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Rural sanitation in Southern Africa: A focus on institutions and actors

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Rural Sanitation in Southern Africa: A Focus on Institutions and Actors

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List of acronyms

AREX	Agricultural Research and Extension
BRL	Blair Research Laboratory
CBM	Community Based Management
CBO	Community Based Organization
CEO	Chief Executive Officer
CLTS	Community-led total sanitation
DA	District Administrator
DANIDA	Danish Agency for International Development
DDF	District Development Fund
DE	District Engineer
DERUDE	Department of Rural Development
DHS	Demographic and Health Survey
DWAF	Department of Water and Forestry
DWD	Department of Water Development
DWSSC	District Water and Sanitation Sub-committee
EU	European Union
FO	Finance Officer
GoZ	Government of Zimbabwe
IRWSSP	Integrated Rural Water Supply and Sanitation Programme/Project
IWSD	Institute of Water and Sanitation Development
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MLGR&UP	Ministry of Local Government Rural and Urban Planning
MOF	Ministry of Finance
MOH & C	Ministry of Health and Child Welfare
MYGEC	Ministry of Youth Gender and Employment Creation
NAC	National Action Committee
NCU	National Coordination Unit
NGO	Non- Governmental Organisation
NORAD	Norwegian Agency for Development Co-operation
NRB	Natural Resources Board
PDC	Provincial Development Committee
PHHE	Participatory Health and Hygiene Education

PWSSC	Provincial Water Supply and Sanitation Sub-committee
RDC	Rural District Council
SCSO	Social and Community Services Officer
SIDA	Swedish International Development Agency
UNDP	United Nations Development Agency
UNICEF	United Nations Children's Fund
VIDCO	Village Development Committee
VIP	Ventilated Improved Pit
WADCO	Ward Development Committee
WatSan	Water and Sanitation
WHO	World Health Organization
WPC	Water Point Committee

1. Introduction

1.1 The sanitation context

Water, sanitation and hygiene are essential for achieving all the Millennium Development Goals (MDGs) and hence for contributing to global poverty eradication (Global Water Partnership, 2000). This thematic paper contributes to the learning process on scaling up poverty reduction by describing and analyzing three programmes in rural sanitation in Africa: the national rural sanitation sector reform in Zimbabwe, the national sanitation programme in South Africa and the national sanitation programme in Lesotho. These three programmes have achieved, or have the potential to achieve, development results at a national scale exceeding the average rates of progress for Sub-Saharan Africa. The lessons from these programmes are useful for other people around the world. None of them is perfect, but they all demonstrate good work at a large scale.

Although water supply, sanitation and hygiene promotion should be considered as one interlinked sector it is increasingly recognized that where programmes or projects are touted as Water and Sanitation (WatSan) very little is done in terms of sanitation improvement and the bias is always to provide water supply hardware. Whilst improved water supply may reduce the incidence of faecal-oral diseases, other transmission routes require intervention through sanitation and hygiene promotion. Sanitation and hygiene promotion create demand for improved facilities. This is important because in some communities people may be satisfied with current sanitation practices, albeit unhygienic, or they may be unfamiliar with alternatives.

Access to safe drinking water and sanitary means of human excreta disposal is regarded as a universal need and key to human development (UNICEF, 2004). Sanitation services are critical to poverty reduction, growth and the achievement of the MDGs. It is estimated that investment must double from the current USD15 billion to USD 30 billion annually to achieve the MDG 7 for the sanitation sector.¹

1.2 Definition of Sanitation

Sanitation has been described as the promotion and prevention of disease by the maintenance of sanitary conditions and the safe management of human excreta (Taigbenu et al., 1999). Excreta is generally recognized as offensive and objectionable, with the resultant social taboos making excreta management strictly a private business. In sparsely populated areas, indiscriminate defecation may be considered acceptable, if it gives no rise to unacceptable sanitary conditions. Where sanitation is not considered necessary and facilities do not exist however, as population densities increase, privacy becomes important (particularly for women and the elderly) and rules for safe disposal of excreta need to be made.

1.3 The scale of the sanitation backlog

More than 2.4 billion people lack access to proper sanitation facilities. Over 2 million child deaths a year can be attributed to preventable diseases spread by dirty water or improper sanitation facilities (UNICEF, 2004).

