

**GENDER OUTCOMES OF THE COMMUNITY LED TOTAL SANITATION  
APPROACH IN SELECTED COUNTIES IN KENYA**

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## DECLARATION

I confirm that this thesis is my original work and has not been presented in any other university. The thesis has been complemented by referenced works duly acknowledged.

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## **DEDICATION**

I dedicate this work to my children Westley and Harriet, also to my mother Edina Awinja Shitote, who inspired and encouraged me constantly even during the toughest moments of research, when things did not go as planned.

I also dedicate this work to all the sanitation and hygiene professionals at the Kenyan Ministry of Health, who work hard to improve the lives of the rural communities, despite the challenges they face.

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## **ABBREVIATIONS AND ACRONYMS**

AMCOW – African Ministers’ Council on Water

APHOK- Association of Public Health Officers in Kenya

AWP – Africa Water Project

AUC - African Union Commission

CEO – Chief Executive Officer

CDC – Centre for Disease Control

CLTS – Community Led Total Sanitation

CHWs – Community Health Workers

CPHOs – Chief of Public Health

CIDA – Canadian International Development Agency

ESARO – East & South Africa Regional Office

FAO – Food for Agriculture

GOI – Government of India

GLAAS - Global Analysis and Assessment of Sanitation and Drinking Water

GSF- Global Sanitation Fund

IDS - Institute of Development Studies

ILO – International Labour Organization

JMP – Joint Monitoring Programme

JSR – Joint Sector Review

JWSR – Joint Water Sector Review

KDHS – Kenya Demographics Health Survey

KESHIP – Kenya Environmental Sanitation and Hygiene Policy

MDGs – Millennium Development Goals

MOH – Ministry of Health

NBA – Nirmal Bharat Abhiyan (India)

NHP – National Health Policy (Zambia)

NGOs – Non- Governmental Organizations

NSC – National Sanitation Campaign

NL – Natural leaders

OECD - Organization for Economic Cooperation and Development

ODF – Open Defecation Free

OHCR – Human Rights Office of the High Commissioner

PHOs - Public Health Officers

SDGs – Sustainable Development Goals

TAWASANET – Tanzania Water & Sanitation Network

TSC – Total Sanitation Campaign

USAID – United States Agency for International Development

UN – United Nations

UNDP – United Nations Development program

UNFPA – United Nations Population Fund Agency

UNICEF – United Nations Children’s Fund

VHC – Volunteer Health Committees

VWSCs - Village Water and Sanitation Committees

WASH – Water Sanitation and Hygiene

WBG – World Bank Group

WHO – World Health Organization

WSDP – Water Supply Development Plan

WSP - Water and Sanitation Project

WSP-AF–Water and Sanitation Project – Africa

WSSCC – Water Supply and Sanitation Collaborative Council

## **OPERATIONAL DEFINITION OF TERMS**

**Gender** – This refers to the socially constructed characteristics of women and men, such as norms, roles and relationships of and between groups of women and men. It varies from society to society and can be changed (UN Women, 2015). This study considered the norms, roles and relationships between men and women in relation to sanitation and hygiene programing.

**Gender needs** – The roles of men and women in societies and institutions are generally different. Thus, their needs vary accordingly. There are two types of needs; practical needs and strategic needs. Practical needs arise from the actual conditions which women and men experience because of the gender roles assigned to them in society. Strategic needs are the needs required to overcome the subordinate position of women to men in society and they relate to the empowerment of women. They vary according to the particular social, economic and political context in which they are formulated (ILO, 2000). This study focused on the both the practical and strategic needs of women in relation to sanitation and hygiene.

**Gender issues** - These refer to any concern determined by gender-based and/or sex-based differences between women and men. They include all aspects and concerns related to women's and men's lives and the situation in society, the way they interrelate, their differences in access to and use of resources, their activities and how they react to changes, interventions and policies (EIGE, 2014). This study focused on the differences of their access to and use of resources their activities, and how they react to changes, interventions and policies in relation to sanitation and hygiene.

**Gender socialization** - A process by which individuals develop, refine and learn to do gender through internalizing gender norms and roles as they interact with key agents of socialization, such as their family, social networks and other social institutions (UNICEF, 2017). This study focused on gender norms and roles in the CLTS implementation process.

**Equity** - The state of being fair and just in accessing and benefiting from an intervention (WHO/UNICEF, 2012). This study focused on the equitability of CLTS outcomes on accessibility and benefits to men and women.

**Sanitation** – Is the hygienic means of promoting health through prevention of human contact with the hazards of wastes as well as the treatment and proper disposal of sewage or wastewater (MOH, 2009). In this study, the focus was on the CLTS approach as a sanitation intervention.

**Social norm** – Is a rule of behaviour that individuals prefer to conform to on condition that they believe that a) most people in their reference network conform to it and b) most people in their reference network believe they ought to conform to it (UNICEF, 2015). In this study, the focus was on the behaviour of not openly defecating.

**Slippage** - refers to a return to previous unhygienic behaviour or the inability of some or all community members to continue to meet all ODF criteria (WSSCC, 2016). The study focused on the unhygienic behaviour of open defecation.

**Triggering** – An event in the community that precipitates the community to take up the responsibility of dealing with their sanitation issues (Kar & Chambers, 2008). This study considered community meetings that facilitated uptake of stopping open defecation.

**Natural leaders (NLs)** - Are activists and enthusiasts who emerge and take the lead during CLTS processes, these could be men or women. Some natural leaders become community consultants who trigger and provide encouragement and support to communities other than their own communities (Kar & Chambers, 2008). This study focused on the enthusiasts who worked within their communities to ensure they became ODF.

**Open defecation** – Is defecating in the open due to lack of proper toilets (Kar & Chambers, 2008). This study considered the behaviour of open defecation as unacceptable and needed to be stopped by both men and women.

**Open Defecation Free** – Is defined as a community where each household of 5–6 people have a latrine with smooth floor, a lid to cover the pit and a superstructure to provide privacy in addition to hand washing facilities (Kar & Chambers, 2008). This study considered open defecation free as an ultimate goal for all households in the community.



## ABSTRACT

Inadequate sanitation and hygiene contribute to morbidity and mortality. The Community-Led Total Sanitation (CLTS) approach is used by the Ministry of Health to increase access to sanitation and hygiene in Kenya. This study sought to assess the gender outcomes of the CLTS approach in three sub counties in Kenya. CLTS is considered successful in Kenya, yet its impact on men and women has limited literature available. Therefore, this study sought to document the impact on gender relations as a result of the CLTS implementation in Siaya, Nambale and Teso North Sub Counties. The Moser Framework, the gender socialization concept and the Gaventa Power Framework were applied. A complete census of the households was done, followed by cluster random sampling to determine the households to be interviewed. The Z-Score was used to determine the respondents. Further, 3 Focus group discussions were held with Village Health Committees and 12 key in depth interviews with Public Health Officers from the Ministry of Health. 384 Structured interview guides and observation check lists were applied in the sampled households. Quantitative data yielded was analysed by statistical package for social science and qualitative data was analysed through Atlas t 6.0 and Open Code 3.4. The data was presented in tables. The study found that the Kenya Environmental Sanitation Policy and the CLTS Trainers' Handbook did not address gender needs adequately yet CLTS was considered a success in Kenya. That 75% PHOs who were mandated to deliver CLTS were gender blind. That 67% of PHOs made decisions based on general data as they did not have gender disaggregated data on CLTS interventions. Further, it was found that men led in decision making at all levels of CLTS implementation. 64% of PHOs were men at county level and 85% at sub county level. 80% of the people present at community triggering were men and 70% of households reported that men led the decision-making process at the household level in relation to sanitation and hygiene interventions. Men were recognized more during the ODF celebrations as compared to women. 56% of VHCs are women who work without pay. The women provided sanitation and hygiene services in the home as part of their reproductive role and served as VHC resulting to unequal division of labour in CLTS with the women shouldering the heaviest burden. Women faced challenges with limited access to key sanitation resources, such as land and building materials where in households interviewed, 23% were women in Nambale, 15% in Teso and 25% in Siaya. Besides, women had limited access to the latrines and bathrooms, such that it curtailed the benefits at 36% in Nambale, 29% in Teso and 37% in Siaya. Participation of women in decision making in CLTS was tokenistic, whereby there was only an increase of 2.3% of women invited in the decision-making space with minimal strategic benefits, they were not able to claim any space or autonomy in CLTS implementation. The study concluded that despite CLTS being considered a great success in Kenya at 58% as reported by PHOs, it was not applied in a gender sensitive manner thus entrenching unequal outcomes. Teso registered at 23% ODF and Siaya and Nambale registered 93% ODF. The study recommends that there should be a review of the KESH policy and CLTS manual to integrate gender responsive impact assessments and initiate critical enablers. Also, all PHOs should be trained on gender mainstreaming. Similarly, gender mainstreaming should be integrated into CLTS intervention through having flexible gender strategies that would ensure equitable outcomes. The study therefore contributes to the existing literature on community led total sanitation and may inform policy formulation and implementation by the relevant stakeholders.

