Improving sanitation access with subsidies, loans, and community-led programs

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Programs involving community behavior-change campaigns and subsidies to boost toilet construction can improve people's access to and use of improved sanitation facilities. However, evidence on the downstream health impacts of common sanitation programs in low- and middle-income countries has been mixed.

Community toilet in India.

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Résumé

As of 2022, 419 million people defecated in the open (in fields, forests, bodies of water, or other spaces), and 545 million people defecated in facilities that did not adequately separate waste from human contact (e.g., pit toilets without a slab, bucket latrines).[36], [1], Defecation in the open or in unsanitary facilities poses serious risks to public health, both by spreading disease through direct human contact with feces and by contaminating water. These unsanitary conditions contribute to the global burden of diseases and can limit children's physical and cognitive growth[39], . The United Nations Sustainable Development Goals (SDG #6) calls for ending open defecation by 2030. Many governments have attempted to reduce open defecation by encouraging the building and use of flush or pit toilets that separate feces from contact with people and drinking water.[10]

However, several barriers affect the construction and use of improved facilities. Households may find the cost of building an improved sanitation facility prohibitively high or lack access to the relevant materials or know-how to build them, while difficulty maintaining toilets can make them unappealing to use. They may also be unaware of the health risks of unsanitary defecation, or

social norms could limit their demand for improved sanitation facilities.

To understand the effectiveness of efforts over the past twenty years to overcome these barriers, J-PAL reviewed 27 randomized evaluations from fourteen countries that measured the impact of awareness programs, subsidies, and loans for sanitation purposes. Common programs provided communities with nudges and informational workshops to highlight the benefits of toilet usage along with financial subsidies to help households build toilets. There were three overarching findings. First, most sanitation interventions improved access to toilets. While many programs also boosted toilet usage, the relationship between increased access and usage was not one-to-one. Second, programs that provided subsidies or other support to build toilets were most successful at boosting household toilet ownership and usage. However, they rarely improved health outcomes like diarrhea, parasitic infection, or child growth, even when they increased toilet access and usage. Programs often fell far short of universal toilet coverage or usage, which may be necessary to realize health benefits from improved sanitation.

Nevertheless, sanitation information, subsidy, and loan programs can help reduce open defecation by increasing the use of improved toilets while governments continue pursuing more comprehensive piped sanitation systems, which have greater potential to minimize the spread of disease.

*Read on and listen to the **VoxDev podcast**, featuring Karen Macours (J-PAL Health sector Co-Chair) to learn more.*

Résultats

Information campaigns can increase both people's access to and ownership of toilets. Information campaigns often involve a technique called Community-Led Total Sanitation (CLTS). CLTS programs aim to help community members understand the negative consequences of open defecation and enact solutions to reduce open defecation rates.[11], Facilitators often describe how fecal contamination can spread from waste to food and drinking water and walk community members through their village to identify areas of poor sanitation. Community members can often then set up community planning sessions to discuss ways to decrease open defecation.[11], The exact structure of CLTS activities can differ in intensity and scale (one review of CLTS programs in Ghana and Ethiopia found they cost between $14 and $82 per household[15]).

CLTS-only programs were largely successful in boosting household access to and ownership of toilets but to different degrees. Five [32], [11], [21], [8], [1], of six studies that evaluated CLTS-only programs[32], [11], [21], [8], [1], [19], found that they increased toilet coverage.[3], A CLTS-only program with frequent facilitator follow-ups in Mali almost doubled household access to private toilets (65 percent versus 35 percent in the comparison group)[32], , while households in Indonesian villages where a CLTS program was scaled up saw smaller gains and increased toilet construction by 2.4 percentage points[11], . By contrast, in Bangladesh, a CLTS-only intervention showed no impact on toilet access[19], . Program intensity, the existing sanitation situation, and other contextual factors likely drove these different levels of impact.[4], [1], For example, an evaluation in Nigeria found that CLTS increased toilet ownership by 10 percentage points in low-income areas but had no impact on ownership in high-income areas.[1]

