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Organisation mondiale de la Santé**

FIFTY-FIRST WORLD HEALTH ASSEMBLY

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Environmental matters

Strategy on sanitation for high-risk communities

Report by the Director-General

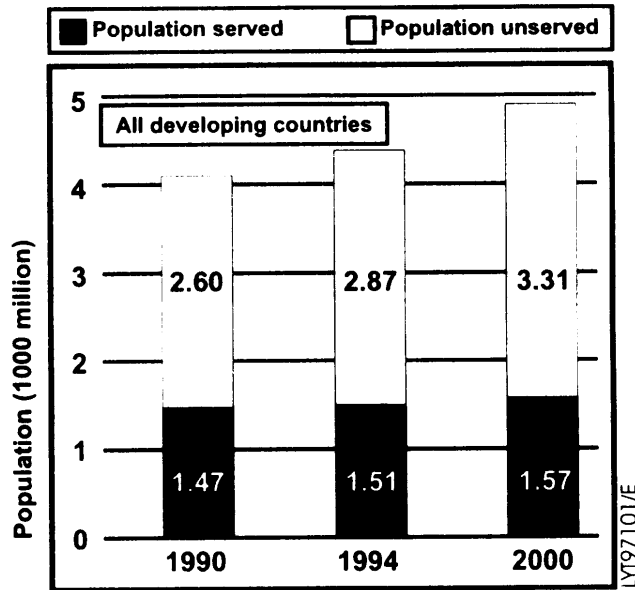
Poor household and community sanitation is a major risk to human health. Nearly two-thirds of all people in developing countries do not have sanitary excreta disposal, and the number without adequate services is growing. Current efforts to deal with the deficiencies are grossly inadequate and change is urgently needed, with a new strategy, particularly for those communities where the conditions are worst and the risk of contracting diseases related to insanitary conditions is highest, and where health would therefore benefit most from investments in water supply and sanitation. This document outlines action to be taken by WHO and other international organizations concerned.

The Health Assembly is invited to consider the resolution recommended by the Executive Board.

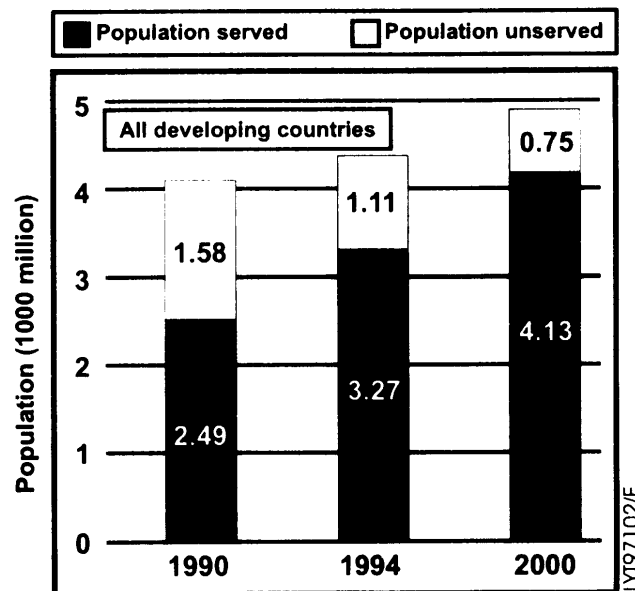
INTRODUCTION

1. The poorest 1000 million people on Earth are seven times more likely to die from infectious diseases - many of which are directly or indirectly related to bad sanitation - than are the least poor 1000 million.
2. Since 1970 sanitation coverage in developing countries has remained constant at about one-third. Projections to the year 2000 show no change in this pattern (see figure below). In essence, the increase in world population leads to an almost equivalent increase in people not served by adequate sanitation. The dramatic proportions of the sanitation deficit become most evident when compared with the progress achieved in water supply.
3. A new sanitation strategy focusing on high-risk communities should guide WHO's activities in the future.