Clean water, combined with safe sanitation and improved hygiene practices prevent disease, save lives, and transform communities. Access to safe sanitation improves health and the

¹ Global resource allocations also need to be translated into national level budgets, to account for national sanitation targets. In the case of South Africa, for example, the water reserve planning director, Fred van Zyl of the Department of Water Affairs and Forestry, recently stated that to achieve the country's sanitation target by 2010 would require a four-fold increase in the Municipal Infrastructure Grant (Mawson, 2005).

nutritional status of children and adults, offering increased opportunities for learning and ultimately improved employment and income potential, with impacts on livelihoods security. (WELL, Briefing Notes 1-6, 2005).

Despite the evidence of the benefits of improved sanitation on broader development objectives, investment in sanitation remains low and levels of improved sanitation remains significantly behind those for water supply, particularly in urban areas, as highlighted in the 3 case study countries.

Table 1. Access to improved sanitation: Lesotho, South Africa and Zimbabwe ²

Country	Rural	Urban	Total	Data source
Lesotho	66%	29%	37%	2000 MICS
South Africa	85%	49%	No data	National census, 2001
Zimbabwe	69%	49%	No data	DHS, 1999

(Source: WHO/UNICEF, JMP, 2004)

2. Development of rural sanitation programmes in Southern Africa

2.1 The development of a preferred technical option: the VIP

The Ventilated Improved Pit (VIP) latrine is known and used in many countries around the world. Within Zimbabwe itself, the VIP latrine, known as the Blair latrine, is a national institution and remains the sanitation technology of choice for most rural households. It is named after Dr Dyson Blair, a former Secretary for Health and early advocate of the health benefits of low-cost and appropriate water supply and sanitation technologies. This innovative latrine was devised at the Ministry of Health's Blair Research Laboratory (BRL) in 1973 and was subsequently adopted as the standard sanitation technology promoted by the Ministry of Health (MOH).

A correctly constructed and used VIP latrine can provide an appropriate sanitation solution, although there are certain constraints to be taken into account. Firstly, the concept of a VIP means that it is not always simple to upgrade an existing pit latrine to achieve the full benefits of a VIP. Secondly, the need to keep the superstructure dark to achieve full benefits of fly control can mean that children fear going into the latrine, the infirm and people with disabilities have difficulty sitting or squatting correctly and women fear attack, or desire more light to assist with personal and menstrual hygiene.

Despite these constraints, the VIP latrine has been adopted as the technology of choice in the development and implementation of many large-scale national sanitation programmes in Zimbabwe, Lesotho and South Africa since the 1970s.

² National statistics need to be read with care, as definition of "improved sanitation" differs from one country to the next. What is of greater importance is consideration of overall trends in coverage, together with data on access to and usage of sanitation facilities, as well as the degree of satisfaction with them by members of the household.

2.2 Rural Sanitation Programme in Zimbabwe

From the 1970s, the MoH was enthusiastic in its support for the Blair latrine. Initially the liberation struggle limited promotion and uptake of the technology by rural households, but the MoH mobilised its network of health workers to promote and build Blair latrines on commercial farms and at government offices, health clinics and small towns around the country. As a result, between 1975 and 1980 tens of thousands of Blair latrines were constructed and many government staff became familiar with this new sanitation technology.

After independence in 1980, the new government, committed to rural development, attracted considerable funding from external support agencies eager to assist in the reconstruction and development of Zimbabwe – notably the World Bank's Technology Advisory Group (forerunner of the Water and Sanitation Program). Despite this support and enthusiasm, the post independence sanitation programme started slowly. The government was undergoing reorganisation, and new challenges were becoming apparent. The MoH recognized that the ferrocement³ VIP latrine, used so successfully in public and institutional settings prior to independence, was not a financially viable model for widespread construction, due to the levels of poverty found in the rural areas. The BRL examined alternative materials and methods of construction, including low-cost mud, grass and timber models, as well as more robust brick-built latrines.

MoH officials, wanting the latrine programme to have long-term benefits, made two decisions with far-reaching consequences. Firstly, they decided to adopt the durable brick VIP latrine design as the national standard in the hopes by lasting a generation they would provide a basis for sustainable improvements in hygiene behaviour and public health. With an obvious drawback of the latrine's expense, secondly, the MoH decided that its sanitation programmes would provide a substantial direct subsidy – in the form of 3 bags of cement – to rural households, in order to make brick VIP latrines more affordable.

Using the VIP latrine and the National Sanitation Programme in 1985, Zimbabwe launched the Integrated Rural Water Supply and Sanitation Programme (IRWSSP). This programme aimed to provide universal access to safe rural water supply and sanitation facilities with the target that every rural household should have a VIP latrine by 2005. It was estimated that 1.4 million VIP latrines would need to be constructed to achieve this ambitious target. The IRWSSP was implemented by existing line ministries, encouraging for the first time cross-linkages between water supply, sanitation and health.

