Commentary on community-led total sanitation and human rights: should the right to community-wide health be won at the cost of individual rights?

Jamie Bartram, Katrina Charles, Barbara Evans, Lucinda O'Hanlon and Steve Pedley

ABSTRACT

The Millennium Development Goals (MDGs) set out to halve the proportion of the population without access to basic sanitation between 1990 and 2015. The slow pace of progress has lead to a search for innovative responses, including social motivation approaches. One example of this type of approach is 'Community-led Total Sanitation' (CLTS). CLTS represents a major shift for sanitation projects and programmes in recognising the value of stopping open-defecation across the whole community, even when the individual toilets built are not necessarily wholly hygienic. However, recent publications on CLTS document a number of examples of practices which fail to meet basic ethical criteria and infringe human rights. There is a general theme in the CLTS literature encouraging the use of 'shame' or 'social stigma' as a tool for promoting behaviours. There are reported cases where monetary benefits to which individuals are otherwise entitled or the means to practice a livelihood are withheld to create pressures to conform. At the very extreme end of the scale, the investigation and punishment of violence has reportedly been denied if the crime occurred while defecating in the open, violating rights to a remedy and related access to justice. While social mobilisation in general, and CLTS in particular, have drastically and positively changed the way we think about sanitation, they neither need nor benefit from an association with any infringements of human rights.

Key words | community-led, human rights, sanitation

Jamie Bartram (corresponding author)
Department of Environmental Sciences and Engineering,
The University of North Carolina at Chapel Hill,
Chapel Hill, NC 27599,
USA
E-mail: *jbartram@email.unc.edu*

Katrina Charles
Centre for Environmental Health and Engineering,
The University of Surrey,
Guildford, Surrey, GU2 7XH,
UK

Barbara Evans
School of Civil Engineering,
The University of Leeds, LS2 9JT,
UK

Lucinda O'Hanlon
Office of the High Commissioner for Human Rights,
Palais des Nations, CH-1211 Geneva 10,
Switzerland

Steve Pedley
Robens Centre for Public and Environmental Health, The University of Surrey,
Guildford, Surrey, GU2 7XH,
UK

INTRODUCTION

Tension between individual rights and actions in pursuit of the common good has a long history in public health practice and in health-related research. This tension is central to the challenge of domestic sanitation, the right to which was recognised by the United Nations in its resolution number 64/292 on 28 July, 2010 (United Nations 2010). Sanitation, which here we take to mean primarily the management of human excreta, deals with an intensely private social sphere, but is at the same time a public good with benefits that accrue well beyond the household boundary. An understanding of the public benefits of domestic sanitation fuelled public investment in municipal sanitation in 19th and 20th century Europe; and it is still used to justify public sector investment in countries struggling with a backlog of unserved citizens. A significant focus of many sanitation 'projects' has for many years been the expenditure of *public* funds on wholly- or partly-subsidised *private* toilets for individual households.

Regrettably, inadequate sanitation continues to be the underlying cause of a substantial proportion of the global burden of disease, contributing 2,213,000 deaths and

doi: 10.2166/wh.2012.205

82,196,000 DALYs (disability-adjusted life years) per year with unsafe water and hygiene (Prüss *et al.* 2002).

The current international policy push, laid out in the Millennium Development Goals (MDGs), sets out to halve the proportion of the population without access to basic sanitation between 1990 and 2015. This modest target will be missed by over half a billion people, leaving 2.4 billion people without even a simple improved latrine at home (WHO/UNICEF 2012).

The slow pace of progress in increasing access to sanitation, and the prospect of failing dismally on an internationally-adopted development target have encouraged a search for innovative responses, such as social motivation approaches, which have been adopted with enthusiasm by several major development agencies, e.g. UNICEF (2009). One example of this type of approach is 'Community-led Total Sanitation' (CLTS), which has been promoted as '… an innovative methodology for mobilising communities to completely eliminate open defecation' (Institute of Development Studies 2011). CLTS represents a major shift for sanitation projects and programmes with its focus on 'igniting a change in sanitation behaviour rather than on constructing toilets' (Kar & Chambers 2008). Importantly, CLTS recognises the value of stopping open-defecation *across the whole community*, even when the individual toilets built are not necessarily wholly hygienic. It also places communities at the centre of the process.

