Sanitation Governance viewed through different lenses

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Abstract

The provision of sanitation facilities – a basic necessity for human health, well-being, dignity and development remains a mammoth challenge for countries in sub-Saharan Africa (SSA). This paper presents concepts that can be used to explain some of the challenges, and discusses approaches that can contribute towards improving the sanitation situation in a sustainable way. The paper posits that part of the problem in the sanitation sector is the contradictions between formal and informal institutions and the disconnect between the actors at the macro, meso and micro governance levels. In addition, the paper asserts that demand driven strategies and private sector involvement in the sector is paramount for establishing new sanitation paradigms and socio-technical regimes. We conclude that a good understanding of agents at all levels i.e. their various roles as well as interactions, and the way they interpret and respond to policies is key to accelerating progress in the sector.

Introduction

Progress in improved sanitation coverage in sub-Saharan Africa (SSA) has remained extremely slow (only about 4% increase in 20 years) despite enormous international assistance characterized largely by supply-driven subsidies (ECA, 2012; Szántó et al., 2012), and national intervention (Szántó et al., 2012) usually with fewer financial resources. In SSA, about 70% of the population still relies on unimproved or shared sanitation facilities or resort to open defecation (WHO/UNICEF, 2013). The region will inevitably miss the sanitation Millennium Development Goal (MDG) (WHO/UNICEF, 2013; WaterAid, 2013). Attention is now shifting from the MDGs to Sustainable Development Goals (SDGs), an outcome of the Rio+20 conference. Sanitation remains one of the top priority areas within the SDGs for the achievement of sustainable development and poverty alleviation.

Lack of clear policies, poor prioritization, inadequate financial support, low investment, technology-driven interventions, and inadequate capacity are some of the challenges faced in the sanitation sector in SSA. These challenges exist at different levels and the responsibility of addressing them rest on different stakeholders – government, private sector and individuals or households. The multi-level stakeholders, their roles, responsibilities, actions and interactions constitute sanitation governance. Sanitation governance entails on-going dialogue between public and private sanitation stakeholders to discern expectations for what results to achieve; translating these expectations including other information as well as perspectives and values of stakeholders into written criteria i.e. policies; and checking to see that criteria are met i.e. through monitoring.

This paper discusses some of the challenges hindering progress in the sanitation sector, specifically in some

Key messages:

This paper provides the following key conclusions that can contribute towards improving the sanitation situation in sub-Saharan Africa in a sustainable way:

- Integrate policy and practice on sanitation and hygiene at all governance levels.
- Focus on demand-driven value chain strategies and technology transfer to ensure that innovative sanitation systems and technologies are sustainable.
- Improve understanding on the prevailing governance arrangements as well as the interpretation of national sanitation policies at the household level.

East African countries where Stockholm Environment Institute (SEI) has on-going multi-level sanitation governance research activities, and highlights different theories that may be used to improve understanding of the challenges faced at different governance levels.

Improving Sustainable Sanitation Coverage in sub-Saharan Africa – A tremendous Challenge

Contradictions between sanitation policy and practice

In Eastern Africa, like in many other countries in SSA, it remains an enormous challenge to translate policy on sanitation and hygiene into practice. Based on Stockholm Environment Institute (SEI) and Kigali Health Institute (KHI) research in Burera district, Rwanda, Ekane et al (2012) found contradictions between prevailing practices and government hygiene and sanitation guidelines. Despite the Rwandan government's commitment to sanitation, the health, hygiene, convenience, and safety of toilets in this district remain unsatisfactory. This is because most of the toilet structures are neither adequately constructed nor properly used. The reasons for this are threefold: lack of prioritization for toilets at the household level, lack of information on sanitation guidelines and standards, and irregular and insufficient inspection. As for Uganda, Achiro (2012) concludes that policies and laws pertaining to sanitation and hygiene exist but the implementation and monitoring of these policies and laws remain a challenge. The most common constraints of law enforcement for improved sanitation in Uganda are weak legal and institutional frameworks, characterized by compromise in implementation, political interference and inadequate resources.