For some years the Government of Zimbabwe's IRWSSP implemented the construction of the VIP at a large scale until the decline of the national economy. This programme was implemented in a coordinated manner through collaboration and shared decision making among implementing government line ministries. Despite that decline, however, the VIP latrine remains a popular technology choice and is currently being promoted in various forms by local NGOs and others. There are now hundreds of thousands of VIP latrines throughout Zimbabwe originating from the early work of BRL.

2.3 Rural sanitation programme in Lesotho

The rural sanitation program in Lesotho offers an excellent opportunity to study the process of sector development, from the implementation of a small-scale pilot project through to the establishment of a nationwide improvement program.

³ A cement-rich mortar, reinforced with layers of wire mesh

A 3 year pilot project, begun in 1983 with financial assistance from the UNDP and UNICEF, laid the groundwork for a large-scale integrated rural sanitation programme at the national level by demonstrating the importance of carefully planned, sustainable approaches to development. The pilot project emphasized the need for the involvement of rural communities and the private sector, together with the need for socio-cultural considerations, including an emphasis on hygiene education and the involvement of women, to be taken into account in project design. Training in latrine construction and maintenance was a key component of the first year of the pilot project, providing a skills-base from which to support a scaled-up programme. Long-term planning and improved collaboration among donors were other important elements of project success.

Within a period of ten years, rural sanitation in Lesotho rose from a neglected sector, devoid of planned improvements, to a model sector under an integrated national programme, supported by the national government and a number of external donors.

Lesotho's rural sanitation programme is of particular interest because of the level of responsibility it has always placed on users to pay for improved on-site sanitation. While government and donors focused their support on aspects of sanitation promotion, awareness raising and training, households were left to pay for the materials and employ builders to construct the latrines (WSP-Africa, 2004). Financing options, including credit schemes were introduced to assist the poorest with affordability, although these have not always achieved the return rates anticipated. As emphasis on user cost recovery is a significant factor in supporting the long-term sustainability of the rural sanitation program, this remains uncertain. Sustainability has however been enhanced through the successful transfer of construction and maintenance skills to members of rural communities. Latrine builders are able to market their skills in their communities, and so have a direct financial incentive to promote improved sanitation.

Transferring responsibility for financing the construction of sanitation facilities to the user community improves the prospects for self-reliance from the government's perspective. While the major expense of many rural sanitation programmes is in latrine construction, in Lesotho very little government or donor money is spent in this area. Well-established district sanitation programmes have created a privately managed, market-led supply of latrines with the flexibility and capacity to respond to increasing demand. The purchase of a latrine within an unsubsidized programme indicates the high priority given to sanitation in response to changes in attitudes and behaviours.

As of mid-1989, approximately 900 local latrine builders had been trained and an estimated 12,000 pit latrines had been constructed by the private sector.

The demand-led approach has affected the rate and style of implementation, as the pace of construction is determined by affordability and priority given to improved on-site sanitation by the users. This needs to be matched by donors taking a longer-term view when evaluating the programme – measuring success in terms of broader performance-based outcomes rather than numbers of latrines constructed in a short space of time.

The integration of health and hygiene education with construction and technical activities was greatly supported through the coordination and cooperation between the Ministry of the Interior (concerned largely with the project's hardware aspects) and the Ministry of Health (generally responsible for software aspects). Coordination of sanitation with the water supply sector also improved, as water supply professionals became increasingly aware of the significant health impacts possible from sanitation and health education accompany water supply.

The Government of Lesotho's commitment to the rural sanitation programme is high, with the programme currently rated as one of the country's most successful development initiatives. Since

the programme started in the early 1980's, rural sanitation coverage has increased from 15% to over 50%. The sector is anticipated to achieve full coverage ahead of the 2010 target date (WSP-Africa, 2004). If the program can broaden its success, maintaining a high level of implementation on a truly self-reliant basis, it offers an approach that other developing countries can learn from.

2.4 Rural sanitation programme in South Africa

A national rural sanitation programme began in earnest following South Africa's democratic election in 1994. Within the Government's broad Reconstruction and Development Programme, significant funds – including those of the reinvigorated donor community – were allocated to supporting the provision of basic services, including water supply and sanitation provision to the as yet unserved rural communities throughout the country. Policy reform supported the re-focus of government investment, with publication of the 1994 Water and Sanitation Policy (White Paper).

