

Role of Gender on Community Led Total Sanitation Processes in Kanyingombe Community Health Unit, Rongo Sub County, Kenya

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Abstract

Purpose: To establish the role of gender integration in Community Led Total Sanitation processes in Kanyingombe Community Health Unit in Rongo Sub county, Kenya.

Design: A cross-sectional descriptive survey design.

Results: The study revealed that 57.0% of the households did not participate in Community Led Total Sanitation (CLTS) processes. More so men (81.4%) dominated in decision making regarding sanitation issues as majority (76.16%) of the Community Led Total Sanitation processes meetings were attended by women. The study concludes that effective CLTS processes implementation and sustainability of Open Defecation Free (ODF) villages can be brought about by effective and adequate involvement and participation of gender in Community Led Total Sanitation processes.

Key words: Community Led Total Sanitation: Decision making: Gender: Involvement: Open Defecation Free: Participation: Processes: Role.

1.0 Introduction

Gender describes the characteristics that a society or culture delineates as a masculine or feminine. While sex as a male or female is a biological fact that is the same in any culture, what that sex means in terms of gender role as a man or woman in society can be different cross culturally. These gender roles have an impact on health of the individual. In sociological terms gender role refers to the characteristics and behaviours that different cultures attributes to the sexes. What it means to be a real man in any culture requires male sex plus what our culture defines as masculine characteristics and behavior, like wise a real woman in any culture requires female sex plus what our culture defines as feminine characteristics and behavior (Kamal, 2011).

Community-Led Total Sanitation (CLTS) is an innovative and integral approach that empowers communities to realize the detrimental effects of Open Defecation (OD). CLTS supports communities in eliminating OD and constructing latrines to attain Open Defecation Free (ODF) status. Total sanitation includes stopping all open defecation; ensuring that everyone uses a hygienic latrine; washing hands with soap after using the latrine, when preparing food and eating, and after contact with faeces. Although CLTS has succeeded in making many communities ODF, the approach has been criticized for not explicitly focusing on gender mainstreaming as CLTS projects are often designed without gender considerations. CLTS facilitators do not often ensure gender balance while facilitating triggering sessions, thus compromising the equal participation of men and women. By not explicitly focusing on gender relations, CLTS processes are more likely to overburden women, rather than making them agents of change (Kamal, 2010).

(Azadegan, 2015), states that there is a global consensus on the importance of addressing gender in development. Yet this is often neglected when it comes to field project design and implementation. Gender equality and the empowerment of women are human rights that lie at the heart of development. When women and men have relative equality, economies grow faster, children's health improves and there is less corruption. Gender equality helps reduce the root causes of poverty and vulnerability while contributing to sustainable growth and the achievement of the Millennium Development Goals (MDGs).

Integrating a gender perspective into the sanitation sector does not only require addressing differences in gender relations, it also means uncovering and challenging uneven hierarchical structures based on gender. Consequently, a gender-sensitive approach seeks to equalize the uneven distribution of sanitation roles and responsibilities and the access to safe and appropriate facilities by considering the basic needs of all men, women and children (UNICEF, 2010)

In many societies, women's views, in contrast to those of men, continue to be systematically under-represented in decision-making bodies. This lack of a participatory approach is closely related to the uneven power structures in decision-making processes that characterize these societies and the sanitation sector in particular. Where sincere efforts have been made to integrate gender perspectives into the water and sanitation sector, these have unfortunately often failed to address strategic gender needs (Belew, 2010)

(Bell, 2010) ,Nepal reiterates that CLTS has recognized the importance of women in creating sustainable sanitation and hygiene services. However, it is essential to take gender considerations on board in CLTS projects in order to avoid overburdening women. A conscious and systematic way of integrating gender equality and women's empowerment as in the Pan-Africa programme gives better results. Over time men and women will be working, discussing and cooperating on CLTS at an equal level. This way, women can assert their rights and improve their social position, obtaining gender transformative results in the process.

Faris and Rosenbaum (2011,Ethiopia) established that one of the most significant divides between women and men, especially in developing countries, is found in the sanitation and hygiene sector. The provision of

water, hygiene and sanitation is often considered a woman's task. Women are promoters, educators and leaders of home and community based sanitation practices yet their own concerns are rarely addressed.

