MANUAL ON THE HUMAN RIGHTS TO SAFE DRINKING WATER AND SANITATION FOR PRACTITIONERS

Lead Author: Robert Bos

Contributing Authors: David Alves, Carolina Latorre, Neil Macleod, Gérard Payen, Virginia Roaf & Michael Rouse

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Alliance House
12 Caxton Street
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Telephone: +44 (0)207 7654 5500
Fax: +44 (0)207 7654 5555
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Annex A Context and contents of the human rights to safe drinking water and sanitation

SYNOPSIS

This Annex reflects on the HRWS in the context of the current global and national drinking water and sanitation challenges and their public health dimensions. It explains the principles of the human rights framework and presents a brief overview of the events leading up to the adoption of the human rights resolutions in 2010. It introduces the concept of progressive realisation, and concludes with an attempt to demystify issues around the HRWS and to clarify common misconceptions.

A.1 THE SCALE OF THE GLOBAL DRINKING WATER AND SANITATION CHALLENGES

The global situation of people's access to drinking water and sanitation is among the best monitored and analysed development issues in the world. A long history of monitoring (which started after the UN Conference on Drinking Water Supply and Sanitation in Mar del Plata, Argentina, in 1977) culminated in focused attention on specific global indicators during the period of the Millennium Development Goals (MDGs) with internationally agreed water and sanitation targets. These MDG targets and indicators left ample room for improvement. However, the methodology of nationally representative household surveys that include questions on access to and use of improved sources of drinking water and improved sanitation facilities provided, at least, an up-to-date global picture of status and progress in the numbers of people without access to these sources and facilities.

We know, therefore, that in 2015 globally an estimated 663 million people lacked access to improved drinking water sources and an estimated 2.4 billion lacked access to improved sanitation facilities (UNICEF and WHO 2015). The household survey approach allows for data disaggregation between regions and between rural versus urban populations. It also makes it possible to attribute levels of access to water and sanitation to wealth quintiles[16] of national populations. This disaggregation reveals, for example, large regional discrepancies (in 2013, an estimated 325 million of the 748 million people without access to improved water sources lived in Africa south of the Sahara). Over 1 billion people continue to

[16]Wealth quintiles are 20% segments of a population indexed for their relative wealth. Wealth quintile analysis is a tool to assess equity (a subjective concept), but not necessarily equality (a legal concept).

practice open defecation, mainly in the South Asian sub-continent and in Africa south of the Sahara. Yet, we also know that between 1990 and 2013 globally an estimated 2.3 billion people gained access to improved drinking water sources, and that in 2013 56% of the global population enjoyed a piped water connection on premises (WHO/UNICEF 2014).

The indicators measured do not fully address qualifiers contained in the MDG target definition, such as sustainability of access and safety of drinking water. Improved sources of drinking water are not a precise proxy for water quality based on technical characteristics. Extrapolations from a limited number of country studies (the Rapid Assessments of Drinking Water Quality or RADWQs[17]) indicate that a much larger group than the 663 million without access to improved sources at the end of the MDG period lacks access to safe drinking water. Worldwide, this group is estimated to number between 2 billion and 4 billion people (Onda *et al*. 2012). In 2014, a global assessment based on multi-level modelling, applied to 319 studies published between 1990 and 2013, estimated that 1.8 billion people use a faecally contaminated source of drinking water (Bain *et al*. 2014). For other parameters, such as reliability or affordability neither global targets nor global indicators existed during the MDG period. This is likely to change when the SDGs take effect. Similarly, collecting and analysing data through a human-rights-based approach will change our understanding of the global situation with respect to access to safe drinking water.

The national datasets used by the WHO/UNICEF Joint Monitoring Programme for Drinking Water Supply and Sanitation (JMP) originate from national bureaus of statistics and generally show important discrepancies in access to improved sources and facilities between different regions within a national territory, and important inequities when linking data on access to data on wealth status. The underlying causes, which are likely to include forms of discrimination, are not revealed by these datasets.

National datasets often show inconsistencies, depending on who is collecting the data, for what purpose and how parameters are defined and measured. The information provided by utilities, often aimed at maintaining an inventory of infrastructure to manage their assets may be hard to reconcile with the information derived from household surveys by national bureaus of statistics on access and use. Many countries do not have comprehensive drinking water quality information and if they do, it frequently is for specific types of provision. In low- and middle-income countries surveillance by regulators is generally confined to formal urban settings. Comparison of datasets from different countries is obstructed by differences in definitions or different interpretations of definitions for the indicators used.

