework for the delivery of health promotion services in South Africa. It aims to provide integrated and comprehensive health promotion interventions for the improvement of the health and well-being of all South Africans through involving all relevant sectors and departments that enhance the physical, social, and emotional well-being of all and contribute to the prevention of the leading causes of diseases, disabilities and death.

Since the publication in 1994 of the White Paper on Water Supply and Sanitation Policy, in the draft National Sanitation White Paper of 1996 and subsequent revisions, national policy principles consistently promote a demand-driven approach. (DWAF, 1996)

In the Framework for National Sanitation Strategy (Annexed to the revised White Paper) the centrality of a "community-based approach" is reaffirmed and given form as guidelines. Four elements to be included in addressing hygiene and four training activities to be included in capacity building suggest that the "developmental approach" leans heavily on education and training (DWAF, 2001: 98).

In South Africa municipalities are responsible for implementing the national sanitation policy vision that "all people living in South Africa have access to adequate, safe, appropriate and affordable water and sanitation services", that they "practise safe sanitation", and that "sanitation services are sustainable and are provided by effective and efficient institutions that are accountable and responsive to those whom they serve" (DWAF policy publications, 2001 to 2003). Policy developments since the White Paper on Basic Household Sanitation (DWAF, 2001) approved by Cabinet, include a draft Water Services White Paper and a draft Free Basic Sanitation Strategy discussion document (DWAF, v4 June 2003). These documents remain consistent in reinforcing the principles of promotion.

Policy principles for health and hygiene promotion

The policy principles for health and hygiene promotion as set out in Strategic Framework for Water Services are the following (DWAF, 2003):

- Sanitation improvement must be **demand responsive**, supported by an intensive health and hygiene programme.
- There should be **community participation**. Communities must be fully involved in projects that relate to their health and well-being as well as in decisions relating to community facilities.
- Sanitation is about **environment and health**. Sanitation improvement must be accompanied by environmental, health and hygiene promotional activities.
- There should be **health for all** rather than for some. Those faced with the greatest health risks need to be prioritised.
- **Environmental integrity** must be ensured. The environment must be protected from the potentially negative impacts of developing and operating sanitation systems.

These principles are based on experience and the knowledge that individual, household and community behaviours and practices contribute significantly to the prevention of contamination and the spread of diseases related to sanitation.

The link between programmes that create awareness and foster practices based on local knowledge, and sanitation systems that differ according to the specific technologies provided in each particular context, is implicit in the statements of principle above. On a municipal level Water Services Development Plans (WSDPs) are required to inform

Integrated Development Plans (IDPs) as a mechanism for ensuring that an equitable spread of resources is made available for clearing the sanitation backlog "so that everybody has access to at least a basic level of service" (DWAF, 2003: 8).

The IDP General Guidelines produced in 2001 to provide a tool for developmental local government and other role-players involved in implementing policy, seek to clarify issues arising from a lack of progress in "dealing with the real issues of residents and communities in a strategic, developmental and delivery-oriented manner".
One of the deficiencies that the document attempts to address, due in part to capacity limitations and the process being new to the actors involved, is an inability to "organise the public participation process in a meaningful way" (DPLG, March 2001).

The functions of participation in the integrated developmental planning process are put forward in the IDP guidelines as summarised below:

- Ensure appropriateness of solutions by using the knowledge and experience of local residents to arrive at appropriate and sustainable measures for addressing problems.
- Provide community ownership through mobilising local initiative and encouraging partnerships between the municipality and residents for implementation and maintenance.
- Empower the community through negotiation, compromise and finding common ground.

Health and hygiene promotion, in the context of adopting a comprehensive approach to sanitation delivery, offers municipalities a way forward towards meeting these objectives.

2.5 Health promotion approaches

2.5.1 The Hygiene Improvement Framework

The Environmental Health Project (EHP) advocates the Hygiene Improvement Framework (HIF) – an integrated approach that links hardware and hygiene promotion and an enabling environment with strong organisational structures to prevent diarrhoeal disease.

The Hygiene Improvement Framework is based on the recognition that behaviours – especially drinking safe water, sanitary disposal of faeces, and washing hands with good technique at appropriate times – are key determinants of worm infestation and diarrhoea risk. In order to prevent diarrhoea, hardware and materials, software or promotion of the behaviours, and enabling institutional and policy environment to achieve improvements in a sustainable fashion must support these behaviours to facilitate hygiene improvement (EHP, 2004).

According to the WSSCC progress report (2000 – 2003), case studies have demonstrated that water supply, sanitation and hygiene can each be an effective means to prevent diarrhoea. These studies point to two conclusions: Firstly, improved water quality and quantity prevent diarrhoea, but excreta disposal and hand washing also have a significant impact. Secondly, interventions aimed at hygiene (such as hand washing) can have a great impact on preventing diarrhoeal diseases as hardware.

The Environmental Health Project (EHP) has usefully developed the Hygiene Improvement Framework (HIF) as an integrated approach to preventing diarrhoeal disease.

The Hygiene Improvement Framework is a holistic approach to water and sanitation efforts. It combines increased access to facilities and the promotion of behaviour change with supportive policies and institutions. Sustainable improvements in hygiene behaviour patterns require more than promotional and educational activities.

Water, sanitation and hygiene facilities, while not sufficient on their own to improve health, are critical components in a comprehensive hygiene improvement programme. The development of policies, institutions and community capacity to manage and sustain hygiene, water and sanitation programmes is essential for long-term success.

The Hygiene Improvement Framework has three components: access to hardware, hygiene promotion, and an enabling policy and institutional environment. These components are discussed below.

Access to facilities

Activities to increase access to facilities include promoting a package of appropriate, low-cost sanitation, water and hand-washing facilities. These facilities must meet the specific needs of communities. The United Nations Children's Fund (UNICEF) programmes promote water, sanitation and hygiene 'ladders' – the introduction of basic technologies that may be upgraded when families can afford to do so.

Hygiene awareness and promotion

UNICEF's hygiene awareness and promotion efforts focus on changing behaviour by communicating key hygiene practices such as hand washing. Children and the youth are encouraged to be agents of change in their families and communities through initiatives such as life skills training programmes, curriculum development and integrated sanitation and hygiene education in schools.

Enabling environments

An environment that enables and supports the improvement of hygiene must be continuously promoted at all levels – from the village household at one end of the spectrum to the office of the global policy maker at the other. The development of national policies that facilitate and promote hygiene improvement is a critical step in many countries. New policy development efforts by UNICEF focus on promoting community-managed systems that are affordable and easy to maintain. Building the community's capacity is equally important in ensuring sustainability. Communities must be equipped with the knowledge and skills to manage their own facilities effectively and to demand high-quality service from duty-bearers in government, civil society and the private sector. The Hygiene Improvement Framework was originally developed by the Environmental Health Project (EHP, 2004).

2.5.2 Integrating the 'hardware' and 'software'

Global experience has shown that the provision of taps and toilets does not transform health on its own, but that better hygiene is the key factor. What exactly are the basics of good hygiene? The United Nations family of agencies – including UNICEF, WHO, UNDP, the World Bank, UNFPA, UNESCO, and the World Food programme – have jointly agreed on the Hygiene Code. The code includes basic hygiene information that all families in the world need to know. It therefore represents a massive communications challenge in which the media has a key role to play (WHO, UNICEF, WSSCC et el., 2000).

UNICEF has noted that children are most vulnerable to the health hazards associated with poor hygiene and inadequate sanitation systems. Regular hand washing and access to toilets can significantly reduce child mortality and improve children's health and development. Therefore, health and hygiene education can prove to be very significant in identifying children as targets in sanitation, because childhood is the best time for children to establish lifelong hygiene behaviours.

The importance of sound hygiene practices has been addressed in a number of ways in a range of situations. Several studies have shown that most diseases suffered by children are related to unsanitary conditions and lack of personal hygiene (WHO, UNICEF, WSSCC et el., 2000). Such survey results show the need for a focus on children. It is also generally recognised that childhood is the best time for children to establish lifelong hygiene behaviours.

Children are future parents and what they learn is likely to be applied in the rest of their lives. They have important roles in the household, such as taking care of younger siblings. Depending on the culture, they may also question existing practices in the household.

They are eager to learn and help, and if they consider environmental care and their role in this as important, they take care of their own health and the health of others. Since they are the parents of the future, children are also likely to ensure the sustainability of the programme's impact.

After the family, schools, which have a central place in the community, are most important places of learning for children. Schools provide a stimulating learning environment for children and promote or initiate change. If sanitary facilities in schools are available, they can act as a model, and teachers can function as role models for schoolchildren. Schools can also influence communities through outreach activities, since through their students; schools are in touch with a large proportion of the households in the community.

2.5.3. Health education and health promotion

The emergence of sanitation and health promotion led to confusion in many people's minds. Some people saw promotion as a concept that replaced education, while others believed that many of the elements of promotion could be accommodated in existing approaches to education (Hubley, 2002).

The Ottawa charter in 1986 defined health promotion as consisting of the following components:

- Reorienting health services
- Creating supportive environments
- Enabling people and developing personal skills.

Reorienting health services contributes to the pursuit of health and results in collaborative partnerships across sectors.

Through the **creation of supportive environments** a socio-ecological approach to health is emphasised in the form of reciprocal maintenance. This involves that everyone will take responsibility for the protection of the environment and the conservation of natural resources. This key challenge for global health is linked to the **strengthening of community action** and the empowerment of communities, their ownership and control of their own endeavours and destinies.

Developing personal skills involves education for health and enhancing life skills. Action in this regard is advocated in multiple settings such as schools, homes, workplaces and communities. It is regarded as crucial to increasing the options available to people to exercise more control over their own health and to make choices that are conducive to health.

These components can be grouped into Health Education, Service Improvement and Advocacy. John Hubley (Hubley, 2002) refers to it as (Table 2.1). This model consists of three components that correspond to health promotion and it shows clearly how health education and empowerment of the communities relate to health promotion.

Table 2.1: The HESIAD model (Source: John Hubley, 2002)

Health Education	**Service Improvement**	**Advocacy**
Communication directed at individuals, families and communities to influence:	**Improvements in quality and quantity of services:**	**Agenda setting and advocacy for healthy public policy:**
Awareness/knowledge Decision making Beliefs/attitudes Empowerment Individual and community action/behaviour change Community participation	Accessibility Case management Education Outreach Social marketing	Policies for health Income generation Removal of obstacles Discrimination Inequalities Gender barriers

Health education relates to communication to individuals and communities. It is fundamental to health promotion.

Service improvement involves reorienting and training field staff, developing teamwork, doing supervision and giving feedback.

Advocacy entails explaining issues to politicians, forming pressure groups and meeting policy makers.

This approach clearly shows the vital relationship between health education and health empowerment. It is thus possible to draw on the research and evaluations carried out on health education and integrate them into the growing body of knowledge on health promotion.

2.5.4 Health empowerment, health literacy and health promotion

Within international settings 'community participation' was the buzzword of the 1980s, while 'empowerment' was the term most widely used in the 1990s. Then a new concept, 'health literacy', was introduced. A charitable perspective is to see this new concept as a sign of a dynamic, forward-moving discipline. Another view is to see this as yet another addition to the plethora of terms and a sign of the continuing insecurity of health education and promotion and its need to reinvent itself.

The term 'empowerment' has mixed origins. It has roots in adult education theory, and in this context refers to a dynamic process of critical understanding, reflection, action and learning from action (praxis). The radical feminist health movements of the 1980s used the term 'consciousness raising'. Empowerment, while not always explicitly acknowledged, forms the rationale for participatory learning methods which, rather than set specific end points such as cognitive learning or behaviour change, emphasise process outcomes. Community development as a strategy has long emphasised the process of developing community power and involvement in decision making. In the 1980s community development developed this further with the emergence of participatory rural appraisal methods as a key methodology.

A concept of empowerment as that of developing power in a group has a key flaw. The importance of this dimension of empowerment for health promotion is certainly self-evident. Evaluations of health education programmes have repeatedly demonstrated that change in knowledge did not result in action and improved health (Hubley, 2002).

It is clear from previous studies – knowledge alone was not enough. People need to have the confidence to feel that they can change their lives. It is not enough to have confidence and power. Translation of this into improved health requires the understanding of health issues in order to make informed health decisions. It is at this point that the concept of health literacy appears to offer some real benefits in redefining the concept of empowerment. According to Hubley (2002: 89) "health literacy represents the cognitive and social skills which determine the motivation and abilities of individuals to gain access to, understand and use information in ways to promote and maintain good health"

This definition has the value of including a cognitive element of basic understanding about health and sanitation issues, interpretation of health education information and applying this to make informed decisions about health as well as life skills such as communication, assertiveness, and the negotiation involved in putting decisions into practice.

The definition is also interesting in its inclusion of social skills, which implies that in health literacy it is not just a question of understanding and processing information but also of using the information to bring about change by communicating with others, resisting pressure, convincing others and organising individual, family and community action. However, inclusion of motivation into health literacy appears to confuse quite

different processes and would be better located within the sphere of self-efficacy (explained below), another component of empowerment.

Hubley (2002) suggests that health literacy and self-efficacy can be usefully considered as the two key components of health empowerment as shown in Table 2.2 below.

Table 2.2: Key components of health empowerment (Source: Hubley, 2002)

Health empowerment =	**Self-efficacy**	+	**Health literacy**
	Affective/Cognitive		Cognitive/Communication
	High self-esteem		Understandings of health and disease
	Feeling of power and control		Decision-making skills
	Confidence to take action		Ability to communicate health issues
	Beliefs about ability to change situation		

One of the benefits of this approach is that it makes explicit the cognitive and affective domains of health empowerment. Thus it shows how the process of empowerment can build upon and incorporate what is already known about the processes of developing self-efficacy, decision making and life skills.

Health literacy can only be achieved through a process of health education and promotion, which seeks to develop understanding of health issues and how to apply these to make decisions. However, many traditional 'top-down' didactic health education methods, while providing knowledge, have a negative effect of disempowering people by creating dependency on professionals. The challenge is to provide this cognitive input

through educational processes, which reinforce community confidence and power and do not undermine it.

Self-efficacy can be achieved in a variety of ways that promote self-esteem and develop individual or community control over people's lives and surroundings. This could involve any aspect of their lives, for example action on housing, income generation, and the process of community participation or democratisation at a national level. The value of control may be at a local level, for example in learning new skills in farming, making clothes, cooking, or creative expression through music and drama. In situations where self-efficacy has already been developed in a community through action on other issues that do not involve health, health promoters can build upon these activities and use shorter and simpler learning processes.

Health education using participatory learning methods provides a possible way forward through the promotion of both health literacy and self-efficacy (Hubley, 2002).

Health promotion approaches suggest that the development of policies, supportive institutions and community capacity to manage and sustain health and hygiene programmes is essential for long-term success.

2.5.5 Discourse on health and hygiene awareness and health and hygiene education from the National Health and Hygiene Strategy

Health and hygiene awareness should not be confused with health and hygiene education. Health and hygiene awareness programmes are short-term activities that normally occur once only. They generally draw people's attention to issues regarding sanitation, health and hygiene.

According to the Health and Hygiene Education Strategy an awareness programme is the process or activity that imparts elementary understanding and sensitisation. Awareness programmes involve short-term, often once-off activities, that will, at best, create short-term sensitisation. There is no guarantee that awareness programmes will result in a change of attitude and/or behaviour (Ukhuthula Development Services, 2004).

The Health and Hygiene Education Strategy also states that education involves a learning process where people acquire knowledge and life skills to solve problems. Thus, in education, increased knowledge must lead to a change in an individual's attitudes and practices. Education will only be achieved through ongoing medium long-term activities (Ukhuthula Development Services, 2004).

Education programmes involve a range of activities including awareness raising, community relations and skills training in schools and adult communities. Thus, in order to achieve sustainable development, education does not only involve awareness raising, but knowledge transfer resulting in positive behaviour change.

Behaviour change is not easy, as it takes a long time to achieve. In order to achieve behaviour and attitudinal change, a life-long, interdisciplinary and integrated approach to education programmes is required. Some programmes are called educational whereas in essence they are awareness programmes.

A key point emerging from these definitions is that sanitation services must include health and hygiene education as an integral and required part of basic sanitation service delivery.

2.6 Summary

The following themes for health and hygiene promotion were derived from the background theory:

- Strengthening action through developing community capacity to take responsibility for their hygiene practices.
    - Determine the capacity of communities and households and encourage a community-based approach
- Reorientation of health services requires collaborative partnerships between different role-players involved in sanitation promotion.
    - Clarify relationships and involvement of role-players in health and hygiene promotion as part of sanitation service delivery.
- A supportive policy environment is needed to implement policy by providing facilities and appropriate health and hygiene programmes.
    - Review the extent to which the implementation of health and hygiene promotion and the provision of facilities is aligned with national policy

Global sanitation advocates a community-based approach, and the empowerment of communities through health and hygiene education would create supportive environments in sanitation delivery.

Inadequate sanitation affects individuals, households, communities and countries. Water, sanitation and hygiene facilities, while not sufficient on their own to improve health, are critical components in a comprehensive hygiene improvement programme. The effectiveness of water and sanitation services in promoting healthy and sustainable livelihoods is dependent on effective health and hygiene promotion.

