

Realizing the Right to Sanitation in Deprived Urban Communities: Meeting the Challenges of Collective Action, Coproduction, Affordability, and Housing Tenure

GORDON MCGRANAHAN*

International Institute for Environment and Development (IIED), London, UK

Summary. — There are serious institutional challenges associated with low-cost sanitation in deprived urban communities. These include a collective action challenge, a coproduction challenge, a challenge of affordability *versus* acceptability, and a challenge related to housing tenure. This paper examines these challenges, revealing both the importance of community-driven sanitation improvement and its difficulties. The nature of the challenges, and the means by which two successful community-driven initiatives have overcome them, suggest that while recognizing the human right to sanitation is important this should not be taken to imply that typical rights-based approaches are the appropriate means of realizing this right.

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1. INTRODUCTION

At least rhetorically, sanitation is rising up the agenda of the international development community. Basic sanitation has been recognized as a human right (United Nations General Assembly, 2010), and universal access is being proposed as a global target for 2030 or thereabouts (The High-Level Panel of Eminent Persons on the Post-2015 Development Agenda, 2013; WaterAid, 2013). By way of contrast, the target of halving, during 1990–2015, the share of the world's population without access to “improved” sanitation was added somewhat late to the Millennium Development Goals, with only water and not sanitation mentioned in the original Millennium Declaration (United Nations General Assembly, 2000). Moreover, while official statistics indicate that the world has already met the water target by ensuring that at least 88% of the world's population has access to “improved” water supplies, it is not meeting the sanitation target, although that would only require 75% coverage (WHO/UNICEF, 2014).

The official statistics (WHO/UNICEF, 2014) show far higher levels of improved sanitation in urban areas (80% globally in 2012) than in rural areas (47%), but this should not be taken to imply that the sanitation deficiencies in urban areas are small and declining. First, the hazards and squalor associated with unimproved sanitation are particularly acute in urban areas, where residential densities are high. Second, and related to this, since the hazards resulting from poor sanitation have spill-over effects, and do not just put those without adequate facilities at risk, the share of urban households facing serious sanitary problems is far more than this figure of 80% coverage might seem to imply – especially where density and crowding combine with other shelter-deficiencies. Third, there has been especially slow progress in urban areas in recent decades, and the share with improved sanitation has only shifted from 76% to 80% during 1990–2012. Since urban populations have increased considerably, this means that the number of urban dwellers without improved sanitation actually increased from 547 million to 748 million over this period (as compared to a fall from 2,175 million to 1,758 million in rural areas).

There is international agreement that bad sanitation is degrading, disagreeable, unhealthy and far too prevalent, even in urban areas. There is widespread disagreement, however, over what should be done. Moreover, the most heated debates, such as those over whether utility operators should be private or public, are of doubtful relevance to the most severe challenges. Neither privately nor publicly operated utilities are inclined to provide affordable sanitation to those most in need, even in urban areas (Budds & McGranahan, 2003). Indeed, by focusing attention on technologies (e.g., conventional sewerage systems) and institutional forms (e.g., centralized utilities) that are better suited to providing higher cost sanitation to well-off populations, these debates have inadvertently diverted attention from those most in need.

Conventional sewerage systems operated by utilities rarely reach more than a small share of residents in the cities of low-income countries, with costs difficult to cover even when user payments are supplemented with public subsidies. Thus, while an estimated 72% of Latin American urban households have a sewer connection, as do a large share of China's urban households, in most countries in South and Southeast Asia and Sub-Saharan Africa, the share is less than 10% (Kjellén, Pensulo, Nordqvist, & Fogde, 2012). With a radical redistribution of power and wealth, it is easy to imagine utilities rolling out high cost sanitations to everyone, but in its absence low-cost alternatives will be necessary if anything like universal provision is to be attained.

Technically, significant improvements can be made using lower cost sanitation systems, such as well-made pit latrines in peri-urban areas, and pour-flush latrines with simple tanks

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(IRC, 2012), or the somewhat higher cost decentralized wastewater treatment systems (Gutterer, Sasse, Panzerbieter, & Reckerzügel, 2009) and condominal sewers (Melo, 2005) in more densely settled areas. However, low-cost provision poses institutional challenges that neither utilities nor private enterprises are equipped to address. It is the integrated piped networks that allow for the centralized and integrated control of water and sanitation systems, which water and sanitation utilities developed with and still aspire to. Low-cost systems are typically based on decentralized on-site facilities, and unlike conventional sewerage systems require users to contribute significantly to their operation and management. Most utilities are poorly prepared to manage these decentralized systems. Alternatively, since sanitation is a quasi-public good, markets do not aggregate individual demands effectively and do not motivate commercial enterprises to supply adequate sanitation.

These institutional difficulties are compounded by the low incomes of the deprived populations, which constrain their economic demand, and by their political weaknesses, which constrain their ability to exert policy pressure on public agencies and utilities. The fact that sanitation problems fall more heavily on women and children than on adult men probably amplify these economic and political hindrances (Tacoli, 2012).