Importantly, with few exceptions none of the monitoring and surveillance approaches include indicators for the basic human rights principles, equality and non-discrimination.

For countries to be held accountable in terms of progress towards the realisation of the HRWS, substantial strengthening of national monitoring and surveillance capacities will be needed, to enhance the scope and to ensure coherence and consistency in addressing all HRWS criteria. This will require a process of harmonisation of methods and procedures, and the monitoring of indicators for all drivers of inequality, not just economic status, to reveal the fundamental causes of inequalities and discrimination.

Providing access to safe and clean drinking water and basic sanitation has its roots in 19th century public health thinking. In the second half of the 20th century, perceptions expanded to consider water and sanitation as basic needs, and as engines for development. Economic analyses of investments in piped water supply and sanitation on the premise or in the home do point to public health benefits, but they predominantly highlight the gains from reducing the opportunity costs incurred by fetching water over great distances (Hutton *et al*. 2007). Yet, in a majority of countries the bottom line for WASH efforts, both in terms of targets and indicators, and as reflected by the regulatory and institutional frameworks

[17]http://www.wssinfo.org/documents/?tx_displaycontroller[type]=water_quality_reports.

Box A.1 The most recent facts on the burden of water-borne diseases

Recent estimates by the World Health Organization (Prüss-Ustün *et al*. 2014) of the burden of diarrhoeal diseases attributable to the lack of access to WASH services or to their poor quality show a significant decline over previous estimates. There is strong evidence that the number of deaths due to diarrhoeal diseases has dropped considerably since 2004 because of a combination of their improved management (especially the use of oral rehydration therapy) and expanded access to safe drinking water and basic sanitation. Earlier, WHO and UNICEF (WHO 2013) reported that diarrhoeal disease deaths of children under five declined by over 50% between 2000 and 2011—the latest estimate of under-five annual mortality is 645,000. These figures result from efforts to monitor progress towards MDG4 on reducing under-five mortality.

The analysis of exposure rates and pathways focused on low- and middle-income countries, where it was estimated that in 2012 502,000 diarrhoeal disease deaths were associated with inadequate drinking water and 280,000 with inadequate sanitation, out of a total of 1.50 million diarrhoeal diseases deaths that year. In addition, it was estimated that 297,000 deaths could have been prevented by the promotion of hand hygiene, although the statistical significance of this estimate is less robust.

Together, after statistical elaboration excluding double-counting associated with the overlap between the two attributable fractions, the number of deaths attributable to inadequate drinking water and sanitation in 2012 is estimated at 685,000. This figure does not include water-borne infectious diseases other than diarrhoeal diseases, other water-washed (i.e. sanitation associated), water-based or water-related vector-borne diseases, nor does it reflect the impact of environmental enteropathy and associated malnutrition caused by repeated or permanent water-associated intestinal infections. The analyses to arrive at an update of the total number of deaths attributable to poor drinking water, sanitation and hygiene are still ongoing. Estimates published by the WHO 2004 gave a number of 3.4 million deaths annually.

Broken down by region (and focusing on low- and middle-income countries only) it is clear that both in terms of annual mortality (number of deaths per year) and in terms of burden of disease (days of life lost due to premature death and days of healthy life lost, expressed as Disability-Adjusted Life Years or DALYs) Africa south of the Sahara continues to carry the greatest burden both in absolute and relative terms, followed by South and South-East Asia, and with the Eastern Mediterranean region in third place.

Sources: Prüss-Ustün *et al*. 2014.
WHO (2013).

for the management of drinking water supply and sanitation, remains the protection and promotion of public health. The most recent statistics produced by the WHO are presented in Box A.1.

Now, a new argument has been added to the imperative of providing universal coverage of drinking water and sanitation services. In 2010, the United Nations acknowledged access to safe drinking water and sanitation as a distinct right within the International Bill of Human Rights. This acknowledgement confirms this right to be derived from the right to an adequate standard of living and inextricable linked to the right to the highest attainable standard of physical and mental health, as well as to the right to life and human dignity.

To understand the significance of this development for governments and, in the particular context of this Manual, for drinking water and sanitation practitioners as defined in Chapter 1, this Annex contains an explanation of the human rights framework and the rights-based approach to development follows.

A.2 WHAT IS THE HUMAN RIGHTS FRAMEWORK?