Health promotion approaches suggests that for long-term success it is vital to develop policies, supportive institutions and community capacity to manage and sustain health and hygiene programmes.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

The study included the investigation of health and hygiene promotion as part of sanitation delivery programmes for improving sanitation delivery in informal settlements in the City of Cape Town. Failure of sanitation systems and inadequate use of facilities results in poor sanitation and unhygienic practices that have an adverse effect on community and environmental health has been identified as the core problem in the case study sites. Therefore the need for developing and implementing approaches that motivate people to change their hygiene practices

Against the background of the Ottawa Charter of the World Health Organisation (1986) inferences will be made through a comparative review of health and hygiene promotion in four case study sites. The Charter suggests that effective health and hygiene promotion

programmes require supportive environments, which can only be established if communities are empowered to join other role-players across departments in taking responsibility for promoting sanitation and environmental health.

3.2 Research methodology

The qualitative approach and action research methodology applied in this research engaged the stakeholders in reflecting on the outputs of research in order to encourage their own learning and inform their future practice.

For the purposes of this study, the research process is defined as a process that involves collection and documentation of data; the presentation of findings to local authority officials and communities for feedback and incorporating feedback as data.

3.2.1 The research was intended to:

- identify the targets and their capacity for the promotion of community-based approaches in health and hygiene promotion; because communities needs capacity to take responsibility for their hygiene practices and ensure sustainability.
- clarify the nature of collaborative partnerships between role-players across departments; because partnerships between different role-players involved in sanitation promotion is pivotal.
- determine the alignment of health and hygiene promotion programmes with national policy, because a supportive policy environment is for the improvement of hygiene.

3.2.2 The research methods included:

- On site observations and interviews to define the capacity of communities and households for community-based health and hygiene promotion
- Stakeholder workshops and interviews with local authority officials to determine their involvement and the current relationships between role-players across departments in health and hygiene promotion as part of sanitation service delivery. Results are captured in appendices.
- Literature reviews of global trends, the South African national sanitation policy environment and local government approaches to determine the extent to which the implementation of health and hygiene promotion is aligned with national policy to improve health and hygiene promotion programmes.

3.2.3 Research was conducted in the following phases:

Phase 1: A comprehensive review of relevant literature provided the background of the broader context and current theories on effective health and hygiene promotion. The review includes literature on the following:

- Global trends, which include the Millennium Development Goals that acknowledge the importance of the promotion of health and hygiene.
- A review of the NEPAD Health Strategy highlighting objectives that enhance the aim of implementing effective and sustainable health and hygiene promotion. The priorities that are pertinent to the planning and implementation of health and hygiene as part of sanitation service delivery are drawn from international discourse.

- The South African National Sanitation Policy and local government approaches to basic service provision. This provided the starting point for investigating the policy environments of local government. National Policy principles consistently promote a demand-driven approach.
- International case studies and health promotion approaches, which were explored as they provided insight into who the target audience for health and hygiene should be.
- Health empowerment and literacy related to health promotion, which provided insight in terms of what capacity role-players in health and hygiene promotion programmes should possess.

Phase 2: An investigation was done into approaches to health and hygiene promotion as part of sanitation delivery in four case study sites in Cape Town by using a general methodology.

The methodology included the following research activities:

- Local authority officials were interviewed to collect data on sanitation delivery programmes. These interviews and responses were captured in research reports (Appendices 2a - 5c).
- Research assistants were involved in field visits, observations and onsite interviews. The aim was to gain insight into who was targeted and what community capacity was built after the health and hygiene promotion initiatives in each of the case studies (Appendices 2a - 5c).

- The researcher attended a project meeting of the City of Cape Town Servicing of Informal Settlements Project to investigate current approaches to sanitation delivery. These discussions were captured (Appendices 7a to 7d).

Phase 3: Stakeholder validation was done in the following ways:

- The community and local authority officials, namely the Health and Hygiene Reference group, consisting mostly of Environmental Health Practitioners within the City of Cape Town, were engaged in stakeholder validation. Stakeholder validation allowed for responses to data collected, and opportunities for further input by the informants involved in current health and hygiene promotion delivery initiatives.
- The Health Department's Working Group was facilitated to develop minimum health specifications for the health strategy (Appendix 7a to 7d).

3.3 Research design

A qualitative research design was utilised to gain perspective, to describe and understand social action. Qualitative methods of data collection were used. The investigation was conducted in a natural setting of stakeholders. The natural setting was formed by stakeholders from local authority departments (e.g. health, engineering, development support) and non-governmental organisations involved in the delivery of sanitation programmes and approaches to health and hygiene promotion in informal settlements.

3.3.1 Selection of case study sites by stakeholders

Four case study sites were identified by stakeholders who participated in the Peri-Urban Strategy Workshops that were conducted through the Provincial Sanitation Task Team (PSTT) between 2002 and 2003.

For the purpose of the investigation of health and hygiene promotion as part of sanitation delivery approaches, these sites were presented by role-players as those in which community demand for improved sanitation was established. In each case a local authority and NGO partnership was engaged in responding to this demand.

A comparative review was done of four case studies through intensive investigation of each approach as part of sanitation delivery.

3.4 Data collection

Data was collected in all four case study sites through onsite observations and onsite interviews. The researcher interviewed local authority officials working in the respective case study sites and attended project meetings. Stakeholder validation involved the various groups of stakeholders in validation sessions.

The resulting baseline data introduced the case study sites by means of community profiles and health and hygiene approaches to sanitation delivery. It is presented in the data summary tables in Chapter 4.

Data collection methods for collecting case study data included interviews with respondents (telephonic and onsite) to collect and validate data on targets and content of programmes, as well as site visits and observations to collect data on the implementation of sanitation delivery programmes. The researcher was responsible for research activities like collection, collation, synthesis and validation of data. The reference group played a pivotal role in the collection and validation of data.

A photo diary (figures 4.1 to 4.4) reflects the current situation in each of the case studies. The selected pictures and comments serve to summarise the situation after the implementation of sanitation delivery approaches.

3.5 Case studies

Data was produced on sanitation delivery programmes in four case study sites. This included the envisaged health and hygiene promotion programme and the actual implementation of such a programme in relation to a particular technology option. Each of the four sites had a different approach to health and hygiene promotion as part of the sanitation delivery programme.

Data collection methods included interviews with respondents (telephonic and onsite) to collect and validate data on targets and content of programmes, as well as site visits and observations to collect data on the implementation of sanitation delivery programmes.

3.6 Data analysis

The approaches to health and hygiene were compared and reviewed for the four case study sites (Khayelitsha, Joe Slovo, Kayamandi and Imizamu Yetho) in respect of implementation, role-players and targeted communities. This covered the following:

- Community-based organisations. Community, women, and youth focus groups, children and all household members (this is the key focus group) and their responsibilities and involvement in the programme.
- Role-players: Environmental Health Practitioners (EHPs) and community-based health care workers in the communities, and relationships between the respective departments (health, engineering, development support and education).
- The implementation of health and hygiene promotion in line with policy in terms of targets, role-players, methodology and materials, funding arrangements and timeframes.

3.7 Summary

This chapter explained the qualitative approach and action research methodology applied in this research. The steps in the research, namely the literature review, investigation into sanitation delivery approaches and stakeholder validation, were outlined. The investigation was confined to a comparative review of approaches to health promotion in four case study sites. Data collection methods included interviews, site visits and observations in terms of sanitation delivery programmes.

CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

4.1 Introduction

Against the background of the Ottawa Charter inferences could be made by comparing and reviewing health and hygiene promotion in respect of role-players and partnerships, community and household responsibilities, and implementation.

The purpose of investigating the approaches to health and hygiene promotion in four case study sites in the City of Cape Town was to:

- identify targets and find out if they have the capacity to execute community-based approaches in health and hygiene promotion;
- clarify the involvement of and relationships between role-players across departments in health and hygiene promotion as part of sanitation service delivery to promote collaborative partnerships; and

- determine the implementation and alignment of health and hygiene promotion with national policy to improve health and hygiene promotion programmes.

4.2 Background to four study sites

Community profiles introduce the four study sites in the City of Cape Town. The case study sites were Khayelitsha Site B, Joe Slovo in Langa, Kayamandi in Stellenbosch and Imizamo Yethu in Hout Bay.

4.2.1 Community Profiles

In **Khayelitsha Site B**, the Khayelitsha Task Team (KTT) had initiated a de-worming programme in 12 schools in response to a 95-98% worm infestation at primary schools. The collaborative task team facilitated participatory research into the causes of worm infestation, thereby stimulating community demand for improved sanitation. The KTT consists of the following role-players:

- Parents and teachers of the school community
- Western Cape provincial departments of Education and Health (Health Promoting Schools programme and nurses)
- The Peninsula School Feeding Association and the Medical Research Council
- The City of Tygerberg Health Services – Environmental Health Officers
- The Healthy Cities Project of the Cape Metropolitan Council
- The Public Health Programme of the University of the Western Cape and the Parasitology Research Programme of the University of the Witwatersrand.

In a review on Waste Management in Khayelitsha (Liebenberg et al., 1999) the following issues were raised in respect of dense informal settlements: poor infrastructure, problems of poor access to closely packed shacks, and a lack of bins for waste collection. These problems were reportedly overshadowed by a consistent emphasis on the lack of sanitation facilities.

Kayamandi, situated in Stellenbosch, is one of nine test cases conducted nationally by the Department of Water Affairs, in collaboration with local authorities and supported by Danida (Danish Aid). The analysis of water stream pollution in the *Kayamandi Test Case: Managing the Water Quality Effects from Settlements* highlighted the issue of maintaining shared ablution blocks. The project attended to community-level roles, responsibilities and local organisation in seeking solutions to servicing the over-burdened facilities. At the time of the investigation, the local authority had not yet taken up proposed plans to improve local management, repairs and reporting of breakdowns in the system through a local complaints office.

Joe Slovo, situated in Langa, was a pilot collaborative project of the City of Cape Town, the Ukuvuka Firestop Campaign, in response to frequent fire outbreaks affecting the overhead ESKOM power lines. The informal settlement is relatively near to central Cape Town, and close to places of work and employment opportunities. Services were typically minimal in this previously uncontrolled development on 28 hectares of land. The National Botanical Institute (NBI) partnered a Greening Project initiative to facilitate the removal of shacks that were situated under the ESKOM power lines. In response to a

demand for sanitation in addition to access roads, electricity and fire-hydrants, the local authority and NBI coordinator of the project attended Provincial Sanitation Task Team (PSTT) meetings to investigate the potential for sanitation service delivery.

Imizamo Yethu, situated in Hout Bay, is a self-built, semi-serviced area with an estimated 7 000 residents. Active street committees and a local Civic Association manage the allocation of plots and negotiate inputs for basic infrastructure and services. The South Peninsula Administration first investigated the development of access roads and improvements were contracted to consultants with a budget from the Provincial Administration of the Western Cape. The South Peninsula Administration engineer subsequently engaged local authority departments, provincial authorities and the collaborative Ukuvuka – Operation Firestop Campaign for funds and support to improve service provision, and managed the appointment of a consultant to implement an integrated project plan that included sanitation.

4.3 Criteria for case study analysis

Emergent themes for health and hygiene promotion were derived from the background theory and the Ottawa charter (WHO, 1986). The data collected in each of the four case study sites was collated and analysed based on the themes and the research questions.

The study compared the local authority approaches in the respective case studies in respect of the following criteria:

- targets in the community to take responsibility for community-based approaches, namely community, women, youth focus groups, children and all household

members (the latter being the key focus group). This includes their responsibilities and their involvement in the programme;

- role-players such as environmental health practitioners (EHPs) and community-based health care workers in the communities. The relationships between the respective departments of health, engineering and development support and education were also relevant in this context;
- the implementation of the programme in terms of identified targets, role-players involved, methodology and material used, funding arrangements and timeframes of programmes.

4.4 Presentation of data on health and hygiene promotion approaches

Data collected is presented as summary data tables for each case study site in Tables 4.1 – 4.5. In this section data is drawn from reports on field visits, onsite observations and interviews (Appendices 2 – 5), illustrating sanitation delivery programmes and actual implementation of health and hygiene promotion as part sanitation delivery.

A photo diary pages on each of the four case study sites (pp.50, 52, 54 and 56), selected pictures, and comments provide a summary of the current situation emerging from local authority approaches and community responses to sanitation delivery.

Checklist (figure 4.6, p.61) included in the review illustrate the involvement of different role-players from the different departments in programmes and how these relationships are manifested.

Reports captured interviews with officials, validating data collected on the delivery status of each case study site and on issues that emerged from the actual implementation of health and hygiene promotion. Participants could raise questions and add information on each site.

Data is also presented in the following appendices:

Appendices 2a and 2b provide data on Khayelitsha (pp. 81 – 82).

Appendices 3a and 3b provide data on Joe Slovo (pp. 85 – 86).

Appendix 4a provides data on Kayamandi (p. 92).

Appendices 5b and 5c provide data on Imizamo Yethu (pp. 95 – 96).

Outputs of the health working group's strategic planning workshop and reports and minutes of the meetings of the City of Cape Town, Servicing Informal Settlements (Appendices 7a – p. 100; 7b – p. 103; 7c – 105 and 8a – p.108).

Table 4.1: Data summary of Khayelitsha Site B

Targets for programmes and developing community capacity	• Children at 12 primary schools, parents and community next to schools • Households involved in pilot of urine diversion toilets • Attendants, working at ablution blocks • Community sanitation facilitators and health promoters, monitoring and evaluation of urine diversion pilot options • Council workers, removing waste from container toilets
Role-players involved in sanitation promotion	• Environmental health practitioner managed two community sanitation facilitators. • Water services and environmental health departments respectively paid the two facilitators. • The Water and Sanitation Forum and Khayelitsha Task Team were involved in awareness campaigns and workshops on health and sanitation. • City of Cape Town EHP designed and conducted health awareness campaign in partnership with Sport and Recreation, schools, and community.
Programme and alignment with policy / strategy	School Programme • KTT & MRC engaged pilot schools, established Schools' Worms Treatment, designed education materials, and organised awareness training workshops. • The Health Promoting Schools programme was in line with curriculum 2005. The community-level role-players responsible for conducting the programme included staff and parents of the school children. The health and hygiene message was conveyed through story telling and a "smiles and frowns" learning system. Monitoring and Evaluation programme for pilot options: • City of Cape Town -EHP: Container toilet use and management education campaign through KTT awareness training workshops • EHP designed and distributed pamphlet on managing container toilets Informal training and a number of two-day awareness workshops were done with sanitation committees and volunteers. There was no intention to monitor and evaluate the programme beyond the end of the programme. • City Council appointed two community facilitators on a contract basis to do health and hygiene awareness workshops. • Local employment opportunities existed for attendants, community sanitation facilitators and health promoters, to oversee public access and clean the facilities, distribute toilet paper to users of ablution facility, control and monitor usage and record number of users daily. • No formalised training was being done. • EHPs did formal monitoring by doing regular inspections and submitting monthly reports. Within the dry systems pilot project community sanitation, facilitators were expected to monitor and record whether the sanitation system was functioning properly, the hygienic condition of the system and the level of knowledge of the users on sanitation health and hygiene.

Figure 4.1 Photo Diary of Khayelitsha

Khayelitsha - Site B

On the City of Cape Town's request the Khayelitsha Task Team trained volunteers from the community along with volunteers from Joe Slovo.

The health and hygiene training programme introduced information on Hygiene and Sanitation, Contamination Routes and Barriers, Health and Social impact of poor environmental hygiene.

The group covered questionnaire design, mapping, three pile sorting and community assessments.

The local Water and Sanitation Forum was established in 2003. Two health facilitators were recently employed by City Council to do health and hygiene education in the community on E.g. Urine Diversion System which is currently on trial.

Table 4.2: Data summary of Joe Slovo, Langa

Targets for programmes and developing community capacity	• Household groups who shared container toilets at a sharing ratio of 1 container toilet to 5 families. • Toilets were erected right next to the canal and children were particularly targeted for health and hygiene promotion because they played in the canal. • Council workers – emptying buckets • Plans for an education programme involving training of trainers, targeting community volunteers
Role-players involved in sanitation promotion	• Environmental health practitioners, City of Cape Town did informal monitoring • National Botanical Institute, Khayelitsha Task Team, University of the Western Cape • Tsoga environmental resource centre, involved in community development and outreach programmes
Programme and alignment with policy / strategy	• Greening project: Programmes include educating the community and raising awareness on the reuse and recycling of material. Programmes include creating greener paths in Langa, and encouraging other communities to take part in greening projects. • An education programme involving training of trainers, targeting community volunteers from Joe Slovo and Khayelitsha participating in awareness workshops • KTT and UWC were approached by a City EHP to do three health awareness training workshops to raise the communities' awareness. • City of Cape Town: Container toilet use and management education campaign, through door-to-door pamphlet distribution • A new sanitation promotion group was formed from NBI (greening campaign) and from the Ukuvuka fire campaign for workshops. The group organised door-to-door health education, concentrating on the behaviour of the community in relation to hygiene and sanitation. • Research was done before the awareness campaign to determine the knowledge level on health and sanitation of the community through a hygiene / perception survey; 116 questionnaires.

Figure 4.2 Photo Diary of Joe Slovo

Joe Slovo

KTT and Public Health Programme (UWC) conducted 3 Health & Hygiene training workshops, funded by City of Cape Town. Volunteers from the community greening project group were targets for the training programme.

A further training workshop took place in preparation for a door-to-door awareness campaign based on pamphlets on washing of hands, diarrhoea and creating a clean and healthy community.

Container toilets, put up along the bank of the canal to accommodate servicing, raised concerns that refuse dumping and use of the canal instead of the toilet can increase health hazards. Initiative by an EHP to take water samples from the canal, before and after the awareness campaign, hopes to serve as an indicator of impact from community's health and hygiene awareness efforts.