Ideally, better organized residents could overcome some of these institutional deficiencies, and indeed community-led sanitation has also received considerable attention over the years, and has been vigorously promoted in some settlements (Mehta & Movik, 2011). But community-driven sanitary improvement also faces serious challenges in urban settlements, including: (1) The collective action challenge of getting local residents to coordinate and combine their demands for sanitary improvement; (2) The coproduction challenge of getting the state to accept and support community-driven approaches to sanitary improvement, and where necessary to co-invest and take responsibility for the final waste disposal; (3) The challenge of agreeing on improvements when what is affordable is rarely considered acceptable to either the public authorities or the communities; (4) The challenge of ensuring that other poverty-related problems, such as insecure tenure, do not undermine efforts to improve sanitation.

A recent review found that “The framing of water and sanitation as a human right can be understood as an affirmation of the fundamental importance of water and sanitation for human dignity, and as a response to global water service trends that have increasingly emphasized efficiency, financial sustainability, and privatization” (Murthy, 2013). This affirmation is welcome, as is the shift in attention away from narrowly defined economic approaches. On the other hand, the growing focus on rights is part of a more questionable tendency to advocate for “rights-based” approaches (Kindornay, Ron, & Carpenter, 2012). What this means is still debated, although there is now a handbook from the Office of the High Commission on Human Rights on realizing the right to water and sanitation, including a 44 page booklet of checklists (Roaf *et al.*, 2014). Given the nature of the political and institutional challenges to improving sanitation, a narrowly legalistic or formulaic version of a rights-based approach is unlikely to be appropriate. For some one of the attractions of a rights-based approach is that it entails political transformation (Uvin, 2007), but many of the core processes are firmly legalistic and somewhat formulaic. In any case, this paper is less concerned with which approaches to sanitation improvement should be termed rights based, important though that may be, and more concerned with the local political, institutional,

physical and economic obstacles that need to be overcome if the right to sanitation is to be achieved.

The challenges to low-cost sanitation improvement in deprived urban settlements are analyzed in some detail in the pages that follow, focusing on their institutional and economic dimensions and how they can be overcome. The report ends with a section on what these challenges imply for realizing the human right to safe and clean sanitation. The ways in which two well-known community-driven initiatives managed to overcome these challenges are summarized briefly, and shown to contrast significantly with narrowly defined rights-based approaches. However, whether or not they are rights based, they are rights fulfilling, and are consistent with a more broadly conceived and politically sophisticated rights agenda.

2. THE CHALLENGE OF LOCAL COLLECTIVE ACTION

A concern with bad urban sanitation helped to drive the public health movement and changed the way the industrializing cities of the 19th century were governed (Melosi, 2000; Szreter, 2005). It is not surprising that sanitation often lags behind household water provision (WHO/UNICEF, 2014; Winters, Karim, & Martawardaya, 2014). It combines some of our most private behaviors (which people tend not to like even talking about publicly) with some of our most public impacts (which people don't have the incentives to do much about individually). Sanitary facilities can in principle be convenient, clean, safe, and “private” from a user's perspective, and still impose a heavy burden on others. According to the WHO/UNICEF monitoring program, an “improved” sanitary facility is “one that hygienically separates human excreta from human contact” (WHO/UNICEF, 2010, p. 34). But the most serious consequences of not separating excreta from human contact arise when people come into contact with the excreta of others, not with their own. Moreover, though largely beyond the scope of this paper, the failure to recycle nutrients in the excreta can have ecological consequences and is inadvertently contributing to global resource scarcities that threaten global sustainability (Cordell, Drangert, & White, 2009).

In those cities where a significant share of sanitary facilities are “unimproved”, an important part of the shared burden is usually local. In deprived urban settlements, it is not uncommon for at least some children to defecate in public spaces such as fields or drains, for fecal material in poor-quality latrines to be accessible to flies, for pit latrines to contaminate groundwater used for drinking or to overflow onto the pathways during the rainy season, for children to play freely and to share facilities, and for infant feces to be disposed of with the solid waste that remains uncollected in piles around the neighborhood. Just a few such hazards create serious health risks in the neighborhood, especially for infants and children. (For a review of urban household and neighborhood hazards in a selection of cities see McGranahan, Jacobi, Songsore, Surjadi, & Kjellén, 2001.)

Households living in such neighborhoods face what amounts to a local public goods problem. Individual households do not have sufficient incentive to invest and act to improve sanitary conditions in the neighborhood because the benefits are shared. In effect, the situation can arise where every household would be better off if they all acted to improve the sanitary conditions, but no individual household has the incentive to improve its own sanitary facilities and behaviors. There may also be important spill-overs between neighborhoods and other parts of the city. Intra-household social and health-related relations, including those of gender,

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