Basic Sanitation

**What do we mean by Basic Sanitation?**

Basic sanitation is the lowest-cost technology ensuring hygienic excreta and sullage disposal and a clean and healthful living environment both at home and in the neighborhood of users.

Access to basic sanitation includes safety and privacy in the use of these services. Coverage is the proportion of people using improved sanitation facilities: public sewer connection; septic system connection; pour-flush latrine; simple pit latrine; ventilated improved pit latrine.

An improved sanitation facility is defined as one that hygienically separates human excreta from human contact (see below).

**Open Defecation Free (ODF) Verification protocol – Ghana**

- **ODF basic**: no visible faeces accessible to flies, domestic & wild animals in the entire community

- **ODF**: No visible faeces + 80% of households own and use improved latrines with hand washing facilities + all households have access to and use sanitation facilities

- **Sanitized community**: No visible faeces + 100% of households own and use improved latrines with hand washing facilities + All public structures have improved latrines + Proper refuse and waste water management

- **Sustainable Sanitized Community**: Community has maintained its Sanitized Community status for three successive years

**IN GHANA: Basic Sanitation context**

- In Upper East region, 89% of the population practice Open Defecation (highest rate in Ghana) and only 3% use unshared improved sanitation facilities.

- Nationally, on average 22.9% of people in Ghana do not have access to ANY sanitation facility (open defecation) and only 15% use improved unshared sanitation facilities.

- **38 districts** in Northern, Upper East, Upper West, Central and Volta Regions are currently implementing CLTS; none of them has been declared ODF yet.

- **Mion district in Northern Region** is leading the process and is likely to become the first ODF district: out of 151 communities, 40 are independently verified ODF communities, 61 are potential ODF communities verified by

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**INCLUDES A QUIZ AT THE END!**
the District alone, 35 are ODF-Basic, and 15 are triggered.

*(MICS 2011, BaSIS 2015)*

**DECLINE OR INCREASE?**

Between 2006 and 2011, the MICS data recorded a slight decline in the proportion of people practicing open defecation (from 24.4% to 22.9%). However, in terms of the actual number of people that these figures represent, there has been an increase from 5.4 million to over 5.7 million (due to population growth over the period).

**Consequences of Lack of Basic Sanitation**

- **Children** – and particularly girls – are denied their right to education because schools lack private and decent sanitation facilities.
- **Poor farmers and wage earners** are less productive due to illness.
- **Diseases** are spread through contamination of food and drinking water which lead to children suffering permanently from stunting as a result of poor sanitation.
- **Health systems** are overwhelmed.
- **National economies** suffer.

**Solutions – Participatory approaches**

Merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene. Prescribing high initial standards and offering subsidies as an incentive often lead to uneven adoption, problems with long-term sustainability and only partial use.

**Community-Led Total Sanitation (CLTS): how to measure Process and Results?**

CLTS is a fairly mature approach, with steps that follow a sequence, from pre-triggering to post-triggering.

“Triggering a community” refers to the process of creating dissatisfaction with current practices in communities to understand and realize the negative effects of poor sanitation. So it is not too difficult to determine how well a community is progressing in the implementation:

Assessing the triggering responses (from the CLTS Handbook):

- The response is categorized as a *Matchbox in a gas station* if the entire community is fully ignited and all are prepared to start local action immediately to stop open defecation;
- *Promising flames* are there when a majority has agreed but a good number are still not decided;
- *Scattered sparks* are observed where the majority of the people are not decided on collective action, and there are many fence-sitters, and only a few have started thinking about going ahead;
- A *Damp matchbox* is where the entire community is not at all interested to do anything to stop open defecation.

The **CLTS Handbook** provides guidance on how to categorize the response at community level, and indicates which activities should be carried out according to the triggering response.

When it comes to measuring the results obtained by the CLTS approach, because of the nature of the topic, it becomes more complex to assess them. To assess “access and use”, indicators rely on reported information.