A significant number of sanitation (and water) projects were initiated by the Department of Water Affairs and Forestry (DWAf), supported to a great extent by the creation of the Mvula Trust, an independent agency, in 1993. Operating as an umbrella NGO, Mvula Trust appointed a broad range of local NGOs, private companies and CBOs to work directly with communities as "implementing agents" of water supply and sanitation projects. Mvula Trust facilitated fund flows from government, as well as a range of bi-lateral donors (including DFID, DANIDA, and AusAid) and multi-lateral agencies (primarily the EU) to these implementing agents. It also provided a platform for coordination and lesson sharing and directly implementing a number of their own projects.

The summary section of the Sanitation White Paper of 1994 identified a basic adequate service of sanitation as "*a ventilated improved pit latrine*" (DWAf, 1994, p.37). In line with national policy, projects focussed on promoting the health benefits associated with VIP latrines as the choice of sanitation technology and VIPs were piloted as the latrine of choice in the project's demand-creation phase. Significant government and donor investment supported a R600 subsidy for each household latrine as part of the government's Free Basic Services policy. This enabled many latrines to be constructed with relatively little household-level financial contribution, most opting instead to make a contribution in kind – by providing labour to dig their own pit and assist in building the superstructure.

A severe cholera outbreak in 2000-01, which resulted in over 200 deaths and infected over 100,000 people with many lost hours of productivity, saw a significant up scaling of national sanitation investment. DWAf, motivated by the dynamism of the then Minister, Ronnie Kasrils, sought to significantly scale-up sanitation coverage, in an attempt to stop the spread of cholera and minimize the chance of a further outbreak at that scale. Modifications were made to programme approaches, such as short-circuiting hygiene awareness and education aspects, foregoing the demonstration of a range of latrine options and fast-tracking payments to communities, so enabling faster construction of latrines (Moiwa and Wilkinson, 2004).

Once the cholera epidemic subsided, demand for improved latrines continued to grow, but the focus on infrastructure provision was not necessarily achieving broader sanitation and health improvements. The 2001 National Sanitation Policy evolved the definition of appropriate sanitation from being infrastructure-focused to a broader definition. The policy, The White Paper on Basic Household Sanitation, defines a minimum acceptable basic level of sanitation as:

- "a) appropriate health and hygiene awareness and behaviour,*
- b) a system for disposing of human excreta..., which is acceptable and affordable to the users, safe, hygienic and easily accessible...*

c) a toilet facility for each household.”

(DWAF, 2001)

Despite this shift, many projects continue to promote VIP latrines as the standard form of improved sanitation, as user demand for a VIP remains high and government subsidy continues to rise, standing at R900 per household in 2002.

3. Institutions and actors

3.1 Introduction

On the international level, multi-lateral organizations such as the World Bank, UN agencies and the European Union (EU), together with bi-lateral agencies such as DFID, NORAD and SIDA, have the opportunity to support the strategies of government institutions to significantly scale-up sanitation provision.

In the case of Southern Africa, the main institutions driving sanitation improvements are their respective lead ministries. In Zimbabwe, the Ministry of Health initiated interest in sanitation improvements in 1973 and has continued up to today. In Lesotho, the Ministry of the Interior (concerned largely with the project's (hardware aspects), and the Ministry of Health (generally responsible for software aspects) are the lead institutions. In South Africa, the implementation of decentralized government policy has shifted the responsibility of DWAF from implementer to facilitator of services, with local government bodies acting as the lead agencies. Ministries of Health and Education, while given defined roles in the policy, in reality play a relatively minor role.

It is clear that where government is weakened (economically) such as in Zimbabwe, sanitation provision declines rapidly and the populace depend more on NGOs. Due to the economic decline since year 2000 the Government of Zimbabwe is facing a resource crisis because her national budget cannot fund all social and economic infrastructure. The national budgets no longer cater for sanitation hardware under the Public Sector Investment Programme (PSIP).

The Government of Lesotho has provided strong political leadership and support since the inception of the national sanitation programme. Clearly defined roles and responsibilities between government and the private sector ensures that different components are shared between those best placed to deliver them, providing the foundation from which pilot approaches have been scaled-up to national delivery. The private sector has been encouraged from the start to assist communities with latrine construction, creating a competitive and dynamic market for private operators.

3.2 Actors involved in rural sanitation delivery

The range of actors involved in rural sanitation delivery has various roles to play in addressing their particular incentives for involvement. The donor community is primarily interested in meeting agreed international targets like the MDGs and improving the livelihoods of those without access to sanitation.

