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Sanitation and hygiene: Grounding the HDR call for a global action plan

Katharina Welle

'Can increased global recognition and funding for sanitation and hygiene be translated into effective action on the ground if the lessons of previous policy failures are inadequately learnt?'

This year's UNDP Human Development Report (HDR) 2006[1] addresses water and sanitation, calling for a global action plan and increased financing to bring about much-needed change. The HDR sanitation chapter highlights the 'vast deficit in sanitation' worldwide, under which a colossal 2.6 billion people – almost every other person in the developing world – lack access to improved sanitation. The report's suggestions for future action focus on conventional fixes. It calls for strengthening national policies and political leadership, increasing public participation and identifying the unserved. But the question is whether increased global recognition and funding for sanitation and hygiene can translate into effective action on the ground if the lessons of previous policy failures are inadequately learnt.

In recent years, the urgent need for more sanitation delivery has gained international recognition, including inclusion under the Millennium Development Goals in 2002 (Goal 7, Target 10). Regular reference is now made to the extent of the sanitation crisis. Yet, despite an increased awareness of the problem, access to sanitation still has to improve at a global level. A global action plan that puts more money through existing systems is not likely to be effective, for two main reasons: first, the conjoining of 'water and sanitation' can hold back, rather than support, action on the ground to fight the main causes of diarrhoea; second, political support for the sector and capacity for implementation remains weak in developing countries.

Recent research carried out by ODI and Tearfund's local partners in francophone Africa highlights existing constraints to implementation of sanitation and hygiene (S&H) policies in a developing country context.[2] In two countries near the bottom of human development (HDI) rankings with very low sanitation coverage figures – Burkina Faso and Madagascar[3] – draft sanitation policies exist and an incipient coordination framework has been established, to clarify the roles of different ministries and enhance cross-sectoral communication and coordination. Yet, key challenges remain, including the ambiguous role that on-site sanitation (i.e. the provision of household latrines) occupies within policy. Previously regarded as a private responsibility, increased international awareness about the detrimental health effects of poor sanitation has now forced the topic onto national political agendas, in spite of the fact that, in most cases, citizens do not demand latrine provision.

Basic indicators for Burkina Faso and Madagascar

	Burkina Faso	Madagascar
HDI (measuring 177 countries)	174	143
Rural sanitation coverage	6%	26%
Urban sanitation coverage	42%	48%
Total sanitation coverage	13%	32%

Source: WHO/UNICEF (2004), UNDP (2006)

The challenge therefore in Burkina Faso and Madagascar is to bridge the gap between global and national policy calls and the lack of capacity of local officials. Our research suggests that key issues to address include reconsidering whether there is a right 'institutional home' for sanitation delivery, supporting political buy-in to the process and improving implementation capacity at national level and below.

Donors frequently conceptualise sanitation as part of the broader 'water sector', replicating in many ways service delivery models adopted from industrialised countries with their strong emphasis on provision of public infrastructure. This model does not translate well into developing country contexts largely because of the investment cost implications, particularly for rural infrastructure provision. One alternative

approach is to arrive at implementation through different sectors, taking account of specific country policy contexts.

In Burkina Faso and Madagascar, for example, there is a case to be made for building on the existing tasks of health extension workers, rather than creating new decentralised structures for the implementation of sanitation. Working through health extension personnel – currently the most accessible decentralised service providers and therefore capable of forming the closest link to people's needs – also provides an opportunity to overcome existing sectoral divisions and to address issues of diarrhoeal disease reduction through combined health, nutrition, hygiene education and epidemiological approaches.

Putting such S&H service provision within a broader basket of development interventions also requires its conceptualisation as a key element of urban planning and rural development. For example, slum upgrading touches upon a wide range of services alongside sanitation, i.e. electrification, land ownership/use policy and water supply interventions. And in rural areas it is important to choose and sequence carefully different development interventions, rather than meticulously following the standard package of 'water supply, sanitation and hygiene'. In sparsely populated areas, for example, the improvement of hygiene practices, together with food security measures to improve nutrition may in the short run take precedence over latrine construction.

As well as reviewing the 'institutional home' for S&H on a country-by-country basis, facilitating political buy-in and enhancing implementation capacity are also critically important. Officials involved in developing sanitation policies need support in making a strong case for sanitation at national and local level. Official statistics on sanitation are often inconsistent or even hopelessly inflated; and there is infrequently any evidence on potential socio-economic benefits related to improved S&H promotion, in spite of the fact that economic benefits may accrue from working days gained, lower medical expenses and higher school attendance by girl children, in particular. This is a case that needs exemplification at national and local levels in order to attract budget prioritisation and political willingness to prioritise concrete actions. Making statistical information more robust would also help to improve overall monitoring of progress against national and international targets, a key element in achieving, over time, a better understanding of actual impact.

At the local level, implementation capacity needs to be enhanced to improve S&H service delivery. This requires a greater focus on 'software' as opposed to 'hardware' including awareness creation, stimulating local markets and ensuring affordability through targeted subsidy regimes or micro-credit options. In many cases, this challenge is now decentralised and rests on the shoulders of local government. As financial, technical and logistical capacity is often constrained, support at this level is particularly urgent. This could come, for example, in the form of research to better understand which strategies work best in which contexts to stimulate demand for sanitation.

A broader understanding of how to strengthen S&H delivery through attention to the above points could enable important steps to be taken to translate the global voice on S&H into hard action on the ground. The message of the HDR focuses largely on existing approaches. We argue, in contrast, that a second, fresh look at the sector is critical to translate global recognition and increased financing into concerted action on the ground.

References

UNDP (2006): Beyond Scarcity. Power, poverty and the global water crisis. http://hdr.undp.org/ accessed 24 November 2006

WHO/UNICEF (2004): Joint Monitoring Programme for Water Supply and Sanitation. http://www.wssinfo.org/en/welcome.html

Endnotes

1. http://hdr.undp.org/nhdr1/default.cfm
2. See also the Briefing Paper on the same topic (http://www.odi.org.uk/publications/briefing/bp_dec06_sanitation_hygiene.pdf)
3. The context of the third country, the Democratic Republic of Congo, is slightly different and is therefore not referred to here.

Written by Katharina Welle, ODI Research Officer with the Water Policy Programme. (k.welle@odi.org)

Overseas Development Institute

111 Westminster Bridge Road, London SE1 7JD

Tel: +44 (0)20 7922 0300

Fax: +44 (0)20 7922 0399

Email: publications@odi.org.uk

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