At Regional and Districts level, **outcome indicators to assess the ODF status** include (among others):

- **ODF Success Rate**: measures the proportion of triggered communities that become ODF; it is a key indicator of CLTS effectiveness and it is used to rank districts;
- **CLTS Coverage**: measures the percentage of communities in a certain district/region that have been triggered;
- **ODF Coverage**: measures the percentage of communities in a certain district/region achieving ODF and/or ODF-Basic;
- **Population in ODF Communities**: measures the number of people living in an ODF-certified community;
- **Proportion of the population using an improved sanitation facility**;

The CLTS Handbook provides guidance on how to categorize the response at community level, and indicates which activities should be carried out according to the triggering response.
Participatory approaches like Community-Led Total Sanitation (CLTS) have proven to be more successful. The focus is to promote local mobilization and facilitation to enable villagers to analyse their sanitation situation and bring about collective decision-making to stop open defecation.

Creating a behavioral change ensures real and sustainable improvements – investing in community mobilization instead of hardware, and shifting the focus from toilet construction for individual households to the creation of open defecation-free communities.

To know more, visit:
- http://www.wssinfo.org/
- http://www.communityledtotalsanitation.org/

Or contact our in-house experts from the WASH team!

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Global situation

According to the latest estimates of the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP), released in early 2013 (collected in 2011), 36 per cent of the world’s population – 2.5 billion people – lack improved sanitation facilities and 1.1 billion people have no access to any type of improved drinking source of water.

Prevalence of Open Defecation in the world, 2012

As a direct consequence:

- 1.6 million people die every year from diarrhoeal diseases (including cholera) attributable to lack of access to safe drinking water and basic sanitation and 90% of these are children under 5, mostly in developing countries;
- 160 million people are infected with schistosomiasis causing tens of thousands of deaths yearly; 500 million people are at risk of trachoma from which 146 million are threatened by blindness and 6 million are visually impaired;
- Intestinal helminths (ascariasis, trichuriasis and hookworm infection) affect 133 million people worldwide; there are around 1.5 million cases of clinical hepatitis A every year.
Where do these numbers come from?

The data in the WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP) reports are obtained from MICS and DHS surveys carried out at the national level. Because routine administrative data from sectoral data systems is often not reliable and not comparable, these surveys provide a more accurate and consistent picture of access to safe water and basic sanitation.

The JMP compiled eight Core Questions on Drinking Water and Sanitation for Household Surveys and has ensured that these questions are included in both DHS and MICS. The terminology of improved and unimproved drinking-water sources and sanitation facilities is now widely recognized and used to enable comparisons to be made across different countries and regions of the world.

Limitations

1. The MDG drinking-water and sanitation targets include issues which are difficult to measure at global scale using existing monitoring mechanisms. Surveys are expensive but represent the best option at the moment.

2. Some issues are not yet addressed by the JMP through the surveys, including:
   - access in informal settlements and peri-urban areas;
   - sustainability of services;
   - when can sanitation facilities be considered as not harmful to the environment;
   - whether there are extreme seasonal variations in access; and,
   - criteria for the safe disposal of children’s excreta and safe disposal of pit contents and treatment/disposal of sewage.

3. No methodology for linking improvements in access to safe drinking-water and basic sanitation to development outcomes such as maternal health, child mortality, school attendance etc.

In Ghana, while MICS and DHS are used for periodic data for measuring trends on use of sanitation facilities by people, there are other mechanisms to provide more regular information on basic sanitation.
Presently, annual forums such as National CLTS Stock-take, and progress reports from the Environmental Health and Sanitation Directorate (EHSD) – the key government agency – provide information on the national and subnational implementation of CLTS.

To improve the routine data collection, storage, analysis, and reporting, UNICEF and the DFATD-Canada have supported the government with the development of the Basic Sanitation Information System (BaSIS), a decentralized sanitation M&E system to address data gaps in the sector.