- NORAD funded Zimbabwe's IRWSSP through the Ministry of Local Government until around 1999, when key milestones had been achieved in the sanitation sector.

Governments typically take the lead in setting the environment within which sanitation services are provided. With recent moves towards decentralization, many local governments are taking a

greater role in sanitation service delivery – either as a direct provider, or by supporting alternative service providers to fill the capacity gap.

Table 2. Key roles and responsibilities of sanitation actors in the 3 countries

Actor	Principal role / responsibility		
	Zimbabwe	Lesotho	South Africa
Donors	Funding	Funding and capacity building initially, but now minimal	Funding – through government
National government ministries	Providing an enabling environment, through: <ul style="list-style-type: none"> - Local Government (lead agency): coordination of inter-sectoral collaboration, - Health: health education and sanitation promotion, - Energy and Water Development: technical advice - Community Development: community mobilization, etc. 	Providing an enabling environment, through: <ul style="list-style-type: none"> - Interior (lead agency): responsible for hardware components, - Health: software components – hygiene promotion, etc. 	Moving from an implementation role to one of facilitation: <ul style="list-style-type: none"> - DWAF (lead agency): coordination, policy setting and review - Health: health promotion and school sanitation - :
Local government authority	Construction and maintenance of sanitation hardware (in principle) District Development Fund: operational agency		Responsible for implementation, with the option to appoint a service provider from the private sector or civil society.
CBOs	Planning services (where consulted) Construction of household-level sanitation hardware	Responsible for financing sanitation (households)	Limited role in management, operation and maintenance
Informal private sector	Supply materials: e.g. cement	Significant role in latrine building, supplying materials and component parts	Limited, but growing, role in latrine building, maintaining services (emptying pits, etc.), supplying materials and component parts
NGOs	Additional source of funding Training latrine builders	Community empowerment	Community empowerment Support to community management, in a few cases
Research institutions	Development of new technologies	Development of new technologies (limited role)	Development of new technologies (larger role)

3.2.1 Zimbabwe

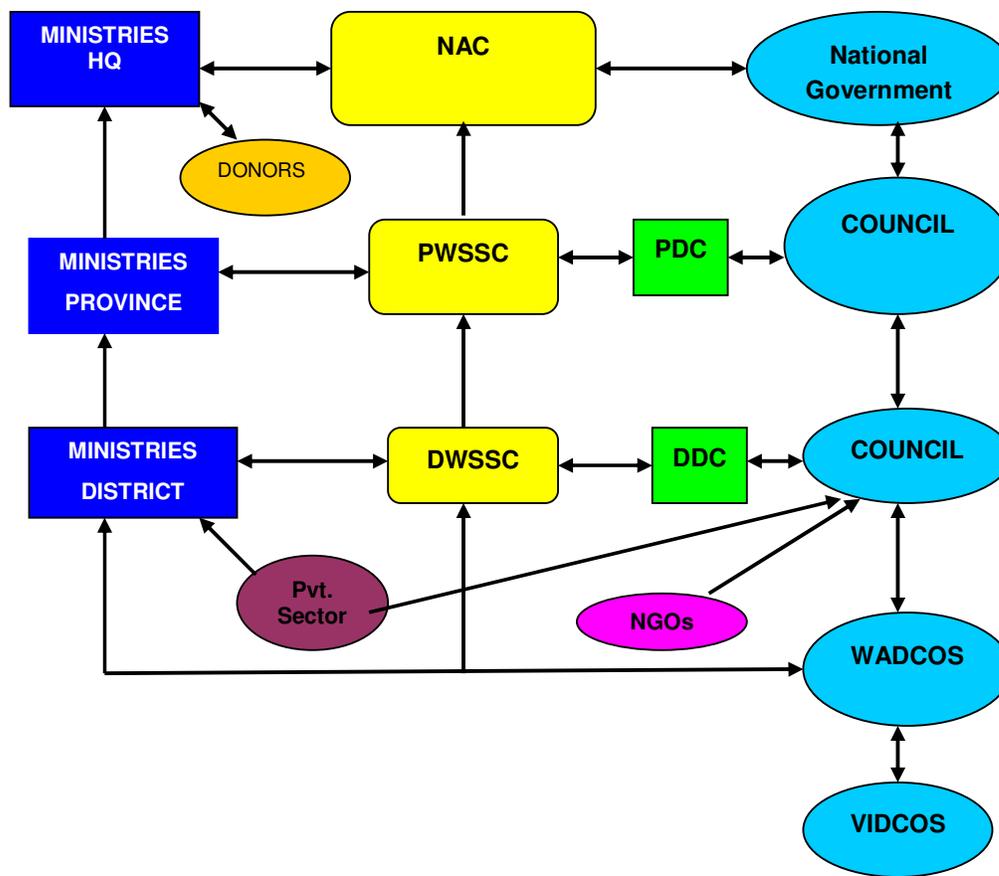
Since independence there has been a greater emphasis on rural development in Zimbabwe, to redress the imbalance of the former colonial powers. Rural local government structures have been incorporated under one system, with the amalgamation of Rural Councils and District (African) Councils since 1993, to form Rural District Councils.