Table 4.3: Data summary of Kayamandi, Stellenbosch

Targets for programmes and developing community capacity	• 26 volunteer health workers for health and hygiene awareness training • plumbers • users of ablution blocks, including children and youth
Role-players involved in sanitation promotion	• Ms Martha Mayembana and Dr Jo Barnes (Stellenbosch University) who trained 26 volunteers to convey health and hygiene messages • Environmental health practitioners • Community block committees, toilet block supervisors • Local project manager
Programme and alignment with policy / strategy	The Danida / DWAF project initiated the rehabilitation of sanitation facilities. Operation and maintenance of facilities was identified as a key issue in Problem Tree analysis (workshop). A range of materials were developed and disseminated including a Problem Tree and Intervention Plan workshop – CD and Booklet. Awareness 1 – distributed pamphlets and Awareness 2 – posters at toilet blocks. • 13 plumbers were trained to repair the facilities. • 30 cleaners were employed to maintain the facilities. • The project trained 26 volunteer health workers for hygiene promotion. • Participants were trained on the appropriate use of flush toilets. • Volunteer health workers conveyed the message through door-to-door visits and pamphlet distribution to educate the broader community. • The purpose of health and hygiene training was to raise awareness and change behaviour in basic hygiene, appropriate use of the flush toilet system and causes of sewer blockages. Ms Mayembana conducted training along with Dr Barnes • Dr Barnes designed posters illustrating issues relating to proper use of toilets and washing of hands after using the toilet. The programme was monitored and evaluated. • Ablution systems rely on daily users, group sharing and voluntary maintenance inputs. A local complaints office was established and a local project manager was employed to improve reporting.

Figure 4.3 Photo Diary of Kayamandi

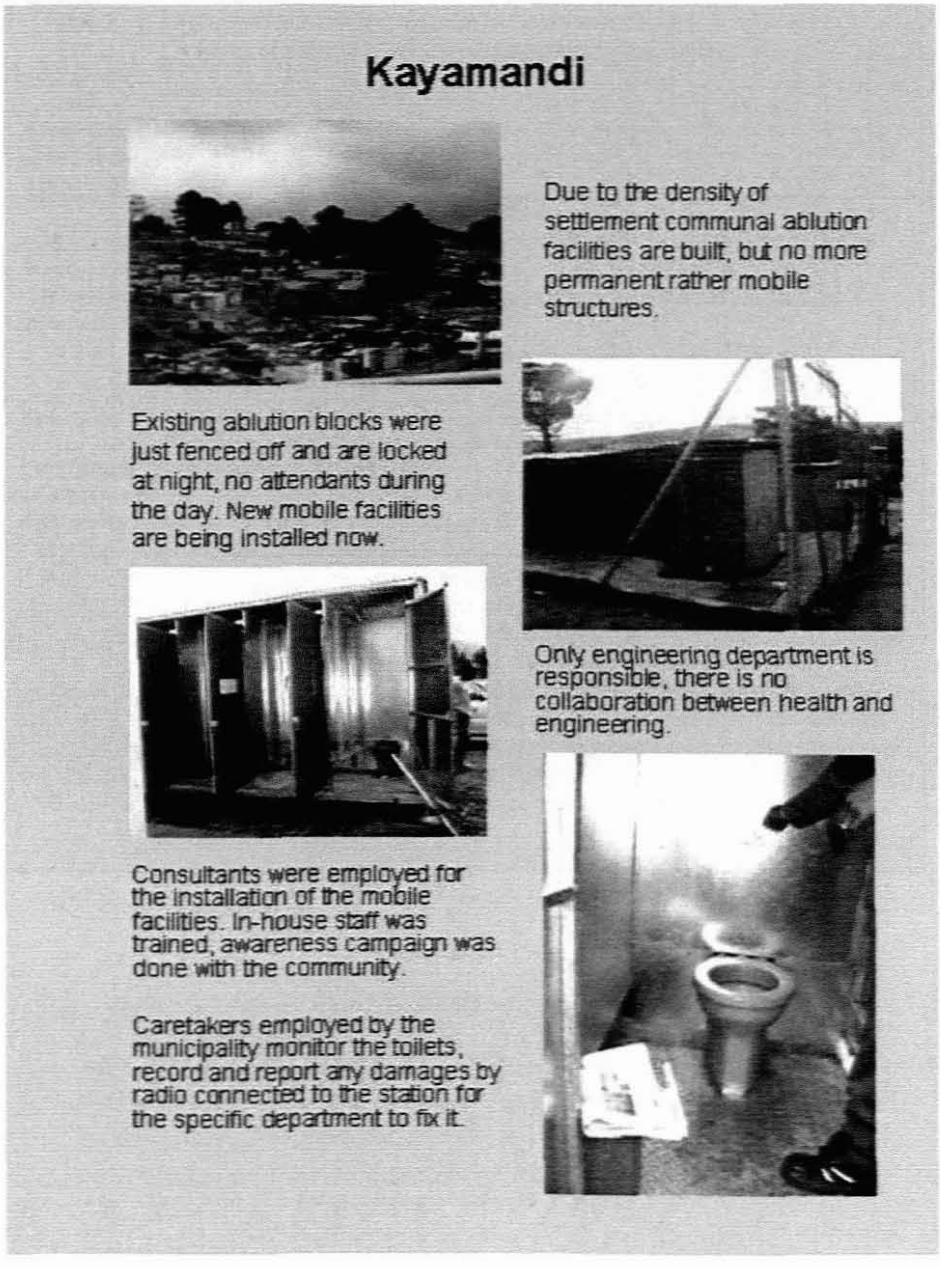


Table 4.4: Data summary of Imizamo Yethu, Hout Bay

Targets for programmes and developing community capacity	• households residing adjacent to the ablution facility • users of ablution blocks, including children and youth
Role-players involved in sanitation promotion	• The environmental health practitioner took on responsibility for informal monitoring and aftercare and tries to arrange disinfectants for which the contractor is responsible • Members of community block committees volunteered to clean the ablution facility • Contracted service providers were responsible for operation and maintenance of facility.
Programme and alignment with policy / strategy	• An education drive was done before the completion of the ablution facilities. A house-to-house campaign was run by the environmental youth group and the EHP, Lavinia Petersen was involved. • Environmental health officers did a two-day workshop on fire, water, drainage, electricity, environmental health and sewage with the community who live adjacent to the ablution facilities. After the workshop they gave the people one week to absorb information. They repeated the workshop one week later. • Pamphlets were designed by all the departments involved. • Pamphlets were distributed and door-to-door explanation on the proper use of the ablution facility was done before the delivery of the ablution facility and during or after. A follow-up was planned for after the facility was built but due to the lack of funding it could not take place. • Informal monitoring and aftercare is done by the environmental health practitioner.

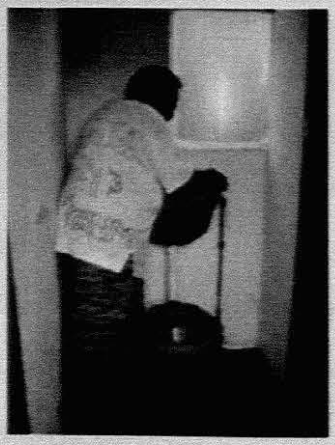
Figure 4.4 Photo Diary of Imizamo Yethu

Imizamo Yethu

An education drive by a local Environmental Youth group, before the installation of two ablution facilities was done.

The installation of facilities was to be followed-up with another education drive which never materialized.

Informal monitoring and aftercare is done by the Environmental Health Practitioner.



No evaluation was done on the initial education drive. The council does not formally employ caretakers at the ablution facilities, and the caretakers that is employed by contractor, responsible for operation and maintenance, received no health and hygiene education and training.

4.5 Data analysis

4.51 Analysis of Khayelitsha data summary, Table 4.1

- Children and the community surrounding the primary schools were identified as the targets in this particular site. Community capacity was built to take responsibility for health and hygiene initiatives. Local attendants were employed but not trained to do health and hygiene awareness. Environmental health practitioners performed formal monitoring, and recorded sanitation delivery and health and hygiene status in reports.
- Health practitioners and engineers formed collaborative partnerships with NGOs in order to deliver health and hygiene programmes.
- The MRC deworming project and the health and hygiene skills training programmes were implemented in alignment with national policy.

4.5.2 Analysis of Joe Slovo data summary, Table 4.2

- Sanitation was not the central focus of integrated service delivery interventions by the local authority. Interventions by NGOs were not effective because they were not sustainable and were not targeted at a particular group.
- Health officials and engineers did not form collaborative partnerships. Informal monitoring was done by the environmental health practitioner (EHP) by taking water samples from the canal to indicate the effectiveness and sustainability of health and hygiene awareness programme.
- The community capacity was not built. Volunteers were facilitated by KTT through two-day health and hygiene workshops along with a group from Khayelitsha. The ad hoc door-to-door pamphlet distribution was a form of information sharing and

awareness raising and merely provided short-term sensitisation on health and hygiene issues, therefore it was not in line with national policy.

4.5.3 Analysis of Kayamandi data summary, Table 4.3

- The appropriate targets were identified as the households staying adjacent to the ablution facilities. Volunteer community members' capacity was built but skills and knowledge were not utilised because local authority did not take ownership of the externally funded projects, which contributed to the sustainability problem.
- The relevant role-players did not form collaborative partnerships across departments nor with non-governmental organisations.
- The health and hygiene training programme was implemented in alignment with national policy.

Analysis of Imizamo Yethu data summary, Table 4.4

- Targets for programmes were not identified. A one-off education drive by a local environmental youth group was done. The intended follow-up education drive never materialised. Local employment opportunities existed but were never pursued.
- Attendants or caretakers at the ablution facilities received no health and hygiene education or training. Informal monitoring was done by the environmental health practitioner. Role-players did form collaborative partnerships.
- The health and hygiene awareness campaign was not sustainable and therefore not aligned with national policy.

Table 4.5: Summary of data in relation to themes

Case study Site	Khayelitsha	Joe Slovo	Kayamandi	Imizamo Yetho
Targets for programmes and developing community capacity	• Children • Households owning UDS, including • School communities • Community sanitation facilitators • Health promoters	• Children • Households who share toilets • Community block committees • Council workers – emptying buckets	• Users, including children and youth • Residents adjacent to the ablution facility • Community block committees Volunteer health workers	• Residents adjacent to the ablution facility • Users, including children and youth
Role-players involved in sanitation promotion	• Community forum – relevant sub-committee • Local health promoters • Council workers – waste removal	• Environmental health practitioners • Local environment group • Contracted service providers • City managers of contractors	• Public facility attendants and supervisors • Community forum – relevant sub-committee	• Environmental health practitioners • Public facility attendants and supervisors – as health promoters • Contracted service providers • City managers of contractors
Programme in line with policy	• Door to door awareness based on monitoring and evaluation • School program • Formal monitoring	• Door-to-door awareness campaign with pamphlets, posters, flyers • Informal monitoring	• Neighbourhood pamphlet distribution, posters • General awareness campaign • No monitoring	• Neighbourhood pamphlet distribution, posters • Targeted education drives • Informal monitoring

The data produced highlighted the continued existence of unhygienic practices and health hazards in each context, the sanitation facilities provided and the attempts that were made to address the needs of the communities by the local authorities.

4.6 Review of health and hygiene promotion approaches

4.6.1 Targets for programmes and developing community capacity

Local authority efforts to promote hygienic and proper use of facilities included communication with community organisations and leaders, house-to-house visits to distribute and explain pamphlets, and the training of volunteer community-based health promoters to conduct broad public awareness campaigns.

The most common interpretation of health and hygiene promotion is evident in a proliferation of illustrated pamphlets and posters, informing the proper use of facilities and containing generic messages about hygienic practices. However, broad public campaigns have not proved to be an adequate stimulus for improving local sanitation conditions, which remain hazardous, particularly for "those faced with the greatest health risks" (DWAF, 2003), as evident in the case study sites.

The project in Khayelitsha has endeavoured to spread through school children, parents and a "sub-committee" to the wider community beyond the school, where a successful worms treatment programme was managed. Whereas the other approaches was linked to the provision of a particular technology choice in the respective case studies.

Figure 4.5 Checklist on targets for community capacity

Analysis of Targets

Case study Site	Khayelitsha	Joe Slovo	Kayamandi	Imizamo Yethe
Targets Who are the targets?	•Children •Households owning UDS, including •School communities •Community sanitation facilitators •Health promoters	•Children •Households who share toilets •Community Block Committees •Council workers – emptying buckets	•Users, including Children and Youth •Residents adjacent to the ablution facility •Community Block Committees Volunteer Health workers	•Residents adjacent to the ablution facility •Users, including Children and Youth
Is their capacity being built through health and hygiene promotion programmes?	•Deworming pilot was successful in primary schools • the capacity of volunteers attending health and hygiene awareness workshops was not built •Health promoters on an accredited skills training programme, capacity built, and still continue to spread health and hygiene messages , they also fulfil a monitoring role	•Volunteers attended 3 health and hygiene awareness workshops with Khayelitsha group by KTT – their capacity was not built.	•Volunteers' capacity was built through participatory were health and hygiene training workshops, however the skills and knowledge gained are not being utilized. •The local authority never took ownership of inputs made by external stakeholders	•Environmental Youth group were trained to perform education through disseminating pamphlets door to door. Their capacity was not built, it was merely raising their awareness around health and hygiene.

It is important to work with target residents and involve them in all stages of improving conditions from identifying and selecting priority hygiene behaviors that need to be practiced, behaviors that need to change and understanding influences on hygiene behaviors, to selecting educational methods, developing appropriate materials and managing implementation.

4.6.2 Role-players involved in health and hygiene promotion

In the past, environmental health practitioners (EHPs) dealing with the public health fall-out of sanitation backlogs in the field have had limited success in mobilising urgent attention by decision-makers in Water Services and other key departments. The strategic planning product of the dedicated working group of EHPs has the potential to contribute substantially to addressing sanitation backlogs. In the current policy environment, the City of Cape Town's Health department clearly has a key role to play, which calls for increased institutional support.

In their Strategy Workshop in May 2003, the City of Cape Town's (CoCT) Health Department's Working Group identified the need to target programmes appropriately. Noting "target audiences determined" as an important requirement for programme development, some examples of targets identified by EHPs during the workshop were schools, households (25 000 households to reach), churches and established health committees.

Targets were further suggested in the working group's submission of Health Standards for Technology Options, requested by the city's Water Services department. Minimum requirements for the 'Health Specs' include, for example, "children as targets of health promotion" in the case of shared container toilets in Joe Slovo, Langa (Appendix 7b, p.110).

Environmental health practitioners have the capacity to focus on challenges with which they are familiar, having been designated to work at the coal-face in their weekly routines. This group has compiled a strategy that draws on their experience in a range of sites and seeks linkages with the strategies of other key departments (Appendix 7a, p.07).

Since the dissemination of a draft Informal Settlements policy document that focuses on addressing the CoCT sanitation backlog, impetus for city departments to attend to the challenge has led to the formulation of a Strategy for Upgrading Informal Settlements (Appendix 7c, p. 112).

An audit was conducted to inform the prioritisation of settlements. Officials were designated to facilitate implementation within that financial year (2004) (Appendix 7c, p. 112).

While an inter-departmental project team was to oversee the process, coordination that included the management of consortia of consultants to be appointed to three prioritised areas or zones, was a challenge that raised questions and issues for the diverse role-players.

Key issues that called for attention in the short-term and that were raised by key stakeholders such as the EHPs' working group are the following:

- How is the health department going to manage consultants in respect of health and sanitation promotion? Who is going to drive the health department strategy?

- Is the pro-poor point of view factored in? What are the pro-poor strategies?
- Are local employment opportunities coming out in the city's requests for proposals (RPF) process and roster system?
- What capacity building plans are underway for staff and community?

Community leaders are central to the communication, consultation and facilitation mechanism that will initiate the implementation of the city's strategy. Community liaison, through community leaders and local committees, aims to spread communication of the CoCT strategy, priorities and plans for upgrading services in informal settlements. This will be followed by community workshops to engender feedback from the broader community. Community education programmes are planned to follow these workshops.

Volunteers, trained by NGOs as health promoters, continue to be considered as a viable mechanism for spreading health and sanitation promotion messages to the broader community. A further development has recently been initiated in Khayelitsha, Site B, where two local health promoters have been employed by the city and provided with office space at the administrative offices alongside staff (Appendix 2, p.89).

Figure 4.6 Checklist on role-players and partnerships

Analysis of Role-players

Case study Site	Khayelitsha	Joe Slovo	Kayamandi	Imizamo Yethe
Role-players Have role-players from the different departments been involved in programmes?	•Community Forum – relevant Sub-committee •Local Health Promoters •Council Workers – waste removal	•Environmental Health Practitioners •Local Env Group •Contracted Service Providers •City Managers of Contractors	•Public facility Attendants and Supervisors •Community Forum – relevant Sub-committee	•Environmental Health Practitioners •Public facility Attendants and Supervisors - as Health Promoters •Contracted Service Providers, City Managers of Contractors
How are these relationships manifested?	•KTT and representatives of the Water & Sanitation Forum interacted at project meetings. •Collaboration was evident Engineering & Health departments respectively appointed and managed the 2 community facilitators to monitor the technology options that was piloted	•Community Liaison meetings took place on a regular bases, to discuss the technology options delivered by the City. •No relationship between the respective departments Health, Water Services and Development Support	•Test case steering committee meetings brought the stakeholder together , however the local authority never took ownership of the externally funded project. • No collaboration between the health and water services departments.	•Water Services assisted Health Department by providing inputs into the design of pamphlets but had no formal relationship with health with regards to health promotion after the installation of the ablution facilities.