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1. Background of the Study**

World Health Organization estimated that about 4.5 billion people in the world have lack access to safely managed sanitation services (WHO, 2017). As a result, 361,000 children under 5 years of age die due to diarrhoea in developing countries, a disease associated with inadequate sanitation and poor hygiene conditions (WHO, 2017). Adequate sanitation is the foundation for social development. Safe water, effective sanitation and hygiene are critical to the health of every community, and thus are essential to building stronger, healthier, and more equitable societies (United Nations Children’s Fund, 2017). The United Nations (UN, 2004) indicates that the existence of improved household sanitation facilities does not necessarily imply that they will always be used. In most societies, women have the primary responsibility of managing household water supply, sanitation and health because of their reproductive role in the communities (USAID, 2010). However, efforts geared towards improving the management and access to safe drinking water and adequate sanitation, often overlook the central role that women play (Mehta, 2017). A WHO report in 2013, stated that women’s participation in decision-making is hampered by cultural barriers and traditional gender roles.

Studies have shown that the lack of safely managed sanitation affect men, women, girls and boys differently, and their roles in ensuring improved access to sanitation and hygiene also varied. This calls for applying sanitation interventions using the gender lenses (Mehta, 2017). Gender was considered as the norms, roles and relationships between men and women in relation to sanitation and hygiene programming. In the absence of a gender

analysis in projects and programmes, there was a risk of failure, less success or reinforcement of inequalities. An analysis of this kind could be undertaken at any stage of the development intervention to ensure that there were limited unintended impacts of the development intervention in relation to reinforcing inequalities (Africa Union Commission, 2015).

Community Led Total Sanitation (CLTS) approach was first developed and tested in Bangladesh as an innovative methodology for mobilizing communities to eliminate open defecation especially in rural areas (Kar et al., 2008). CLTS began at the community level where respected individuals in the community, identified as “community champions,” were trained to facilitate a process known as “triggering.” Triggering was a 2–3-hour process using hands on exercises designed to persuade communities to realize that residents “eat their own faeces” because of poor hygiene and sanitation. One tool used for triggering the community was the transect walk, often referred to as the “walk of shame” involving leading participants around their village and surrounding area to locate faeces resulting from open defecation. The communities would then respond to the triggering process in different ways as follows;

- a) *Match in a gas station* - Entire community is fully ignited, and all are prepared to start local action immediately to stop open defecation.
- b) *Promising flames* - Majority of the community members have agreed but a good number are still not decided.
- c) *Scattered sparks* - Majority of the people are not decided on collective action, and there are many fence-sitters, and only a few have started thinking about going ahead.

d) *Damp matchbox* - Entire community is not at all interested to do anything to stop open defecation. (Kar et al., 2008).

After the triggering, communities would usually decide to create a formalized sanitation committee and to try to become ODF, leading to latrine building and waste management improvements (Kar et al., 2008). It is worth noting that these decisions emerge from the community members, rather than being imposed by the CLTS implementers.

Scholars have noted that CLTS is an effective way of initiating the process of behaviour change in relation to sanitation and hygiene particularly in rural areas, and its reputation amongst national governments, national and international agencies and donors is strong (Myers et al., 2016). Therefore, as part of the pre triggering phase, it is important to take time to understand the wider context and the range of different stakeholders relevant to addressing water and sanitation (Ulrich et al., 2016).

In the CLTS approach, there are reported varieties of interconnected emotive factors that influence community members to construct and use latrines (Lawrence et al., 2016). These encompass shame and disgust, pressure from hierarchical powers and community groups and competition among villages to achieve ODF status. Shame from triggering emerges as a significant factor in behavioural change and the transect walk is noted as the most important aspect of triggering. Hierarchical pressure has a strong influence on behaviour; it is brought by traditional leaders, including chiefs and village headmen, who have important cultural and legal influence on the communities (Morris-Iverson et al., 2011). These play a major role in changing sanitation behaviours, often creating and enforcing binding local regulations or by-laws that require households to construct and use toilets.

Some basic principles of CLTS that made it a success were not gender responsive and do not attempt to present any disaggregation or acknowledgement of varied needs of the genders.

Assumptions are made as follows;

- a) *Participation* - that the community members are at the heart of the process and should drive the agenda.
- b) *Empowerment* - that the communities make their own decisions and are encouraged to take their own actions.
- c) *Collective behaviour change and collective action* – That the process focuses on all, everyone must change unsafe sanitation and hygiene practices in order for the risk of faecal-oral contamination to be reduced.
- d) *Community ownership* – That this is achieved through the communal consultations to attain community buy in directly and symbolically.
- e) *Triggering* – That this takes place to create demand for everyone using a set of tools used to evoke powerful emotions and confront the negative impacts of open defecation and poor sanitation.
- f) *Natural leaders* – That these people are considered activists and champions who emerge and take lead of the process.
- g) *Open Defecation Free* - This is the main objective of the CLTS process, it is not considered a success unless all the people have sanitation facilities and use is sustained regardless of situations. (Kar et al., 2008).

Household surveys of sanitation practices in Cambodia, Indonesia, and Vietnam showed that it was not obvious if people had latrines at home, they used them. In many households with latrines, individuals still occasionally defecated in fields and irrigation canals, which may be located at some distance from the village and latrine site. Hence, the UN (2007) opined that an estimated 2.2 billion people ought to have accessed improved sanitation services before the end of 2015 in order to meet the Millennium Development Goals (MDGs) target of halving the percentage of people without access to improved sanitation. Much of the world was however not on track to meet these goals due to compounded problems of population growth, urbanization and historically inefficient service provision (UN 2017).

Due to the increasing demand and historically low success rate of sanitation projects, there was an increasing need to develop methods for scaling-up sanitation projects. There was a growing awareness of the sanitation problem within the international development community and initiatives such as the International Year of Sanitation (2008) were an indication of the increasing amount of funds invested in the sector over the coming years. Yet, the challenge of the MDGs was not only to achieve statistical improvements on paper, that was, the number of toilets constructed, but also to do it in a sustainable manner that led to lasting positive change for the entire community. Strategic planning for the implementation, operation, and maintenance of community-wide sanitation systems was therefore a critical component to increase the efficiency, scope, and longevity of investments (UNICEF, 2016).

According to the MDG assessment report of 2015, global coverage for use of improved sanitation facilities by 1990 was at 54% and as at 2015, it was at 77%. Worldwide 2.1 billion people had gained access to improved sanitation; however, the proportion gaining

access varies across developing regions. The proportion of people practising open defecation had fallen almost by half since 1990 at the onset of the MDGs. It was estimated that 2.4 billion people globally still used unimproved sanitation facilities, with the vast majority living in 3 regions, namely: Asia, Africa and Oceania with the biggest proportion being in Sub-Saharan Africa. There were twice as many people using unimproved sanitation facilities in Sub-Saharan Africa than in Eastern Asia (UN, 2015).

In July 2010, the UN Human Rights Council resolved that sanitation would be defined as a system for the collection, transportation, treatment and disposal or reuse of human excreta and associated hygiene. The human right to sanitation entitles everyone to sanitation services that provide privacy, ensure dignity and be physically accessible, affordable, safe, hygienic, secure and socially and culturally acceptable. The human rights principles of non-discrimination and equality, access to information, participation and accountability must be ensured in the context of realizing the human right to water and sanitation (OHCHR, 2010).

Sanitation falls into two broad categories; (i) onsite, mainly pit latrines and (ii) offsite or waterborne. Onsite sanitation is the common mode of human waste disposal globally in rural, suburban and unplanned settlement areas. The waterborne sewerage systems, which are prevalent in cities and larger municipalities, are in most instances under the Ministry of Environment, Water and/or Natural Resource, while promotion of onsite sanitation is in most African governments under the Ministry of Health's docket (WB- WSP, 2005).

The situation in Africa demonstrated the biggest challenge ahead in meeting the MDG target on sanitation. The continent had the lowest water supply at 64% and sanitation coverage at 30% of any region in the World. Kenya was one of the countries listed that had a rural

population practising open defecation at 68% (JMP, 2016). However, there are no specific gender disaggregated data. In an effort to deal with the shortcomings of not meeting the MDGs, efforts were made to increase access to sanitation and hygiene in communities and at school in Kenya. The Ministry of Health in Kenya launched an Environmental Sanitation and Hygiene (KESH) policy in 2007 that sought to improve the sanitation and hygiene situation in Kenya. The enactment of the KESH policy in 2007 put into place a framework to improve the sanitation and hygiene situation in Kenya with a bias for the rural areas. This move facilitated a campaign that was initiated in 2009 with the aim of ensuring that the Kenyan rural community was Open Defecation Free (ODF) by December 2013.