Development of the National Master Plan for Rural Water Supply and Sanitation (NMWP) in 1985 took an integrated approach, hence Integrated Rural Water Supply and Sanitation Projects

(IRWSSP) have incorporated the promotion of health and hygiene education, capacity building of personnel and institutions, community mobilization, the establishment of sustainable operation and maintenance systems and the transfer of technical and organizational skills and knowledge to user communities (IWSD *et al*, 2000). To achieve this integration, IRWSSP projects are run on an inter-ministerial basis in which key sector ministries and agencies provide integrated services within the legal limits of their areas of expertise as depicted in Table 2.

Under the chairmanship of the Ministry of Local Government Rural and Urban Planning (MLGR&UP), stakeholders are coordinated through a National Action Committee (NAC). Local level (provincial and district) Water Supply and Sanitation sub-committees have been established, linking through to ward-level and village-level development committees and through these to water point committees, health clubs, ward-level and village-level water and sanitation committees. This is illustrated in Figure 1.

Figure 1. Organisational framework for IRWSS projects, Zimbabwe



With the formation of Rural District Councils in 1993, the Government of Zimbabwe has decentralized most functions, including the management of water supply and sanitation projects. Under the IRWSSP, RDCs are the managers and resources are channelled directly to the RDCs instead of line ministries, who make representation on district-level committees (the DWSSC).

3.2.2 South Africa

In a similar move to Zimbabwe, South Africa has undergone a gradual process of decentralization since the late 1990s. Amendments to government legislation, notably the Water Services Act of 1997 and the Local Government White Paper of 1998, transferred responsibility for providing community-based services from central to local government structures. Local government, designated as the Water Services Agent (WSA), is responsible for appointing a Water Services Provider (WSP). In many cases local government acts as both the WSA and the *de facto* WSP, while legal technicalities, primarily in the Municipal Systems Act of 2000, makes it difficult for NGOs and CBOs to register as WSPs and bid for contracts. In exceptional cases, such as Alfred Nzo District Municipality, the local government pro-actively appointed NGOs to act as WSPs, in recognition of the limited capacity within local government to delivery sustainable services to rural communities (see Box 1).

Box 1. An innovative government-CBO-NGO partnership, South Africa

In the Alfred Nzo District of South Africa, the Municipality has recognized that the only viable option for ensuring sustainable water supply and sanitation services to its predominantly rural population is through the contracted-out services of community-based groups (the recognized Water Services Provider in contractual terms). The Municipality also contracts-in support services to the CBO from other non-state providers, including a local private company and local NGOs, in a creative partnership arrangement. (Delay et al, 2004).

4. Challenges facing rural sanitation provision

4.1 Impact of decentralization

The amalgamation of local government structures increases autonomy, responsibility and ultimately power at the district level. In Zimbabwe, while the Ministry of Local Government Rural and Urban Development acts in a coordinating role, it is not directly involved in the provision of rural water supply and sanitation facilities. RDCs, as the local authorities of their areas, have the responsibility for managing IRWSS projects in their areas, with assistance from relevant sector agencies and ministries.

Since decentralization is an ongoing process, not a one-off event, there are challenges to be addressed as the process evolves – particularly in relation to the power relationships that evolve and aspects of capacity.

4.1.1 Power relationships

As decentralization shifts the balance of power from the centre to the regions / districts, it can lead to unequal power relations between and within district level authorities. In the case of Zimbabwe for example, the power of the DA's Office is now considerably reduced, which has led to resentment. This in turn has affected their efforts to support and build capacity within RDCs, such that some RDCs have experienced problems in accessing project funds.

Conversely, the delegation of powers can leave staff in central government offices feeling that their jobs are under threat, as their responsibilities are delegated to local authorities. This is a particular concern where the new roles and responsibilities for central government agencies and line ministries have not been significantly developed, or are not clearly understood.

- In Zimbabwe, a capacity building programme was unsuccessful since most the facilitators, from the Ministry of Local Government, felt threatened by developing capacity in the districts.