The human rights framework emerged under the auspices of the United Nations in the wake of the Second World War with the adoption of the Universal Declaration of Human Rights in 1948. The treaties that are part of this framework are international, legally binding instruments to tackle inequality and discrimination. The universal and egalitarian human rights are divided into (1) civil and political rights and (2) economic, social and cultural rights, each governed by an internationally binding treaty known as a Covenant. The International Covenant on Economic, Social and Cultural Rights was drafted in 1954 and took effect in 1966. By 2013, it had over 160 parties: governments that either signed, or signed and ratified, the Covenant. It includes the right to an adequate standard of living, initially with an explicit reference to food, clothing and housing.

A process of negotiations, led by the UN Human Rights Council (formerly the UN Commission on Human Rights), aims at making the scope and focus of the rights under the Covenant more explicit. Through the adoption, in 2003, of General Comment 15 on the right to water, the Committee for Economic, Social and Cultural Rights re-interpreted the Covenant under its responsibility to include the right to water[18]. This position has now been re-affirmed by the adoption of Resolutions by the UN General Assembly and the UN Human Rights Council in 2010, which extended the formulation to include sanitation as well (see Box A.2).

Governments of UN Member States are the duty bearers when it comes to meeting the human rights obligations: to respect, protect and fulfil the rights. This does not necessarily imply the State's direct involvement in the actions required (in the case of water and sanitation: the provision of adequate

Box A.2 Excerpts from the UN resolutions on the human right to safe drinking-water and sanitation

UN General Assembly Resolution 64/292 (28 July 2010) "… *recognizes the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights.*" It recognises "… *the commitment of the Human Rights Council to water and sanitation*" and it re-iterates "… *the commitment of nations to halving, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation*", as one of the targets under the Millennium Development Goals.

Resolution A/HRC/RES/18/1 adopted by the UN Human Rights Council (28 September 2010) recalls the UN General Assembly Resolution, and affirms that "… *the human right to safe drinking water and sanitation is derived from the right to an adequate standard of living and inextricably related to the right to the highest attainable standard of physical and mental health, as well as the right to life and human dignity*", and re-affirms that "… *States have the primary responsibility to ensure the full realization of all human rights, and that the delegation of the delivery of safe drinking water and/or sanitation services to a third party does not exempt the State from its human rights obligations*".

Sources: http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/64/292 and http://www.ohchr.org/ENG/Issues/WaterAndSanitation/SRWater/Pages/Resolutions.aspx.

[18]Committee on Economic, Social and Cultural Rights, General Comment 15, The right to water (Twenty-ninth session, 2003), UN Doc. E/C.12/2002/11 (2002), reprinted in Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, UN Doc. HRI/GEN/1/Rev.6 at 105 (2003).

services); rather, governments should create the conditions that enable a range of actors to make their contribution to the full realisation of the rights. This includes the creation of a national legal framework, the establishment of an institution or institutional arrangements to coordinate and monitor human rights actions, public awareness campaigns explaining the nature and boundaries of the human rights to the rights holders and the stimulation of additional education and training curricula aimed at preparing water and sanitation professionals to integrate the human rights criteria and principles into their daily routine.

In this context, the role of those providing or regulating drinking water and sanitation services can cover multiple objectives:

- actions to ensure that the criteria and principles of the human rights to water and sanitation are effectively addressed;
- monitoring and surveillance of the impact of these actions, in particular on the reduction of inequalities and discrimination; and
- assessment of proposed elements of human-rights-based policies, legislation and regulation, so that feed-back to the authorities helps maximise the intended impact on human rights criteria and principles, with due consideration of hurdles and obstacles to the day-to-day delivery of services that may be created inadvertently.

Human rights are a corner stone for public policy, and increasingly the economic, social and cultural rights are considered as important as the civil and political rights. Poverty generally goes hand in hand with inequality and discrimination. Human rights are increasingly influencing policies for international cooperation and development, including through the so-called rights-based approach to development. While adding legal and moral arguments to development assistance, human rights also raise the issue of resource constraints on recipient governments to fully respect, protect and fulfil the rights in accordance with their obligations.

Clearly, in adopting an approach that fully embraces the principles underpinning the human rights to safe drinking water and sanitation, service providers similarly will need to consider the resource implications. They will need to include a new set of criteria in their decision-making processes for resource allocations. Their role in promoting the human-rights-based approach in partnership is dual: the already mentioned assessment of and advice on policies, legislation and regulation proposed by national and local authorities, as well as the effective information of their customers, the rights holders, about the nature, scope and contents of their rights in the context of the framework.