The checklist illustrates the involvement of role-players from the different departments and organisations in programmes and how these relationships were manifested in each of the four case study sites:

Lack of communication between those stakeholders directly involved in health and hygiene awareness and the broader community hinders the impact of participative approaches.

4.6.3 Implementation of health and hygiene programmes

The attempt by the City of Cape Town to address health and hygiene promotion programmes was based on the strategy developed by EHPs of the health department's working group on sustainability. Health and hygiene awareness was put forward as an

output of programme development that is based on drawing lessons from experience and creating an environment for ongoing improvement. Distinct programmatic elements providing a frame for the working group's strategy were the following:

- Developing programmes for sustainability
- Context (technology) and roles
- Learning by doing

In developing programmes appropriate to each technology, context-appropriate materials and direction for methods are to be evolved through 'learning by doing', and improving models through practice (Appendix 7a, p.107). Many questions have been raised by EHPs concerning possible methodologies for extending their capacity as part of implementing the strategy.

Participatory methodologies, such as the popular Participatory Health and Sanitation Transformation (PHAST), are often inexpertly applied in a public campaign or information dissemination approach, short-cutting the participatory assessment, action-planning, implementation, monitoring and evaluation project cycle. The materials and techniques that have evolved into the PHAST methodology are based on activist adult education principles, intended for mobilising action by communities.

PHAST techniques are explicit in providing for the facilitation of integrating 'hardware' (basing choice of technology on community input in assessing appropriate and affordable options) with 'software' (assessing local knowledge and practices of different target

groups) in order to plan specific and effective actions for local conditions with target community groupings.

The most feasible, sustainable technology option is therefore not separated from planning, decision-making or community action, including hygienic behaviour that relates directly to the daily use of sanitation facilities by target user-groups.

Many participatory methodologies, such as PHAST, are widely accessible to sanitation practitioners and are spelled out in publications and manuals that have been produced and disseminated over the past decade. These field-tested approaches and methods that have evolved over decades in response to learning from an abundance of failures, point unambiguously to the need to engage users in improving their conditions. The EHPs have called for the opportunity to develop their own capacity to engage and build community-level capacities to improve and sustain health and sanitation.

Figure 4.7 Checklist on programmes and policy alignment

Analysis of Programmes

Case study Site	Khayelitsha	Joe Slovo	Kayamandi	Imizamo Yetho
Programme To what extent is the implementation of health and hygiene promotion programmes aligned is with national policy?	•Health and hygiene promotion is inline with policy because of accredited skills training programmes based on participatory methods	•Health and hygiene promotion is NOT inline with policy because Door to door awareness campaign with Pamphlets merely created short term sensitisation	•Health and hygiene promotion is NOT inline with policy because roleplayers never took ownership externally funded project, volunteers not utilised	•Health and hygiene promotion is NOT inline with policy because once off short term initiatives, no funding for planned follow-up drive
What did these programmes entail?	•MRC/ KTT Deworming Pilot schools, Project roll-out for community surrounding schools, •pamphlet distribution •Developing materials, health and hygiene training workshops •Container toilet use and Management awareness campaign •Health promoters did an accredited skills training programme •Formal Monitoring	•Hygiene/ Perception survey, 116 questionnaires • EHO Plan: KTT trained volunteers from Joe Slovo & Khayelitsha in awareness workshops •Door to door awareness campaign with Pamphlets, Posters, flyers •Informal monitoring	•Neighbourhood pamphlet distribution, posters •Training of 26 participants •Problem Tree & Intervention plan Workshop - CD + Booklet •Awareness drive 1 – distribute pamphlets •Awareness drive 2 – posters at toilet blocks Informal monitoring	•Once off education drives •Design inputs collected as contribution to "Integrated Education & Training programme approach" •Pamphlets and posters distributed door to door •NO H&H campaign: after ablution block handover •Informal monitoring

Comparing approaches to health and hygiene promotion:

The efficacy of health and hygiene awareness, promotion, education and the training materials developed, was assessed from the perspective of the stakeholders' experience in each study site. The status and outcomes of these programmes were determined by identifying project participants on site for interviews and engaging them in stakeholder workshops.

In the Khayelitsha project, schools were used as a local institution with a focus on a particular health problem. The project Task Team (Khayelitsha Task Team - KTT) engaged the school community in research, identifying poor sanitation as a cause of parasite infestations. Assessment of problems and causes in the environment formed part of the awareness process and was followed by a related education programme and materials development

This project has endeavoured to spread through school children, parents and a "sub-committee" to the wider community beyond the school, where a successful worms treatment programme is managed. It has been difficult to establish what has happened regarding wider community awareness and demand for improved sanitation, beyond committee plans to engage informal residents surrounding one of the pilot schools in the trial of an on-site technical option.

A similar process was conducted by the KTCSC, with a participatory approach that sought to engage the broader community. Volunteers and residents were invited to participate in researching the causes of severe pollution of the local stream, conducting a survey and linking the assessment of poor sanitation management with a wider education drive of disseminating findings in the area.

A Problem Tree analysis was developed in a workshop, generating informative visual material, subsequently disseminated on posters and in booklets. These participative planning approaches have stimulated promisingly innovative proposals. However, the

lack of progress in implementing these plans has reduced the value of externally funded health promotion interventions to an apparently costly exercise, whereas the intention of funding was undoubtably to add value.

In other instances, the approach of public "awareness drives" targeted all users of infrastructure, based on the assumption that circumstances have resulted in new conditions for the transmission of disease due to accomplished changes in service provision.

The promotion, campaign or "education drive" was designed to create an awareness of these new conditions (ablution facilities and shared container units), and provide information related to the maintenance and use of the infrastructure at a local level through the distribution of pamphlets. Visually represented hygiene "messages" have been added to this information on posters and pamphlets.

The consequences of the case studies brought the following to the fore:

Despite interventions through engineering as well as short and powerful hygiene awareness interventions, sanitation health and hygiene still did not improve.

Awareness programmes were short-term, often one-off activities, which at best, created short-term sensitisation of sanitation health and hygiene issues. In contrast, education imparts knowledge and skill, with long-term impacts relating to attitude and behaviour.

The difficult and challenging task for the 'soft', social and qualitative nature of health and hygiene promotion that seeks to change behaviour requires consistent application and continuity, rather than one-off investments.

Local authority adoption and support of ongoing programmes is essential to effective investment in promotional campaigns that have lasting value. Local authority departments must link with local institutions and support local NGOs to form partnerships for ongoing health and sanitation promotion functions and activities.

A strategic programme will be considerably strengthened by deliberately tying health and hygiene promotion design and implementation of sanitation facilities. Given the impact of hygiene behaviour on the effectiveness of sanitation systems, the necessity of aligning engineering and environmental health services arises during initial planning and implementation.

CHAPTER 5

SUMMARY AND CONCLUSIONS

5.1 Summary of findings

Capacity-building activities are not being extended beyond education and training that is limited to hygiene messages, technical guidance and operation skills, to developing community-level roles and responsibilities.

There is an assumption within each approach that users of facilities will take responsibility for maintaining the facilities they use as an outcome of education and 'awareness' drives.

In all but one site (Kayamandi); the extent to which community responsibility for sanitation is translated into active roles and responsibilities during planning and decision-making is limited to a representative committee with a facilitation function in the project. Community mobilisation, awareness and 'education drives' appear to be "synonymous with capacity building" (Pybus et al., 2001), while clearly defined functions, specific roles and responsibilities located within the community, that contribute to sustainability of the systems, are lacking.

The findings are presented in Table 5.1 below.

Research questions	Findings
Who are the targets? Is their capacity being built through health and hygiene promotion programmes?	The targets are children, youth, and households living adjacent to facilities. Capacity was build through participatory health and hygiene training workshops but not through door to door pamphlet.
Have role-players from the different departments been involved in programmes? How are these relationships manifested?	Role-players from different departments were involved but in most cases there was no collaboration between the role-players. Relationships between role-players were not clear and definite. Ad-hoc relationships between role-players were established.
To what extent is the implementation of health and hygiene promotion programmes aligned is with national policy? What do these programmes entail?	Once off campaigns and education drives were not aligned with national policy, it merely created short term sensitisation. Pamphlets were distributed door to door.

Participatory approaches to development interventions deliberately seek out relevant user groups such as women, youth or children, to engage the inputs and perspectives of target groupings within a community for planning sanitation improvements that are appropriate to the specific, local context (WHO, Soul City and PHAST). As the provision of a particular technology option becomes part of the local context, particular targets for health and hygiene promotion programmes are suggested. These targets relate to essential user components of functioning sanitation systems.

(In all but one of the case study sites the targets for health and hygiene programmes were properly identified but their capacity was not built due to inappropriate programmes.)

An environment that enables and supports the improvement of hygiene must be continuously promoted at all levels – from the household at local level, to the role-players in delivering sanitation services.

(Therefore there is a need for clear roles and collaborative relationships between departments and their involvement in health and hygiene promotion.)

There is a clear differentiation between awareness and education. Health and hygiene promotion includes both awareness and education, thus education cannot be replaced by awareness or promotion. Education imparts knowledge and /or skills, whereas awareness imparts elementary understanding or sensitisation.

Long-term ongoing health and hygiene promotion should form part of sanitation delivery programmes. Health and hygiene promotion interventions like these need to be strengthened by stronger community involvement.

The impact of promotion programmes will ultimately manifest in the effective functioning of the sanitation system. It follows that the educational methods used should be those that strengthen and empower individuals and communities to undertake and work for change by maintaining risk management over time.

5.2 Conclusion

Experience suggests that sanitation facilities alone do not guarantee the improvement of health. This emphasises the need for a broader approach to sanitation implementation where health and hygiene promotion is included as an integral part of sanitation delivery programmes.

Many well-constructed water and sanitation facilities do not have the desired health impact, simply because they do not guarantee changes in hygiene practices. The question is whether it is possible to guarantee such change. It may not be possible, but local authorities can certainly be motivated to adopt appropriate programmes to enhance the health impact of water and sanitation facilities by developing and implementing approaches that motivate people to change their hygiene practices.

Sustainable improvements in health and hygiene behaviour patterns require more than promotional activities. Water, sanitation and hygiene facilities, while not sufficient on their own to improve health, are critical components in a comprehensive health and hygiene promotion programme. The development of community capacity, institutions and policies to manage and sustain hygiene, water and sanitation programmes is essential for long-term success.

Building the community's capacity is equally important in ensuring sustainability. Communities must be equipped with the knowledge and skills to manage their own

facilities effectively and to demand high-quality service from officials in local government, civil society and the private sector.

An environment that enables and supports the improvement of hygiene must be continuously promoted at all levels – from the household at local level, to the role-players in delivering sanitation services and the policy makers of the national sanitation policy.

The development of national policies that facilitate and promote hygiene improvement is a critical step in many countries. New policy development efforts focus on promoting community-managed systems that are affordable and easy to maintain.

Hygiene improvement requires behaviour change in the use and maintenance of facilities and suggests that to achieve improvements in a sustainable fashion in order to prevent diarrhoea, 'hardware' or facilities, the promotion of changing behaviours, and an enabling institutional and policy environment must support these behaviours.

Analysis of the case studies highlights the ineffectiveness of one-off awareness campaigns and the need for a more comprehensive approach to health and hygiene promotion in line with the Ottawa Charter.

The push towards universal coverage of basic sanitation services will not bring the intended health benefits of delivery if the provision of toilets is not complemented by appropriate health and hygiene promotion programmes.

5.3 Recommendations

The following recommendations are made based on the comparative review of the four case study sites:

- Health and hygiene promotion can be strengthened through targeting the appropriate audience in relation to the particular technology option being used. Appropriate targets include children, youth, and households sharing facilities, health forums and committees within that particular community. Community capacity should be developed so that they will be able to take responsibility for their hygiene practice and also to have employable skills.
- Clear relationships between departments and involvement of role-players in health and hygiene promotion can lead to the reorientation of health services as part of sanitation service delivery through collaborative partnerships. Local authorities must have inter-departmental teams to work on water and sanitation services and related projects to address sanitation backlogs.
- Implementation of health and hygiene promotion needs to be aligned to national policies and strategies if appropriate facilities and appropriate health and hygiene programmes are provided. Local authority officials should take responsibility to facilitate the implementation of such policies and strategies.

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DESCRIPTION OF CATEGORIZATION OF APPENDICES

Appendices 1 a – b: *Presentation of evidence of the request for stakeholders to be part of a reference group for health and hygiene promotion. The reference group played a pivotal role in the collection and validation of data. A group of research assistants were responsible for research activities to collect, capture, collate, synthesize and validate data.*

1 a: Letter - Stakeholder involvement request
1 b: Stakeholder / Case study reference groups
1 c: Stakeholder Validation workshop invite
1 d: Research Activity list & research team

Appendices 2 – 6: *Presentation of data on sanitation delivery programmes in four case study sites which include the conceived health and hygiene promotion programme, actual implementation of such a programme in relation to a particular technology option. Each of the four sites had a different approach to health and hygiene promotion as part of the sanitation delivery programme. Data collection methods included interviews (telephonic & onsite) with respondents to collect and validate data on targets and content of programmes, site visits and observations to collect data on implementation of sanitation delivery programmes.*

Appendix 2: Khayelitsha
2 a: Onsite interview with engineer
2 b: Interview & minutes of project meetings
2 c: Report on field visit & observations

Appendix 3: Joe Slovo
3 a: Interview with Environmental Health Practitioner
3 b: Onsite Interviews – development support official & community liaison & EHP
3 c: Report on field visit & observations

Appendix 4: Kayamandi
4 a: Interview with Trainer
4 b: Onsite interview with participants of health and hygiene promotion training
4 c: Report on field visit & observations

Appendix 5: Imizamo Yethu
5 a: Report on field visit & observations
5 b: Onsite interview
5 c: Interview with EHP, Imizamo Yethu

Appendix 6: *Presentation of current data after intervention*
6a: Overview of current interventions implemented in 4 case study sites

Appendix 7: *Presentation of data on the stakeholders involved in health and hygiene promotion. Stakeholder collaboration between departments of health, engineering and community developments support is manifested in some cases.*
7 a: Health Strategy workshop outputs (captured at workshop)
7 b: Collaboration between engineering & health - producing Health standards
7 c: Update on informal settlements strategy - City of Cape Town
7 d: Health Promotion Resources - City of Cape Town

Appendix 8: *Presentation of a report on current implementation and departments involved and also include illustrations of structures of development support, sewage, and health departments*
8 a: Institutional Collaboration - City of Cape Town

APPENDIX 1 a: Stakeholder involvement request

05 March 2003

Dear All

This project is a response to Regional Stakeholders' request at the Provincial Sanitation Task Team (Western Cape).

This letter requests all interest environmental health officers, health promotion practioners to form part of a sanitation and health reference group for the data collection stage of the comparative review of health and hygiene programmes in the City of Cape Town.

As stakeholders you will assist in:

- Assessing the opportunities and constraints in health and sanitation promotion
- Identifying and validating possible health and sanitation programmes that can be linked to the strategic elements; and
- Identifying and validating key elements of sanitation service delivery presented by the present situation

Please express your interest to accommodate coordination for a meeting towards the end of March and to allow for planning of future monthly meetings. All expressions of interest to be forwarded by 12 March 2003.

Yours in sanitation and health promotion.

Renay Van Wyk

APPENDIX 1 b: Reference Group members for each of the four case study sites:

Khayelitsha

Name	Organisation	Contact
Ruth Stern	Manco	Tel:959-2809 Cell: 0825054262
Johannes Mokgatla	KTT/Tygerberg	Tel:360-5577 Cell:0834830203
Martin Ngcime	KTT sub- committee	Tel:360-3290
Tertius de Jager	Tygerberg, Adm.	Tel:360-1104
N. Kotyi	Khayelitsha, ward councilor	Cell:0836355437
Benita Mayosi		
Solomzi Mzamo		

Joe Slovo

Name	Organisation	Contacts
Nombongo Tshongoyi	Sanco Langa	Tel.694 0132
S. Ndamani	Tsoga centre	Tel. 694 0004 Cell.0834830203
P. Plaatjies	Sanco LANGA	Tel.694 3113
Alex Godden	City of Cape Town, Health	
Francois Van Niekerk	City of Cape Town, Development Support	
Thando Myamya		
Duke Gumede		

Imizamo Yethu

Name	Organisation	Contacts
N. Hendricks	SPM- engineer	Tel: 710 8055 Fax: 762 5273
L. Peters	SPM - EHO	Tel: 789 1367 Fax: 789 1556
Jongi Mzombe	Siziziwe Dev. Consultants	Tel: 448 8193 Fax: 447 7957 Cell: 083 992662

Kayamandi Reference Group

Name	Organisation	Contact
Jakes Conradie	Stellenbosch Municipality: Health Department	Tel- 808 8484 Fax – 808 8477
Martha Mayembana	KTCSC, Kayamandi Clinic	Fax – 8896550 Cell- 0833524536
Dr Joe Barnes	Stellenbosch Univ. KTCSC	Tel- 939 9480 Fax – 938 9166
Sipho Menziwa	KTCSC: Community rep.	Cell- 0722721300
WilnaKloppers	DWAF: Water Quality	Tel- 950 7141 Fax - 9463666
Gavin Pridgeon	Stellenbosch Municipality: Eng.	Tel- 808 8320 Fax – 808 8318

APPENDIX 1 c

5 May 2003

Health and Sanitation Reference Group:
Stanley Nomdo, Ruth Stern, Leander v Oordt, Mabatho Mokhole, Thando Myamya, Shafiqa Davids, Malcolm Cupido, Valencia Ravell, Zanele Figlan, N Sikweyiya, August Hoon, Andrew Carolus, Gerard Van Wyk, R. Awenandt, Joe Mokgatle, Solomzi Mzamo

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Dear All

Requests were send out to all interested environmental health officers, health promotion practioners to form part of a health and sanitation reference group for the next stage of the research project on health and hygiene programmes in the City of Cape Town. Expressions of interest were received from the environmental health officers listed.