The Tanzanian approach to close the sanitation gap is demand-driven and relies greatly on the private sector and civil society (Kjellén, 2009; 2010), a strategy that owes its origin partly to the 1970s Nyerere's campaign. Despite this, the percentage of the Tanzanian population that had access to improved sanitation facilities in 2011 was merely 12%. This backlog in sanitation provision in Tanzania 'has led to the introduction of a commercial approach to the provision of these services on which they must be paid for, rather than a free right' (EWURA, 2007/2008). The greater reliance on private initiative in Tanzania is also mirrored in water sector management, where Kjellén (2009) poses that even the piped water network development has been demand-driven and includes elements of market logic rather than one of central planning. Sanitation provision in Uganda is mainly led by government performing policy and regulatory functions, and households taking sole role of accessing sanitation facilities (Achiro, 2012). In 2011, 35% of the Uganda population used improved sanitation facilities. In Rwanda, political leadership and commitment plays an active role in standards-setting, enforcement and investment support in addressing

the sanitation gap. 61% of Rwandans used improved sanitation facilities in 2011. In neighbouring Burundi, the absence of a national hygiene and sanitation policy is explained by lack of political will and prioritization of the sector. The percentage of Burundians that had access to improved sanitation in 2011 was 50%. The municipalities in Burundi play a key role in the operation and maintenance of sanitation facilities. Tanzania is the largest and most populated country of all four countries. This partly explains the country's worst performance. It is worth noting that the above sanitation coverage figures (WHO/UNICEF, 2013) would be significantly lower if both the human and environmental functions of the facilities are considered (Kvarnström et al., 2011) i.e. whether the toilets function as intended (Ekane, 2013).

Technology-driven sanitation interventions

The UNDP Human Development report (2006) summarizes the barriers for why sanitation lags far behind water: Many technologies are inappropriate for their settings, and the higher value placed by women on convenient sanitary solutions often fail to translate into commensurate household spending on sanitation. For the poorest, the household level infrastructure needed is out of reach in the absence of support from beyond the community. However, the perceptions commonly underestimate the social benefits from improved sanitation, making it to be regarded as a private affair. Unfortunately, investments and behaviour change may be dependent on others doing the same, which is also when the social benefits of improved sanitation may materialize. Analogously, effective national-level policies for sanitation are conspicuously absent (UNDP, 2006: p. 118).

Inadequate resources in the sector

The most recent GLAAS report (UN-water, 2012) emphasizes the inadequate commitments and actual spending in the sector, with severe consequences for staffing and capacity of policy implementation. A review of 23 EU funded projects in six SSA countries performed by the EU court of auditors revealed difficulties such as lack of technical skills; failure to build ownership; low priority ascribed to sanitation; absence of relevant data and environmental indicators, and lack of a clear and effective integration of water, sanitation and hygiene issues. Less than half of these projects met the needs of the beneficiaries (ECA, 2012).

About 8% of Ugandans mainly in Kampala are served by the sewerage network. The majority of Ugandans (about 92%) provide their own sanitation services through private means (Achiro, 2012). Only 3% of inhabitants in Dar es Salaam, Tanzania have access to sewerage systems (Szántó et al., 2012). Rwanda and Burundi are still to construct sewerage systems. In short; sanitation solutions are mainly implemented at the household level, where benefits of improved comfort,

cleanliness, convenience and dignity for the household members can be immediate. The full set of benefits, including health and a cleaner environment, will only be achieved when most community members access and use improved and functional sanitation, and adopt hygienic behaviours and prudent environmental management.

With mixed potential gains from increased sanitation investment and behaviour change, the backlog in sanitation coverage is costly for society (Prüss-Üstün et al., 2002; Fewtrell et al., 2005; UNDP, 2006; Prüss-Üstün et al., 2008; Yardley, 2010; Cheng et al., 2012). The health risks associated with poorly functioning sanitation systems are well established (Cairncross and Feachem, 1993). Whereas there is still much uncertainty regarding actual disease transmission routes, the role of safe sanitation for human health is undisputed (Esrey, 1996; Prüss-Üstün et al., 2002; Fewtrell et al., 2005).

Functional sanitation is key to the well-being of society

The common adage 'health is wealth' is often used to mean good health is real wealth. In other words, this implies that the money and time used in treating sanitation related diseases could instead be used in carrying out productive activities (Rosemarin et al., 2008). This makes safe and functional sanitation one of the key pillars in the fight against poverty. However, a decent and functional toilet facility remains an unknown luxury for most SSAs. Poor sanitation and related diseases remain one of the key health issues in the region. Children in the poorest households suffer the greatest sanitation-related health burden. The loss of a young life every 17th second due to sanitation related diseases, and the decrease in productivity of adults as well as significant loss of educational opportunities for young people, girls in particular, due to lack of access to safe and dignified sanitation are taking a toll on poor countries. Due to the interconnectedness between sanitation, water, health and poverty, absence of functional sanitation has much wider impacts than on just health alone. Poor health impairs the productive ability of people and keeps them away from school, farm and other income generating activities.

