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WATER AND SANITATION FOR ALL: PARTNERSHIPS AND INNOVATIONS

Contributions to sanitation in KwaZulu/Natal

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ACCESS TO SAFE and reliable supplies of water and hygienic sanitation facilities is skewed, both racially and geographically, in South Africa. The Department of Water Affairs and Forestry (DWAF, 1994) argues that "more than 12 million people do not have access to an adequate supply of potable water; nearly 21 million lack basic sanitation". The black rural poor have the least access to these services in South Africa (RDP, 1995). And it is estimated that 90 percent of rural schools and approximately 50 percent of rural clinics lack adequate sanitation facilities (Palmer Development Group, 1995).

In an effort to overcome the backlog in services, the South African government has offered considerable subsidies for household sanitation. Underlying the subsidy policy are two related assumptions: one, that sanitation, while vital to household health, is not a high priority among disadvantaged communities whose scarce financial resources are utilised for even more basic needs, such as food, shelter, clothing and schooling; and two, that it will be more efficient to lower the cost of a toilet (through a subsidy) than to raise the priority people assign to sanitation. The subsidy is also seen as critical to the new government's efforts to provide basic needs support to historically marginalised black South Africans who were denied basic services for political and racial reasons (Hartley and Blackett, 1996).

Operation Hunger is a South African NGO which, in 1996, implemented a sanitation and health/hygiene promotion initiative in Kwa-Jobe, KwaZulu/Natal. The programme is unusual in South Africa because community members have paid 44 percent of the capital costs of the VIP latrines. The programme has not only provided improved sanitation facilities for recipients, but also tested whether historically-marginalised South Africans will willingly contribute significant amounts of money towards the costs of their toilets. The initiative is influenced by international experience which suggests that subsidies are unsustainable and ultimately undercut attempts to improve local health and hygiene.

This paper probes Operation Hunger's successes and failures as it tried to mobilize support for community-financing, to strengthen the sanitation committee and to heighten local awareness of sanitation-related problems in Kwa-Jobe. The paper also describes some of the programme's innovative features, such as training child-to-child educators, and suggests implications for sanitation policy, subsidisation and future programme implementation.

Overview of the Sanitation Programme in Kwa-Jobe

The sanitation programme in Kwa-Jobe emerged from a lengthy "PRA" programme concentrating on health-related challenges. This programme revealed that sanitation was not a top priority for residents of Kwa-Jobe. Clean water, jobs, electricity and agricultural support were consistently identified as higher priorities by a wide range of residents from different parts of the village (Breslin and Madrid, 1997).

Nevertheless, "proper household" sessions in Kwa-Jobe consistently highlighted the importance of toilets as an integral part of a household's physical infrastructure (Breslin and Delius, 1996). Community members readily accepted Operation Hunger's offer to assist with a sanitation programme. Interest was further heightened by the prospect of creating local jobs and by modifying the programme so that household contributions were reserved for further development work. Residents agreed to pay R350 (US$78.47, exchange rate = R4.46/US$1.00, May 1997) for a toilet as long as the payments were made over a period of six months. Of that amount, R200 (US$44.84) is contributed in advance to cover the full cost of labour.

Operation Hunger spent approximately six months training the local sanitation committee in project management. The greatest difficulty was to ensure that local finances were managed transparently by the committee. Regular financial reports are given to the community development committee, and we are currently exploring ways to communicate this information to the broader community in a user-friendly manner, such as over the radio and on community billboards.

An additional challenge was to find mechanisms to ensure household compliance with the repayment schedules. The mechanisms agreed upon include the use of the tribal court system to discipline those who fail to pay. Also incorporated is a staggered delivery system where Operation Hunger only releases funds and materials for new applications once the sanitation committee demonstrates that their accounts are up-to-date and previous recipients have fully complied with the repayment schedule. To date, only a single case has been referred to the tribal court. The court upheld the recovery schedule, and naturally, as a result, there has been 100 percent compliance repayment with the schedule at the time of this writing.

The sanitation construction team was trained by both field staff and a local resident who had built hygienic

sanitation facilities in the past. The sanitation committee is responsible for paying the construction team (R200 per completed toilet, or US$44.84) and managing the remaining finances.

Linked to the sanitation programme is a multi-phased health/hygiene initiative. The first component of the campaign was simply to promote sanitation as a health intervention (in addition to a household infrastructure intervention) in the community. This was done through a poster competition at the local high schools, by using Radio Zulu to promote the initiative, and by asking community health workers to identify needy households and promote the programme at the household level.

Second, efforts to promote the use and maintenance of toilets were pursued. Mediums to promote these messages include radio, locally-developed posters and community health workers. The community health workers' role in this is particularly important as they regularly monitor toilet cleanliness, maintenance and use at the household level.

Third, a child-to-child programme has been initiated where high school children are the primary advocates of handwashing and the safe disposal of children's (0-4 years) faeces. This initiative includes the provision of handwashing facilities at school toilets (basin, water, towel, soap/ash) and signs developed by the children to promote handwashing. Children who do not use these facilities at school are reprimanded by other students.