Key elements of sanitation service delivery presented by the present situation was identified and validated in the first phase of the research.

As stakeholders you will assist in:

- Identifying and validating possible health and sanitation programmes that can be linked to the strategic elements; and
- Assessing the opportunities and constraints in health and sanitation promotion

Date of meeting: Friday, 16 May 2003 at 10h00 – 11h30
Venue: Crit Room, 2nd Floor, ABC Building, Peninsula Technikon

Please bring along available information related to health and sanitation, hygiene education awareness programs in your area.

Your attendance and contributions will be appreciated, if you could please confirm your attendance.

Yours in health and sanitation.

Renay Van Wyk

APPENDIX 1 d: Activity List for each of the case studies:

Khayelitsha research activities:

Date	Activity	Comment
24/07/03	Meeting	Observation and confirmation of the community involvement in sanitation options at Khayelitsha
29/07/03	Interview	Validation on awareness on KTT's sanitation options – Tertius de Jager.
22/08/03	Meeting	KTT Meeting - Report and minutes
22/08/03	Validation	Consolidation of data collected.
08/07/04	Field research:	Field visit, observations and onsite interview with City officials

Joe Slovo research activities:

Date	Activity	Comments
28/05/03	Meeting	Report on Community Liaison Meeting
31/07/03	Interview	Alex Godden on Health and hygiene approach for Joe Slovo
15/08/03	Interview	Alex on Health and Hygiene Michael Page on delivery Francois van Niekerk on community liaison meeting
10/10/03	Interview	Interview to validate health and hygiene promotion approach
09/07/04	Field research	Field visit, observations and onsite interview with City officials

Kayamandi research activities:

Date	Activity	Comments
26/07/02	Meeting	Kayamandi Test Case Steering Committee meeting in Stellenbosch
10/07/03	Interviews	Health and Hygiene Interviews Kayamandi
02/08/03	Interview	Interview trainer of health & hygiene programme, Martha Mayembana
03/08/03	Data Analysis	Health and Hygiene Interviews Kayamandi

Imizamo Yethu research activities:

Date	Activity	Comment
26 /07/03	Field research	Investigation on Delivery options: onsite interviews with engineer
14/08/03	Interview	Telephonic interview with Consultant
07/09/03	Interview	Validation on case study data
01/07/04	Interview	Questionnaire on implementation of sanitation delivery with EHP

APPENDIX 2: Sanitation Delivery Programme - Khayelitsha

Appendix 2 a: Onsite interview with engineer

Research Assistant: Carl October **24th July 2003**
Respondent: Tertuis de Jager

Topic: KTT - Options

1. Do you have any knowledge on the deworming programme and if so, how does the engineering department contribute? Are you aware of the sanitation options that KTT is embarking on?

Yes he knows and is quit involved. He views KTT as a research like team that is assisting the community with options. He went together with KTT to Gordons Bay to see the Conveyer Belt system, which he feels is not going to work as an option for Khayelitsha because of space constraints. At first J.M proposed that he purchase the 10 Enviro loo's and 10 Econo loo's, but the supplier was only willing to offer 5. He later asked him to withdraw from that proposal.

2. How many Urine diversions units are in place and who is responsible to construct the units?

10 Urine diversions systems, and not familiar with the design.

3. What is your involvement in sanitation?

Responsible for the bucket system, which is not supported by Health Department.
Planning to upgrade the bucket system by: Privatising it to 2 contractors who will be chosen by the community. Put in place manholes for onsite bucket - system like Aprikas containers.
Twice a week collection adds up to R30 per household.

4. According to the community, containerised toilets are not collected as supposed to, what developments are in place on improving that?

T.d. J bought two disinfectant tankers that he is considering for privatisation to give to a community tender for the cleaning of the containerised toilets.

5. Are you informed about the process followed to put the UDS structure in place, if so who informed you and when?

The location of UDS is questionable according to T. d. J. J.M insists on the community driven sanitation. The community is supposed to be involved for buy in to the options.

6. What is the recent budget on sanitation for Khayelitsha?

There is some money he found when he took over office and would like to utilise it for sanitation improvement. The budget of R500 000 is to be used to purchase the top structure for options.

Ablution Blocks

T. d. J. proposed to the LA that:
The ablution facilities were handed back to the Technical team (in-house cheaper), because of experience and potential in maintenance. It cost the authorities R12 000 for Operation and maintenance and R2500 for the tender.

Khayelitsha, Informal Settlement Site B - Technical Options Onsite

- Ablution Facilities: Shared by 350-± people/day. Two caretakers are responsible for managing the facility.

Local Authorities provide containerised toilets:

- EHO, J.M responsible for monitoring the facilities.
- 5 – 8 families share one unit. They are supposed to be collected once a week.

KTT: Urine Diversion System

- Has open back of Urine Diversion System, which has a pipe taking urine to soil.
- *Lid:* Must be removed or shifted by hand to reach the net that collects solid waste.
- Weekly waste collection.
- Dumping of the collected waste was supposed to be done at the selected grounds of Ikhusi Primary School. But an alternative place that is convenient to the household which is burying it in the grounds next to the shake.
- *Cost:* R900, Initial option for testing. Mvula Trust funded the supply of material.
- Other options under consideration: Enviro-loo and Ecosan.

Appendix 2 b: Interview & minutes of project meetings

Research Assistant: Sandra Simelani **Date: 22 August 2003**
Report and minutes from Benita (KTT Coordinator)

KTT Team	MVULA Trust, R.H), Coordinator (B.M), Local Authorities (Tygerberg Adm.) TdJ – Eng., J.M – EHO, N.K- Ward Councillor Community, MANCO – KTT management.
Informing Demand	MRC/ Health, KTT, volunteers (h/h)
Choices/ Options	Urine Diversion System, Enviroloo, Communal Chest
Cost	DWAF – R600 Subsidy Ecosan – R2800 Cemforce – R900
Process	Looking at different options, and additional funders to assist. KTT links to funding. Visit to Namaqualand (KTT was invited by Mvula Trust) EcoSan
Organisations	Department of Education, Department of Water Affairs and Forestry, Department of Health, Schools Pupils and parents
Process	Interaction through schools. KTT and sub committees, meetings.
Possible funders	DWAF, Anglo American Chairman's fund, AUS Aid, De Beers, Anglo Gold Funds, SAB Corporate Social Investment, WHO, DG Murray Trust, Unicity, PSFA

With reference to health and hygiene promotion the data collected included a table that reflected what was intended and what has actually happened. The information presented on Khayelitsha needed to be validated. Therefore a follow up interview and request for minutes from the KTT project meeting.

Study Site	Programme	Plans	Outcomes
KHAYELITSHA, SITE B **KTT Worms Pilot**	▪ Engages pilot schools, establishes Schools Worms Treatment, Education materials, Training workshops ▪ CoCT -EHO: Container use and management Education Campaign	▪ KTT Project roll-out for Khayelitsha ▪ SACLA health promotion link explored ▪ KTT Target – parents?	▪ KTT workshops ▪ EHO designs, conducts Health Awareness campaign in partnership with Sport & Recreation, Schools, and Community ▪ Pamphlet on managing containers distributed ▪ Targets?

Appendix 2 c: Report on field visit & observations on actual implementation

Khayelitsha TR Section Field Report **8 July 2004**
Research Assistant: Karen Smith

Introduction

Research was done to determine the Health Status in Informal Settlements of the City of Cape Town and to what extend Health and Hygiene Promotion is done in Informal Settlements.

Methodology

Information was gained through observations during field visits, interviewing Community members, Environmental Health Practitioners and the Ablution Facility attendants.

Research method: Observation and Interview with Facility Attendant / Caretaker

Design of Ablution facility

- About 150 people use the facility daily.
- The Facility consists of 3 showers, 4 toilets + 1 for handicapped people and 3 hand washbasins both on the male and female side.
- Outside - 6 laundry facilities, not in use because there are no taps or water pipes connected.

Attendants

- Two local residents (women) are employed by the local contractor for maintaining public service, overseeing public access and cleaning the facilities.
- They did not receive any health awareness training.
- Disinfectants for cleaning purposes are provided by the council.
- They open at 7'oclock in the morning and close the facility at 6 o'clock.
- The community makes use of alternative toilets after-hours and also throws their overnight soil into other facilities (including stormwater drains).

Responses

The caretaker responded that they have a problem with the community who does not clean after they have used the toilets. No soap is provided for the hand wash facility. The backyard of the Facility was found to be very dirty with faeces and waste.

Ablution Block 1

The first ablution facility was built in behind Ikhusi Primary, the washing troughs were in-use but the toilets were locked because the facility was not in use for a couple of months. There was a dispute between the contractor and the community but problems have been solved.

Ablution Block 2

The total number of ablution block facilities is 10, 2 have been built by nongovernmental organisations. The one we visited are in the TR – Section area in Khayelitsha. The community staying in TR – section makes use of the ablution facility. The attendants record the number of people that visit the area every hour. Approximately 148 people use the facility per day.
The two attendants are contract workers and they are paid; they work from 7am until 6pm daily. Ablution facilities are locked overnight and people use the bucket system. The ablution facilities are cleaned daily.

Role	Procurement	Functions
Local Attendants	• Employed by contractor on contract basis • Payment? • No training in health and hygiene awareness	• Maintaining public service, overseeing public access and cleaning the facilities • Distribute toilet paper to users of ablution facility control & monitor toilet paper use • Provision of cleaning materials • Record number of users daily
Community Sanitation Facilitators (CSF's)	• 6-month contracts are until May 2004. • 2 Community health facilitators are paid by Council, and managed by the EHP • Work 40 hours per week at R11.50 per hour. • Water Services and Env. Health Departments respectively pay the 2 facilitators.	• Training community to use toilets in the pilot project • Provide chemicals and other necessities • Monitor all dry sanitation and pour-flush systems • Regular inspections of toilets • Draft and submit monthly reports
Environmental Health Practitioners (EHP's)	• Employed by the City of Cape Town, Department of Health	An Environmental Health Practitioner manages the two community sanitation facilitators. • Stimulate demand for sanitation services. • Initiate, manage, and conduct health and hygiene education programme • Conduct risk study and perception survey. • Develop monitoring and evaluation tools • Develop Information systems to support the monitoring and evaluation of services provided. • Develop of norms and standards for rudimentary and basic sanitation services.

APPENDIX 3: Sanitation Delivery Programme – Joe Slovo

Appendix 3 a: Interview with Environmental Health Practitioner

Institutional Collaboration – Joe Slovo **Date:** 28 May 2003

Meeting: Notes on Community Liaison Meeting
Research Assistant: Charity Gaosenkwe

Sanitation issues

Francois van Niekerk reported the sanitation issues. The prices of the sanitation systems were received by the Sewerage Branch (Michael Page) for the container toilets to be purchased. The toilets will be installed soon. The existing toilets at zone30, next to the Jakkalsvlei canal need to be lowered as a result of construction of the tracks.

Alex Godden reported to Francois that he had a project proposal relating to raising awareness of hygiene and sanitation from Mickey Chopra (UWC). There was a discussion over the type of toilets, as some community members wanted flushed toilets.

The community was going to meet over the weekend to discuss the issue. Francois suggested that those community members, who do not want container toilet, must not be given the toilets because it will lead to vandalism.

The community leaders will report back on the outcome of the meeting after consulting with Counsillor Gophe. Odwa was introduced to the community as the field researcher. Arrangements were made for the Joe Slovo and SANCO representative to attend the workshop held on 26 April 2003.

Contract and related work:

The clearing of firebreaks, building of tracks, installation of water mains, fire hydrants and stand pipes are about to be competed. The provision of electricity will take few months to be completed. The people from residing under the power lines will be relocated to Delft. The capturing of residents details has been completed and the information must still be collated and checked.

Flooding project:

The tender for the previous relief work and the Council will award the contract to the lowest tender.

Greening project:

There was a workshop on permaculture that took place on the 4th-8th March at Isilimela School. A food gardening workshop was also held on the 12th-14th March. There was an alternative container workshop that took place. The actual greening will start during winter.

Appendix 3 b: Onsite interviews with development support official & community liaison & Environmental Health Practitioner

Activity: Interview (Alex Godden) **Date: 31 July 2003**
Research assistant: Charity Gaosenkwe

Questions:
1. What were the results of the perception survey that was done?
2. How far are you with arranging the health awareness workshop?

Responses
- The results of the survey that was done are ready, but they might not be reliable and valid because only 116 questionnaires were filled out of 400 people staying in Joe Slovo. The results may not be representative of the whole population.
- The hygiene workshop has not been done yet. The Khayelitsha
- Alex will ask the KTT to help him train the people who are going to train the community
- The NBI will also help in making the workshop a success.

Activity: Interview with City of Cape Town Officials **Date: 15 August 2003**
Research assistant: Charity Gaosenkwe

Task: Interview Alex Godden, Francois van Niekerk and Michael Page.

Questions to Alex Godden (Environmental Health)
1. How far are you with the health education workshops?
2. Who is going to tender the workshop?
3. Who are the people who are going to be trained to conduct the workshop?
4. Do you have the brief of the workshop?
5. Do you have the results of the hygiene survey that you performed?
6. Were you present in the last community liaison meeting?

Response
- He is still arranging the workshop. He is thinking of asking Mickey Chopra from the UWC to help him. The KTT will also help with the aid of the NBI. He is trying to get people together who are going to help him with the workshop. There will be a meeting regarding the workshop on 5th of August 2002.
- The tender is already given up to the KTT since they are going to do the training.
- The trainers are going to be the community members who are actively involved in sanitation, for example the people from Tsoga or those involved in the greening project.
- The brief is available but it cannot be given out to outside organizations because it has not been circulated through the council yet.
- The results are available but they cannot be given out because they are not circulated through the council yet. The results are also not effective and valuable because only 116 questionnaires were issued out of 4400 people.
- He was not present because he wants to go to the meetings if he has something solid to say about the workshop.

Questions to Francois van Niekerk (Development Support)
1. Do you have minutes of the community liaison meeting that was held on the 25th of July 2002?
2. When will the next meeting be?

Response

- There are no minutes available since there was no meeting. People did not pitch up for the meeting.
- The date for the next meeting was not set because of the absence of people, but the meeting will be probably within the next two weeks.

Questions to Michael Page (Engineering)

1. How far are you with the delivery?
2. Who is maintaining the toilets?

Response

- Nearly 1000 toilets are finished. There is going to be a hundred more toilets built because there are 4400 dwellings and there should be 1 toilet per household.
- 1000 toilets are going to be maintained by Kuyasa community agency and Sanitee will maintain the other 100.

Validation of Health and Hygiene Promotion Approach

Interview with Alex Godden (EHO) **Date: October 2003**

With specific reference to health and hygiene promotion the data included a table that reflected the interventions in each of the sites in terms of what was intended / planned and what has actually happened. The information presented on Joe Slovo was not complete.

Study Site	Programme	Plans	Outcomes
JOE SLOVO, LANGA Ukuvuku Campaign/ Greening project	▪ Initiate Greening project ▪ CBO Organise and Conduct Training Workshops related to Greening ▪ EHO link-Community Liaison Committee	EHO Plan: ▪ KTT to train volunteer trainers in workshops ▪ help from Greening project	▪ Hygiene/ Perception survey, 116 questionnaires, results are not available ▪ Awaiting response from contracted trainer ▪ Targets? (Also of trainer of trainers?)

A follow-up telephonic interview was done to validate data on Joe Slovo: Alex Godden

- Alex Godden met with the Langa stakeholders on the 13th of September 2003.
- He was focusing on the awareness raising on health and hygiene and sanitation.
- The training sessions will be held on the 3rd and 4th of October 2003
- He is still waiting for the names of the trainees (at least 15 people).
- Trainees will be trained and they will train the community.
- Trainers will be KTT, NBI and UWC
- At the last meeting of the Unicity said there is no money for grey water in Joe Slovo.
- Only one service per week in a toilet serves 4 families, which is more or less than 25 people.
- Issue arising is why the city can't fund the community direct.

Appendix 3 c: Report on field visits & observations

Joe Slovo (Langa) Field Visit Report **Date: 9 July 2004**
Research Assistant: Karen Smith

General information: Joe Slovo used to be a dumping site; future plans are to convert it into a recreational area. The area is divided into 3 areas, Zones, 30, 31 and zone 32.

The population growth is about 4,500 multiplied by the estimated number of households, which is 4 per h/h and gives us 18,000 inhabitants.

Zone 30 was the first to receive container toilet provided by the CoCT, at first the community rejected them by demolishing the toilets, but now they accept provided toilets.

Since the last count of 1100 toilets provided last year, 100 toilets more toilets were delivered and it is said that more toilets are coming.

