Sustainable Development *in action*
United Nations Commission on Sustainable Development
BACKGROUNDER

Sanitation: Key to Better Health

The challenge

Providing access to sanitation remains one of the biggest challenges for many developing countries. Today, 2.4 billion people - nearly two-thirds of the developing world - lack access to basic sanitation. Of these, 911 million live in South Asia, 761 million in East Asia and 303 million in Africa.

The challenges of providing adequate sanitation are greatest in urban slums and the rapidly growing informal settlements located on the outskirts of cities. There, sanitation coverage is extremely low, and insecurity of tenure hampers public investment in sanitation infrastructure.

Diseases related to water and sanitation remain among the biggest killers in the developing world, especially of children. Lack of sanitation and poor hygiene are responsible for the transmission of diarrhoea, cholera, typhoid and many parasitic infections. In 2002, 1.8 million people died from diarrhoeal diseases, overwhelmingly children. Human excreta remain among the most serious contaminants of drinking water.

The harm wrought by poor sanitation extends well beyond the health impacts. Health risks and epidemics from water-borne diseases greatly reduce tourism and food exports. Economic costs total far more than the investment costs needed in water supply and sanitation to address the problem.

Goals and targets agreed at the Johannesburg Summit

At the World Summit on Sustainable Development in 2002, governments committed **to halve by 2015 the proportion of people without access to basic sanitation**. This complemented the Millennium Development Goal of halving the proportion of people who are unable to reach, or to afford, safe drinking water and recognized the role of sanitation in improving human health and reducing infant and child mortality.

Countries agreed to prioritize water and sanitation in national sustainable development plans, ensuring that by 2025 sanitation coverage is achieved in all rural areas. They pledged to: improve sanitation in public institutions, especially schools; promote safe hygiene practices and affordable technologies; integrate sanitation into water resources management plans; and develop innovative financing and partnership mechanisms.

How are we doing?

During the 1990s, improved sanitation reached an additional 1 billion people, and the proportion of people worldwide with access to improved sanitation increased from 51 to 61 per cent.

In urban areas, sanitation coverage has increased from 80 to 84 per cent (representing 573 million people), while in rural areas it has risen from 29 to 40 per cent (436 million people). The degree of imbalance between urban and rural coverage that existed in 1990 has been reduced but still remains significant in some areas. It is highest in South Asia, where an urban resident is three times more likely to have access to improved sanitation than a rural resident.

The overall coverage rate declined slightly in sub-Saharan Africa, although in rural areas there was an increase by 16 million people, or 10 per cent, in sanitation coverage. In contrast, coverage more than doubled in East Asia, and increased by almost three quarters in South Asia.

One sanitation success story during the 1990s was the extension of rural coverage in East Asia to an additional 213 million people, representing more than a twelve-fold increase.

Some small island developing States have achieved rural access rates of near 100 per cent due to the introduction of successful sanitation programmes. Most notable are those countries with tourism-based economies such as Mauritius, the Maldives and Seychelles.

Communities are working with local governments, non-governmental organizations (NGOs) and local entrepreneurs to provide low-cost sanitation systems in urban and rural areas.

Many successes have been achieved in the absence of large public funding. Small private entrepreneurs play a significant role in Africa and East Asia. With only modest investments in the 1990s, especially in rural areas, the additional number of people served with sanitation was large, partly due to investments made by households in low-cost technologies. The average cost of extending sanitation coverage to an additional billion people in the 1990s was around $30 per person.

What needs to be done?

In order to achieve the sanitation target, an additional two billion people – half each in urban and rural areas — will need to gain access to basic sanitation between now and 2015.

Combining culturally-sensitive hygiene education with increased access to sanitation is the key to reducing the burden of water-borne diseases in developing countries. The result would likely be increased school attendance, especially for girls.

It is essential that women are fully involved in the planning and implementation of sanitation programmes as they are primarily responsible for managing water resources, sanitation and health in the household.

Substantial additional financial resources are required. It is estimated that the annual costs of meeting the 2015 sanitation target are about $7 billion for sanitation facilities, and $53 billion for wastewater treatment. This represents approximately twice the $3 billion invested annually in sanitation facilities in the 1990s and three-and-a-half times the $14 billion invested in municipal wastewater treatment.

Technologies and system designs need to be well suited to the local environment and needs. Suitable low-cost technologies exist that are technically simple and cheap to operate and maintain.

Sanitation and hygiene are, in large part, the result of private household decisions, and policies to promote improved sanitation must seek to influence preferences and resource allocation at the household level.

Governments can promote public awareness of the importance of sanitation and hygiene, expand community programmes, support small-scale providers, make available facilities in public areas, and provide trunk sewers and wastewater treatment.

Snapshots of Success...

In **Guinea**, a 1999 survey showed that only 5 per cent of the population had acceptable sanitation, and 51 per cent had no access to latrines at all. In 1997, sanitary platform latrines were introduced and provided to some 1.5 million people (20 per cent of the population). In 2000, community leaders and rural authorities were trained on the necessity of hygienic latrines and sanitary practices, and village masons were trained to build the latrines. A water sampling in 2000 found 69 per cent of samples entirely free of coliform bacteria, compared with 48 per cent in 1998. Simple sanitation improvements have yielded significant improvements in standards of living.

In **India**, the Medinipur Intensive Sanitation Project in West Bengal involves a partnership between local and state government agencies and NGOs. The project mobilizes the community through the delivery of sanitation messages and supports households to invest in on-plot latrines. Households invest their own money for the construction of latrines by small private providers. Over 10 years, this programme has delivered roughly 1.2 million latrines throughout West Bengal, increasing sanitation coverage from almost zero to 80 per cent.

A successful programme in **China** has lead to widespread use of ecological sanitation that treats human excreta to provide safe fertilizer for agriculture in over 15 provinces.

In **Thailand**, for the past 40 years, the rural environmental sanitation programme has been integrated into the country's five-year economic and social development plans. By 1999, 92 per cent of the rural population had access to safe drinking water, and 98 per cent of rural families had built and were using sanitary latrines. As latrine coverage has increased, mortality related to gastro-intestinal diseases has decreased by more than 90 per cent. The programme's success depended largely upon capacity building: intensive training of project personnel and technical staff at local and national levels; and social mobilization and community health education conducted by mobile units and village volunteers.

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