The KESH Policy was the basis of the launching of CLTS as an approach to ensuring rural Kenyan communities have full access to latrines and was directly implemented by the Government through the Ministry of Health as well non-governmental organizations. The CLTS approach had emerged as one of the most effective approaches in promoting sanitation in over 60 countries since inception (Water Aid, 2015). The CLTS approach had been recognized by the UN and other development agencies to significantly contribute in promoting sanitation. There was a prevalent view from the CLTS implementers that many of the inequalities between men and women were overcome in the CLTS programme design process and that it was sufficient to achieve gender equality (IDS, 2014). The gender outcomes of the CLTS programme, however, often vary tremendously due to differing socio-cultural norms (Halcrow, 2014)

In August 2010, the Ministry of Public Health and Sanitation and UNICEF embarked on a pilot programme for rural sanitation using the CLTS approach in 6 sub counties in the then, Nyanza and Western provinces. The sub counties were: Nyando, Siaya, Bondo, Kisumu



West, Rachuonyo and Busia. The selection was based on areas that were considered hotspots for cholera in addition to their poor sanitation indicators (MOH, 2010). This initiative registered over 100 villages ODF within 1 year and as a result of this success, CLTS was adopted by Government of Kenya as a national strategy to accelerate access to sanitation. In May 2011, the government launched the ODF Rural Kenya 2013 Campaign, which entailed working through partnerships and devolved government structures throughout rural Kenya to reach out to all the communities and ensure that they are ODF by 2013. According to the Ministry of Health annual report of 2014, there are 5,832 villages that have claimed ODF status with 3,832 of these having been certified.

This study interrogated various approaches to gender analysis that provided a wide range of information in various contexts that could be applied to development projects. These include: the Harvard Analytical Framework, the Moser Framework, the Gender Analysis Matrix, Capacity and Vulnerability Analysis, Women's Empowerment Framework, Social Relations Approach and the People Oriented Planning Framework (March, 1999).

The Moser Framework provided tools that were applicable to various development programmes, and it was designed to closely analyse the way men and women related and how the introduction of any development intervention affected these relationships. This framework has been used in analysing the success of programmes globally such as in Europe, Asia and Africa. Some of the development programmes such as aquaculture, agriculture, micro enterprise and water, implemented by the Food for Agriculture Organization (FAO) benefit from this framework (FAO, 2001). The framework was also applicable in interventions that directly affect and involve communities and households such as sanitation and hygiene (CIDA, 2000). However, there were limited studies available that

had interrogated by gender the effects of the CLTS approach in Asia and Africa that sought to improve access to sanitation for rural communities. This presented an opportunity for the study that was carried out in 3 sub counties in Western Kenya that had received the CLTS intervention, namely Nambale and Teso North in Busia County and Siaya in Siaya County. The aim was to establish the gendered outcomes of CLTS in the three sub counties.

## **1.2. Statement of the Problem**

Poor access to water, sanitation and hygiene results in tremendous human and economic costs and reinforces gender and other societal inequalities, most notably for women and girls. The Kenyan Constitution 2010 recognized access to safe water, sanitation and hygiene as a basic human right. Access meant that everyone was able to get to a sanitation and hygiene facility every time they needed it, at any place they were at, whether at home or in a public place and were able to utilize it comfortably.

The KESH Policy identified CLTS approach as the most effective scalable approach to get all the rural communities in Kenya open defecation free (ODF). This led to the development of a roadmap that outlined the implementation of CLTS in Kenya in 2009. The KESH policy was reviewed in 2017 and an implementation plan also introduced with costed activities. None of the frameworks reflected any gender specific issues that could have possibly emerged. This study therefore intended to examine the gender outcomes, concerns and issues of CLTS in selected counties in Kenya.

The study targeted the rural based Sub-counties that were recipients of the CLTS intervention as follows; Teso North and Nambale sub counties which form part of Busia

County and Siaya Sub county which is part of Siaya County. The 3 sub counties were selected based on the varied rates of the CLTS intervention results, with Nambale at 100%, Siaya at 85% and Teso North at 40%, yet the intervention was introduced at the same time, with the same resourcing under the KESH policy using the CLTS handbook by the public health officers (PHOs).

### **1.3 Objectives of the Study**

The general objective of the study was to assess the gender outcomes of the environmental sanitation and hygiene policy implementation through the Community Led Total Sanitation (CLTS) Approach in Nambale, Teso North and Siaya Sub counties of Western Kenya.

#### **1.3.1 Specific Objectives of the Study**

- i. To identify gender needs that were addressed in the Kenya Environmental Sanitation and Hygiene Policy and the CLTS Trainers' Handbook.
- ii. To assess gender related factors influencing the successful implementation of the Community Led Total Sanitation approach
- iii. To identify gender roles in the implementation of a successful Community Led Total Sanitation approach
- iv. To identify the effects of the CLTS approach on women and men in the three sub counties
- v. To identify strategies that would alleviate negative impacts of the Community Led Total Sanitation approach

#### **1.4. Hypothesis**

This study supposed that community led total sanitation (CLTS) as a development intervention for sanitation increased the burden on women.

H<sub>0</sub> – The CLTS approach as a development intervention did not increase women’s chores in the home.

#### **1.5. Research Questions**

- i) What were the gender needs that were addressed in the Environmental Sanitation and Hygiene Policy and CLTS handbook?
- ii) What were the gender related factors influencing the successful implementation of the Community Led Total Sanitation approach?
- iii) What were the gender roles in the implementation of a successful Community Led Total Sanitation approach?
- iv) What were the effects CLTS approach on women and men in the three sub counties?
- v) What strategies would alleviate negative impacts of the Community Led Total Sanitation approach?

#### **1.6. Significance of the Study**

This study hoped to influence policy designers and implementers of sanitation programmes to consider the practical and strategic gender needs of the various community members since sanitation was considered a public matter that concerned everyone but did not affect everyone the same way. The study brought out issues on equitable involvement and participation. It also underlined some unintended outcomes of the sanitation interventions sought by international donors and development assistance interventions. These issues

raised, affect how the outputs and outcomes of policies are determined at design stage to ensure that one gender is not burdened, and gender inequalities are not perpetuated in future programming. The findings would be useful to other researchers and sanitation and hygiene implementers on designing sustainable gender responsive CLTS programmes.

### **1.7 Justification of the Study**

To achieve universal realization of gender equality, programmes have to be gender responsive to address the key areas of gender inequality including: the unequal access to sanitation and hygiene facilities and services, division of unpaid care and domestic work and women's limited control over assets and property that directly affect sanitation matters in the household.

Little peer-reviewed literature has been published regarding community attitudes and behaviours toward CLTS (Lawrence et al., 2016). This study thus aimed to examine the sanitation gender beliefs and behaviours of CLTS participants and the perceived gender outcomes of CLTS on sanitation practices in three sub counties where CLTS implementation was initiated in Kenya. This study intends to contribute towards a body of knowledge that will provide gender strategies associated with CLTS that are important in ensuring equitable gains made by the CLTS intervention, heavily influencing the implementation of the Sustainable Development Goals (SDGs), the 2015 NGOR Hygiene and Sanitation Declaration enacted by the African Ministers' Council on Water (AMCOW), as well as impact the social pillar of the Kenya Vision 2030.

## **1.8. Scope and Limitations of the Study**

The study focused on the gender related outcomes of implementing the CLTS approach in 3 sub counties, namely; Nambale, Teso North and Siaya. The study concentrated in these sub counties which were among the first sub counties that CLTS was applied in Kenya. All the 3 sub counties were in the western part of Kenya and were considered rural with small towns serving as the Sub-county headquarters. One of the sub counties was declared Open Defecation Free (ODF) after implementing the CLTS approach by 2011, namely Nambale and Siaya was declared ODF in 2015 by the Ministry of Health and were still ODF to date. Teso had not been declared ODF as a sub county by the time of the end of the study.

There were challenges during the study, namely, accessing some of the homes of respondents, due to rains that periodically caused flooding, during data collection. The researcher tried to plan data collection to take place before or after the short rains, but due to the irregular weather, rains still affected the data collection in households especially in Teso North. This limitation caused the data collection to take longer than anticipated to ensure that all the targeted respondents were reached.