Programs that reduced the cost of building toilets had more consistent impacts on access to and ownership of toilets, though subsidies often had to be large to be effective. Twelve evaluations reviewed here[5], [19], [29], [12], [13], [28], [20], [25], [26], [22], [30], [16], examined the effect of fully or partially offsetting the cost of building or maintaining a toilet, for example, through subsidies or providing materials, alongside toilet promotion campaigns. All twelve programs increased toilet coverage. In Bangladesh, for example, households living in villages with CLTS that also ran a lottery for 75-percent-off subsidy vouchers increased their toilet access by 7.3 percentage points, while CLTS programming alone had no effect.[4], [19], In the Indian state of Odisha, toilet coverage among households receiving a combined subsidy and toilet promotion program increased by 51

percentage points relative to the comparison group (63 percent compared to 12 percent), while coverage of functional latrines increased by less (28 percentage point increase, or 38 percent compared to 10 percent).[5], [13], While construction subsidy programs helped households to build toilets, making sure they continued functioning over time often proved challenging, suggesting that strategies to help households maintain toilets are also critical.[27], [35]

Subsidies for toilet *maintenance* can help households address the challenge of keeping toilets functioning. This may involve manually emptying waste pits, which directly exposes individuals to fecal matter and raises the possibility of contamination and disease. In Senegal, urban households received a subsidy worth 32 percent of the cost of emptying waste pits with a vacuum truck (a $16 subsidy for a $50 service), as opposed to manually desludging the pit with a shovel. Households receiving the subsidy increased mechanical desludging by 2.6 percentage points (34.1 percent mechanical desludging in the program group compared to 31.5 percent in the comparison group).[24]

Beyond direct subsidies, other financial interventions like offering microloans can also increase toilet ownership. In the Indian state of Maharashtra, households who were offered a low interest rate loan that was marketed as being for sanitation were 9 percentage points more likely to own a toilet two-and-a-half years later (50 percent compared to 41 percent in the comparison group).[5], In Cambodia, households offered small loans to purchase toilets at an unsubsidized cost of $40 increased toilet purchase rates by 33.8 percentage points. However, less than 40 percent of households who purchased toilets installed them. These low installation rates might have been caused by households' preference for more advanced (and expensive) toilet room designs with a roof and walls, causing them to postpone their toilet installation.[7], People's low willingness to pay market prices for toilet supplies, vendors' limited marketing activities, and intra-household gender dynamics can also affect the impact of offering loans for sanitation purposes.[31], [5]

Social interactions like social pressure, reciprocity, and learning from peers, as well as people realizing there are health benefits when other people use improved sanitation, can influence how people respond to sanitation programs. In Bangladesh, households who received vouchers covering half the cost of a toilet and its installation were 7.2 percentage points more likely to actually buy a toilet when half of their neighbors also received the vouchers, compared to when only 25 percent of their neighbors received them.[19], On the other hand, households in Cambodia who had more neighbors purchase a toilet were less likely to install a toilet of their own.[7], In this context, many households shared toilets or reported co-owning a toilet with their neighbors. As a result, a neighbor's decision to install a toilet may have decreased the incentives for a household to install their own.[7]

Interventions that increased toilet access consistently increased toilet usage and reduced open defecation, though the strength of the relationships varied by context. In the Indian state of Madhya Pradesh, households who received subsidies for toilet construction through a version of India's Total Sanitation Campaign were 17.7 percentage points (40.3 percent, relative to 22.6 percent in the comparison group) more likely to own an improved toilet.[28], Further, adult open defecation rates decreased by about 9 percentage points (about 75 percent open defecation among adults receiving the program, relative to about 84 percent in the comparison group).[28], On the other hand, a CLTS intervention in Tanzania increased household use of improved toilets by 15.1 percentage points, a rate higher than that by which household toilet ownership increased (8.2 percentage points).[8]

The extent to which households participating in CLTS programs increase toilet usage may depend on the intensity of the program and the presence of follow-up activities. Some CLTS programs only included an initial visit from a facilitator, after which community members were expected to take over leadership of the program. Programs from Mali and Pakistan that increased toilet usage in specific populations featured facilitators who frequently followed up with community members, and researchers hypothesized that this continued engagement was a factor in these programs' overall effectiveness.[10], In Pakistan, for example, households in communities with low-quality public infrastructure who received follow-up reminders were 26

percentage points less likely to openly defecate (versus 64 percent in the comparison group) and 26 percentage points more likely to use a functional toilet in their home (versus 44 percent in the comparison group) than those who did not receive follow-up reminders.[4] However, more intense CLTS programs require more follow-up visits by facilitators, which drives up their costs.