As part of investigation of delivery of shared container toilets the following were observed:

- The containerized toilets are erected in single rows.
- The notice on the toilet door explains the way that sharing should be managed.
- There are four households sharing each toilet. One householder keeps the key.
- The number on the door is the number of the household that is keeping the key and also is one of the toilets that are built by a community member.
- This toilet looks clean and shows that the owner is aware of health and hygiene.
- This toilet looks almost like the container toilets that are being delivered.

Problems

- Children are not using toilets properly.
- Drainage – channels are provided at the houses but no one is cleaning it, stagnant water at the laundry facility causing insect breeding and causing diseases especially to the children
- Community leaders nominate themselves for jobs and don't give other people a chance to job opportunities.
- Community fighting over sharing of the toilets, most people want to own their own toilets. Those without toilets prefer to use the field or the canal for the toilet.

Plans towards improvement or options

- A workshop with the community to explain and educate how the toilet must be used and mobilize group who did clean-up campaign.
- Give out an official telephone number where the community can report illegal dumping and make the households responsible for their own waste i.e. using the skip

Waste and Grey Water Disposal

Conditions of the communal washing facilities and drainage system as observed.

Water Sampling form the Canal

The Purpose for taking the water samples from the canal

Water samples were taken from the canal in July 2003 before the intervention of door-to-door pamphlet distribution and awareness raising started. Another round of water samples is planned to be taken six months after intervention started to measure the E.Coli level in the water that will serve as an indicator of an improvement in the Community's Health and Hygiene Awareness and Practices.

Methodology

- R. Van Wyk M.tech Environmental Health and T. Myamya Environmental Health Practitioner took water samples. 3 series of water samples were taken at weekly intervals at inflow and outflow of canal in Joe Slovo-Langa
- James Zietsman at the Microbiology Laboratory, Health Sciences, Science Faculty did the testing of the water samples.

Purpose of the Water Samples:

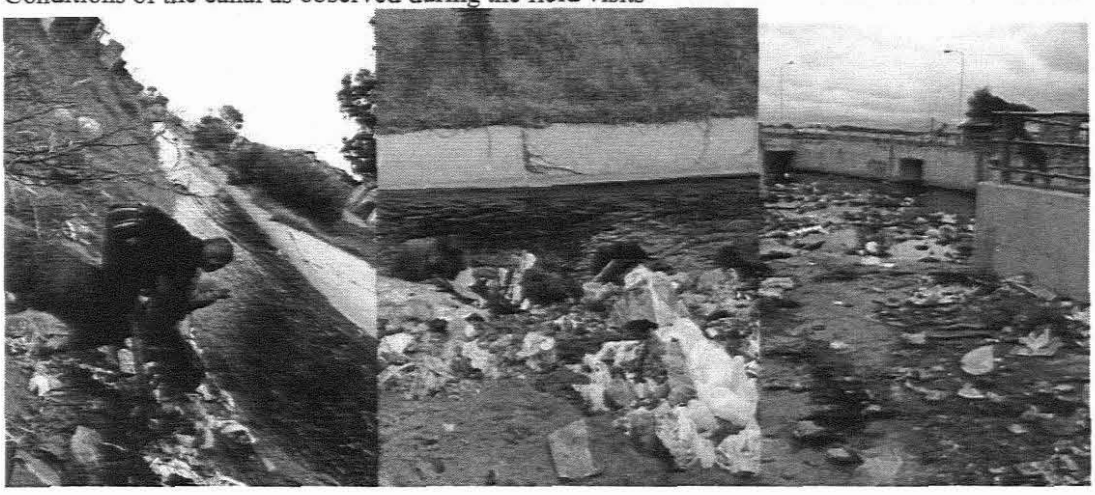
- To obtain evidence of the presents of E.coli /Coliforms in the samples taken on the respective dates. Before and after study.
- Water Samples to be taken after 6 months. Intervention started in July 2003.

Results

Weather Conditions 3 days before sample			**Inflow**	**Outflow**
Sample 1 Date: 07/08/03	No rain	Sample Results Not Available, because sample was too concentrated and resulted in clogging up the filters.		
Sample 2 Date: 14/08/03	Rain	**Faecal coliforms**	50,000/ 100ml	170,000/100ml
		Coliforms	2 300,000/100ml	1700,000/100ml
		Total	2000,000/100ml	3 000,000/100ml
Sample 3 Date: 21/08/03	Rain	**Faecal coliforms**	16,000/100ml	2300/100ml
		Coliforms	19,000/100ml	9 000,000/100ml
		Total	20 000.000/100ml	9 000,000/100ml

The Canal

Conditions of the canal as observed during the field visits



Onsite Interviews - Joe Slovo **Date: 9 July 2004**

Researcher: R. Van Wyk

1. **Onsite Interview with Sonwabo Ndandani** – Coordinator at Tsoga Environmental Resource Centre (Community development & Outreach Programmes)

Current programmes include educating the community and raising awareness on the Reuse & Recycling of material. These programmes include creating greener paths in Langa, encouraging other communities to take part in projects concerning greening like the Delft community, life skills programs for the youth such as the display of their art in the centre for tourist, Career guidance exposure and Tourism Projects like Transportation of tourist around Langa (some became Qualified Tour Guides). Eskom funded R1.2 million for greening and a Sports field. The Project is not currently being funded; they are in partnership with the Local Municipality.

2. Onsite Interview with Duke Gumede

Development role and link between integrated services under management of Dave Hugo. (He worked for Stuart Scott Consultants.) The City needed someone on the ground to coordinate and support Integrated Services.

- Problem around delivery of housing
- Improve contracting of services
- Improve service delivery
- Construction and delivery as well as technical support

This technical link developed in response to disaster management onsite – during emergency phase. The Development Support department /group are working with what happens in terms of waste, grey water/ storm water and sanitation.

They are learning as they are doing.

Suggestions:

- Children are one of the targets in terms of health and sanitation promotion for the use of the toilets.

- Technology options or toilets need to be practical and adequate to health standards.

Zone 30, next to power lines. New toilets, in sets of 5 and 5 back to back, the structure is a solid precast unit, these toilets are standing under the power lines after a big negotiation process between the CoCt and Eskom. Grass is planted on the periphery.

The 100litre container toilets are cleared once a week; toilets were numbered and geographically referenced by using the GPS technology. When toilets are delivered the Environmental Health practitioner allocates toilets to the particular households.
Before the toilets was given in zone 30, people using the field. Workshops are done on the usage of toilets.

Problems
- Community leadership – when job opportunities arise
- First go to community leaders to nominate possible candidates for the job
- Community leaders can sometimes be a barrier to community
- In Zone 32 –the people wanted flush toilets

3. Onsite Interview with Environmental Health Practitioner

Toilets are numbered using the GPS method, and a contractor is responsible for cleaning toilets once a week. The owners must clean the inside themselves; no disinfectants are provided. The weakness of the bucket system is that there are no vent pipes and no lids, which leads to bad odours. It also attracts insects leading to the spread of disease. There is also no proper drainage system at the laundry facilities causing unnecessary waste of water.

There is no hand washing facilities near the toilets; only at the laundry facilities, a distance from the toilets. The E.H.P. reports to the cleaning department - he is not directly in contact with the contractors. The members of the NBI (Greening campaign) and from the Ukuvuka Fire campaign group have split, and a new group was formed made up of new members and some old members of the NBI and Ukuvuka. Research was done before the Awareness Campaign to determine the knowledge level on health and sanitation of the community.

Another community volunteer workshop is planned for next year to determine if there is an improvement where children will be targeted for health and sanitation promotion. This new group meets on Sundays for workshops and organizes door-to-door health education. It concentrates specifically on the behaviour of the community in relation to hygiene and sanitation.

Health training was also given during the installation of the draining system. There is stagnant water around the drainage system which attracts mosquitoes and children play in the water leading to skin problems. There was a clean-up campaign for the streets, but it failed within 2 days.

APPENDIX 4: Sanitation Delivery Programme - Kayamandi

Appendix 4 a:
Interview with Trainer on Health and Hygiene Training Program in Kayamandi

Research assistant: Mthetho Memela (field researcher) **Date:** 10 July 2003
Respondent: Martha Mayembana (health & hygiene trainer)

QUESTIONNAIRE

a) What was the duration of the training?
b) What did you expect to happen after the training?
c) What were the modules / materials used in the training sessions?
d) How did you verify whether the trainees were well-empowered and ready to practice what they've been taught?
e) How many participants were involved?
f) Was the program being monitored / evaluated?

The purpose of health and hygiene education was to raise awareness on the appropriate use of flush toilet system. It also focused on basic hygiene awareness and the causes of sewer blockages. Ms. Martha Mayembana conducted the training in conjunction with Dr. Joe Barnes.

The duration of the training was one day, of which 26 participants were involved, and they were used to convey the message / educate the broader community and that was done door to door. One of the questions that I asked Ms. Mayembana was:

What did you expect to happen after the training?
Her response was "my expectations was to see the community changing the behaviour and prioritizing their health status by taking responsibility towards a healthy living and understanding the risks and consequences of living in conditions associated with inadequate sanitation and poor maintenance of ablution facilities."

Materials and modules used in the training sessions
The materials that were used were the posters designed by Dr. Barnes. The issues that were discussed were those that were illustrated in the posters that are the issues relating to the proper use of toilets and washing of hands after using the toilet. The participants did presentations after the session, reflecting on the knowledge they have gained.

Monitoring and evaluation of the program:
She said that she was not involved, but Dr. Barnes was responsible for that, her part was just to train the participants, "therefore I don't know whether the program was monitored / evaluated or not".

Appendix 4 b:
Onsite interview with participants of health and hygiene promotion training

Interview with a participant of the training program:

1. **What have you envisaged in this kind of training?**

Response: I can't really say that I have learned something in this training, because issues that were discusses were more of basic things, things that I already knew about.

2. **Do you think that the education that you did was effective to the community in terms of information that you gave them?**

Response: in terms of awareness raising think it was effective because most of the residents knew about things that I taught them, but they were not aware. The information was more based on the proper use of toilets and causes of blockages, but least on health related issues.

3. **What difficulties did you came up with during community health education?**

Response: there were some difficulties, for instance questions like, how can you educate us with something that we don't even have? And all the questions and comments were recorded.
He also told me that there was a questionnaire that was used together with the health education.

Appendix 4 c: Report on field visit & observations

Community Responses to health & hygiene education
Respondents: 10 houses (females between the age of 25 & 40)
Research assistant: Mthetho Memela **Dates:** 02-03 August 2003

I have gathered this information through door to door interviewing the people in the informal area of Kayamandi. I covered the Zone L area, and selected the five houses that are very closely located to the ablution facilities (that are affected mostly when the ablutions are malfunctioning/ blocked), and houses that are far from the toilets. The reason that the respondents were only the females was that, during the education most people that were available mostly were the females. The objectives of these interviews were to assess and evaluate the views and attitudes of the community towards the health and hygiene education that was provided to them. How does the community respond towards the capacity building and sanitation project of KTCSC? (Kayamandi Test Case Steering Committee)

Five respondents felt that the health and hygiene education was a good intervention to the sanitation problem, in the following ways:

- To those people who come from rural areas who are not used to flush toilets, to make them aware of the things that can give rise to the malfunctioning of the ablution facilities.
- To raise the awareness to the users who do not co-operate with other users in sharing the toilet facilities,
- Informing about types of papers that may cause the system to block, because there are few people that use toilet papers, some people don't give their children guidance on the appropriate use of toilet.

Other comments from respondent project included:

- Some of the people that were conducting the health education were not introducing themselves, in order for the residents to know who they represent and why are they teaching them.

- One female resident told me that she didn't like the questions that they asked her; She said, "They asked me if were my children having diarrhea? I became upset and asked them, Are they doctors, are they going to cure my children if they appear to be sick? I felt as if they were undermining me, because I'm living in shacks then my children must be unhealthy?"

Four respondents said that:
- that the municipality is wasting time and money by doing health and hygiene education,
- nothing will change as long as there are few ablution facilities, and that the health education could have been effective if there was one toilet per house.
- that the education didn't change any thing.

Two respondents said that:
- they didn't like the whole idea of health education; they don't see any use in it, why is the municipality educating them with something that they don't have?

Conclusion

Lack of ownership still exists; people still have the attitude that "I'm not the only one who is using that toilet", and "why must I care, municipality will or someone else". Currently they are using a method where by one house family per week cleans the toilet, but sometimes, "you find the toilet in an unpleasant condition, or blocked with papers. If the toilet is blocked we try as users to fix it on our own".

Based on these interviews was that people presumed that the volunteers that were conducting health and hygiene education were employed or from the municipality. And that the name of the project (which I can refer to as community health promotion) was never mentioned during the education program. That could be one of the reasons that led to little or poor community participation in the health education program.

People have different attitudes and behaviours in maintaining good hygienic conditions.
Firstly, there are people within the community who want to take responsibility in keeping the ablution facilities in hygienic conditions, and also want to make sure that the ablutions are working properly while they are sharing them.

Secondly, there are people who do not want to take responsibility and ownership of the toilets, because they are sharing the toilets. Because they don't have keys (access) to toilets they are sharing with their neighbours. There is also a negative attitude that the municipality will clean therefore they must litter. Some said in that way they are creating job opportunities

Study Site	Programme	Plans	Outcomes
KAYAMANDI Western Cape Test Case - Water Stream Pollution	▪ Problem Tree & Intervention Plan - Workshop. ▪ Training 26 participants ➢ *Awareness 1* –Distribute pamphlets, Posters at toilet blocks ➢ *Awareness 2* – Ownership of toilets	▪ Complaints office ▪ Trained plumbers to repair ▪ Sharing h/h to manage, clean, maintain.	▪ Complaints office not in operation ▪ Plumbers not employed ▪ Once off H+H training ▪ Used pamphlets + posters, door to door visits ▪ CD + Booklet (target?)

APPENDIX 5: Sanitation Delivery Programme– Imizamo Yethu

Appendix 5 a: Report on field visit & observations

Site Visit to Imizamo Yethu, Hout Bay **26 July 2003**
Research assistants: Sivatho Nzima & Lwandile Maseti

Interview with Noahman Hendriks (Engineer)

- New Ablution Upper Block Facility- under construction.
- Material delivery truck arrived with fascia boards for upper ablution block- not sure who received them.
- Ablution facility constructed of pre-cast concrete slab units and around 10 toilets.
- Poorly graveled and pot-holed access roads lead to upper ablution facility.
- Road construction team of SPM was busy with road construction activities en-route to Upper ablution facility.
- The cost is R200 000 including service (underground sewer pipes and manholes)
- Inadequate solid waste transfer station - not enclosed, and frequented by dogs, health hazards
- South Peninsula Municipality collects solid waste twice a week.
- Collected Health Awareness Campaign brochures from SPM (N.Hendricks)
- The new ablution was block under construction: 8 toilets on each female and male side, wash troughs outside, wash basin inside and one shower on each side
- A janitor system is proposed at ± R250 per week
- Health campaign including management of facility will be held soon after hand-over and completion of ablution blocks.

Ablution Block Facility - General information

Hector Peterson Ablution Facility

The area is very densely populated with no streets in the area where the ablution blocks are needed. The ablution facilities consist of 5 toilets, 1 shower both on the ladies and men side and washbasins outside for laundry and there are only 2 of these ablution blocks. There is no hand washing facilities inside the toilets and no electricity to provide warm water for the showers. No toilet paper are provided at the toilet and therefore papers are being used which leads to the blockage of the system and then the toilets are then locked until it is repaired.

The ablution block opens at 07:00 and close at 22:00, the community then makes use of the pour flush or the container toilets. The waterborne system seems to be in a poor condition because it is blocked, water keep on running and causes over flooding and which leaves to the children getting sick in the surrounded area. The community are generally happy with the facility especially the washing facilities and willing to pay for toilet paper. They would also like to see more ablution facilities in the area because the most households are using the container system.

The Madiba Ablution facility

There is no caretaker and the facility is in an unhygienic state and vandalized. The male side is not in use because of blockages and vandalism. At the ladies side there is no water, but it is still being used. Volunteers come to clean the facility. The community feels there is a serious demand for a caretaker. Someone was appointed but apparently did not do his job. They also want the facility to be locked at night. These community members are also willing to pay at least 20 cent for toilet paper. At the moment community make use of the bucket system.

Telephonic Interview with Jongi Mzomba (consultant): **14 August 2003**

- Spoke telephonically to Jongi Mzomba (Sizizizwe Consultants)
- Project was positively received by local community, not so by broader Hout Bay community
- Training programme will take place after ablution facilities complete

Interview with the caretaker onsite:

The caretakers did not receive any health training, no protective clothing is provided, and no disinfectants are provided for the cleaning of the toilets. The Environmental Health Practitioner does informal check-ups and tries to arrange disinfectants for which the contractor is responsible.

Interview with Lavinia Petersen (EHO):

The Environmental Youth Group of the community did health and hygiene promotion before the toilet was built. Pamphlet distribution and door-to-door explanation on the proper use of the ablution facility before the delivery of the ablution facility and during or after. A follow-up was planned for after the facility was built but due to the lack of funding it could not take place.

Appendix 5 b: Onsite interview

Interview with Lavinia Petersen (EHO) **September 2003**

With specific reference to health and hygiene promotion the data included a table that reflected the interventions in each of the sites in terms of what was intended / planned and what has actually happened. The information presented on Imizamo Yethu was outdated and not complete.