A.3 A BRIEF OVERVIEW OF EVENTS LEADING TO THE ADOPTION OF THE UN RESOLUTIONS IN 2010

The main landmark events leading to the UN resolutions acknowledging the rights to safe drinking water and sanitation have been mentioned in the previous section. For a better understanding of the rationale behind this process, the timing of events and the current implications of these resolutions, it is useful to provide a slightly more detailed historical perspective.

The human rights to water and sanitation were not explicitly included in the original Covenant on Economic, Social and Cultural Rights, negotiated in the 1950s and 1960s, and adopted in 1966. A new awareness of the potential threats to the supply of safe drinking water and the contribution of poor sanitation to diminishing quantities of good-quality water, led to decision by the United Nations to declare the 1980s as the International Decade of Drinking Water Supply and Sanitation, with an aspirational goal of achieving universal coverage by 1990. While the 1977 Mar del Plata Conference referred to the need

to establish the right to water, no relevant indicators were included in Decade monitoring. Several mindset shifts took place during the Decade, paving the way for the recognition of safe drinking water and sanitation as a human right 20 years later:

- a shift in focus from purely infrastructure-centred understanding of the challenges faced, to a comprehensive economic, social, institutional and governance perspective;
- a shift in thinking about water and sanitation as a sectoral public health issue to a cross-sectoral development issue with multiple dimensions;
- a shift in the perception of drinking water and sanitation from one of two inextricably linked issues, to a recognition that they are issues in their own right sharing certain determinants and impacts. Amalgamating drinking water and sanitation ultimately has been to the detriment of sanitation, as underscored by the fact that sanitation was not even considered in the initial formulation of the MDG targets, nor in the early attempts to formalise the human right to water.

With the world population meanwhile expanded to over 6 billion at the turn of the millennium, the first concrete step towards acknowledging safe drinking water and sanitation as a human right was the adoption, in 2003, by the Committee for Economic, Social and Cultural Rights (CESCR) of General Comment 15 on the "right to water". The CESCR is the treaty body responsible for monitoring State compliance with the International Covenant. Its General Comments are authoritative interpretations of the Covenant. General Comment 15 states that the "right to water" is implicit in Article 11 of the Covenant, which confirms the right to an adequate standard of living. Sanitation was considered as part of the "right to water" in the 2006 UN Draft Guidelines on the "right to drinking water and sanitation". In 2010 the CESCR re-affirmed the inclusion of sanitation in this interpretation and established the links to the rights to adequate housing, to health and to life. This was rapidly succeeded by the adoption of the UN resolutions in the same year, achieving unequivocal recognition of the rights to safe drinking water and sanitation by the UN Member States.

A.4 PROGRESSIVE REALISATION AND ITS IMPLICATIONS

The term "progressive realisation" refers to the principle that States, as the duty bearers, are required to act to the best of their abilities and capacity to maximize progress towards a situation where their entire population enjoys human rights without inequalities or discrimination. It is included in Article 2 of the International Covenant on Economic, Social and Cultural Rights which puts the duty on each party "… to take steps […] to the maximum of its available resources, with a view to progressively achieve the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures".

In the context of the HRWS, this concept acknowledges that the ultimate goal of universal coverage cannot be attained overnight. Yet, States have the obligation to demonstrate tangible progress on all criteria and principles. Progressive realisation rules out deliberately regressive measures (such as those that may be considered under an austerity scheme at times of financial or economic crisis) that impede the gradual extension of the right to all, in particular those that contribute to a further deepening of inequalities. When resource constraints seriously limit the capacity of a State, special measures may be needed to provide, at least, minimum essential levels in the provision of safe drinking water and sanitation, such as programmes targeted at the most vulnerable or at those subject to discrimination.

In her 2013 report to the Human Rights Council, the UN Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation links the principles of progressive realisation and non-retrogression to the sustainability of the extension and improvements in service delivery (see Chapter 3). The explicit

incorporation of human rights targets, standards and norms into drinking water and sanitation policies will be an effective buffer against retrogression at times of crises (Albuquerque 2013).

Interestingly, guidance on some critical drinking water parameters, such as drinking water quality, has evolved along the principle of progressive realisation, even if the term as such is not used. The WHO Guidelines for Drinking Water Quality (WHO 2011a) have adopted an integrated risk assessment and management approach which allows individual WHO Member States to adopt politically and socially acceptable health-based targets (see Box A.3) in an incremental way.