Sanitation programs—whether involving CLTS or subsidies—had mixed impacts on people's health outcomes, even when they meaningfully increased toilet access and usage. Eight[3], [33], [32], [13], [28], [26], [8], [22], of eleven studies examining the impact of sanitation programs on diarrhea rates[3], [33], [32], [13], [28], [26], [8], [22], [25], [20], [17], found no impact on diarrhea rates.[6], Further, all three of the studies that found reduced open defecation rates and also studied impacts on diarrhea rates found no reduction in diarrhea.[28], [8], [22], In Kenya, for example, 78 percent of participants in a program that upgraded household toilets and promoted toilet use had access to improved sanitation facilities after the program (compared to 20 percent with access to improved toilets in the comparison group), but this increase had no impact on diarrhea rates.[26]

Similarly, sanitation-only interventions increased child height-for-age in two[32], [20], out of the ten studies where it was measured.[32], [20], [33], [11], [13], [28], [25], [26], [22], [8], Stunted growth can be caused by many factors, including nutritional deficits, so improved sanitation might not decrease stunting unless other barriers are also lifted.[25], For example, in Bangladesh and Kenya, providing nutritional supplements and counseling alone or alongside water, sanitation, and hygiene programming meaningfully increased children's height, while providing sanitation programming alone did not.[25], [26], In contrast, an intensive CLTS program in Mali reduced stunting rates by 6 percentage points.[32]

Although sanitation programs have inconsistent—and often limited—impacts on health outcomes, interventions that increase overall household toilet usage to sufficiently high levels may still yield bigger health impacts. Because diarrhea-causing pathogens can still spread if open defecation rates remain relatively high, sanitation programs may not affect health outcomes if communities do not reach this toilet usage threshold.[7], [23]

Until piped sanitation systems are feasible in a given context, policymakers can build on existing evidence showing that reducing financial barriers to toilet construction and intensively improving information can be effective at increasing toilet usage, while continuing to work with researchers to identify and test effective ways to sustainably increase coverage and usage of improved sanitation facilities and improve related health outcomes. In addition, as sanitation programs may also positively impact other outcomes like mental health, quality of life, and children's cognitive development[34], [39], more research is needed to test impacts on a wider set of outcomes to understand the full potential returns to sanitary interventions.

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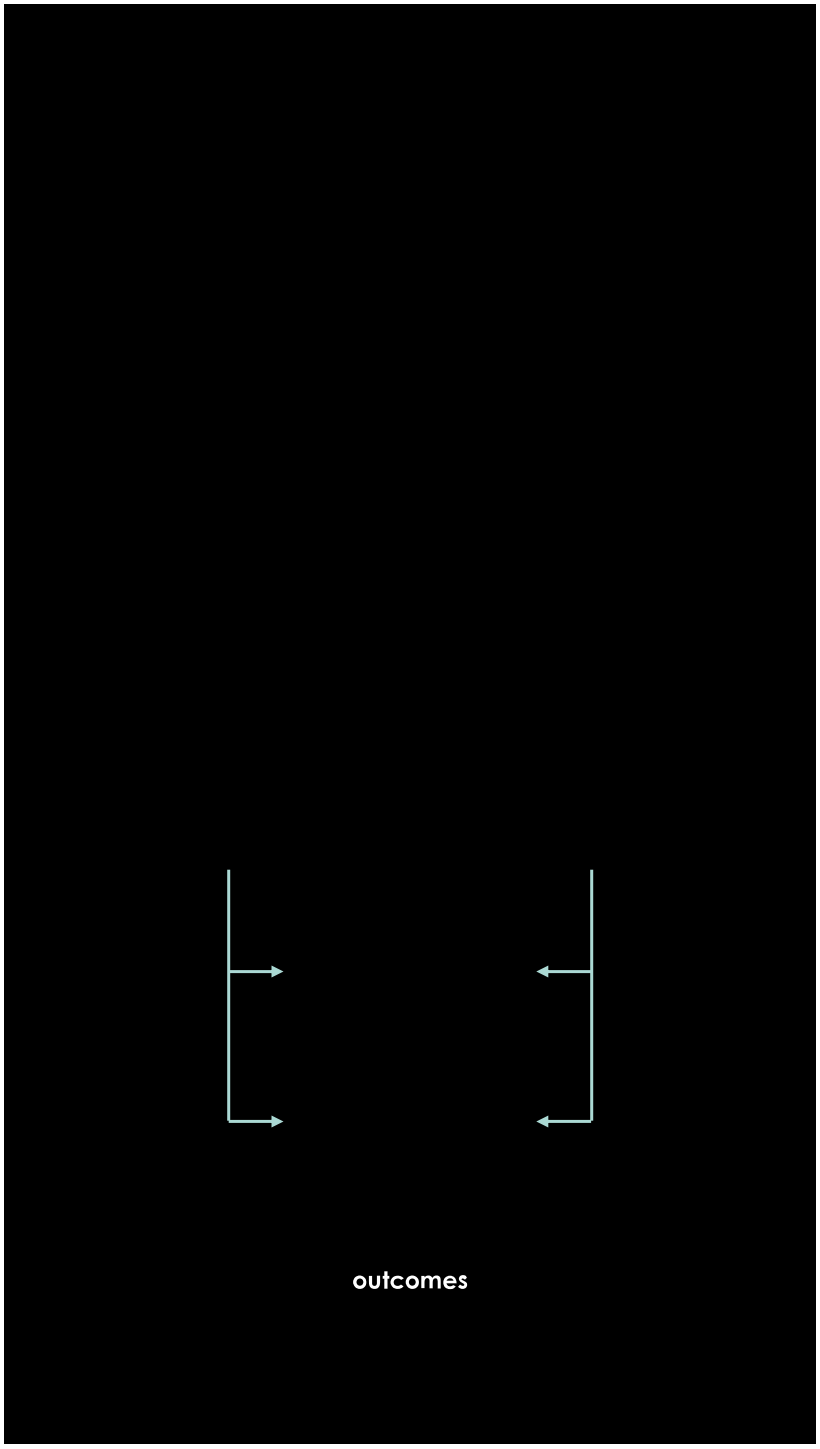
Figure 1. Theory of Change: Sanitation