Study Site	Programme	Plans	Outcomes
IMIZAMO YETHO Local Authority Service Provision	▪ Collects educational inputs from internal depts as contribution to Integrated Education & Training programme approach	Educ. + Training drive planned: ▪ R12, 500 allowance for materials; ▪ R3, 000 for x Trainer H&H campaign: after ablution blocks handover	▪ Pamphlets designed ▪ Ukuvuku helped with distribution ▪ Education drive (house visits) will start a month before toilets are in place ▪ Follow up? ▪ Targets?

Inputs from SPM Environmental Health Officer, Lavinia Petersen:

- Environmental Health Officers did a 2-day workshop on fire, water, drainage, electricity, environmental health and sewage with the community staying adjacent to the ablution facilities
- After the workshop they gave the people 1-week to absorb information and 1 week later they repeated the workshop.
- Pamphlets were designed by all the departments involved and were distributed from door to door.A rollout was planned for Monday, 16 September 2002.
- Next step: to measure the efficiency of ablution blocks with constant evaluation until December 2003. If this works more ablution blocks will be provided.

Appendix 5 c: Interview with EHP, Imizamo Yethu

Onsite interview with Environmental Health Practitioner **1 July 2004**
Researcher: Renay Van Wyk
Respondent: Lavinia Petersen

1. How many ablution blocks are in the area?
   2 ablution blocks for Imizamo Yethu
   Where? (Section/ residents) What is the name of the area?
   Imizamu Yethu is not divided into sections or blocks/ wards.
2. Who uses the ablution facility?
   The communities staying in the surrounding areas of the ablution facilities are using the facilities.
   How many people use this ablution facility?
   There is no control or monitoring on how many people uses the facility daily.
3. Is the caretaker still working at the ablution facilities?
   The caretakers employed by the contractor are not always on duty at the ablution facilities. Caretakers are not being trained. No protective clothing is provided e.g. gloves and boots.
   Who cleans ablution facilities?
   Community members cleans facilities voluntary and they are using their own cleaning detergents.
   How regular are toilets being cleaned?
   According to the contractor the 8 caretakers employed by him to service the ablution facilities are supposed to clean and sanitize the facilities once a week.
4. Is soap & toilet paper provided?
   Neither detergents nor toilet paper are provided. So communities are to use their own toilet paper, and it was evident that people are using newspaper because they do not have toilet paper. The newspaper causes blockages.
5. Is the ablution facilities locked? When is the ablution facilities locked?
   The facilities are locked when the caretaker is not around or when the facilities are flooded.

   What is used when ablution facilities are locked?
   The people make use of the container toilets, the ablution block seems to have lightened the load off the container toilets and they do not fill up as quickly as previously.

   Where is overnight waste disposed off and how?
   The contractor also has the contract to empty the containers twice and clean them.
6. How many basins/toilets per ablution facility?
   No washing basins at the ablution facility, only 6 washing troughs and 1 shower per block for females, 5 toilets, a urinal but no hand basins inside the ablution facilities.
7. What H&S promotion/ H & H awareness programs or education is being done specific for ablution facilities?
   An education drive was done before the completion of the ablution facilities. House to house campaign by the environmental Youth group, The EHO, Lavinia Petersen was involved. Households surrounding the ablution facilities were targeted.
8. What does EHO do? About what? How often?
   Informal Monitoring is done by the Environmental Health Officer because
9. Users: Do you experience problems using ablution facilities?
   YES. Facilities are not cleaned on a regular basis, no detergents are provided.

APPENDIX 6a: Overview of current interventions in four case studies
Researcher: R Van Wyk (edited by D. Cousins) (2003/04)

Khayelitsha (Site B and Site C)

In 1999 the Khayelitsha Task Team (KTT) project, a school-based worms treatment programme, targeted 12 Primary Schools in Khayelitsha (Site B and Site C) respectively. The Khayelitsha Task Team (KTT) core group consisted of representatives of Public Health Programme (University of Western Cape), (Medical Research Council (MRC), Department of Health (Provincial Administration Western Cape), and Western Cape Education Department (WCED), as well as city health officials.

The Health Promoting Schools programme was in line with curriculum 2005. The community-level role players responsible for conducting the programme included staff and parents of the school children. The health and hygiene message was conveyed through story telling and a "smiles and frowns" learning system.

Households residing next to two of the schools participated in assessing the causes of worm infestation and a community-based sub-committee of the KTT was established. The pilot Household programme involved the households in a mapping exercise of their residential area, identifying causes of worms and taking pictures. Parents were encouraged to teach children to wash hands after using the toilet.

On the City of Cape Town's request the Khayelitsha Task Team trained volunteers from the community along with volunteers from Joe Slovo in 2002. The health and hygiene training programme introduced information on Hygiene and Sanitation, Contamination Routes and Barriers, Health and Social impact of poor environmental hygiene. The group covered questionnaire design, mapping, three pile sorting and community assessments. The local Water and Sanitation Forum was established in 2003. Two health facilitators were recently employed by City Council to do health and hygiene education in the community on E.g. Urine Diversion System which is currently on trial.

Joe Slovo (Langa)

KTT and Public Health Programme (UWC) was responsible for conducting three 2-day sessions of Health and Hygiene training workshops that included volunteers from Joe Slovo. This took place towards the end of 2002 until January 2003, and was funded by City of Cape Town. The targets for the training programme were volunteers from the community greening project group. Currently participants from the Greening project and TSOGA Environmental group have amalgamated to form one local Sanitation Task Team. The city EHP conducted a further training workshop in July 2003 to train the volunteers in preparation for a door-to-door awareness campaign based on pamphlets on washing of hands, diarrhoea and creating a clean and healthy community.

Container toilets, put up along the bank of the canal to accommodate servicing, raised concerns that refuse dumping and use of the canal instead of the toilet can increase health hazards. Initiative by an EHP to take water samples from the canal, before and after the awareness campaign, hopes to serve as an indicator of impact from community's health and hygiene awareness efforts.

Imizamo Yethu (Houtbay)

An education drive by a local Environmental Youth group, before the installation of two ablution facilities in December 2002, was intended to be followed-up with an education drive that never materialized. No evaluation was done on the previous drive. The council does not employ attendants at the ablution facilities, and they received no health and hygiene education and training.

Kayamandi (Stellenbosch)

Due to the density of settlement communal ablution facilities are built, but no more permanent rather mobile structures. Existing ablution blocks were just fenced off and are locked at night, no attendants during the day. New mobile facilities are being installed now. For this particular project only engineering department is responsible, thus there is no collaboration between health and engineering. The installation of mobile toilets started after a lengthy consultation process, funding is from DWAF, CMIP and local government. Consultants were employed for the installation of the mobile facilities. Engineering department only budgeted for in-house staff to be trained but no was provided training for community only awareness and campaigning. Caretakers employed by the municipality monitor the toilets, record and report any damages by radio connected to the station for the specific department to fix it.

Materials, Costs and EHPs involvement in Current Initiatives

Site	Materials/ programme	Costs		EHPs role
		Training/ awareness	Materials	
Joe Slovo	Use 3 different pamphlets Door-to-door	R24 900	Not available	Informal monitoring
Khayelitsha	KTT Training on PHAST	R24 900	Not available	Formal monitoring
Imizamo Yethu	Door-to-door pamphlet distribution	R 3 000	R 12 500	Informal Monitoring
Kayamandi	Ongoing Awareness programme	R200 000		Informal monitoring

APPENDIX 7a: Health and Sanitation Promotion Strategic Planning Workshop Goodwood Municipal offices, 06 May 2003.

1. SUMMARY OF OUTPUTS

Overview of Health and Sanitation Strategy ⟶ **Steps**

1. Policy ⟶ Develop Guidelines (principles)

2. Develop your Programmes

   - Health and hygiene awareness
   - Monitoring & evaluation
   - Build Capacity
   - Target (Who?)

   E.g. - Community leaders & households
   - Focus? For programme
   - How does it progress? (Monitoring & evaluation)
   - "Sensitizing" immediate need?
   - **SUSTAINABILITY**
   - Payment? Allocated budget for O&M
   - Indicators of success
   - Ongoing Improvement (M&E)
   - Transfer for sense of pride

3. Context (Technology)/ Roles
   - M&E
   - Building capacity
   - O&M – impact/ cost/ payment – for sustaining systems

4. Learn by Doing
   - Transfer of skills to EHP and community
   - Continually adapt…

ACTIONS

1. Write up strategy discussion outputs – send to Gys White
2. Set Standards for options (working group – 16th May) –to N. Hendricks
3. WRC Research: Health and Sanitation Promotion Reference Group (16th May) – test H&S table from WRC Framework
4. N. Hendricks needs a Strategy for H&S Promotion for integrated project

2. Overview of INPUTS

Aim: Health and Sanitation Strategy to be put in place

Policy – needs alignment for planning
- Health education is included in the Sanitation Policy
- Own Heath Policy (Integrated Service related)
- Enough or Add? Work group)
- Add Health Act, budget allocation entitled to? With infrastructure to enable planning for health and hygiene.

Procedures

- Mechanisms for Delivering (Health and Hygiene)
- Partnerships (internal and external) to be developed (WHO?)
- Direction for methods
- Technical Options

Issues:

- Funding (additional) from DWAF and others
- Capacity building
- Prioritization Criteria: project – Micro design (5 years)

Strategy

- To implement policy
- Need a Framework

Programmes

To enact/ do

- Develop programme
- Tender for implementation
- Access to Budgets
- Skills transfer to EHPs

} SUSTAINABILITY

- Appropriate Materials
- Community implement – build capacity for ongoing programme
- Qualification? – Recognition of skills?

Programme development to include:

- Draw from experience – local examples (good and bad)
- Contractual arrangements with partners, best practice
- Time frames of contracts vs. sustainability
- Generic message to households
- Specific message for technology options to community/ households
- How to:
  - Spread message through facilitators
  - Plays and posters
  - Highlight awareness and options at public meetings
  - Door to door

3. <u>Discussion: HOW to do Health and Sanitation Promotion?</u>

<u>Capacity Constraints:</u>

- "People" power
- People on the ground to implement
- 25,000 units or households to reach
- *Absence of organizational framework*

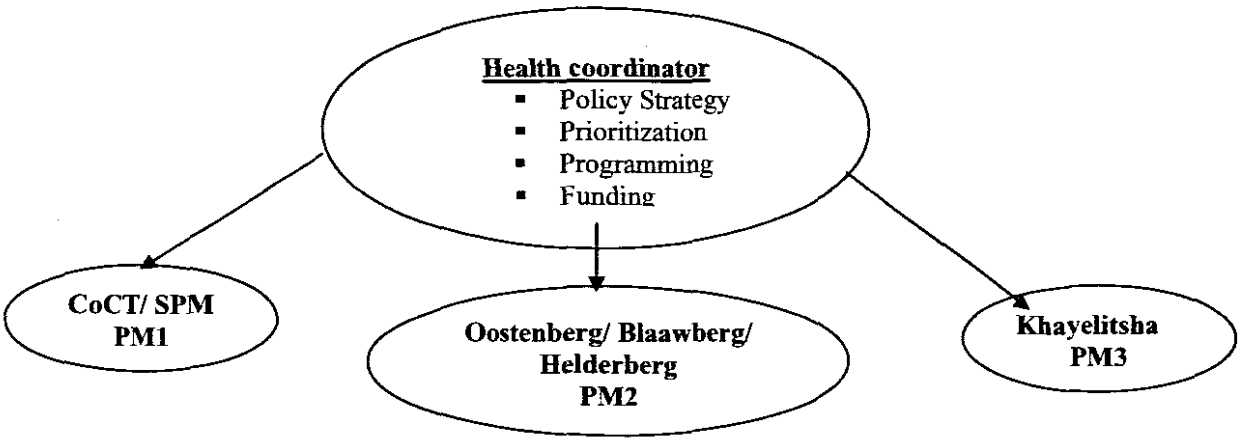
<u>Resources Available:</u>

- **Finances** – 2.5 Million Rand
- Partnerships with other departments (with strengths)
- Focus: **Water, Sanitation** and refuse removal
- Existing programmes to link with MAC (Fairest Cape), WASH, Water Week, Healthy Cities, Skills Development (funds programme), AIDS awareness?
- Contracting/ outsourcing/ partnerships
- Train the Trainers to train people

Develop Roles, Responsibilities

- EHO's develop message with other departments

- Our role as EHPs –with Committees



- Each area all directorates will have representatives E.g. Health to ensure that Health Issues are Monitored and Evaluated
- In each area Environmental Health Practitioners/ Service Provider will be responsible for their informal settlements that falls into their areas of jurisdiction.
- Resource Allocation

PROGRAMME DEVELOPMENT ENTAILS:

WHO?	
▪ Community leaders - councilors, committees ▪ Households ▪ Ongoing maintenance people ▪ Attendants	
HOW?	**WHAT?**
Schools	materials e.g. rulers, etc
Educare facilities	Transfer of Skills
Target audience determined	M&E
Churches	O&M
Established Health committees	
Opportunities – funding, assistance	
Linkages	
Training + capacity building	

APPENDIX 7b: Health Standards by engineering and health department officials

Technology	Design specs.	Health Standard specs.	Current Practice
RUDIMENTARY – (TEMPORARY) Container (100ltr) *Shared Units* 3 years max	• Gaps to be reduced • Durable – top structure • Latch - access • Robust, stainless, free from corrosion, impervious • Containment: onsite, offsite • Ventilation – lids • Location of units: wind, sun,	SUPERSTRUCTURE: • Doors – gaps are too large • Lids – closing after use must be monitored Locally • Locks and latches - access • Ventpipes: whirly / flyscreen – fly control, reduce odours • Floor – smooth surface to be cleanable not rough concrete OPERATION & MAINTENANCE: Twice weekly – frequency of service • Type of chemicals, Faecal matter • Containment – buckets only in transitory camp • Not without H&S programme, local Jobs? TRANSPORTATION: from User to Disposal: Replace with clean one; empty contents into contained tank; protect workers. • Local labour for waste removal – perverse incentives to committee MINIMUM MANAGEMENT & MONITORING REQUIREMENTS for adequate sanitation service • Locking/ access issue needs to resolved- local management of access. Child access? • Good drainage around facilities (toilets, laundry, taps) Area around facilities must be stable and well-drained (grey-water drainage) • Containment/ Safety for disposal • Children as target of health promotion	JOE SLOVO • 4 h/h per unit (can mean 20 people on average) • More than 3 years – permanent facilities • Access is essential • Monitoring for Access • Appropriate ACTION • Monitoring for ACTION • Monitoring for ACTION • Reporting • Communication with –Manager of contractors (brief) –Where/ dept/ person who is responsible (Dev Support)

Technology	Design specs.	Health Standard specs.	Current Practice
BASIC offsite (AFTER 3 YEARS) Ablution Blocks/ *Public toilets* Permanent/upgrading utilities	Building section to provide details on design specs – how many people per block, range of facilities (washing), etc • Location of facilities **Rudimentary** • Hand washing basins and soap dispensers • Min. 4 showers/ block • Accessible for handicapped users • Proper drainage and gutters • Lighting inside **Basic** • Storeroom for equipment & materials • Lighting outside	➢ *Public toilets vs. un-attended Blocks* **Rudimentary** • Provide toilet paper to ensure proper use • Soap dispensers for hand washing • Provision of Cleaning equipment & materials • Adequate access times/ no. of attendants **Attendants** • Provision of Hygiene Awareness/Promotion Training • 2 caretakers on duty full time/ facility • Protective clothing to be provided (boots, gloves) • Control & monitor toilet paper use & cleaning materials • Clean facilities daily, Record number of users daily **Formal Monitoring & Evaluation** • EHO – health & hygiene of facility • Supervisor – attendants • Contractor – operation and maintenance of facility	*Khayelitsha,* **Optimal & maximum ratio to be established** *KHAYELITSHA*, TR Section • Approx. 150 people/ per block/ per day • No. of cubicles/ block = 6 • No. of hand basins = 7 • 6 Showers • 6 Washing troughs • Toilet paper to users • Cleaning materials provided to attendants • Facility open 7am – 6pm Council: • Responsible for maintenance, repairs • Provide cleaning materials & toilet paper • Employing attendants
(BASIC) ON SITE **Individual Units** **UDS** **VIPs**	• Replaceable bags	Location *next to house **Monitoring & Evaluation – testing faeces** • Gloves -No contact with faeces • Dry, Waterproof - 50 kg replaceable bags • Collection by bucket service subject to the same standards as containers ***Location:** next to house, face north *Odours, Personal Safety Privacy, Wind, Sun, Distance from Shacks; Floodlines **Monitoring and Evaluation** • Flyscreen, closed doors and lids	**Gordon's Bay, Khayalitsha** KHAYELITSHA (KTT trials) Ecosan, UDS KLIPHEUWEL /BLAAUWBERG (DWAF projects) 56 Farmers in Phillipi - VIPs

APPENDIX 7c: Update on Informal Settlements Strategy

Interview with City of Cape Town (CCT) officials

Date: 25th August 2003
Researchers: CWSS research team
Respondents: Mr. F. Van Niekerk (Dev Support), Ms. L. Van Oordt (EHP)

1. **Update on draft Health Department Strategy:**

   L. Van Oordt (as health department's dedicated working group member compiling the draft strategy), explained the status of the document to F. Van Niekerk (as delegated manager for implementing the CCT's informal settlements strategy). Dr Ivan Thoms (Health Department manager) had provisionally approved the substance of the strategy but has required that the draft document be "formatted for general consumption".