SANITATION



WATER SUPPLY



SITUATION ANALYSIS

4. Environmental sanitation seeks to control or change the physical environment and related human behaviour in order to prevent the transmission of disease. It ranges from safe disposal of human excreta and other household waste to prevent infections, domestic water supply for drinking, cooking, and personal and household hygiene, community sanitation efforts, to environmental safeguarding, including water pollution control. In each of these areas high-risk population groups and communities at risk can be identified.

5. Sanitation is universally accepted as a foundation for good health, and total coverage thus remains a vital aim. However, epidemics of cholera and plague in recent years and continued high endemic rates of diarrhoeal diseases and intestinal helminthic infestations have increased the awareness that certain communities are living in conditions of very high risk and are suffering disproportionately. Generally such communities are crowded urban and periurban settlements, often without recognized legal status, and rural communities where polluted surface water and unprotected wells and springs prone to contamination are used for drinking-water. Such environments, both urban and rural, lack hygienic toilets, proper drainage, solid waste disposal and water for good personal and domestic hygiene. The recognition of the very high risk in these areas and the need for appropriate action should be given priority in national and local planning, as they stand to benefit by far the most from investments in water supply and sanitation.

6. The number of people at high risk is difficult to estimate. It will be the responsibility of each Member State to determine who should have priority for sanitation services according to environmental sanitation conditions and - where data are available and relevant - disease patterns. In most developing countries half of all urban residents and a large proportion of rural communities may fall into the high-risk category. In preparing the grounds for strengthened sanitation programmes, high-risk communities, periurban as well as rural, require further specific definition and identification.

ENDURING VALUE OF INVESTMENTS IN SANITATION

7. Poor sanitation is largely responsible for many diseases, such as schistosomiasis (with an estimated current global prevalence of 200 million cases), typhoid fever (16-17 million cases), intestinal helminthic infections (1500 million people infested) and various diarrhoeal diseases (over two million infant and child deaths annually). Although these diseases can be treated using good case management and effective medicine, the existing needs far exceed the capacity to deliver such services.

8. A strictly medical approach with case detection and treatment will not result in complete interruption of transmission and would represent a continual burden on resources for health. Even if all people suffering from these diseases could be cured, in the absence of sanitation infection would still recur in an endless cycle. Countless days of productive work and, for children, days at school are lost and each disease episode brings a setback in child growth and development. Even if ideal conditions of treatment and cure could be achieved for all (which is far from true today), repeated cycles of treatment corresponding to outbreaks are not the answer. A more permanent solution needs to be found for the elimination of the root causes.

9. Those who suffer most are children and women of child-bearing age, as these diseases also result in anaemia and malnutrition. Governments which have taken the decision to invest in environmental sanitation have already cut high rates of infant and child mortality to minimal levels, whereas people in countries where such a decision has not been taken still suffer (see table below).

10. Rapid population growth, urbanization, and overcrowding, in the absence of sanitation services, results in increasingly polluted environments and increasingly high risk of disease epidemics. Through good sanitation services, together with safe and ample water supply, hygienic behaviour and safe food, this risk can be reduced

to nearly zero. The investment in sanitation breaks the cycle of disease transmission and lasts for generations, as demonstrated by many countries and cities with high population densities.

INFANT MORTALITY, CHILD MORTALITY, WATER SUPPLY AND SANITATION COVERAGE, AND GNP PER CAPITA IN SIX COUNTRIES, 1994 AND 1995

Country	Infant mortality rate (1995) (0-1 year) per 1000 live births	Child mortality rate (1995) (0-5 years, cumulative) per 1000 live births	Access to safe water (1994) (percentage of population)	Access to adequate sanitation (1994) (percentage of population)	GNP per capita (1995) (US\$)
Afghanistan	159	251	10	8	<765
Chile	15	17	96	71	4 160
Ghana	77	113	56	42	390
Guinea-Bissau	135	207	57	20	250
Philippines	39	48	84	75	1 050
Sweden	5	6	100	100	23 750

Source: WHO, 1996.

11. For decades sanitation has been given extremely low priority in comparison with other general development needs. With the advance of treatment of diseases associated with poor sanitary conditions, preventive measures have unfortunately been relegated to a minor role. There is a lack of political will for - and investment in - sanitation, and those in need of such services cannot exert sufficient public pressure to bring about change; they are also less willing to pay for sanitation than for water supply.