Mahbub A. (2009), in Bangladesh found out that women do not necessarily play a leading role in toilet construction, rather, village Development Committee members do and they are dominated by men from elite groups. According to Curtis et al. (2004), women are more strongly moved by emotions of shame and disgust than men, and disgust sensitivity tends to decline with age. These notions are supported by findings from the PLAN Bangladesh case study, which points to adolescent girls as being among the most enthusiastic promoters of improved sanitation (Mehta 2010).

Mehta (2009) India found out that Participation of women in CLTS processes and improved well being for women as a result of better sanitation do not equal empowerment. While it is true that there are extraordinary benefits to be derived for women in terms of their dignity, privacy, safety, comfort and wellbeing, it is not always clear whether women also end up taking on additional burdens. Unequal traditional divisions of labour may also be reinforced, with women being seen as responsible for sanitation and for the maintenance and cleaning of toilets. With CLTS making claims for community empowerment, it is crucial that gender and power relations are also taken under scrutiny.

Movik and Mehta (2010), Malawi established that men dominate the planning and decision making around water and sanitation investments. Construction of latrines is considered a man's job. They are the providers and hold the purse strings. In CLTS they see their role as supervisory, overseeing monitoring and hygiene and taking decisions. Hygiene and sanitation issues are considered the responsibility of women. They are usually staying at home and look after the family. They are not involved in decision-making processes and their views and wishes are often not addressed.

In a study by Musyoki (2007), Zambia it was found out that women tend to be less involved in latrine construction and seem more active and responsible in their maintenance and cleaning which has led to an increase in women's workload and hence reinforcing stereotypical gendered labour divisions and roles, such as women being responsible for household health.

Adenike A (2011), Nigeria, on the role "gender mainstreaming" plays in the progress of Ekiti State CLTS projects. It was found out that men are responsible for constructing latrines or hiring contractors to construct latrines. After the construction phase is completed, they are less involved in ongoing maintenance of the latrines and are not involved in household water management.

According to a study by Sanchez (2011), it was found out that women and girls in Uganda, as in other sub-Saharan African countries, are the major water collectors, users and managers in homes. They are also the major promoters of household and community sanitation activities. They therefore bear the impact of inadequate, deficient or inappropriate water and sanitation services. However, men still dominate the arena of planning and decision making regarding water and sanitation investments and women's views are often under-represented, implying that women's practical and strategic needs are not addressed.

A study by Kamal (2010) in Kenya, findings showed that, regarding the design, location and construction of sanitation facilities, inadequate attention is paid to the specific needs of women and men, boys and girls. Sanitation program, as with many other development programs, have often been built around assumptions of some gender-neutrality. This results in gender-specific failures, such as, latrines with doors facing the street in which women feel insecure, school urinals that are too high for boys, absence of disposal for sanitary materials by women, pour-flush toilets that require considerably more work for women in transporting water. Also, sanitation blocks are sometimes used for multiple functions, including washing and drying, shelter from rain etc., but are not designed for these purposes since they don't involve both gender in the design and construction.

The gender perspectives of sustainable sanitation projects have not been fully explored yet. In Kanyingombe Community Health Unit, lack of political will or attention and inadequate legal structures have resulted in the negligence of women's needs. There is lack of women involvement in sanitation development and planning which shows that

there is an urgent need to bring a gender perspective into the sanitation programs and to involve and address both women and men in these efforts as gender mainstreaming leads to benefits that go beyond good sanitation performance, empowerment of women ,more gender equality and benefits to children.(UNICEF 2014) Despite the implementation of CLTS in Kanyingombe Community Health Unit (CHU) to reduce sanitation related diarrheal infections, the CHU has the highest cases (54%) of diarrheal infections. More so the cholera outbreak in Rongo in which 784 cases were reported, 46% of the cases were originating from Central Kamagambo Ward with seven CHUs, whereby Kanyingombe CHU was leading with 127 cholera cases (DHIS 2015).

