Crossfire

In this month's Crossfire, **Daniel Gubler** argues in support of the following statement, while **Amaka Obika** puts the case against:

'Single-purpose programmes for sanitation are preferable to including sanitation components in integrated programmes, where they are usually neglected.'

Dear Amaka,

I am convinced of the high priority that must be given to sanitation. However, including sanitation components in so-called integrated programmes is the wrong solution to the problem. Integration leads to programme failure, investment wastage, and a lot of frustration among dedicated people.

Integrated programmes are inevitably water-focused: the largest share of investment goes to water supply, the managers are water engineers, the recipient administration to which they report is the water department, and so on. In addition, the expressed demand of the beneficiary community is usually for water supply, and not for sanitation or hygiene education. Sanitation components, then, are ineffective (objectives are not met), inefficient (achievements are too costly), and of low impact (facilities are not used, attitudes and practices do not improve, no significant health benefit can be recorded).

It is true that both water supply and sanitation involve the element 'water', and that both have essential health implications. Beyond that, however, they have little in common.

Water supply is about providing a commodity to individual households. Water can be sold, at the service level that users are willing to pay and able to afford; sustainability can be based on a demand-responsive approach: people refusing to contribute to the costs will be denied the service without affecting the well-being of others. Sanitation is about bringing a social and environmental service to communities. It follows a different pattern: a group not 'buying' sanitation does not only deprive itself, it also threatens the entire community.

In institutional terms, water departments (or privately managed water utilities) are ill equipped (and frequently insufficiently motivated) to deal with sanitation, which should best be in the hands of environmental health authorities.

Throughout numerous evaluations of integrated programmes I have carried out in various parts of the world, I have never come across a clearly successful sanitation component. On the other hand, I have seen successful single-purpose sanitation programmes, with budgets fully allocated to sanitation, and officers selected according to their ability to run sanitation programmes.

It seems to me that so-called integrated programmes have more to do with parallelism than integration: strategies that work for the water component (a demand-responsive approach for an engineering 'product') are also expected to be appropriate for the sanitation component. Why don't we think in terms of co-ordination rather than integration?

Yours,
Daniel

Dear Daniel,

When you say that 'single-purpose programmes for sanitation are preferable' I would like to know – *preferable to whom?* I think we need to ask ourselves, what is the aim of improving people's access to sanitation?

The ultimate aim of improving access to adequate sanitation and water supply is to improve the health and well-being of the people. Water- and sanitation-related diseases place a great burden on many people, especially the poor in developing countries. Diarrhoeal diseases, malaria and intestinal nematode infections are all water- and sanitation-related diseases, and they account for over 3 million deaths in low- and middle-income countries (The World Health Report, 1999).

The combination of water, sanitation and hygiene is important for breaking the faecal–oral disease transmission route. Sanitation on its own is not enough to prevent these diseases.

Several studies have emphasized the impact of combined water supply and sanitation programmes on the health of the end users. One found a high impact of improved water and sanitation facilities on health, which was measured by significant reductions in morbidity rates and higher child survival rates.[1]

More recent studies have further supported the argument that an integrated programme of water supply, sanitation and hygiene education is more likely to show significant health benefits than a programme that concentrates on one area alone. A study conducted in selected villages in northern Pakistan indicated a 25 per cent reduction in the incidence of diarrhoea in children.[2] The study also showed that children not living in the area where the integrated programme was being implemented had a 33 per cent higher chance of getting diarrhoea than children living in the programme area.

Although sanitation plays a major role in improving the health and well-being of the people, the impact is more effective when it is integrated with water supply and hygiene education. Improvements in sanitation are often facilitated with increased access to water supply. Integrated programmes are therefore more effective for achieving the ultimate aim of improving people's health and general well-being than single-purpose sanitation programmes.