## **1.9 Summary**

The chapter outlined the background of the study, outlining the sanitation situation and the background on the community led total sanitation approach. It also presented the problem statement, hypothesis, objectives and research questions. It also provided the significance and justification of the study, providing the scope and limitation of the study as well. The next chapter explores the various literature that was available that related to the study as well as discussing the theoretical framework of the study.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter thematically reviews related literature. The chapter looks at, gender and sanitation as well as CLTS as an intervention that has worked well in improving access to sanitation and hygiene in rural communities worldwide. It also considers some environmental sanitation and hygiene policies, CLTS protocols, programmes that address gender concerns and needs of the rural communities, the gender factors that influence CLTS implementation, gender roles in implementing CLTS, the effects of CLTS implementation on the men and women and strategies that could facilitate an equitable outcome of CLTS. The chapter also presents a theoretical and conceptual framework used in the study.

#### **2.2 Gender Needs and sanitation**

Gender is an important concept in sanitation and hygiene because women often have the primary responsibility over facilities and practices of the household and consequently experience a significant extra burden, for example, the added collection of water for hygiene practices and need to walk long distances to relieve themselves (Mitlin, 2011). Women are also role models for children in establishing accepted norms around responsibilities of women and men (UN Women, 2014b). Further, women's voices and participation in community decision-making are often marginalized, which impacts their ability to influence decisions around sanitation and hygiene facilities and services (World Bank, 2010). Limited access to sanitation for the women and girls affects them differently as opposed to men and boys, in such contexts, research has demonstrated that inadequate access to WASH is linked to psychosocial stress, especially among women. This makes them more likely to encounter

social and physical risks during their daily sanitation routines. In particular, issues of accessibility may impact on women with disabilities, aged, pregnant or nursing mothers (Grant et al., 2016).

However, while gender is identified as an important issue in sanitation, this aspect is not well covered in the sector research literature (Mitlin, 2011) and there is a lack of data available on the programme, at national and global levels (WHO/UNICEF, 2014). At the national level, 39% of countries report sex-disaggregated data on access to sanitation (United Nations, 2013). Even though the collection of data is recommended, Seagar in 2015 found that there was extremely limited sex-disaggregated data collected at the global level. This built on Fletcher and Schonewille's finding in 2015 that the Global Analysis and Assessment of Sanitation and Drinking Water (GLAAS) and WHO/UNICEF Joint Monitoring Programme (JMP) no longer included the sex-disaggregated data in their reports.

In a practical sense, addressing gender aspects in sanitation and hygiene does not mean excluding men, but making the concerns and experiences of women as well as men, an integral dimension of the design, implementation, monitoring and evaluation of policies and programmes in all spheres, so that women and men benefit equally and inequality is not perpetuated (World Bank, 2010). Existing sanitation and hygiene studies confirm an approach advocating for gender sensitive and participatory strategies throughout the project cycle from design, to implementation to monitoring (Carrard et al., 2013). A study by Plan Uganda carried out in 2012 based on the CLTS approach recommended a community sensitization on gender equality to allow the community to consider and identify their own gender issues and potential solutions, rather than have them imposed by others. Two gender



studies carried out in Uganda in 2012 by Plan Uganda and IOD Parc consultants in 2015 focusing on CLTS as the widely promoted approach for rural sanitation, found that gender activities were not embedded in the CLTS programmes and called for an articulation of a gender inclusion strategy in CLTS.

### **2.3 Factors that contribute to CLTS adoption**

Some of the factors that inhibit the adoption of CLTS after triggering include sociocultural traditions and taboos regarding sharing a toilet facility and embarrassment while using a latrine, because others may see someone going to the toilet and even if they are not told; they know that he or she is defecating. Particularly influential is the long-standing taboo that disallows sharing the same toilets with in-laws, members of the opposite sex, or different generations within a family (Lawrence, 2017). Conversely, this gender-related cultural dynamics like not sharing toilet with in-laws may influence some individuals to use pit latrines, rather than the bush with the fear of being found by the in-laws. Although still an important factor in behavioural change, the effect of these cultural taboos may be diminishing over time, as the CLTS approach integrates other development issues.

Equity of access and participation, including by age, gender, and other social groupings are all factors to be taken into account in CLTS. There was little evidence of systematic and regular monitoring of these issues in the national CLTS reports from the headquarters and the counties. There were some gender aspects covered in evaluation studies carried out by funding agencies but as the issues were only looked at late in programme implementation the findings were often weak (Robinson, 2016; UNICEF, 2014) and did not lead to changes. To effectively measure impacts requires advanced planning from the start of a programme and the collection of baseline data. However, positive and significant results could provide

useful data for advocacy for CLTS efforts from the national and county levels (Wamera, 2016).

The literature reviewed indicates a lack of a centralized place for consolidating data and monitoring progress in various countries, and very limited indicators that would measure engendered process, especially those with a longer history of CLTS such as Cambodia, Timor-Leste, Indonesia, Lao PDR, Ethiopia, Tanzania, India, Zambia and Kenya. Most of these countries are supported by UNICEF in implementing CLTS and are working towards dealing with the challenges relating to effective data collection and utilization (Jones, 2015; Mukherjee, 2016; Kumar et al., 2010, Coombes et al., 2011 & UNICEF ESARO, 2015).

Proponents of CLTS (Kar & Chambers, 2008; Bongartz et al., 2010) argue that CLTS is effective and sustainable because it empowers local communities to perpetuate long-term sanitation behaviours. Some argue that CLTS is highly effective because it is widely participatory, class-neutral and engages both men and women in the whole of the community action (Kanji, 2006). In addition to the positive sanitation outcomes for the whole community such as improved health (Milward et al., 2014), the CLTS process lead to some positive gender outcomes such as increased respect for women for their contribution and new roles, improved community interactions and reductions in domestic violence (Kanji, 2006; Plan Uganda, 2012; Water Aid, 2009; Mehta et al., 2011).

However, critics of CLTS argue that the approach fails to recognize and respond to gender roles and relationships at the community level, thereby missing the opportunity to empower women and men, potentially exacerbating existing social problems and increasing the burden of work for women (Mehta et al., 2011; Roose et al., 2015). Plan Uganda's research

in 2012 found that gender issues were not systematically addressed in CLTS processes and that CLTS did not improve the social status of women. While women have been encouraged to take leadership roles through CLTS, it has been seen to add an extra burden to women's traditional workload (Mehta et al., 2011; UN Women, 2014b).

Ivens (2008) argues that even though benefits of interventions for women and men are clear, the lauded goals of women's empowerment and gender equality are far less evident. While CLTS did not necessarily have explicit gender equality objectives (Roose et al., 2015), several authors argue that women's empowerment is necessary for more sustainable sanitation and hygiene programmes for both sexes (Ivens, 2008; UN Women, 2015; Plan International, 2013; Brewster et.al., 2006).

As CLTS achieves impact at a larger scale, gaps and challenges have emerged. The immensity became apparent as sustainability studies showed that results are often fragile. The challenges included monitoring of the sustainability of behaviour change post ODF, issues of equity and inclusion, and assessing short- and longer-term impacts (e.g. on empowerment) among other issues (Pastuer, 2017). The literature indicated that there were clear gaps influenced by lack of gender sensitive approaches in CLTS implementation. None of the literature indicated any research carried out in Kenya on the gender outcomes of the CLTS implementation or any studies calling for equitable CLTS implementation.

#### **2.4 Environmental Sanitation and Health Policies, Protocols and Programmes that Address Sanitation Provision**

The environmental sanitation and hygiene policies that are studied are gender neutral and do not provide specific provisions for the various genders. These kinds of documents used as

guidelines for governments to offer service to the citizens target homogenous rural communities as they implement the work aiming to attain homogenous outcomes like open defecation free (ODF).

There is limited literature that indicates governments that have recognized engendering the CLTS approach but are promoting the CLTS approach as a successful approach in meeting the rural sanitation need and indicating this fact in their policies or guidelines. Some of the governments that have incorporated the CLTS approach in their government policies include India, Tanzania, Zambia, Madagascar and Kenya. Each of the processes used in the implementation of CLTS in these countries was briefly examined.

The rural sanitation programme in India was introduced in 1954 as part of the first 5-year plan of the Government of India. From 1999 a ‘demand driven’ approach under the ‘Total Sanitation Campaign’ (TSC) was initiated with various aspects of communication to create awareness on the sanitation status and responsibilities of the citizens to ensure total sanitation. The Nirmal Bharat Abhiya (NBA) succeeded the TSC in 2012 to accelerate sanitation coverage in rural areas. Under the Ministry of Drinking Water and Sanitation in India in the Nirmal Bharat Abhiya (NBA) Division, the government of India in 2013 issued a memorandum to indicate the modification of the policy on drinking water and sanitation indicating the inclusion of activities related to CLTS, specifically indicating that sanitation would be measured according to Open Defecation Free (ODF) zones and not toilet coverage as previously indicated in the policy. But this information did not indicate any gender disaggregation in the process of getting the ODF zones.