   - Cooperation between departments will be enacted through an informal settlements upgrading Project Team made up of dept representatives.
   - While the Strategic Planning Framework (output of previous WRC research) has been adopted by the health dept.'s working group, Dr Thom's has requested adaptations that may diverge from the working group's intentions.
   - Prioritisation of informal settlements, based on priority zones, is still underway due to another audit being conducted and inclusion of the Mayor's "Listening Campaign" outputs.

   Concern about the plan to engage Consortia of Consultants from outside the city to conduct the strategy was expressed by the EHP, and the health department's control over management of consultants raised as an issue.

   - Building EHP capacity to oversee programmes forms an important part of the health dept's strategy.

   It was agreed that the Project Team must address the issue of managing Consultants, particularly the concern of health dept EHPs about how to control quality. Representation of the Health Dept dedicated Working Group was identified as key to ensuring the aim to integrate and coordinate across city departments.

2. **Update on implementation of the CCT's Informal Settlements Strategy:**

   F. Van Niekerk explained that the CCT's strategy (as presented by D. Hugo, Implementation Manager, at a WISA meeting in July 2003) has been interpreted into implementation and added some aspects.

2.1 Consultation, Communication and Facilitation has been added as an important component of implementation, aimed at buy-in from communities, involving:

- Communication of current crisis situation
- Objective of Consultation has been added
- Ensure that all stakeholders are consulted and involved

The implementation involves targeting of Local Ward Councillors and Community leaders for meetings, leading to presentations to broader groupings followed by a workshop for community feedback a week later. CCT's Excutive is still to approve this strategy at this stage, after which community engagement will proceed according to prioritisation of zones and settlements.

2.2 Community Education element will be coordinated and linked across several departments, to include:

- solid waste, disaster management, health, etc;
- using existing materials and resources of the different departments, and drawing on an audit of the CMC Resource Centre materials;

- departments will fit together, working in particular settlements;
- Communication and Education (CMC) people will develop more definite programmes for engaging settlements, a Programme Identity (logo).

2.3 Technical Options:

- Hierarchy of standards have added another 'Temporary' level at the bottom of scale, for Unsuitable and Private Land.
- To accommodate cases on Private Land a legal document/opinion has been prepared - requires political approval. With consent of owner, costs for emergency/temporary services will be carried by the city. Where there is no consent, a By-law (takes one year) will be promulgated. In excessive immediate needs, a medical officer of health is to advise delivery priorities.
- Rudimentary services stand in the configuration of Levels of service.
- In line with a national emergency level, 5 families may share 1 toilet facility.

2.4 Implementation update:

- Re-prioritisation is underway, with the current year's budget shrinking to about R28mill. due to lack of city capacity to spend R53mill. within current financial year.
- A spreadsheet is being produced for prioritisation and ranking – criteria reactive to data on spreadsheets (eg how many standpipes etc)
- Health inputs to Audit to come (Chris O'Connor).
- Implementation will start in November 03 - to get hard services on the ground by end January 04.
- Programme to tie in with Housing Programme – some settlements are already identified.
- Boundaries of areas to be established, dates to be set for facilitation to begin.
- A Coordination Team with Servicing, Housing, Community Services, etc legs to be endorsed by Mayor – there may be a few changes.
- Consortia will be appointed to work in 3 Areas. A Project Office with a Planner (Johan Keeler), Engineer (Denzil Faure), Community Education
- The city intends to develop best practice and believes there are competent people. (Best currently is Containers being services by external contractor who is paid for the service).

3. Outstanding Issues:

1. How is health department going to manage Consultants in respect of health and Sanitation promotion? Who is going to drive the Health dept Strategy?

2. Is the pro-poor point of view factored in? What are the pro-poor strategies?

3. Are local employment opportunities coming out in city's Requests For Proposals (RPF) process, Roster system? – O&M and M&E gaps are acknowledged but not yet addressed.

4. What capacity building plans are underway for staff and community?

5. How will Operation and Maintenance of different levels of service, and Monitoring and Evaluation of services establish what is enough?

APPENDIX 7d: Health Resource Centre (City of Cape Town)

Date: 14 February 2003
Researcher: Renay Van Wyk
Purpose: To explore their resources related to Health and Sanitation Promotion

Contact Details:
Priscilla Beeton – resource librarian
Health Resource Centre, 64 Duncan Street, Parow, 7500, Tel No. 931 8140, Fax No. 931 8585
Maureen Mccrea, Metropole Health promotion, 021 – 918 1708, Mmccrea@pawc.wcape.gov.za

- The center offers access to health promotion literature and materials
- Assist in designing of posters and pamphlets conveying health and hygiene messages
- They also distribute these materials to the respective administrations in the City of Cape Town
- Members of the Health Promotion Forum developed *The Tool for the Planning of Health Promotion Interventions.*
- This tool is being introduced to managers, health practitioners and environmental health officers.
- They encouraging city officials and health practitioners to use the health promotion tool by disseminating the tool to the various administrations and health practitioners.

Report on Meeting at Health Resource Centre (City of Cape Town)
Date: 28 February 2003
Researcher: Renay Van Wyk
Purpose: To collect Health and Sanitation Promotion related material and literature

HPLAAC - Health Promotion committee

- This body act as a talking body
- The Committee meet monthly to discuss emerging issues in terms of health promotion in the City
- Decide what actions should be taken to address the health problems/ issues
- The body consists of EHO's , health promoters and clinical staff

ENVIRONMENTAL WORKING GROUP

- The EHOs have representatives serving on HP committee but also established the Environmental Health Working Group to discuss issues pertaining environmental health at a separate meeting and then the representative give feedback at the HPLAAC monthly meeting

Health Resource Centre

- Design materials e.g pamphlets or booklets as requested by HPLAAC
- Collect a variety of health promotion and health related material and disseminate it to all the administrations in the City of Cape Town

➢ Priscilla Beeton gave contact lists of two forums HPLAAC and the ENVIRONMENTAL WORKING GROUP to us.

➢ These contacts were used along with other contact persons within the City of Cape Town to request Environmental health practitioners to express their interest in forming part of a health and sanitation reference group.

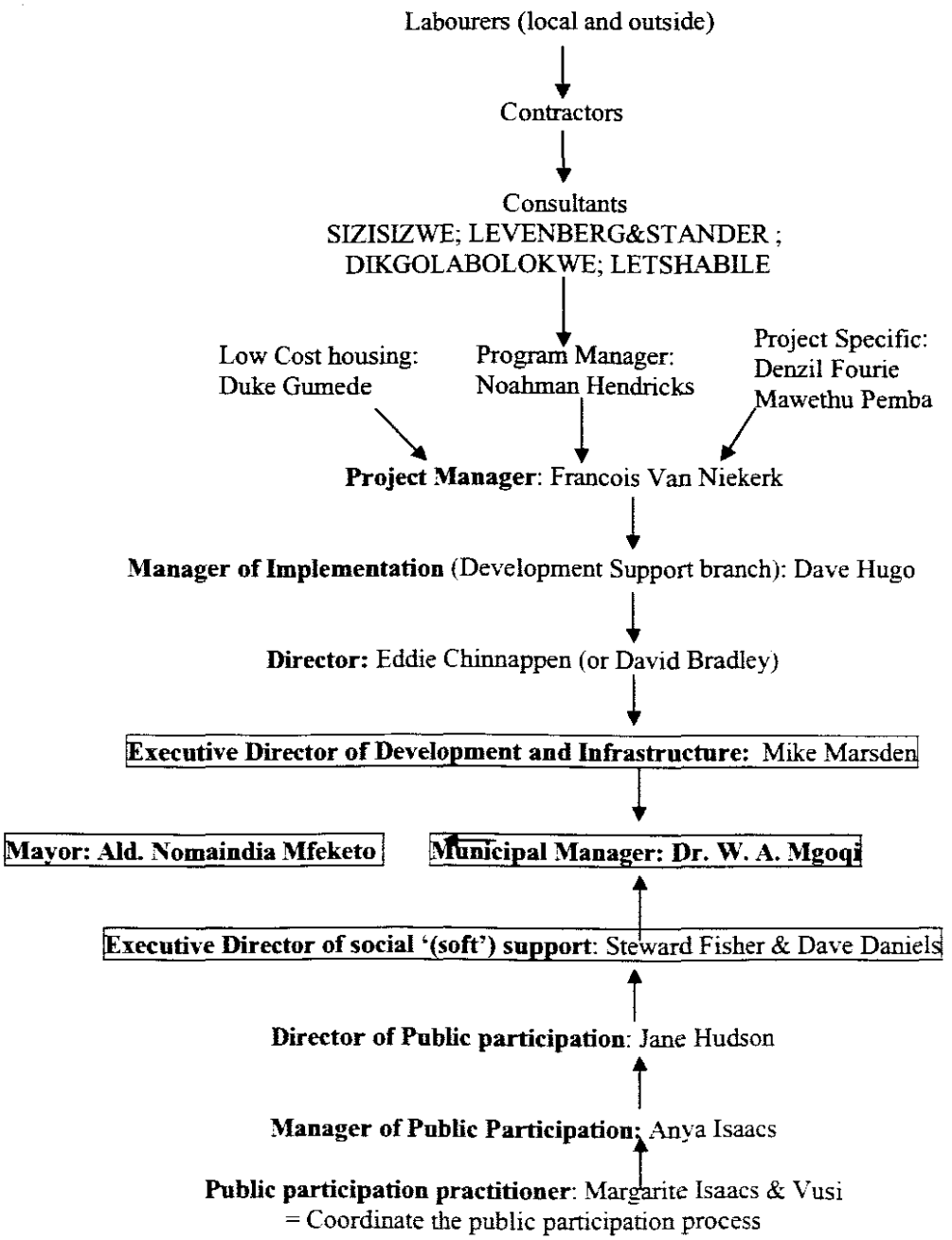
APPENDIX 8 a: Current status of implementation and procurement in informal settlements in City of Cape Town: January 2004

	IMIZAMU YETHU	SWEET HOME	N2 STRIP
OFFICIALS (responsibility)	**Project management Team**: N. Hendricks (reports to Van Niekerk) **Solid Waste**: Jonathan Fortuin **TRS**: Martin Thompson **Electricity**: Lien Labuschangne **Social Development:** Pam Naidoo (reports to Vusi Magagula) **Waste Removal:** Fred **Water Services:**	**Project Management Team:** J. Gerber (reports to Van Niekerk) **Sanitation:** Michael Page (reports to T de Jager) **Solid Waste:** Colin Ruiters/Eric Kwaaiman **TRS:** Alvin Singama/ Gershwin Fortune **Electricity:** R. Macfarian **Disaster Management:** Lennox Mashazi **Social Development:** Russell Dudley (reports to Vusi)	**Project Management Team:** J. Gerber (reports to Van Niekerk) **Sanitation:** Michael Page (reports to T de Jager) **Solid Waste:** Colin Ruiters/Eric Kwaaiman **TRS:** Alvin Singama/ Gershwin Fortune **Electricity:** R. Macfarian **Disaster Management:** Lennox Mashazi **Social Development:** Russell Dudley (reports to Vusi)
CONSULTANTS	SIZISISWE (PDI) *-See report: appendix 2* -The city is workikng on a prelim budget. They have given the report and their brief to CCT and are waiting for their response LIEBENBERG & STANDER Joint venture: previously they were leaders but now they are working on a 50/50 basis with Sizisizwe and more or less independently (split up area)	ILISO (consulting engineer) Dave Martin: 418 1075 Brief: Terms of brief not finalized yet, still working on it. Basically the design, construction and supervision of the area.	ILISO (consulting engineer) Gov fees: *See Appendix 1* Brief: Terms of brief not finalized yet, still working on it. Basically the design, construction and supervision of the area
CONTRACTORS	MASICOCO –Local contractor for maintenance (collecting buckets, overseeing ablution blocks) until new tender.	Still to be decided	SANNITREE: delivers service, until tender
LOCAL EMPLOYMENT	Cleaners of ablution facilities	None	None
STATUS	- Completed S/T interventions - Established a PSC - Meeting to implement Med. to L term service interventions on the 29th Jan 2004 - Consultants completed report assessing existing services in Imizamu Yethu -Project Team meeting on 5/02/04 - Disaster management occurring after the fire on 7th: 800 shacks were burnt.	- Land acquired for R16 000 by CCT - Officials met with community for the first time on the 26th Jan to form a PSC. -Busy communicating with communities in area	-Has received Rudimentary status. - Still with consultant (ILISO) to decide how to take project forward. Until then SANNITREE will continue with what they doing. -Officials still need to go into area to busy communicating with the community -Geo-technical report declared area unfit for settlement

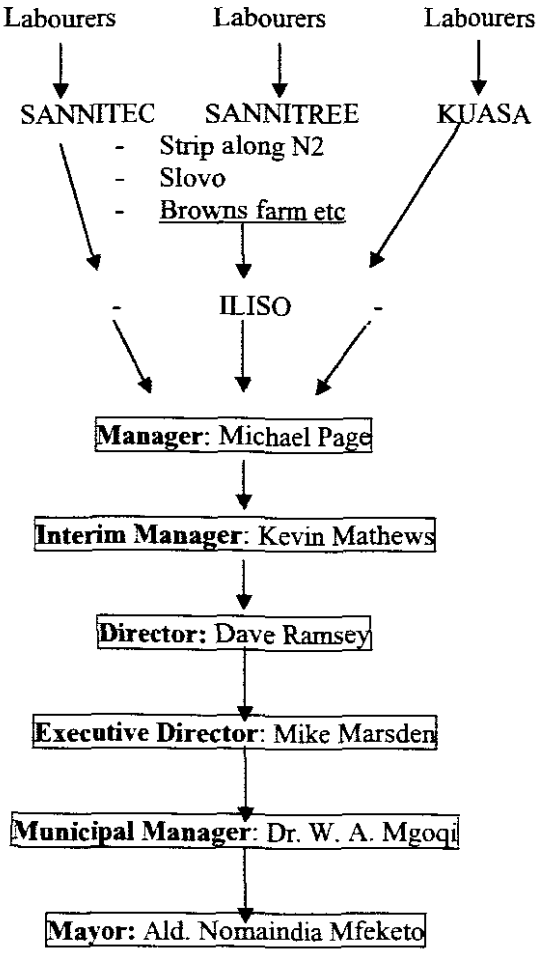
HOW CITY IS INVOLVED WITH INFORMAL SETTLEMENTS

The city has 3 departments which are currently involved with Implementation in Informal Settlements

1. Structure of Development Support Department: Who reports to who?
Information gathered from Margarite Isaacs and Duke Gumede

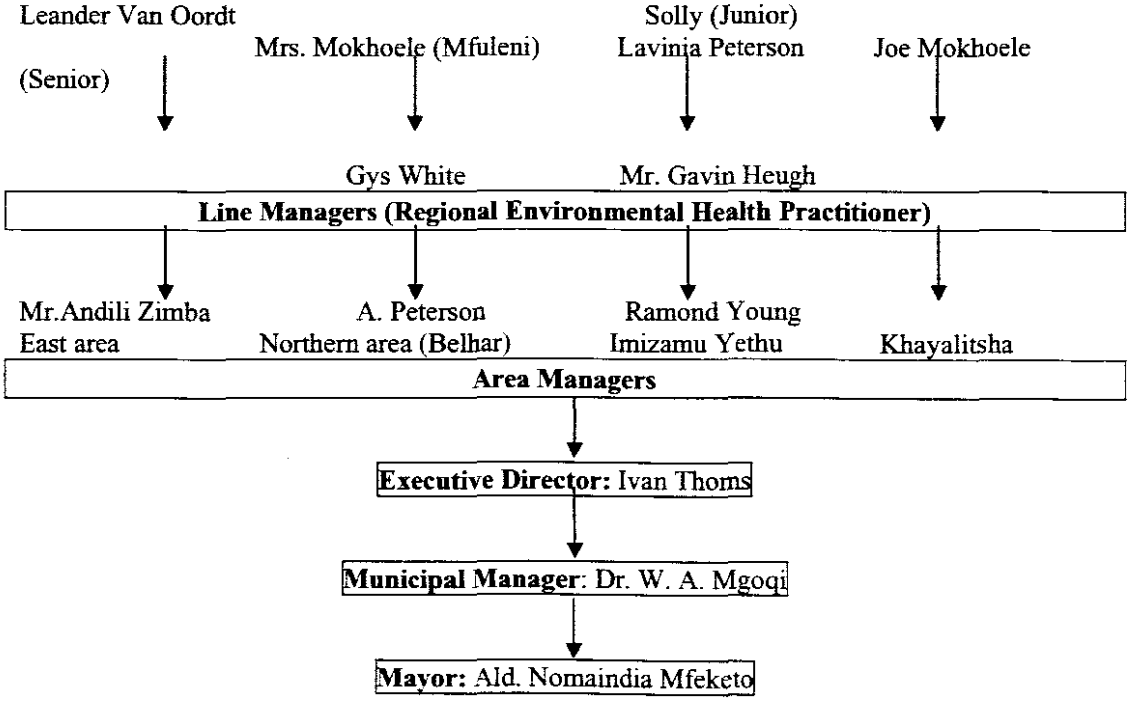


2. Structure of the Sewage Dept.: Who report to who?



3. The Structure of the Environment and Health Department

In charge of monitoring, education and possible new job of coordinating departments



TIMELINE: PROGRESS IN ADDRESSING SANITATION AND HEALTH IN INFORMAL SETTLEMENTS IN CT