4.1.2 Capacity gaps

Decentralization brings additional responsibility to district level government agencies, many of whom are under-resourced, both in terms of financial and human capacity. Without sufficient support, delegation, empowerment and capacity, local government's ability to disburse and expend funds may be hindered.

4.2 Community participation and interaction

With responsibility for sanitation service provision moving to the local level, an increase in Community Based Management (CBM) can bring increased opportunities for local government interaction with communities – enhancing the role for communities from planning through to the operation and maintenance stages. In Zimbabwe, this approach has helped communities to become aware of the local authority's plans, created transparency in local government operations and increased community awareness of operation and maintenance requirements and their role under CBM. This has however brought a dilemma to local authorities, who were previously used to operating in a more clandestine manner.

In South Africa on the other hand, the decentralisation of government has gradually reduced the operational space for civil society: NGOs, faith-based groups, CBOs, Mvula Trust and its implementing partners, except in the few cases where they have been appointed as the contracted-in WSP by the WSA. With government financing basic sanitation provision, incentives for community-based management of sanitation services are limited and communities wait for government to provide new, or maintain existing services.

The role of the private sector is slowly increasing, but the slow disbursement of government subsidies to households, compounded by limited local government capacity to effectively engage the services of the private sector, severely hinders progress in sanitation provision.

4.3 Implementation approaches

There is rarely one approach consistently applied to sanitation programmes within a country, or even within a district or region within that country – although the case of Lesotho is an exception. Here, close collaboration between the donor community during the planning stages of the national programme in the 1980s, followed by a relatively quick transfer of responsibility to the government, has enabled consistent approaches to be established and applied at scale.

In Zimbabwe and South Africa, greater diversity between local government institutions and a less coordinated approach from donors and government agencies, has resulted in various approaches being adopted in the design and management of rural sanitation projects. Until recently, a degree of coordination and support for sanitation projects has been provided with the assistance of national institutions, such as the Institute of Water and Sanitation Development (IWSD) in Zimbabwe and the Mvula Trust in South Africa. However, political instability in Zimbabwe and the shift of responsibility in South Africa is, as previously mentioned, reducing the operational space for such institutions. It is hoped that as the capacity of local government to oversee decentralized programmes strengthens, a more coordinated and consistent approach can be applied.

4.4 Subsidies

Heavily subsidised sanitation provision may support "latrine construction" programmes, but potentially at the expense of hindering innovative, sustainable low-cost sanitation solutions derived from within the community (this is a significant factor in the success of demand-led approaches such as Community Led Total Sanitation in Bangladesh and neighbouring countries). The sustainability of such high-levels of government subsidy should also be considered.

In Zimbabwe, subsidies were given to rural households in the form of three bags of cement, causing rural households to rely heavily on the government subsidy to build a particular type of latrine (the VIP). Since the end of IRWSSP funding by donors, little has been achieved in terms of sanitation hardware and most projects concentrate on software components such as health and hygiene education. Since the programme has not encouraged households to invest in hardware, this remains a major barrier to seeing sanitation improvements in the absence of infrastructure subsidies. The same situation could face South Africa, if the reliance of government subsidies cannot be sustained.

Conversely in the case of Lesotho where no subsidies for the sanitation hardware component were applied, the national programme has been sustainable, as households from the start have taken responsibility for paying for their own latrine.

4.5 Matching demand with supply

While demand for sanitation is high in all of the three countries studied, satisfying that demand is particularly restricted in Zimbabwe and South Africa. In South Africa, the limiting factor is primarily capacity of government to deliver, but this is also skewed by the presence of high subsidies. While delivery remains in the hands of government, it may be difficult to stimulate the private sector to support delivery with specific tasks (latrine construction, supplying materials, pit emptying, etc.). Households are also reluctant to finance local solutions, as they wait for government to provide. In Zimbabwe, demand for sanitation infrastructure is high, but constrained by limited government finances and reduced donor support.

5. Engaging with non-state providers and civil society

5.1 Donor engagement

A key aid route for donor support to sanitation provision is via international and national NGOs (I/NGOs). As typically registered organisations, with a demonstrated degree of successful project outcomes, I/NGOs offer greater stability and security for donors. The national government may have limited capacity to fulfil obligations of service delivery, or be unprepared to for reasons such as fragility of the state, inherent corruption, misappropriation of resources, or some other cause for non-engagement. The experience and expertise of NGOs operating in each of the three countries provides an opportunity for donors to engage with and through them to interface with communities.