Guidelines for the Swachh Bharat Mission (Gramin) were issued in 2014 by the Ministry of Drinking Water and Sanitation focusing on rural sanitation aiming at getting rural India ODF by 2019 (GOI, 2014). These guidelines provided flexibility to State governments, as sanitation is a state subject, to decide on their implementation policy and mechanisms, taking into account state specific requirements, providing a framework that could utilize provisions effectively. In these guidelines and provisional framework, there were no clear indicators provided for gender disaggregated data in either pre-ODF or post-ODF provisions. Capacity building of the personnel involved in the implementation of the guidelines was well outlined, inclusive of the CLTS approach but with no provision for the gender allocations.

Reference was made to women, children, people of certain castes, faiths, ethnicities, older people, pregnant women and people with disabilities (GOI, 2014) under the equity and inclusion strategy in the Gramin guidelines, indicating that these aspects would be taken into account, targeting these groups as beneficiaries and not implementers. Provisions were made on the various levels of managing sanitation whereby there were no clear gender provisions at the National Secretariat, State water and sanitation missions, district water and sanitation missions and block management units. There was a provision of 50% requirement for women out of the 6 members of the village water and sanitation committee (GOI, 2014). These committees worked on a full-time basis although there was no permanent cadre and were only given a minimal honorarium. This literature indicates that India as a federal government has put structures in place that may be considered gender responsive but, there is a lack of monitoring to ensure that the state governments adhere to it.

The Government of Tanzania did not have a specific sanitation policy, but through the Ministry of Health and Social Welfare launched the four-year National Sanitation Campaign (NSC), which was under component II of the Water Sector Development Programme (WSDP I:2005-2025). The campaign was designed to accelerate the proportion of people with improved access to Sanitation in Tanzania. In 2013, the preventive services division, made revisions to their sanitation campaign framework as part of the National health policy to include CLTS as an approach to increase improved sanitation in the rural areas. There was mention of gender as a cross cutting issue, but there was no clear description of how this would be achieved. There was no mention of sex disaggregated data in the national policy or the national sanitation campaign. In an equity report for 2014, prepared by the Civil Society group – Tanzania Water and Sanitation Network (TAWASANET) indicated that 91% of districts in Tanzania received the same amount of money for sanitation needs despite various challenges and needs expressed. The report was a stance that indicated that equity was crucial for the sector but had not been tackled effectively.

The equity report also indicated that the triggering that was done in the communities to mobilize communities to improve access to sanitation did not focus on gender sensitivities. The report presented a finding that public health officers were in charge of implementing the CLTS approach as part of the National Sanitation Campaign (NSC) and yet, 80% of the interviewees, who were public health officers had not been trained on equity issues. They did not feel confident discussing equity issues in relation to sanitation needs and that the data that they generated for the campaign was not sex disaggregated, but the focus was on households. This led to TAWASANET recommending that the public health officers in Tanzania should be trained on equity issues to improve on the CLTS implementation that

would continue into the phase two of the Water Sector Development Programme (WSDP II), that runs from 2016-2020. The WSDP II did not take into consideration capacity building of public health officer in integrating gender issues in sanitation provision. The literature indicates that Tanzania government through the ministry did not take gender equity issues on sanitation and hygiene as an important issue to monitor.

The Ministry of Health in Zambia carried out reforms in 2010 that led to the drafting of the National Health Policy (NHP) that was meant to complement other policies related to or relevant to environmental health. The situation analysis provided in the policy provided statistics of population divided only into two categories; urban and rural. Most of the text in the policy refers to the Zambians as a population; there was no disaggregation of data by gender in any of the text in the policy document. In laying out the framework, the policy indicated that, due to poor community mobilization and lack of empowerment, community participation around environmental health activities was an area, which had not been fully realized in the country. This was indicated despite being noted as a crucial requirement for sustainable demand –led and effective interventions for sanitation intervention (MOH, 2010).

The NHP further indicated that lack of access to basic safe water and sanitation were some of the gender issues negatively affecting the women and girls, among other issues. However, there was no laid-out plan how that discrepancy would be addressed. The NHP set out to ensure effective interventions in the community but did not disaggregate the data at the objectives level of the policy. When discussing community participation, the NHP stated

that it intended to legalize community-based institutions in order to reduce duplication of functions and engender power play (MOH, 2010). The term ‘engender power play’ is not further explained or qualified in the policy as to what it actually means. This phrase is used in two aspects, under the community participation and gender and environment aspect with no clear outlines of how to achieve it. With the elaboration of the term, there would have been a laid-out plan on how to tackle gender variances, but this was not addressed. The NHP intended to promote enhanced data collection and compilation of environmental health data at various levels pertaining to different special groups and only listed elderly and disabled in this category. The text appeared under the section on data management, it did not indicate sex disaggregation as a critical point for data collection, only mentioning the general population categorized into urban and rural data sets.

The JMP Report (2015) on Zambia indicated that it had 44% population with access to improved sanitation and the target to attain an ODF by 2020. None of the data is disaggregated despite great support provided by UNICEF in promoting the CLTS approach. The Ministry developed national guidelines for CLTS, to be used for verification and certification of Open Defecation Free (ODF). The aspiration was made based on an assumption that as long as a household had a latrine, then the target of an ODF Zambia will be attained, despite not indicating how this would be interpreted by men and women or and how it would impact their lives in productive, reproductive and communal roles.

Progress in the sanitation sector in Madagascar was very low with only 12% of the population having access to improved sanitation (JMP, 2015). There was no specific policy on sanitation but there was a guiding framework from the Ministry of Health, which did not have a mention of gender, equity or any targeted interventions for women or men. There



were no indicators noted for disaggregated data. CLTS was introduced in Madagascar by UNICEF in 2008, and since then the sanitation situation improved, making positive progress, motivating communities to eliminate open defecation and building their own latrines. A study carried out by Davies (2015), in two regions of Madagascar revealed that there was a negative gender-based influence on women's engagement in village meetings and CLTS interventions. Both women and men felt that women had less ability and opportunity to actively participate in village meetings, which were the primary governance and decision-making fora for the villages. The study found that women were not as actively engaged as men in contributing to decision-making in the village meetings, nor in CLTS triggering meetings. This also confirmed a study by Buchy et al. (2014) that revealed that participation was indicated as integral to CLTS but found to be rather instrumental rather than empowering, due to limited disaggregated data during work-planning detail, making it difficult to assess the success in gender dimensions. There was evidence of higher levels of empowerment on the part of both women and men in regard to talking about the subject of sanitation within their households and in the broader community. There was also evidence that the CLTS intervention facilitated new, respected roles for women and improved relationships in the villages.

The studies in Madagascar subsequently indicated that there were positive ODF outcomes for both women and men, but there was no evidence that primary outcomes differed by gender. While these benefits seemed to be evenly distributed, there was evidence that improved sanitation created additional duties for both men and women, and that these duties fell particularly on women, though neither gender perceived such additional duties as "work" or as a negative burden (Davis, 2015). This revealed the absence of a universal

gender strategy for CLTS presented a desire for flexible guidelines to accommodate local contexts and recommended further research on the basis of developing such gender guidelines. There were certainly signs that CLTS was making significant progress, but the scale of the achievements across the country remained unclear, until realistic and regular sex disaggregated monitoring could be conducted.

The literature reviewed in Madagascar indicates that CLTS was applied as an approach without a policy framework that did not recognize the various gender needs of men and women and the CLTS intervention did not provide clear indications of gender sensitive outcomes of the process. Also, the Malagasy culture seems to support some gender biased perceptions in relation to sanitation work.

Kenya had an Environmental Sanitation and Hygiene Policy (KESHP), by the Ministry of Health which promoted the CLTS approach as the most scalable approach for sanitation. The KESHP did not have explicit consideration for various gender strategic and practical needs in relation to participating in sanitation provision to the various households. That included accessing land to build latrines or having the financial or physical capacity for building the latrines as required with no subsidies. 90% of the Public Health Officers in Kenya are male with only 10% being women (APHOK, 2014), this translated to the dominant gender that supervised the implementation of the CLTS approach although this aspect was not documented as having any specific adverse effects.

The KESHP refers to “people” rather than groups of people such as women and men, which in effect serves to exclude a gender or diversity dimension. The use of language and concepts determine the direction of policy implementation, the results obtained and the

interpretations of the results. These could constitute and create gender bias, or simply fail to take gender into account. Attention needs to be paid to the meaning of given concepts and to the recognition and understanding of gendered concepts (EU, 2001). The KESHP presented a perspective that completely ignored the gender dimension, or differences between men and women. There were no differences considered between men and women, although they were relevant in the policy, which implicitly reproduced the male norm in the implementation of the policy through the CLTS approach. This was likely to affect the process of implementation of CLTS in relation to issues such as gender, age or even location.

