

New water forum will repeat old message

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Background documents for the World Summit for Sustainable Development indicated that “addressing the water needs of the poor through concerted global action has not been given enough priority”. The same assertion will be made at the forthcoming 3rd World Water Forum (Kyoto, Shiga and Osaka, Japan, 16–23 March). This is hardly news as most water conferences over several decades have made a similar observation. At Johannesburg the widely held expectation was therefore for real commitments, especially from governments — of both developing and developed nations — to take action on this as a key priority. However, comments since the Summit have emphasized the limited “new money” despite the welcome presence of “new initiatives”.

Nevertheless the Summit did lead to changes in commitments concerning water, sanitation and hygiene, including the major achievement of adding a sanitation target to mirror the one for water in the Millennium Declaration Goals: to halve the proportion of the population without access to safe drinking-water (and now sanitation as well) by 2015. Both targets were largely justified by arguments about poverty, development and health. How much of a difference will they really make? And are they really the best way to go about tackling poverty, promoting development and protecting health?

WHO's own work has shown how the burden of disease related to water, sanitation and hygiene is disproportionately borne by children in developing countries. In fact, they bear about 68% of the total global burden of diarrhoeal disease. Any attempt to reduce this burden will inevitably fail unless efforts concentrate on those most affected. There also seems to be little doubt that interventions to reduce water-related disease would benefit the world's poor: diarrhoea related to water, sanitation and hygiene constitutes around 88% of the total. Reducing that burden would also reduce costs incurred by poor families because of poor health. These costs include

direct health care costs and loss of time that could otherwise be spent in productive activity, schooling and child care. At the same time, improving access to water reduces the disproportionate cost borne by the poor for procuring it — either financially or through the labour involved in fetching water from long distances. According to the World Commission on Water for the 21st Century, 1999, the poor on average pay 12 times as much per litre for drinking-water as those connected to municipal systems. Tackling this problem would free their resources for better use.

Improving water supply, sanitation and hygiene benefits health twice: directly with reductions in disease, and indirectly through improvements in economic prospects and education. Similar arguments can be made for the diseases related to water, sanitation and hygiene — including malaria, schistosomiasis and trachoma — and the effects of chemical drinking-water contaminants like fluoride and arsenic.

Fierce debate on the achievability of the new targets for water supply and sanitation “coverage” began well before they were adopted, with widely divergent views. WHO's projections suggest that simply continuing the pace of work maintained through the 1990s would lead to meeting the Millennium Development Goal for water. It is therefore hardly an ambitious target, but one that may assist in keeping efforts on track. The target for sanitation is another matter: if the rate of extension of coverage of the 1990s is maintained we will still have a global shortfall of around 332 million people. Even achieving the target would leave almost a quarter of humanity without access to even a simple improved latrine in 2015. At the regional level realities can be seen which do not appear in the globalized statistics. For example, our work suggests that in sub-Saharan Africa the number unserved will actually increase between now and 2015. Even if the targets for both water and sanitation are met, in 2015 there will still be some 736 million people without

access to improved sources of drinking-water in 2015 and some 1692 million without access to improved sanitation. And those populations will continue to suffer the health effects we see today associated with poor living conditions.

In addition to extending coverage with infrastructure which may be little more than a minimal lifeline for health, much can be done to assist unserved populations in improving their health through effective action on water, sanitation and health. There is plenty of evidence that interventions supporting improved hygiene can deliver health gains even in populations with inadequate water supply. There is also more than enough data to show that real health gains are possible through improving water quality management in the home.

In addition, we know that households are willing to invest in better water and waste management and hygiene, both for reasons of direct health benefit and because of perceptions of cleanliness and dignity.

These measures individuals can take may provide a way of bringing forward the benefits of improved health rather than insisting that the poor ‘wait in line’ to benefit from extensions of coverage with basic services. They are not an alternative to working for universal access to basic water supply and sanitation, but they might enable many more people, especially amongst the poor, to reduce the burden of disease they carry related to water and sanitation. In work not yet published, WHO has documented how in some regions such improvements may even yield a net economic benefit. That is to say that their costs are outweighed by the reductions in losses incurred by health problems within households and to the health system. Why wait?

The United Nations Millennium Development Goals, set in the year 2000, are about improving health, promoting development and alleviating poverty. Achieving them will require redoubled efforts not only to extend coverage with essential services but to ensure that the unserved have access to the means of minimizing their burden of water-related disease. ■

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