2.0 Statement of the problem.

Integrating a gender perspective into the sanitation sector requires addressing differences in gender roles (UNICEF, 2010). Gender involvement and participation in CLTS activities is a challenge in Kanyingombe Community Health Unit, Central Kamagambo ward in Rongo Sub County. As pertains to CLTS processes, participation and inclusion of gender during CLTS activities is usually poor (UNICEF, 2014). This has been observed from the attendance and participation of gender during the CLTS triggering sessions. More especially from the high cases of cholera that have been reported from the area. This has impacted negatively on the spirit of CLTS as entrenched in the Environmental Sanitation policy (WHO/UNICEF 2015). Moreover very few studies have been done to establish the roles of Gender on community Led Total Sanitation processes. There was therefore need to establish the roles of gender on Community Led Total Sanitation given that CLTS is a new sanitation concept in Kanyingombe Community Health Unit

2.1 Specific Objective

1. Establishing the role of gender integration on Community Led Total Sanitation Processes in Kanyingombe Community Health Unit.

2.2 Research Question

1. What is the role of gender integration on Community Led Total Sanitation process in Kanyingombe Community Health Unit?

3.0 Materials and Methods

3.1 Location of the study

The study was located in Kanyingombe Community Health Unit, Central Kamagambo Ward in Rongo Sub County of Migori County in the western Kenya Region of the Republic of Kenya.

3.2 Research design

The study was conducted through a cross-sectional descriptive survey design. The study was concerned with describing the roles of gender on community led total sanitation processes.

3.3 Target population.

The study targeted 1014 households distributed within 12 villages in Kanyingombe Community health unit where the Ministry of Health and other development partners have implemented CLTS activities (Table 1.0).

Table 1.0 Distribution of household population per village

S/NO	Village Name	Frequency	Percentage (%)
1	Kochier	78	08
2	Kaguda	93	09
3	Wameda	84	08
4	Kawanyumba	103	10
5	Kemunto A	95	09
6	Kemunto B	61	06
7	Nyasoti A	86	08
8	Nyasoti B	77	08
9	Kawahaya A	88	09
10	Kawahaya B	66	07
11	Kombura	108	11
12	Karoa	75	07
	TOTAL	1014	100

3.4 Sample size determination.

For the sake of this study, the following formula was used to calculate the sample size from the target population. Thus,

$$n = \frac{Nt^2 S^2}{Nd^2 + t^2 s^2}$$

$$n = \frac{1014 \times (1.96)^2 \times (0.867)^2}{1014 \times (0.118)^2 + (1.96)^2 \times (0.867)^2}$$

$$n = 172 \text{ Households}$$

Whereas:

n = samples size

N= Number of population.

t^2 =Trust of 95% (Confidence Interval)

s^2 = Pre-estimation of the variance

d^2 = Difference between the average of the sample and the population.

3.5 Sampling techniques.

The study employed probability and non probability sampling techniques. The study applied cluster sampling in selecting the household heads by grouping the villages into twelve clusters according to their names. To obtain the participants from each cluster, the names of the possible participants (household heads - from household registers managed by Community Health Volunteers) each cluster were assigned random numbers and these numbers were written on small pieces of paper, folded and placed in twelve different containers each representing a village. Simple random sampling by randomly handpicking the folded pieces of papers equivalent to the required proportional sample per cluster and those whose names coincided with the random numbers picked were included in the study. The sample from each village was selected using the proportions and formulae as shown below.

$$\frac{\text{No. of HHs in each village}}{\text{Target population}} \times \text{Sample size}$$

Thus, the distribution of the sample size per village is as were. (Table 2.0).

Table 2.0. Distribution of sample size per village.

S/no	Village Name	Frequency	Percentage (%)	Sample size
1	Kochier	78	8	13
2	Kaguda	93	9	16
3	Wameda	84	8	14
4	Kawanyumba	103	10	18
5	Kemunto A	95	9	16
6	Kemunto B	61	6	10
7	Nyasoti A	86	8	15
8	Nyasoti B	77	8	13
9	Kawahaya A	88	9	15
10	Kawahaya B	66	7	11
11	Kombura	108	11	18
12	Karora	75	7	13
	TOTAL	1014	100	172

3.6 The Instruments

The study utilized a questionnaire to collect data from household heads on the basis that it offer considerable advantage in administration, present an even stimulus potentiality to large numbers of people simultaneously and provides the investigation with an easy accumulation of data and at a relatively low cost.