The policy documents of India, Zambia, Tanzania, Madagascar and Kenya that are reviewed indicate that the CLTS approach was most recommended and supported by governments and donors. Yet these countries through their sanitation programmes and government policy documents did not address the gender needs adequately despite some documents indicating the discrepancies of benefits between men, women and children on sanitation matters. Noted in the documents, was that there was recognition of the role of women in sanitation in Tanzania and Zambia documents, but there were no specific provisions made. India and Zambia noted that women and girls suffered more due to lack of proper sanitation, but there were no clear provisions on how to address the gender variations. Notably, CLTS programming without gender considerations had adverse effects to the intended beneficiaries, causing them harm, such as increased burden of work as opposed to providing dignity, comfort and privacy. The study sought to investigate further the KESHP and the CLTS documents if they had any specific provisions on gender during implementation to ensure equitable access and benefits to sanitation and hygiene facilities.

## **2.5 Gender Related Factors Influencing Successful Implementation of the CLTS Approach**

The 2014 MDG evaluation report by UNDP, stated that availability of disaggregated data could identify problems in local areas and specific population groups, thus allowing effective interventions. In relation to CLTS as an approach in improving access to latrines, data sought before identifying areas of intervention focuses on number of toilets, as opposed to the number of people in a household or who constitutes the household. Sex-disaggregated data are urgently needed, along with gender sensitive indicators, which will ensure deeper and more nuanced understanding of progress.

Social factors are often deep rooted and have developed socio-cultural norms, practices and traditions that are not considered a priority in sanitation interventions. Defecation practices are surrounded by cultural taboos and beliefs, which are well understood before any sanitation programme could hope to be effective (Eade et al., 1995). Various cultures, norms and beliefs have negative impacts on sanitation efforts, such as laws and/or customary practices of many countries still deny women an equal right to access land. Women experience serious challenges after the death of their spouses and these challenges are compounded at the point of inheritance (World Bank, 2016). Research found that in 35 of 173 countries in Africa and Asia, female surviving spouses did not have the same inheritance rights as their male counterparts. As a consequence, women's economic opportunities overall are hindered, as well as their ability to access and use sanitation and hygiene facilities. According to the Gender Equality Index (2015), Madagascar ranked in the top 10 countries for overall performance in Africa. However, single women in the

Malagasy community are particularly vulnerable because women relied on men for decision making and they were voiceless in the community (Loi, 2007).

Women continue to be more vulnerable than men in speaking out and thus remain unheard, which adversely impacts on development outcomes on sanitation (World Bank, 2012). What compounded the challenge of limited access to latrines was when the available latrines were not actually used due to other reasons, such as their level of cleanliness, in cases of shared latrines, where the women had the responsibility of ensuring the latrines were clean (Splash, 2014). Other cultural practices that may limit latrine access include, the prohibition of sharing sanitary facilities between adults and children, men and women and in-laws and outsiders. In such cases the women were expected to access the toilets to clean them but not to use them, or in cases whereby they are daughters' in-law or where they were having their menses in some communities (O'Reilly, 2010). Other reasons would include location of latrines and privacy challenges to women as a result of not being consulted during latrine construction by men (O'Reilly, 2017).

The control over resources to finance sanitation intervention at the policy level to the household levels is dominated by more men than women. A UN Water report (2012) indicates that only 10% women occupied offices that controlled such financing. It also noted that only 15% of women were in ministerial or chief executive officers' positions in line with sanitation in Africa. Control of land where latrine construction takes place was controlled by men which was due to the fact that most of the communities practise the patriarchal system (O'Reilly, 2017). Men own the land through inheritance or buying, this is slowly changing, as women were able to buy land with a low number in the rural areas in Kenya (Wamera, 2016). Women in Africa access land as daughters, wives or sometimes

owners. This does not provide them with enough space to make decisions on how to manage the land, as opposed to the landowners who are predominantly men (Ulrich, 2016).

The literature interrogated indicated that data management was critical to indicate the number and gender of people reached with programming and how they benefitted. Social cultural factors were listed as key determinants of access and control of resources that would ensure equitable access, usage and benefits to the sanitation facilities that are provided by the CLTS programmes. Limited financing for sanitation was noted as a key perpetrator to unequal access to sanitation, especially in cases where the women had other underlying factors making them more vulnerable, such as poverty, widowhood or living in households that shared latrines. The study sought to understand if the same gender related factors affected the implementation of CLTS in Siaya, Nambale and Teso Sub Counties and if not, what else would contribute to the situation.

## **2.6 Gender Roles in the Implementation of a Successful CLTS Approach**

It was noted that improved access to sanitation and hygiene facilities and services, as a result to equal distribution of unpaid sanitation and hygiene work between men and women meant that women had more opportunity to devote time to other aspects of life such as livelihoods and education. A meta-analysis carried out by the Australian Aid Water Partnership of household surveys across 45 developing countries found that 72% of the household water and sanitation related tasks were done by women and girls (Grant et al., 2016). A study carried out in 16 countries, whereby Kenya was included indicated that 10% of girls aged 5-14 years performed household chores for 28 hours or more each week, which kept them away from studies and among these chores, was sanitation and hygiene provision for the family (ILO 2009). Work done within the home is not counted as contributing to the growth

of an economy, only work done outside of it is. This economic assumption seems harmless but has severe consequences for women and girls (Viterri et al., 2016).

Women in various countries spend over two thirds of their working day on unpaid work, with an equivalent statistic one quarter of men (UNDP, 1999). In Britain, just the value of unpaid childcare was more than three times that of the financial sector. Housework was not as hard to measure as some of the parameters that are measured and included in the Gross Domestic Product (GDP) of a country. However, there was no effort made to measure the effort put in by the women in housework, which sanitation and hygiene is part of. This is because women's work is considered a natural resource that does not need accounting for, as it was assumed that it would always be there (Valerie, 2010).

The need to meet sanitation and hygiene needs has been left mainly to communities or individual households, which naturally fall on the women, regardless of their economic status or capacities (SNV, 2012). There was positive and statistically significant impact on social behaviours such as cooperation and community empowerment as a result of a CLTS intervention reported in a Mali programme. The community empowerment aspect of the programme indicated that the improved interaction between men and women contributed to more consultative processes between men and women that contributed to improved livelihoods (Alzure, 2015).

Sustaining gains made in CLTS includes ensuring the cleanliness of the latrines, a responsibility left for the women (Splash, 2014). Generally, the latrines will be less used if they are not frequently cleaned and maintained well on a daily basis. The role of hygiene promotion in the communities is well taken up by the Community Health Workers (CHWs)

who are predominantly women (USAID, 1998). The CHW in Kenya were previously tasked with community work in relation to health. The role of the CHWs has evolved over time to include most of the health development interventions in the community as well as sanitation (MOH, 2010). This, by default has seen the increase of the responsibility of the CHWs, who are tasked with frequent follow ups to communities to ensure that gains made through the CLTS intervention are maintained (Wamera, 2016).

Some instances indicate that the gender of the CLTS facilitator is indicated as less important for the CLTS process compared to the level of trust in the facilitator (Davies, 2015). However, it is also noted that women do not participate equally in the CLTS process, and strongly argue for both women and men facilitators and for women to be involved in all levels (UN Women, 2014a; Kar & Chambers, 2008). This suggests that the barriers women face in freely participating during meetings are more related to pre-existing social and cultural barriers rather than the subject matter or the gender of the facilitator. Robert Chambers, being a main architect of the CLTS process, suggests that if in the triggering and post triggering processes, the facilitators ensured that women's voices are heard and there is an equal or majority representation of women on the sanitation committees, then there is more active engagement of men and women. He asserts the balance of gender representation could have a significant effect on CLTS outcomes (Davies, 2015).

The literature interrogated indicated that there was gender bias in division of labour in relation to sanitation and hygiene and that it was not considered in programming nor counted or measured. The literature indicated further that sanitation provision was the responsibility of the household, which fell on the woman as part of her reproductive role. This was further experienced beyond the home having more women serving in the village



health committees or as CHWs more and also directly maintaining the sanitation facilities in the home to ensure the ODF gains made are maintained by the households having functional latrines. It was also noted that beyond the home, the gender of a CLTS facilitator did not matter, but actually it did, as women had limited decision-making power in the community. Moreover, women had limited participation in programming that affected their contribution. The study sought to understand what the roles women and men played in CLTS implementation in Teso, Nambale and Siaya sub counties in the CLTS programmes. The study also sought to understand if it was the same situation as indicated in the literature reviewed, who did what in the study areas for the success of the programme.