The next stage of the child-to-child programme is to determine whether a.) handwashing and the safe disposal of infant faeces is being *communicated* by children within their homes; and b.) improved handwashing and faeces disposal is actually *occurring* within the household as a result of the students' messages and influence.

Lessons learned

A number of problems were encountered as the project developed. These experiences have proven useful for future programming. First, the initial deposit was originally set too low (at R50, US$11.21) to cover the cost of labour and as a result the sanitation committee went into overdraft. This has now been rectified so that the initial deposit is R200 (US$44.84). The programme has however slowed since the deposit was raised, which could mean that many households cannot afford to pay this initial lump-sum payment. Alternatively, it may indicate that households are willing to pay R50 (US$11.21) to initiate construction but would rather use the larger sum of R200 (US$44.84) for other purposes.

Second, the relationship between the sanitation committee and the local development committee is often strained. Part of the reason is that the sanitation committee manages a large amount of money but only wants to report to the development committee and not have the latter involved in financial decision-making. Conflicts over the use of the extra money (in excess of labour costs and administrative expenses) collected by the sanitation committee will likely escalate.

An original goal of the cost recovery exercise was to use the extra money collected to target households who can not afford toilets with support. This objective has not been reached at the time of writing, although the sanitation committee, the local *induna*, and the community health workers recently identified households who would qualify for this cross-subsidy.

Operation Hunger also did not set up a proper construction monitoring programme at the start of the initiative. A modified and more user-friendly "job card" (Murphy and Still, 1995) is currently being designed to overcome this limitation. Unfortunately, Operation Hunger has had to play a large, time consuming, and in the end unnecessary role in monitoring construction. A better strategy would have been to strengthen the capacity of the sanitation committee to monitor this aspect of the programme.

Perhaps the biggest lessons learned relate to:

- the on-going support required to strengthen the sanitation committee's capacity to manage the programme;
- the need to find multiple and reinforcing methods to convey health/hygiene messages throughout the community.

Operation Hunger's experience with community-level management is that training must be on-going, practical and field-based to be effective. In the past, Operation Hunger would host a short management training course for community committees only to find that the messages had, unsurprisingly, not been internalised by trainees. Problems always emerge when implementing, and these problems can only be creatively addressed if training is seen as a long-term process of capacity-building rather than a one-off event.

Operation Hunger has also moved away from the "event approach" to health/hygiene promotion. The organisation no longer provides lectures on the linkage between water supply, sanitation and health to trainees or depends solely on large community meetings, poster competitions or drama. Instead Operation Hunger tries to link its interventions into on-going educational programmes offered in the village (usually through the formal health sector) while identifying alternative methods to communicate information and monitor behavioural change at the household level. Our efforts to understand what appropriate, locally-specific hygiene problems are apparent in a given village has been assisted by a behavioural survey administered at the start of, and periodically during, the sanitation initiative.

Operation Hunger staff are increasingly encouraged to:

- utilise available resources for promotional purposes;
- think beyond health/hygiene promotion events;
- think beyond the exclusive use of formal health care sector personnel and infrastructure as vehicles for health/hygiene promotion and behavioural change.

Conclusions

Operation Hunger's experience suggests that there is scope for South Africa to reconsider its subsidy policies, although it is recognised that the politics surrounding subsidies is considerable and just. Two alternatives could nevertheless be considered.

First, a loan as opposed to an outright subsidy appears to be possible. Our experience suggests that poor people will invest in household infrastructure, like toilets, if a scheme can be devised that recognises the financial constraints they face. Loans with repayments spread out over long periods of time are possible. Moreover, repayment schedules which recognise and accommodate periods of financial stress within poor households, such as when school payments are due or before the planting season in areas where agricultural production is important to household sustainability, have an even greater chance of success and support at the local level.

The key will be to identify a range of institutions with the potential infrastructure, resources and skills to promote a loan-based initiative. Institutions like the KwaZulu Finance Corporation (KFC) could be considered under such a scheme. Government may wish to pilot some loan-based programmes in the future to see if Operation Hunger's experiences in KwaZulu/Natal can be replicated and brought to scale by institutions with far greater financial resources and capacity than Operation Hunger.

Second, even though subsidies will continue, implementing agents could try to increase the household cost recovery element by promoting schemes that redirect the revenue back into the village. This money could be managed locally and used for other development interventions in the village, thus increasing the impact of an initial sanitation intervention. By redirecting the funds back into a community, more local jobs could be created, village infrastructure could be upgraded or developed, and local revenue could be used to assist the poorest households who will struggle to meet even minimal repayment schedules.

Debate continues on the future level of subsidised support for sanitation. If the gap between the full cost of a toilet and the subsidy widens in real terms, then alternative financing strategies will inevitably be required to assist poorer households. Either lower cost sanitation options, such as sanplats, or alternative funding mechanisms, like loans, will have to be reconsidered if government's objective of providing some service for all is to be attained. It is hoped that Operation Hunger's experience in Kwa-Jobe will be useful to programme managers, implementers and policy makers as they struggle with this difficult issue.

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