The wider economic impacts – beyond the effects on human health – of the sanitation backlog have been increasingly acknowledged (Bartram and Cairncross, 2010). The World Bank Water and Sanitation Program (WSP) quantified these burdens and estimate that inadequate sanitation costs a colossal sum of US$5.5 billion/year. In relation to Rwanda, Uganda, Tanzania and Burundi, the WSP studies estimate that poor sanitation costs Rwanda some US$54 million/year, Uganda about US$177 million/year, Tanzania a whopping US$206 million/year and Burundi about

US$30 million/year (WSP, 2012). These losses are equivalent to around 1% of the national GDPs of these countries. The greatest proportion of this cost is as a result of premature death due to diarrheal diseases.

Addressing the sanitation challenge at multi-levels

The concept of multi-level sanitation governance

The concept of multi-level governance enables an understanding of policy and decision-making processes involving the simultaneous mobilization of public authorities at different jurisdictional levels as well as that of the private sector, non-governmental organizations, social movements and households. The concept also allows for an understanding of complexity at and between levels (Stubbs, 2005; Pahl-Wostl, 2008). Bache and Flinders (2004) identify four key dimensions of multi-level governance. Firstly, the increased participation of non-state actors; secondly, the need to move away from understanding decision-making in terms of 'discrete territorial levels' and, instead, the need to conceptualize it in terms of 'complex overlapping networks'; thirdly, the transformation in the role of the state towards new strategies of co-ordination, steering and networking; and lastly, the ways in which traditional notions of democratic accountability are being undermined and challenged.

In-between the national policies (macro level) and the individual households (micro level) is the – meso level – web of actors, ranging from government employees, e.g. health inspectors, to private sector formal and informal service providers and civil society organizations. They operate in relation to the – macro level – policies and plans of national governments and donor agencies.

Actions in the sanitation sector are distributed in a way that hygiene behaviours are at the discretion of the individual in a more or less private setting. Similarly, sanitation solutions outside of urban centers are commonly on-site individual household concerns. Sanitation services are, hence, not amenable to be 'rolled out' as many other social or infrastructure services, but instead need to be in support of the individual hygiene behaviours and household solutions, with information, regulation, private sector involvement through financing (subsidies and/or credits) as well as necessary collection services.

Furthermore, at the level of sanitation sector governance and professional work, there is a predominance of males, particularly as regards the engineering aspects of sanitation solutions, but also at the level of urban planning and higher levels of policy making and societal leadership. With individually different but also gender-based cognitive filters, issues related to sanitation needs of women and girl children may be downplayed and receive less understanding and priority, compared to in a situation with a gender-balanced profession.

Formal and informal sanitation institutions

North (1990) defines institutions as a set of formal (devised by human beings) or informal (conventions and codes of behaviour) rules, that actors generally follow, whether for normative, cognitive, or material reasons. All institutional forms result from social compromises that are then embedded in law, jurisprudence, social norms and conventions. Each of these institutional forms induces some specific behaviour (Boyer, 2005). Included in the definitions of institutions are such features of the institutional context as the rules, the structure of the systems, the relation among various branches of government and society, and the structure and organization of actors (Thelen and Steinmo, 1992). Thus, institutions enable interactions, coordination, cooperation, and information exchanges among agents (Amable, 2003). Ostrom (1990) and Hall and Soskice (2001) add that institutions provide capacities for: exchange of information among the agents; the monitoring of behaviour; and the sanctioning of defection. Institutions are said to be coherent if they are designed according to identical principles. Different institutions can be structured in a coherent way, or they might impose different, perhaps conflicting, governance modes and therefore lack coherence (Höpner, 2005).

The formal sanitation institutions such as policies, statements, guidelines, standards and strategies are formulated at the macro level; these formal institutions are interpreted, communicated and executed by meso level agents; the actual implementation of the formal institutions on the ground is done at the micro level mainly by households. Informal sanitation institutions such as norms and customs prevail especially at the micro level and often contradict government standards and guidelines on hygiene and sanitation. As a result, prescribed hygiene standards or sanitary requirements in terms of structure, design, health and safety as well as labour safety are difficult to meet and maintain.