## **2.7 Effects of the CLTS Approach to Women and Men**

Women from ODF communities in Madagascar and Sierra Leone were noted to be much more vocal and confident in engaging with outsiders, as compared to non ODF communities, in relation to increased women voice (Davis, 2015; Plan, 2013). In ODF villages, the empowerment of women and men was evident especially in regard to an increased village voice when speaking about sanitation with others within the village. It also facilitated new roles for women and improved relationships in the village. The women's voice was increasingly improved in village meeting formats. It was noted as an advantage for ODF village, women enjoyed a mutual level of trust and felt safer and more empowered to voice their needs and preferences in relation to sanitation. This aligned with the goal of the CLTS approach that sought to empower people to take action to improve their circumstances in a range of community-determined problems (Movik et al., 2010).

According to Malagasy, Bangladesh and Indian cultures, CLTS programmes created additional burden for women as an outcome of improved sanitation, and in general men did not perform household tasks (Davis, 2015; Mehta et al., 2011; Mahbub, 2011). Women were responsible for taking care of the household, men would take up some of the responsibilities in the household when the women were sick, which was perceived negatively by programme and development actors. CLTS sustainability results depended on the voluntary engagement and contribution of communities whereby volunteers were women who served as CHWs in rural areas, but in urban areas there were contractual obligations for service delivery through management consultants (Myers, et al., 2016; IDS, 2016). Kenya relies on the voluntary services of CHWs, who are predominantly women, to implement CLTS (Wamera, 2014). To counter the possibility that sanitation programmes entrenched unequal gender roles by creating additional burden, Plan Sierra Leone implemented a CLTS programme which involved additional awareness raising to promote everyone's responsibility for sanitation. An example of a change in cultural behaviour occurred in villages that ensured that boys and girls took responsibility for sweeping and cleaning the latrines on a weekly rotational basis (Plan International, 2013).

The literature interrogated indicated that CLTS implementation impacted on the women and men both positively and negatively. There was an indication of empowerment through increased participation and women becoming more vocal. However, there was no indication of how much empowerment had taken place in relation to decision making beyond being heard and the level of participation of women evidenced could not be determined. It was also noted that there was increased burden of work for the women, indicating unequal division of labour, which was also alluded to under social cultural factors. It was evident

that CLTS did not challenge existing inequalities and help to transform them, but actually entrenched them. Besides, CLTS encouraged voluntary service by the village health committee and natural leaders, who in most of the instances were women. The study sought to understand whether there were positive and negative effects of CLTS implementation on women and men in Teso, Nambale and Siaya sub counties. The study also sought to understand how these outcomes affected women in relation to performing their communal, productive and reproductive roles in lieu of the success of the programme.

### **2.8 Strategies that would Ensure Gender Equitable Impact of the CLTS Approach**

A realization that the world is not equitable at any level is critical and needs a closer look at various aspects of inclusion (Gosling, 2013). A focus on gender differences is of particular importance with regard to sanitation initiatives, and gender-balanced approaches are encouraged in plans and structures for implementation to ensure that there are no disproportionate burdens to a specific gender.

A gender impact assessment done in 3 states in India, indicated that relationships between men and women improved due to joint commitments given during community forums in relation to sanitation (Nathan, 2013). Involving both men and women in project designs and not just implementation is critical. Where only men were involved in the design and construction of latrines, it resulted in some instances where the toilets were not being used because they were either too dirty or had faecal worms. This was because the women who has been expected to clean toilets, did not know how to do it properly (UNWater, 2013). In these instances, there was an assumption that cleaning within the household was a chore of the women and they were expected to know how to do it, yet no consultation or training had taken place.

CLTS experts indicated that there was no universal gender strategy for CLTS (Davies, 2015). Guidelines ought to be developed to support a gender-sensitive approach which must be flexible to accommodate local realities and facilitate investigation of any unique aspects to inform programme actions, accompanied by relevant capacity to deliver any resulting actions and adequate budget integrating monitoring the approach (WSP, 2011; USAID, 2014; UN Women, 2014a).

Carrying out social assessments before any intervention that specifically considers the gender dynamics could be considered during the pre-triggering phase of the CLTS implementation (Davies, 2015). This would uncover local perceptions, traditions and beliefs concerning gender relations that would inform the CLTS process and provide a basis of comparison from which to measure any social change as a result of the intervention. In an effort to improve the CLTS intervention, some agencies and governments designed interventions that did not consider the local realities and complexities thereof put women into more risk (O'Reilly, 2017). Governments and Organizations implementing CLTS need to be clear about their role as agents of empowerment in facilitation and capacity-building. Legal reform is one step in ensuring equal land, water and sanitation rights for women. However, it must be accompanied by awareness-raising and gender sensitization for both women and men in order to challenge dominant gender biases that affect the implementation of CLTS Programmes (Plan, 2012).

The gender analysis principle that calls for ensuring active participation of women is critical. There is a need to be gender aware through training for program representatives, facilitators and communities (GWP, 2000). The Dublin Principles No.3 states that "*Women play a central part in the provision, management and safeguarding of water*" (UN, 1992). The

Dublin principle requires positive policies to address women's specific needs and to equip and empower women to participate at all levels in programming, including decision-making and implementation, in ways defined by them. Gender sensitive participatory processes are required to ensure that all peoples' needs are heard and addressed equitably. For policies to be effective, both men and women need to effectively participate in their formulation in a genuine and not tokenistic manner in decision making process at all levels (UNDP, 2009). Challenging socially constructed gender stereotypes through sanitation and hygiene provides a pathway to shift social norms that are contributing to gender inequality (Wamera, 2016). Sanitation and hygiene issues are closely associated with women's traditional roles, programmes and policies and these can provide a forum to proactively promote women's voices, participation and leadership. Positive outcomes of CLTS programmes went beyond 'practical' gains for women and indeed led to improvements in women's confidence, voice and respect, therefore, positively affecting their power and status in the community (Willett et al., 2009). Conducting stakeholder consultations in a way that gives women and men adequate representation and voice in the proceedings of the consultations was noted as important (OECD, 2012).

A gender audit provides a tool and approach to assess compliance with the gender equity amendments and to develop an action planning process for moving forward (Harvey, 2010). This process uncovers the specific patterns of gender relations in a community and makes it possible to work within the policy or programme to change the unequal patterns and reinforce the equalizing ones, making policies or programmes more gender responsive (Harvey, 2010). Good sex disaggregated data underpins good practice that contributes to gender equality. Data can be a tool for empowerment if it is disaggregated to identify

disparities between groups within communities (AWP, 2016). However, sex-disaggregated data on global access to sanitation and hygiene was not reported in a consistent and comprehensive fashion, highlighting most data and policy statements being gender blind. Highlighting data on the economic and social consequences on women and girls lacking access to improved sanitation underpins increased and targeted investments in the areas of need (Grant et al., 2016).

Gender gaps were not only caused by unequal access to inputs but also unequal returns to the inputs women had. Introducing new ideas and strategies for making the connection between the different genders' inputs and benefits in programmes as part of gender mainstreaming is critical (WBG, 2014). Gender mainstreaming holds the power to bring women and men together to battle the forces that keep them separate, poor or disadvantaged (Meryl, 2005). Identifying active and effective champions of gender mainstreaming, can get gender equality issues considered during the CLTS programming, but it can also cause other implementers to lose sight of gender issues as they work. Also having a cadre of gender specialists to champion issues often gives other CLTS implementers the impression that they no longer need to worry about gender issues because there are gender specialist on board who will take care of them (WBG, 2014). Finding an effective way to mainstream gender is a relative task that needs to be considered on a case by case basis to ensure that it remains relevant to all the CLTS implementers at all levels in various contexts. Proponents of gender mainstreaming recommend that when beginning any development project, the implementing party should consider both how the gender division of labour will affect the programme and how the programme will affect the gender division of labour. This would determine aspects that need to be realistically addressed within a project (Hunt, 2004). What needs to be

upheld is to improve dialogue on gender concepts and approaches in order to ensure consistency among all the stakeholders from government to the community. Focusing on open defecation alone is not enough, rather sustainable or gender-responsive sanitation should put particular emphasis and re-enforcement on the objective of encouraging and advocating for women's participation at all levels throughout the CLTS implementation (UN Women, 2014; Davies, 2015).

The literature reviewed indicated that CLTS was not gender responsive and some strategies had been applied to address these. They included: the gender impact assessments, gender sensitive social assessments, gender analysis, gender audits and gender mainstreaming. The study sought to investigate which strategies or aspects of strategies would be applicable in the implementation of CLTS in Teso, Nambale and Siaya sub counties to make the CLTS approach gender responsive.