3.7 Data analysis.

The questionnaires were edited and coded to check that all responses were given and accuracy is ensured. Descriptive statistics was used to analyze the data as it allows for narration to be used to interpret the data on variables. Data from the household were entered using Statistical Package for Social Scientists version 21.0, an SPSS family module that tracks and triggers quality control designs in the SPSS builder, which ensures that clean data files will be produced. Pearson's Moment Product correlation was used to determine the relationship between variables.

4.0 Results

The majority of the respondents were female 74.4% compared to that of male 25.6%. This is an indication that at household level females are mostly available except where the head of the household is a female. This is as a result of men leaving the house to look for daily bread for the rest of the family members (Table 4.1)

Table: 4.1 Gender of respondents

Type	Frequency (n)	Percentage (%)
Valid	Male	44
	Female	128
	Total	172
		100.0

The majority of the respondents which were represented by 57.0% did not participate in Community Led Total Sanitation (CLTS) processes. Only 43.0% of the respondents confirmed to have participated in the Community Led Total Sanitation (CLTS) processes. This is indeed a clear indication as to why there is slow pace in implementing CLTS activities as there is low latrine coverage making it possible for open defecation and consequently resulting into diarrheal infections which are still experienced in the study area (Table 4.6).

Table 4.6 Participation on CLTS process.

Response		Frequency (n)	Percentage (%)
Valid	Yes	74	43.0
	No	98	57.0
	Total	172	100.0

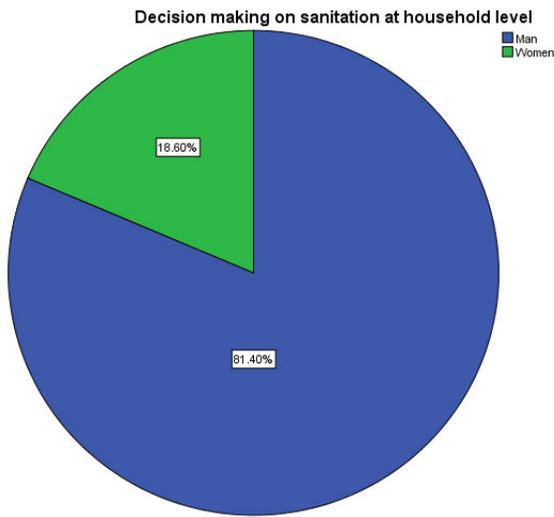
Although the study found out that approximately 43.0% of the respondents participated in the Community Led Total Sanitation (CLTS) processes, it was realized that majority of them 15.1% had participated in both triggering and post triggering. They were followed by those respondents who participated only during triggering session representing 13.4%. Pre triggering, triggering and post triggering sessions had the same number of respondents to that of pre triggering and post triggering representing 4.1% while the least participated session was pre triggering represented by 1.2%. The majority of the respondents were female perhaps because they are mostly affected from the detrimental effects of poor sanitation. It was also revealed that they participated in both triggering and post triggering which basically entails health education and provision of latrines (Table 4.7).

Table 4.7 Level of participation on Community Led Total Sanitation process

Level of participation		Frequency(n)	Percentage (%)
Valid	Pre triggering	2	1.2
	Triggering	23	13.4
	Pre triggering and triggering	9	5.2
	Pre triggering and post triggering	7	4.1
	Triggering and post triggering	26	15.1
	Pre triggering, triggering and post triggering	7	4.1
	Total	74	43.0
Missing	Not participated in CLTS process	98	57.0
Total		172	100.0