Yours,
Amaka

Dear Amaka,

I agree with your analysis: combined water supply, sanitation and hygiene are essential to break the transmission route of faecal–oral diseases. But I disagree with the strategy of integrated programmes. You are assuming an ideal world of *successful* integrated programmes. Evidence suggests that integration is rarely successful for a number of reasons, which I started developing in my first letter.

For decades, donors have been telling their partners in developing

countries: 'You want water supply, you must take a sanitation component as well.' Such a strategy is based on a number of assumptions, most of which simply do not hold: balanced interest from the beneficiaries, versatility from the recipient organizations, an even-handed attitude from the managers and politicians, and so on.

Furthermore, community work for sanitation requires different time schedules and approaches than for water supply. For water, you want social marketing before construction, while for hygiene and sanitation you need long-term support after water has been made available. All this explains why package programmes hardly stand a chance of success.

Why does almost no language have a single word for our 'WATSAN'? Because water and sanitation are two different things. Now, I agree with you, they should be combined: *co-ordination* is the key. Instead of insisting on utopian integration, let us follow successful single-purpose sanitation programmes such as the National Low-Cost Sanitation Programme in Mozambique (that unfortunately was recently 'integrated' with water supply . . .). Under single-purpose programmes, top managers have only one objective on their minds; they cannot cover up failure in one component (sanitation) with success in the other (water supply).

My vision of an ideal world is one in which recipient governments would tell donors: 'You want to fund a water-supply programme (say, with our water-supply authority)? Then you must also support a sanitation programme (with our health service). Our municipal or district officers will make sure both are co-ordinated.'

Yours,
Daniel

Dear Daniel,

I am in agreement that sanitation requires a high priority, however, I am concerned with the approach that you are suggesting for ensuring that this is achieved in practice. Due to the generally low demand for sanitation, water supply often serves as an entry point into the community, upon which sanitation promotion and implementation can be based. I have seen and have been involved in integrated projects with successful sanitation components, where water was used as an entry point because it was the priority need.

Experience has shown that sanitation improves immensely if people have increased access to water supply. I therefore tend to disagree with your arguments that we should implement parallel water and sanitation projects and think in terms of co-ordination rather than integration. I am a bit concerned about how this co-ordination will work in practice. Currently in most developing countries, especially in Africa, implementing agencies hardly communicate with one another and each project goes on to implement a parallel programme sometimes in competition with the other. The existing lack of co-ordination has meant that agencies strive to work with different structures in the community, again creating unnecessary competition within the community. This often defeats the purpose of many interventions, which is to improve the health and well-being of the people. If we now decide to separate sanitation from water supply, how will it be different from the current situation?

Another question is: whose responsibility will it be to co-ordinate the parallel water supply and sanitation interventions? You suggested the municipal or district officers in your last response. In my opinion, it is untenable to assume that municipal or district officers will be able to take on this responsibility. In the first instance, most municipalities or districts do not have adequate resources (even manpower), and the existing staff lack the necessary skills and capacity to perform the basic services required of them.

Another key issue is the baseline assessment that is usually conducted at the beginning of projects. I am again concerned about how this will be co-ordinated, or will there be two different assessments (e.g. participatory rural appraisal activities) with one concentrating on water supply and another on sanitation? This will mean carrying out the same exercises with a community twice. I think the community will get bored and lose interest in the intervention, as has happened in many countries, where a number of participatory assessments have already been conducted.

I think co-ordination of parallel water and sanitation programmes will be difficult to achieve in practice.

Yours,
Amaka

References

1 Esrey, S.A., J.B. Potash, L. Roberts and C. Shiff (1991) 'Effects of improved water supply and sanitation on ascariasis, diarrhoea, drancunculiasis, hookworm infection, schistosomiasis, and trachoma', *Bulletin of the World Health Organisation*, 69 (5): 609–621.

2 Nanan, D., F. White, I. Azam, H. Afsar, S. Hozhabri (2003) 'Evaluation of water, sanitation, and hygiene education interevention on diarrhoea in northern Pakistan', *Bulletin of the World Health Organisation*, 81 (2): 160–165.

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