

## Editorial

### Limited services? The role of shared sanitation in the 2030 Agenda for Sustainable Development

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#### ABSTRACT

Target 6.2 of the Sustainable Development Goals calls for universal access to sanitation by 2030. The associated indicator is the population using 'safely managed' sanitation services. Shared sanitation is classified as a 'limited' sanitation service and some donors and governments are reluctant to invest in it, as it will not count towards achieving Target 6.2. This could result in poor citizens in dense slums being left out of any sanitation improvements, while efforts are diverted towards better-off areas where achieving 'safely managed' sanitation is easier. There are sound reasons for labelling shared sanitation as 'limited' service, the most important being that it is extremely difficult – for global monitoring purposes – to differentiate between shared toilets that are hygienic, accessible and safe, and the more common ones which are poorly designed and managed. There is no reason to stop investing in shared sanitation. 'Safely managed' represents a standard countries should aspire to. However, the 2030 Agenda and the human rights recognise the need for intermediate steps and for reducing inequalities. This calls for prioritising investments in high-quality shared toilets in dense informal settlements where it is the only viable option (short of rehousing) for improving sanitation services.

**Key words** | limited services, shared sanitation, Sustainable Development Goals

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#### INTRODUCTION

Target 6.2 of the Sustainable Development Goals (SDGs) calls for universal access to sanitation by 2030, with the associated indicator being the 'proportion of the population using safely managed sanitation services'. The WHO/UNICEF Joint Monitoring Programme (JMP) classifies

shared sanitation as a 'limited' sanitation service, below both the 'basic' and 'safely managed' service levels.

Shared sanitation facilities include: (a) *shared household toilets* (toilet in one household also used by other households); (b) *compound toilets* (toilets used only by the people living in a particular compound); (c) *community toilets* (non-household toilets used by a restricted group of households); and (d) *public toilets* (open to anybody). This is a simple typology to help frame the issue, but in practice shared toilets vary along multiple dimensions including user group size, user group restrictions, distance from

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dwelling, ownership, payment model (if any), and operation and maintenance arrangements.

In part, the JMP classification of shared sanitation as a limited service reflects a longstanding concern that such facilities are often poorly maintained and become unhygienic: as a result, instead of protecting people from contact with excreta, they may even become a focus of infection. Another common concern is that shared toilets are rarely designed and managed in a way that ensures accessibility, safety and dignity for all users, particularly women and girls.

However, not all shared toilets are poorly maintained, unhygienic and unsafe. And for millions of people living in densely populated urban areas, especially informal settlements, shared sanitation is the only alternative to open defecation, which has much more serious consequences for health, safety and dignity. In the Ghanaian capital Accra, for example, 75% of families living in the growing slums depend on shared toilets. Many slum dwellers in Accra and elsewhere live in tiny single-room dwellings within which there is insufficient space for a toilet. In such conditions, high-quality shared toilets are the *only* viable option (short of rehousing) for improving sanitation services. Even if there is physical space for a small toilet (for example a container-based toilet), few people would find it culturally acceptable to defecate in the family living/sleeping space.

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## WHY WAS SHARED SANITATION NOT INCLUDED UNDER 'BASIC SANITATION'?

The 2030 Agenda for Sustainable Development, which sets out 17 SDGs and 169 targets, was adopted by the UN Member States in 2015. During development of the Agenda, the JMP convened expert Task Teams to advise on the formulation of targets and indicators for global monitoring of drinking water, sanitation and hygiene. After extensive consultations, the Sanitation Task Team made ambitious recommendations for monitoring open defecation and access to 'basic' and 'safely managed' sanitation services.

During the 2015 Millennium Development Goals period, shared sanitation had been excluded from the indicator for monitoring sanitation ('use of improved

sanitation facilities'), which had caused some controversy. The Sanitation Task Team therefore recommended that the JMP adopt a benchmark which would consider households using facilities shared by no more than five families and no more than 30 people (taken as a proxy for adequate management) as having access to 'basic' sanitation. Despite limited evidence on the impact of shared toilets, the Team believed there was a compelling case for encouraging countries to consider limited sharing as a step in the progressive realisation of the human right to sanitation.

However, the JMP finally decided not to include shared facilities in the normative definition of 'basic' or 'safely managed' sanitation. The main reason was that, in large-scale national and global monitoring processes, it is extremely difficult to differentiate between shared facilities that are poorly designed and managed, and shared facilities that are hygienic, accessible and safe. First, most censuses and national household surveys do not ask whether facilities are shared: in 2015, only 85 countries had information on the number of households sharing sanitation facilities. Second, there is very little evidence on the relationship between the number of households sharing facilities and their hygiene, accessibility and safety, making it difficult to find an adequate proxy indicator. Given this lack of data and evidence, the JMP decided it would classify improved facilities which are shared with other households as a 'limited' sanitation service.

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## IS THIS A PROBLEM?

Having goals and targets for specific interventions can be a powerful incentive driving investment. For example, SDG Target 6.2 (calling for safely managed sanitation) seems to be leading to increased funding for faecal sludge management in urban areas.

Conversely, there is a risk that excluding shared sanitation from the SDG core indicators becomes a disincentive for funding and other support. This is already happening in some countries, where external donors and government agencies are reluctant to invest in slum sanitation, as this would involve improving existing shared facilities or building new shared toilets, which do not count towards the provision of 'basic' or 'safely managed'

sanitation. They prefer to focus on better-off areas instead, where achieving those service levels is more feasible. This is clearly not a good outcome.

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## SO WHAT IS THE SOLUTION?

Governments, donors and development partners should support investment in high-quality shared sanitation in areas where it is the most appropriate solution, notably where people live in dwellings that are too small for a private toilet. Investments need to focus both on extending access through new high-quality shared sanitation facilities, and on improving the quality and management of existing ones.

The JMP reports on global indicators, enabling countries to compare progress over time. Core indicator 6.2.1, by measuring the population using safely managed sanitation services, sets a standard that all countries should aspire to, but does *not* require that countries get there immediately or focus solely on that service level. The SDG framework, in line with the principle of reducing inequalities and the progressive realisation of the human right to sanitation, recognises that intermediate steps will be needed along the way. Governments need to strike an appropriate balance between extending access to unserved populations and progressively improving service levels. They should therefore set ambitious but realistic targets, based on their own strategies and specific situations, and focusing on the most vulnerable. As a first step, this will likely mean prioritising service levels below 'safely managed', including shared sanitation in dense informal settlements.

Governments, donors and development partners should strive to find criteria to characterise 'high-quality

shared sanitation', and set up realistic monitoring protocols. Research is needed to build the evidence around these criteria (of design, use, ownership management ...) and help distinguish high-quality toilets from unacceptable ones. Such criteria may include location close to the dwelling, good lighting, and use by a restricted group of people (public toilets would not be considered an acceptable residential sanitation solution). These characteristics favour cleanliness, maintenance, and safety of women and children. Increased clarity around the definition of 'high-quality shared sanitation' would enable it to be incorporated into financing agreements and monitoring protocols.

In parallel, longer-term strategies are needed to address the root causes of the dire situation faced by slum communities, including land tenure issues, legal insecurity, lack of decent affordable housing, poverty and inequalities. These strategies will need to integrate sanitation as part of a comprehensive effort to ensure universal access to adequate, safe and affordable housing and basic services for all, aligning with SDG 11 to make cities inclusive, safe, resilient and sustainable.

As this will take many decades, in the meantime governments and donors must recognise the urgent needs of slum communities and invest in high-quality shared sanitation.

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