Early reports of the impact of the approach in Bangladesh on latrine construction and use and on achievement of 'open-defecation free status' were welcomed with cautious optimism, but it rapidly became evident that the impact was indeed significant. The first South Asia Ministerial Sanitation Conference (SACOSAN) held in Dhaka in 2003, for example, saw ministers from seven South Asian countries endorse the approach and commit to rolling it out in their own countries. Roll out has been rapid and a recent estimate suggested that as many as 44 countries (Kar 2011) and many major aid agencies are now experimenting with this social motivation method and with the measures which are applied to encourage compliance with desired behaviours.

Without doubt, improvements in sanitation are in the common good and are likely to promote a better global enjoyment of many human rights. However, the laudable commitment within social mobilisation approaches to allow communities to choose and make use of an array of traditional sanctions to encourage individual conformity with community-wide decisions may be a cause of alarm. They raise the question as to whether it is ever acceptable to prejudice the human rights of individuals in the interests of the common good.

The areas of concern fall broadly into three areas.

Firstly, there is a general theme in the CLTS literature encouraging the use of 'shame' or 'social stigma' as a tool for promoting behaviours. The participation of children as 'monitors' of private behaviour is particularly encouraged. The 'Handbook of Community-Led Total Sanitation' for example cited an area of Bangladesh where the children were known as the '*army of scorpions*' and,

> 'They were given whistles, and went out looking for people doing [open defecation]. One youth said that during the campaign for [open-defecation free status] he had blown his whistle at least 60 times. In a few cases they … flag[ged] piles of shit with the name of the person responsible' (Kar & Chambers 2008).

Similarly,

> 'To ensure that social mobilization was conducted with sensitivity to local customs, in each village a local community-based organization – the implementing agency – helped the community to establish systems of fines, taunting or social sanctions to punish those who continued to defecate in the open' (Pattanayak *et al.* 2009).

> 'Squads threw stones at people defecating. Women were photographed and their pictures displayed publicly. The local government institution, the gram panchayat, threatened to cut off households' water and electricity supplies until their owners had signed contracts promising to build latrines. A handful of very poor people reported that a toilet had been hastily constructed in their yards without their consent' (Chatterjee 2011).

Secondly, and perhaps more disturbing are reported cases where monetary benefits to which individuals are

otherwise entitled or the means to practise a livelihood are withheld to create pressures to conform. For example:

> 'A local official proudly testified to the extremes of the coercion. He had personally locked up houses when people were out defecating, forcing them to come to his office and sign a contract to build a toilet before he would give them the keys. Another time, he had collected a woman's faeces and dumped them on her kitchen table' (Chatterjee 2011).

> 'Punishments can involve monetary fines or social sanctions such as mocking or throwing stones at those who continue to practice open defecation' (Devine 2009).

> 'Negative motives include: shame; disgust; law enforcement; fines and by-laws; social exclusion; water supply only if sanitation is improved' (International Water and Sanitation Centre 2008).

> 'Gofur and his widow mother lived on daily earning from van pulling. As Gofur was not installing latrine at his household one day the UP [union parishad] member took away his van and kept it in the UP office. Gofur's earnings were completely stopped for two days. They did not have enough savings for survive. However as Gofur was a member of Caritas (NGO) he could manage loan from that organisation. With that loan he bought latrine and on showing that latrine to UP member he could recover his van' (Mahbub 2009).

Thirdly, at the extreme end of the scale, the right to justice has reportedly been withheld as for example:

> '… no bichar (arbitration) would be held if the young women and adolescent girls of the household were raped during defecating outside' (Mahbub 2009).

The questions which concern us are: To what extent is it acceptable, in pursuing the common good of widespread sanitation, to compromise individual human rights: to restrict access to justice in the case of rape; to confiscate property (especially when this represents the source of family income); to threaten physical integrity in the case of stoning; and to withhold water in the case of deprivation of water supply? And to what extent is it tolerable and reasonable to sanction systematic humiliation of community members who will often represent the least educated and those with the least means to act in the manner demanded?