In Zimbabwe, a national NGO has provided support to community-based health clubs, who are instrumental in promoting improved sanitation provision in rural communities (see Box 2).

Box 2. Community Health Clubs, Zimbabwe

With the support of ZimAHEAD, a national NGO, Community Health Clubs (CHCs) have been operating in Zimbabwe since 1994. These community-based organizations are formed at village level to promote and improve family health. The clubs work on the basis of incremental improvements in knowledge and attitude, supported through the provision of sanitation facilities (such as latrines and hand washing devices) and improved hygiene practices (using soap for hand washing, keeping the latrine clean, covering food, etc.). The impact is sustainable hygiene practices across whole communities – not just within individual households. The experience is being successfully replicated in other countries, including Burkina Faso and northern Uganda. (WSP-Africa, 2002)

In Lesotho, donors were initially involved in providing short-term funds to initiate the training of local artisans in latrine construction. Their role was also intended to decline, to enable the local private sector to become more active and self-sufficient.

Following democratization in South Africa and the return of donor support, the national NGO Mvula Trust has acted as an umbrella agency to assist with the coordination of small-scale NGOs and provide an interface with communities. Recent changes in government decentralization has now limited the role of NGOs, who are moving more into advocacy and direct implementation (certain NGOs operating as direct consultancy-based service providers).

5.2 Government engagement with non-state providers

Government institutions are becoming increasingly driven to achieve national targets for sanitation coverage in pursuit of the MDGs, but are constrained by both limited capacity within local government bodies to deliver services at the scale required to meet these targets and having to optimize budgetary allocations. There is growing interest in the opportunity provided by non-state providers to fill capacity gaps and release private funds in support of infrastructure, operation and maintenance of sanitation services.

Three broad groups of non-state providers (NSPs) offering sanitation services can be identified (Sansom, 2005), reflecting the type of service provided:

- **informal private providers**, who have been supporting household-level sanitation services over many generation;
- **civil society organizations** (including NGOs, CBOs and faith-based groups), supporting community-based management of larger-scale, or public, sanitation facilities such as communal latrine blocks; and
- **Public Private Partnerships (PPPs)**, who tend to operate where sanitation services (typically sewerred) are coupled with water supply services, such as in concession contracts for the management of urban water and sewerage.

As Governments explore the potential from innovative partnerships, they are looking at ways of engaging the services of such NSPs, for example through contracting-in NSPs as a means of maximizing their potential while maintaining overall regulatory control. This has been demonstrated in the case of Alfred Nzo District Municipality in South Africa (Box 1).

Contracting-in the services of NSPs involved in sanitation is way for government to engage with the range of different service providers. Other forms of engagement that are receiving increased recognition at an international level include, but are not limited to:

- Low level engagement: simple non-interference of “accepted” activities such as manual pit latrine emptying, or limited formal recognition of NSPs; and
- Medium level engagement: supporting the registration of NSPs to enhance their social standing, developing opportunities for policy dialogue (at the national or local level), and regulation of service providers as a means to enhance service standards and therefore promote fair competition between providers.

6. Key lessons

The following are the key lessons drawn from these case studies:

- Current drives to achieve national sanitation targets is increasing pressure on government to deliver. The governments in each of the case study countries can support large scale service delivery, but cannot provide adequate services to achieve national targets on their own. Having recognized this, they need to enable and facilitate the role of the private sector and non-state actors, creating innovative partnerships to ensure appropriate roles for those best placed to fill the capacity and delivery gaps.
 - In Lesotho, roles have been clearly defined, household investment in infrastructure has been stimulated and the private sector has found a service delivery niche to support households, even in the absence of a formal project.
 - In Zimbabwe, where government took a strong lead in basic service delivery in the past, the weakening of government has jeopardized the future sustainability of sanitation provision as there is not a sufficiently resourced and capable NGO community, private sector or civil society to step-in and support ongoing provision at the scale required.
- As governments move towards decentralization, capacity in local governments to facilitate sanitation provision is key. Sanitation typically takes a second place to water supply and falls far behind in government priorities and resource allocations. Additional resources are necessary, together with an increased commitment to develop local authority capacity to oversee sanitation projects.
- Community-based management of sanitation facilities is achievable, if communities are given appropriate support from local government and other agencies, together with the recognition that they are key players in development processes.
- Strongly subsidised sanitation infrastructure appears to be a disincentive to innovative programmes and enabling a dynamic private sector. A refocus in government and donor support towards supporting promotional aspects of sanitation and developing a strong role for the private sector – as has occurred in Lesotho – would appear to be a more effective and sustainable approach.

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