12. Other constraints are a lack of appropriate technology for difficult situations (such as crowded urban settlements and areas where pit latrines cannot be dug) and the difficulty of legislating for improvement in sanitation in illegal settlements.

NEW STRATEGY

13. Given the persisting low sanitation coverage, the high prevalence of diseases caused by poor environmental conditions, low investment in sanitation, and population growth and urbanization, a new approach to sanitation is considered to be the best course of action. Focus on high-risk communities will allow maximum health benefits to be derived from investments in sanitation and related programmes. In the context of the health-for-all strategy this approach has to be an integrated and interdisciplinary one, based on strengthened internal coordination and cooperation among organizations of the United Nations system and with appropriate nongovernmental organizations.

14. Consequently, it is proposed that Member States of WHO and all other organizations concerned should focus sanitation efforts on high-risk communities, with renewed emphasis on sanitation as a whole, in terms both of overall investment and of integration with related development activities. Of great importance to the success of this effort will be the involvement of communities in planning, implementing and maintaining their services

and the development of sanitation technology suitable for difficult geographical and residential conditions, taking into account cultural beliefs and habits, and long-term ecological and financial sustainability.

15. No illusions should be nourished, however, that sanitation for the rural and urban poor could be provided on a full-cost-recovery or even on a self-financing basis, as is increasingly the case of urban water supply, with its current trend towards privatization. In the case of sanitation, gains for public health more than justify public expenditure. Considerable community involvement and self-help will be needed in order to offset costs and to ensure greater sustainability of sanitation systems.

16. The high-risk approach must be both ethical and promotional (see paragraph 17(2) below). Public health principles demand that those at highest risk should be given priority. Lack of social equity in supporting communities' efforts for sanitation is a main reason for the heavy disease burden and many epidemics observed today. Environmental sanitation has therefore to be closely linked, and provide support, to the reduction of infectious disease transmission, with particular emphasis on children and women of child-bearing age.

17. The main elements of the new strategy are:

(1) **focus on communities at high risk from diseases related to insanitary conditions:** Member States should: identify and give high priority to high-risk communities and subgroups in urban and rural areas according to existing conditions, taking into account health statistics (including intraurban health differentials) and other systematic data from screening, where available and relevant; support and participate in research on sanitation methods and technology specially suited to the needs of communities in difficult geographical and social conditions (e.g., rocky soil, high water-table, extreme crowding, no legal status, extreme poverty), and should analyse successful cases and establish models of "good practice"; and ensure the suitability and sustainability of sanitation services through programmes of meaningful community involvement, stimulating community action and self-help, and remaining sensitive to cultural and ecological needs. The competent authorities and agencies could greatly benefit from collaboration with nongovernmental organizations and other groups with successful experience in community participation;

(2) **higher priority to sanitation in national planning for health and investment in infrastructure:** Member States, international development organizations and nongovernmental organizations should begin a sanitation promotion programme to increase political will at every level; priorities should be established in the preparation of national action plans for health and environment, and should be firmly integrated into programmes for implementation; sanitation should be integrated with as many other aspects of development as possible, such as programmes on child survival, maternal and child health, communicable disease control, essential drugs and agricultural development (with recycling of waste where feasible and appropriate).

WHO'S ROLE

18. WHO has a responsibility to provide leadership in sanitation as a major determinant of health, bearing in mind that most of the public works and other measures are undertaken by authorities other than health agencies, such as municipal services and local government.

19. WHO's mandate includes support to such programmes initiated by authorities in other sectors than the health sector (see the corresponding provisions in paragraph 4 of resolution EB101.R14).

20. Thus WHO, in cooperation with other appropriate organizations in the health sector will play an effective and dynamic role in changing attitudes and establishing priority for sanitation.

MATTERS FOR THE PARTICULAR ATTENTION OF THE HEALTH ASSEMBLY

21. The Health Assembly is invited to consider the resolution recommended by the Executive Board in its resolution EB101.R14.

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