We are not criticising CLTS and its many variants *per se* – there is no evidence that such infringements are widespread; indeed, one concern is that there is precious little evidence of exactly what is happening on the ground at all. However, the methods selected by some communities or encouraged by some practitioners should be a matter of concern to us all, particularly when we already know that such approaches can spread very rapidly in a local area where they meet with apparent success (Mahbub 2009). Despite this, numerous academic publications and professional reports have described such methods without critical comment. It is never possible to justify such infringements of basic human rights even if the potential benefits to the community are significantly large. If we were to accept such a justification we are surely condemning some of the poorest and weakest members of society to selective exclusion from their universal rights.

The maxim 'first do no harm' in medicine, and the principle that public health improvement should come through just and respectful means are widely accepted. Academic ethics provides a point of reference and typically requires that every researcher apply the principles of 'rigour, honesty, integrity, respect for life, the law and the public good and responsible communication'; and 'ensure the health and safety of those associated with research' (this wording is a representative example from the University of Surrey, UK 2007). They further require study cessation and positive intervention against actions such as stoning if they were detected in an approved study. Indeed ethical clearance would require no risk 'to a subject's personal social standing' (Economic & Social Research Council 2010) as well as no risk of injury or harm. The question is, if such things are not acceptable in research, are they ever acceptable in practice? And further, if we hold to the intrinsic value of communities being able to determine their own developmental path, how should we respond when their choices about '*internal community pressure*' result in actions which are more harmful than the very worst '*external force*' (Harvey 2011)?

In the context of the international human rights framework, these infringements of individual rights cannot be encouraged; neither can they be justified. At the World Conference on Human Rights (1993), State delegates agreed to the proclamation that, 'all human rights are universal, indivisible and interdependent and interrelated' and must be treated 'globally in a fair and equal manner, on the same footing, and with the same emphasis' (United Nations 1993). This is interpreted to mean that promoting the realisation of a given right (in this case sanitation) cannot justify the violation of other human rights, such as physical integrity, access to justice and respect for the human dignity.

In recent years, the health sector has moved away from its early fixation on the perceived conflicts between public health goals and human rights norms. Jonathan Mann and colleagues observed early in the HIV/AIDS epidemic that there exists an inextricable linkage between health and human rights, pressing for a public health response that would seek 'to maximize realization of public health goals while simultaneously protecting and promoting human rights' (Mann *et al.* 1999). Out of this relationship between public health and human rights, it has become accepted in health policy that vulnerability to ill-health as a society can best be reduced by taking steps to respect, protect and fulfill individual rights. This acceptance has been codified as part of the United Nations' Siracusa Principles which state that, while certain limitations on rights are permissible on various grounds, including serious threats to public health, these must be specifically provided for in law, must not be arbitrary or unreasonable, shall be clear and accessible to everyone, and subject to review and remedies (Principles 15 and 25, Siracusa Principles, United Nations 1984). Punishments imposed in the context of a small number of CLTS programmes have not met these requirements.

The Siracusa Principles also explain that if a limitation is determined to be 'necessary', it must be (a) 'based on one of the grounds justifying limitations recognized by the relevant article of the Covenant, (b) responds to a pressing public or social need, (c) pursues a legitimate aim, and (d) is proportionate to that aim'. Any limitations must also be non-discriminatory. A report of the Special Rapporteur on extreme poverty and human rights, UN Doc. A/66/265, focused on criminalisation of poverty and includes a discussion of legitimate restrictions on human rights. The report of the Special Rapporteur on the human right to water and sanitation, mission to the United States of America, UN Doc. A/HRC/18/33/Add.4, contains a useful related discussion on punishment of homeless people for urinating and defecating in public.

Ethical and legal standards for human rights have been developed in recognition that, despite good intentions, researchers and practitioners may privilege the perceived needs of their study or programme over the actual needs of its subjects; or may assign greater importance to large-scale potential downstream benefits over the immediate consequences for individuals.

Social mobilisation in general, and CLTS in particular, have been 'game changers' for the way we think about sanitation. Their contribution to advancing progress is undeniable. But they neither need nor benefit from an association with any infringements of human rights. We firmly believe that any approach to social mobilisation or its study that may incite such infringements should be the subject of critical review and accountability; as CLTS spreads, the need for systematic analysis becomes increasingly important.

ACKNOWLEDGEMENTS

Comments on a draft of this manuscript from Jack Colford and Catarina de Albuquerque are gratefully acknowledged.