A.5 DEMYSTIFYING HUMAN RIGHTS TO SAFE DRINKING WATER AND SANITATION

In spite of a powerful communications campaign by the first UN Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation, Catarina de Albuquerque, several misconceptions and misunderstandings continue around the questions of what the rights imply and what they do not imply.

The fundamental concept of progressive realisation has been explained in the previous sub-section. Other questions frequently arising include the following.

In the context of the HRWS, do States have to provide water and sanitation services to their population free of charge?
No, the HRWS does not imply the free provision of water and sanitation services. The formulation of the rights refers to affordability, meaning that people should contribute reasonably within their means, financially or in kind. For those whose rights are jeopardised by their inability to contribute, governments should create facilitating arrangements. Contributions in return for water and sanitation services should not be at the expense of the enjoyment of other rights (i.e. affordability is relative to the capacity to purchase other essential goods and services under the broad human rights umbrella).

Does the HRWS exclude private service provision?
No, the human rights framework does not prescribe any particular organisational model of service provision. States, as the duty bearers, must ensure access for all, and must put in place an adequate regulatory framework, including effective monitoring, surveillance and complaint procedures, that prevents public and private actors from committing human rights violations.

Is there a hierarchical relationship between the right to water and the right to sanitation?
No, the human rights to safe drinking water and to sanitation hold equal status. The recent (2015) adoption of the UN General Assembly Resolution recognizing the two rights as separate but inter-connected re-affirms this: access to safe and to affordable drinking water and sanitation are crucial for the quality of life, for health and for dignity. The lack of adequate sanitation is a major cause of contamination of drinking water sources. A reduction in the burden of water-borne and water-washed diseases requires action to improve both drinking water and sanitation services. Water is not necessarily an element of an effective sanitation system, but safe water is essential for domestic purposes including drinking, cooking, washing and hygiene.

Is everyone – even those living in remote areas – entitled to piped water and a flush toilet connected to a sewerage network?
No, States have to ensure that services comply with the human rights criteria and principles, but it is recognised that the technologies used in the delivery of water and sanitation are contextual. States

Box A.3 Water Safety Plans

The WHO Guidelines for Drinking Water Quality are based on the concept of integrated risk assessment and management along the entire chain of events from collecting water for consumption from a source to its delivery to the consumer. This concept is made operational through water safety plans (WSPs). The primary objectives of a WSP in ensuring good drinking water supply practice are the prevention or minimisation of contamination of source waters, the reduction or removal of contaminants through treatment processes and the prevention of contamination during storage, distribution and handling of drinking water. These objectives are equally applicable to large piped drinking water supplies, small community supplies and household systems. A WSP has three components guided by health-based targets:

(1) a *system assessment* to determine whether the drinking-water supply chain (up to the point of consumption) as a whole can deliver water of a quality that meets identified targets. This also includes the assessment of design criteria of new systems;
(2) appropriate means of *operational monitoring* for each of the control measures identified as part of a collective and incremental risk management package, to ensure that any deviation from required performance is detected in a timely manner;
(3) *management and communication plans* describing actions to be taken during normal operation or at times of incident conditions, and documenting the system assessment at all stages, for all aspects and under all conditions.

This risk assessment and management approach aims to meet health-based targets, a subjective measure determined by the burden of local water-related diseases, by the local capabilities and capacity to prevent and/or control them, and by the social/political acceptability of threshold options for disease incidence. Similar to the HRWS, practitioners are expected to ensure gradual progress towards higher standards and better practices linked to lower acceptable risks to health. Establishing health-based targets requires (and, hence, stimulates) effective collaboration between water practitioners and public health professionals. In the absence of agreed health-based targets, practitioners, at a minimum, should seek to establish basic microbiological, chemical and physical parameters that indicate the quality of water in relation to risks to public health.

Linked to these targets, they should develop corresponding water quality standards and best practice rules that befit the prevalent socioeconomic reality. The globally recommended guideline values for (micro)-biological, chemical and physical contaminants and pollutants remain in place as the ultimate goal. The attainment of that goal is an incremental process in which governments upgrade the health-based targets, standards, norms and procedures in line with their socioeconomic development. The instrument for implementing this process is the water safety plan.

Source: WHO 2011a.

therefore have a margin of discretion to promote measures and ensure appropriate services most suited to local circumstances.

Is 20 litres of safe and clean drinking water sufficient for the full realisation of the right to water?
No, 20 litres per person per day is not sufficient to remove health risks associated with a lack of adequate access to water. Full realisation of the right requires at least 50–100 litres per person per day (see Table 3.1; WHO 2003).