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1. WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene 2023 report. Improved facilities include flush/pour flush toilets connected to piped sewer systems, septic tanks, or pit latrines; pit latrines with slabs (including ventilated pit latrines); and composting toilets. Unimproved facilities are defined as pit latrines without a slab or platform, hanging latrines, or bucket latrines that do not separate waste from human contact.

2. Jennyfer Wolf et al., 2023, "Burden of Disease Attributable to Unsafe Drinking Water, Sanitation, and Hygiene in Domestic Settings: A Global Analysis for Selected Adverse Health Outcomes," *The Lancet* 401, no. 10393: 2060–2071, https://doi.org/10.1016/s0140-6736(23)00458-0.

3. One study reviewed here mixed CLTS with a training program for local masons to build and market toilets in Tanzania and improved toilet coverage. See Bertha Briceño et al., 2017, "Are There Synergies from Combining Hygiene and Sanitation Promotion Campaigns: Evidence from a Large-Scale Cluster-Randomized Trial in Rural Tanzania," *PLOS One* 12, no. 11: e0186228, https://doi.org/10.1371/journal.pone.0186228.

4. In addition to examining the effect of CLTS and subsidies, this study also examined whether making it easier to build a toilet without offering explicit financial support affected toilet ownership. Villagers who were linked with toilet suppliers and given more information about toilet quality and availability did not increase their hygienic toilet ownership. See Raymond Guiteras et al., 2015, "Encouraging Sanitation Investment in the Developing World: A Cluster-Randomized Trial," *Science* 348, no. 6237: 903–906, https://doi.org/10.1126/science.aaa0491.

5. Functionality was defined as having a roof, not being used for storage, with a complete pit, etc.

6. The mixed evidence on sanitation programs' effect on health outcomes may partly result from challenges with measuring the direct impact of sanitation programs on outcomes like diarrhea rates. Diarrhea rates are often self- or caregiver-reported, and recall error, misperceptions, or other reporting biases may induce substantial measurement error, possibly leading to biased estimates. More research featuring objective measures (e.g., laboratory validated) of fecal contamination is therefore necessary. See Joe Brown and Oliver Cumming, 2020, "Stool-Based Pathogen Detection Offers Advantages as an Outcome Measure for Water, Sanitation, and Hygiene Trials," *American Journal of Tropical Medicine and Hygiene* 102, no. 2: 260–261, https://doi.org/10.4269/ajtmh.19-0639.

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