REFERENCES

Chatterjee, L. 2011 *Time to Acknowledge the Dirty Truth Behind Community-led Sanitation*. Guardian News and Media, London [updated June 9, 2011]. Available from: http://www.guardian.co.uk/global-development/poverty-matters/2011/jun/09/dirty-truth-behind-community-sanitation (Accessed 06/12/11).

Devine, J. 2009 Introducing SaniFOAM: A framework to analyze sanitation behaviors to design effective sanitation programs. Water and Sanitation Program. Oct 2009. Available from: http://www.wsp.org/wsp/sites/wsp.org/files/publications/GSP_sanifoam.pdf (Accessed 06/12/11).

Economic & Social Research Council 2010 *Framework for Research Ethics*. Economic & Social Research Council, Swindon, UK. Available from: http://www.esrc.ac.uk/ESRCInfoCentre/Images/ESRC_Re_Ethics_Frame_tcm6-11291.pdf (Accessed 15/02/10).

Harvey, P. 2011 Community-led total sanitation, Zambia: stick, carrot or balloon? *Waterlines* **30** (2), 95–105.

Institute of Development Studies 2011 Community-led total sanitation [homepage on the internet]. Sussex. Available from: http://www.communityledtotalsanitation.org/page/clts-approach (Accessed 06/12/11).

International Water and Sanitation Centre (IRC), Network for Water and Sanitation (NETWAS), Institute of Water and Sanitation Development and Water Supply and Sanitation Collaborative Council 2008 Seminar of Practitioners: Household and School Sanitation & Hygiene East and Southern Africa IRC and partners, Nov 19–21, 2007, Moshi, Tanzania.

Kar, K. 2011 Community Led Total Sanitation (CLTS), Origin, Spread and Scaling up. WASH Conference May 16–20, 2011, Brisbane, Australia, Conference report. Available from: http://www.watercentre.org/resources/publications/attachments/wash-conference-2011-report (Accessed 07/06/12).

Kar, K. & Chambers, R. 2008 *Handbook on Community-led Total Sanitation*. Plan UK and Institute of Development Studies, Sussex, UK.

Mahbub, A. 2009 Social dynamics of CLTS: Inclusion of children, women and vulnerable. *CLTS Conference*, 2008 Dec 16–18, Sussex, UK, Brighton.

Mann, J. M., Gostin, L., Gruskin, S., Brennan, T., Lazzarini, Z. & Fineberg, H. 1999 *Health and Human Rights*. Routledge, New York and London.

Pattanayak, S. K., Yang, J.-C., Dickinson, K. L., Poulos, C., Patil, S. R., Mallick, R. K., Blitstein, J. L. & Praharaj, P. 2009 Shame or subsidy revisited: social mobilization for sanitation in Orissa, India. *Bull. World Health Organ.* **87** (9), 580–7.

Prüss, A., Kay, D., Fewtrell, L. & Bartram, J. 2002 Estimating the burden of disease from water, sanitation and hygiene at a global level. *Environ. Health Perspect.* **110**, 537–542.

UNICEF 2009 *Soap, Toilets and Taps. A Foundation for Healthy Children*. UNICEF, New York.

United Nations 1984 Siracusa Principles on the Limitation and Derogation of Provisions in the International Covenant on Civil and Political Rights, Annex, UN Doc. E/CN.4/1984/4. United Nations, Economic and Social Council, UN Sub-Commission on Prevention of Discrimination and Protection of Minorities.

United Nations 1993 The Vienna Declaration and Programme of Action. World Conference on Human Rights, Dec 20, 1993.

United Nations 2010 The Human Right to Water and Sanitation, G.A. Res. 64/292, UN DOC. A/RES/64/292 (August 3, 2010). Available from: http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N09/479/35/PDF/N0947935.pdf?OpenElement.

University of Surrey 2007 *Code on Good Research Practice*. University of Surrey, Guildford, Surrey. Available from: http://www.surrey.ac.uk/about/corporate/policies/code_on_good_research_practice.pdf (Accessed 07/06/12).

WHO/UNICEF 2012 *Progress on Drinking Water and Sanitation: 2012 Update*. UNICEF and WHO, New York and Geneva.

First received 6 December 2011; accepted in revised form 15 August 2012. Available online 12 September 2012