A study examining contradictions between sanitation policy and practice in the Burera district, Rwanda revealed that health, hygiene, convenience, and safety of the toilets remain unsatisfactory. This is because most of the facilities are neither properly constructed nor properly used. A survey of 194 households with pit toilets and UDDTs in the Burera district collected data on hand-washing activities, operation and maintenance of toilets (including the productive sanitation system), and subsidies from UNICEF-Rwanda. 24 respondents stated that they were members of the local productive sanitation cooperative (Dusukure PHAST). The survey found that 31 of the households had received UDDT slabs from UNICEF-Rwanda, of which 28 households had installed their UDDT slabs. However, seven of the 28 households indicated that they use water to flush faeces dropped onto the slab. Only about 3% had a hand-washing facility installed close to the toilet. Furthermore, during the survey it was observed that

in 17 households the urine compartment had been detached (Ekane et al., 2012).

Path dependency in the sanitation sector

According to Campbell (2004), when institutionalists (Stinchcombe, 1968; North, 1990; Powell, 1991; Nelson, 1994; Roe, 1996; Pierson, 2000) talk about path dependence they refer to a process whereby contingent events or decisions result in the establishment of institutions that persist over long periods of time and constrain the range of future actions for actors, including those that may be more efficient or effective in the long run.

The concept of path dependency highlights the extent to which existing technologies and practices structure avenues of future development. Patterns of path dependency have consequences for change and stability at various levels: between firms, within technological communities, amongst users and across the plane of social meaning, convention and expectation (Shove, 2003; Rip and Kemp, 1998). Shove (2003) states that the concept of socio-technical regimes consolidates the notion that irreversibilities and path dependencies occur at different levels – macro, meso and micro. The rules, paradigms and dominant technologies framing current actions and informing beliefs about what is and is not possible in the future are referred to as regimes or landscapes.

The 'flush and forget' and 'drop and store' sanitation systems remain the two major dominating sanitation regimes or landscapes in SSA. The take up of other sanitation options such as ecological sanitation ('toilet to farm') has been slow at all levels – amongst decision makers, experts, and individual households. Systems involving urine separation and use of human derived nutrients in agriculture have been piloted in many countries in SSA, and have proven to be good options in improving rural livelihoods. Yet, scaling up these systems in the region faces huge psycho-social, technical and capacity constraints.

Psycho-social aspects related to sanitation

Shove (2003) points out that historically, the institutionalization of hygiene had immediate impact on the bathroom for sanitary reformers were convinced that when safely and properly constructed, bathrooms provided the facilities required to keep disease at bay. This of course applies also to toilets. Notions about purity and pollution (Douglas, 2002), along with hygiene habits and cultural or religious traditions greatly affect the way different sanitation solutions are perceived and taken up – or not. Increasing number of sanitation programs exploit the feeling of disgust to trigger changes in hygiene behaviour e.g. Community-led Total Sanitation (Movik and Mehta, 2010). Barriers for changing hygiene behaviours or those in relation to the

environment might include coping devices, established cultural models, real and/or perceived inconveniences, as well as social pressures, including stigma and ridicule (Thompson, 2004). Massie and Webster (2013) stress that future hygiene promotion should take a participatory form, rigorously identifying and working with existing beliefs.

Conclusion

Whereas clear messages from the highest political levels are important, there are many layers of policy interpretation before policy messages reach the household level where the implementation of sanitation mainly occurs. Moreover, sanitation policy development usually occurs at central ministry level, with implementation responsibilities being that of the district governments that usually have little or no capacity and financial resources for effective implementation and monitoring. In addition, a range of informal policies and norms prevail at the household level and these usually contradict national policies. These norms dictate prioritization, responsibilities and division of labour - who does what and why. The gender and equity-based biases resulting from such norms and arrangement at the household level need to be better understood and addressed in implementation strategies.

According to ECA (2012), sustainable sanitation coverage is achieved through strategies wherein sanitation promotion and marketing are funded rather than supply-driven subsidies for sanitation infrastructure. Thus, a greater involvement of private entrepreneurs and other meso level agents in the sanitation sector, and the creation of a value chain is vital in the institutionalization of new sanitation paradigms and socio-technical regimes or landscapes. Demand-driven strategies and capacity development would support the value chain and promote ownership of sanitation facilities at the micro level.

At the macro level, clear assignment of rights and responsibilities for policy implementation and enforcement is key. Policies should be fully comprehensible, as well as effectively disseminated and practiced: they must be clearly understood by stakeholders, and the implementation must be effectively monitored.

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