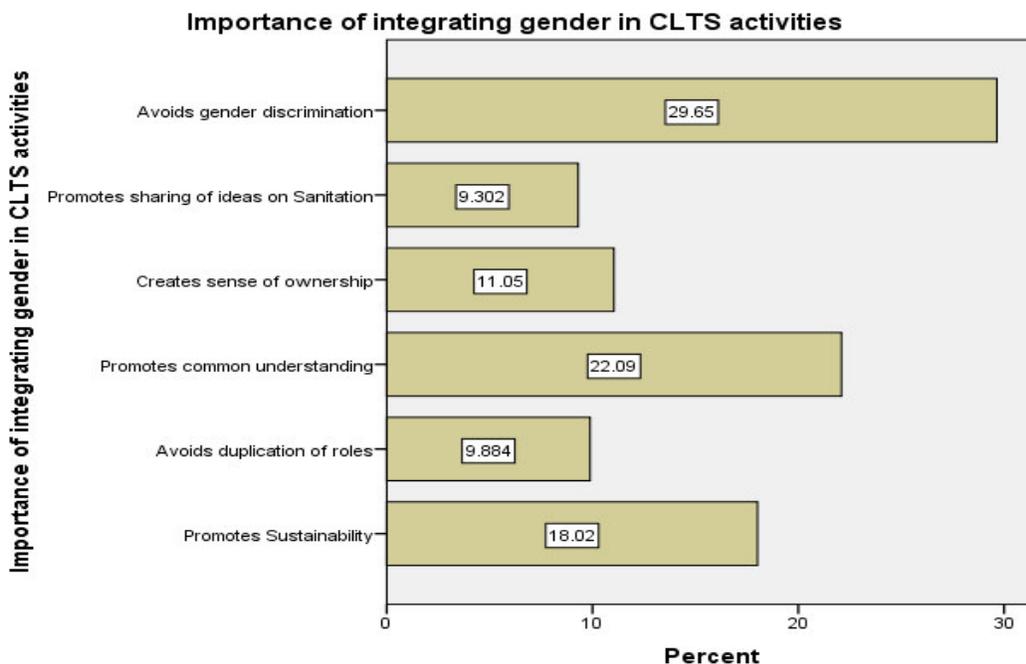
Men who were represented by 81.4% dominate in decision making at the household level when it comes to issues to do with sanitation compared to women who were represented by 18.6%. The study revealed that decision making on sanitation issues was dominated by men despite the fact that they are less affected by the consequences of poor sanitation and thus sanitation issues slow down and indeed it's the reason as to why the implementation of CLTS has not been fully done. More so the cases of diarrheal infections are still reported in this study area (Figure 4.3).

4.12 Decision making on sanitation matters at household level.



The majority of the respondents (29.65%) mentioned that integration of gender on CLTS process avoids gender discrimination. 22.09% said it promotes common understanding. 18.02 mentioned that it promotes sustainability as 11.05% mentioned that it creates sense of ownership. 9.88% mentioned that it avoids duplication of roles while 9.3% mentioned that it promotes sharing of ideas on sanitation. The study indicates that there is poor gender integration during CLTS implementation processes which is due to one gender dominating in sanitation activities without recognizing the significance of the other gender (Figure 4.5).

Figure 4.5 Importance of integrating gender in CLTS activities.



5.0 Discussion

The study found out that 57% of the respondents did not participate in Community Led Total Sanitation (CLTS) processes. The findings are in harmony with a study by Oko *et al* (2011), which found out that active participation of both men and women in water and sanitation service, as well as shared responsibility of managing the water and sanitation services, are important due to their different roles and needs.

The study found out that men (81%) dominated in decision making which concur with Pedi *et al* (2009) whose study indicates that in many societies, women's views, in contrast to those of men, continue to be systematically under-represented in decision-making bodies. This lack of a participatory approach is closely related to the uneven power structures in decision-making processes that characterize these societies and the sanitation sector in particular. A case study by Adenike (2011) further indicated that women do not have the same decision-making power as men, even if they hold the same leadership positions as men. Finally a study by Sanchez (2011), indicated that men still dominate the arena of planning and decision making regarding water and sanitation.

5.1 Conclusion

The gender integration in CLTS process is a challenge, since there was inadequate involvement and participation of both gender either in decision making process on CLTS and more so attending the CLTS triggering session. As pertains to power relations in the area, the roles and responsibilities of each gender were not well defined when it comes to sanitation activities. This has brought about lack of clear understanding of roles and responsibilities of either gender in CLTS activities.

5.2 Recommendations.

The implementers and or facilitators should ensure involvement and participation of both gender during CLTS processes from planning, to implementation and finally to monitoring and evaluation. This will create sense of ownership and by all means they will sustain ODF status within their villages. The county government of Migori under the department of social services should hold gender awareness sessions for all village members so that they can appreciate gender relations and relevance of gender mainstreaming in CLTS processes. Social mobilization by health staff for triggering should be intensified to ensure all village members are reached and participate during triggering sessions. Gender dialogues and gender analysis should be organized by CLTS implementers at community levels to raise gender awareness among community members and to inform the design of the CLTS programs respectively. The County government of Migori should integrate gender concerns and issues on Community Led Total Sanitation by developing a gender integration policy document.

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