The following section discusses the theoretical framework that the study applied to interrogate the gender outcomes of the CLTS approach in the 3 sub counties in Western Kenya.

## **2.9 Theoretical/ Conceptual Framework**

The study employed the Moser Gender Planning Framework developed by Caroline Moser in 1993. This framework was employed to analyse two objectives of the study that sought to establish how gender needs were addressed in sanitation and hygiene policy as well as programme documents. It was also used to identify gender roles in CLTS implementation. The gender socialization concept based on the gender schema theory by Sandra Bem was applied to assess gender related factors that influenced the CLTS implementation and

provided suggestions for strategies that would ensure gender equitable outcomes. The Gaventa Power Cube Framework developed by John Gaventa in 2006, was applied to interrogate the effects of the CLTS approach on women and men in the three sub counties of Siaya, Nambale and Teso.

### **2.9.1 The Moser Gender Planning Framework;**

The Moser Gender Planning Framework is a tool for gender analysis in development planning. The Framework was developed as part of a Gender and Development (GAD) approach to development planning in the 1980s. The framework lays out the women's 'triple role' in production, reproduction and community affairs, and the multiple roles women perform simultaneously. In contrast, men are often less involved with household chores and more engaged in production and community-managing activities. This framework facilitates the examination of how women and men manage their various roles and identifies the men and women's specific needs. The analysis links gender roles to gender needs by distinguishing between women's practical needs; those that help in everyday life, and strategic needs, the ones that women need to address gender disparities. The triple roles are further explained as follows;

- a) *Reproductive roles* – these roles involve childbearing and caring as well as domestic tasks that support the household's wellbeing, such as cooking, cleaning, fetching water, washing and attending to the sick and elderly members of the family or society. These responsibilities are rarely considered 'real work,' or paid for and they are performed primarily by women and children.



- b) *Productive roles* - these roles are related to activities that produce goods and services for consumption or trade. Both men and women can be involved in these activities. However, women often carry out these roles alongside their reproductive roles in a household farm or home garden, which makes their contributions less visible and less valued than men's productive work.
- c) *Community roles* - these roles involve community work, such as holding social events, activities to improve or care for community resources and/or participating in communal groups.

The framework analyses situations using six tools, namely: Identifies gender roles, the practical and strategic needs of women and defines an access and control profile for resources and benefits of economic activity. It also examines the impact that a new policy, project or programme will have on the three roles, looks at how efficiency or empowerment approaches will address practical or strategic needs and ways women and gender sensitive organizations and individuals can be involved in the process.

This framework emphasizes the importance of gender relations through quantitative empirical facts, investigating reasons and processes that facilitate access and control of resources and services. The Moser Framework also highlights provisions for planning for balancing the triple role played by women, distinguishing between different aims in interventions and involving women in planning. The framework acknowledges a political element to gender planning, and assumes that the process will have to deal with conflicts (Moser, 2010)

The framework rests on three basic concepts that were applied in this research for CLTS implementation and outcomes. These include: the triple role played by women in relation to sanitation. Practical and strategic gender needs that ensured sanitation needs were met as well as contributing to the outcomes of relationships between men and women in relation to power relations in the CLTS programmes. It also provided a platform to interrogate the Environmental Sanitation and Hygiene Policy and the CLTS approach, if they were equitable and empowering, and if they addressed practical or strategic needs of the women and men.

The research applied the Moser framework to the CLTS programme in the 3 sub counties of Teso North, Siaya and Nambale by systematically interrogating the following areas;

- a) Identifying gender roles: what women and men did in various productive, reproductive and community-managing activities in relation to the CLTS
- b) Identifying the practical and strategic needs of women and men in CLTS programme implementation.
- c) Defining an access and control profile for resources and benefits of sanitation activities.
- d) Examining the outcomes of the CLTS programme on the three gender roles. Checking for changes that addressed one area and affected others in a positive or negative sense.
- e) Interrogating how the CLTS programme addressed the practical or strategic needs of the communities in the 3 sub counties.
- f) Identifying strategies for gender responsive programming in sanitation.

The framework had some limitations that the research took note of. First, the concept of gender roles tended to obscure the concept of gender relationships. It therefore gave a false sense of natural order and equality, yet there could have been on-going negotiation, conflict and compromise that were set off in relation to the implementation of CLTS. The framework is also static and does not examine change over time as a variable; it does not consider evolution of the socioeconomic structure over time and the fact that CLTS programme implementation impacted on the lives of the communities in ways that had not been experienced before. Due to the limitations identified, the gender socialization concept which is based on social learning and cognitive theories was applied to deal with the aspect of gender being dynamic by nature and that various aspects contribute towards the behaviour, beliefs, attitudes and practices of communities towards having an equitable community that benefits from CLTS implementation.

### **2.9.2 The Gender Socialization Concept**

The study sought to interrogate the gender socialization concept focusing on the CLTS Approach. This theory puts culture at the centre of application creating consistency and predictability (Stockard, 1999). It draws out two arguments that gender schemas tend to be polarized, so that children believe what is acceptable and appropriate for females is not acceptable or appropriate for males and vice versa. And secondly, gender schemas tend to be androcentric; that is, children internalize the message that males and masculinity are the standard or norm and are more highly valued than females and femininity (Wharton, 2005).

In further examining the gender socialization concept, the study considered the mechanisms of socialization interrogated as identity processes that the family and community or other social groups help to create and maintain. The impact of gender is a systemic- ecological

perspective that considers gender and family socialization as neither parent-to-child nor child-to-parent process. Rather, family socialization is embedded in an environment of context that could have great impact on the individual and thus it's a social system with multiple sources of socialization simultaneously impacting on both parents and children (Carter, 2014). In this study, it interrogated the newly acquired behaviour of ODF and how it impacted on the family norms and how the culture affected the CLTS implementation.

The importance of broad socialization that is witnessed in the current generation due to a wide spectrum of agents of socialization that goes beyond the family (Grusec et al., 2006) is critical. Culture is an important socialization force throughout life and is most efficacious in shaping behaviours of young rather than older adults (Pasupathi, 2001). Older adults effectively exercise individual agency to shape how, why and whom they are socialized with; these are the people who influence the adults' behaviours, beliefs and emotions (Grusec et al., 2006). When generations adopt social structures and modes of social behaviour that are different, it means that a transmission of specific patterns of behaviour has been disrupted (Pasupathi, 2001). This provides an internalization of certain enduring social norms that are introduced within the social structure through the various development interventions which contribute as agents of socialization and the CLTS approach could be identified as one of these.

Another perspective on gender socialization is influenced by ethnomethodology (West et al., 1987), in this perspective, gender is understood as created and maintained while actors assume and play out roles in society. Gender socialization is a process by which individuals develop, refine and learn to 'do' gender through internalizing gender norms and roles as they interact with key agents of socialization, such as their family, social networks and other

social institutions. The process occurs over time and is influenced by inter-related context specific social, economic, and cultural factors operating at the structural, social-interactional and individual levels (Kretchmar, 2009). This aspect was applied to the CLTS approach to investigate how these factors contributed towards CLTS implementation.

Furthermore, sociology highlights the notion that gender beliefs and schemas are dynamic thus shaped and re-constituted over time. Understanding how the gender socialization process unfolds over the life course is a necessary precursor to any efforts that aim to influence its trajectory (Wharton, 2005). Structural factors play a critical role in the gender socialization process; this is because they influence core institutions and agents of socialization and shape opportunities available to groups within society, including men, women, boys and girls (Pasupathi, 2001). Changes at the structural level present both opportunities and challenges to policies and programmes, presented as strategies aimed at ensuring that there are gender responsive sanitation and hygiene outcomes out of the CLTS implementation.

The limitation of the gender socialization concept is that there is a limited ability for governments and societal leaders to control events and processes at the macro level and may not drive patterns of change in relation to cultural settings. These changes by policy-makers and programme implementers with opportunities to promote more equitable gender norms would be construed to be disruptive at a particular point in time.

The Gaventa Power framework was further introduced into the study to understand the power dynamics that could determine social change and shape the outcomes of the CLTS process in communities.

### 2.9.3 The Gaventa Power Framework

In an effort to understand the outcomes of the CLTS process, this study found the Gaventa Power Framework to be a useful conceptual and practical tool for understanding how the CLTS approach affected the relationships between men and women post ODF. The framework analyses levels, spaces and forms of power, and their inter-relationship.

- The ‘forms’ dimension of the cube refers to the ways in which power manifests itself, including its visible, hidden and invisible forms.
- The ‘spaces’ dimension refers to the potential arenas for participation and action, including what is called closed, invited and claimed spaces.
- The ‘levels’ dimension of the cube refers to the differing layers of decision-making and authority.

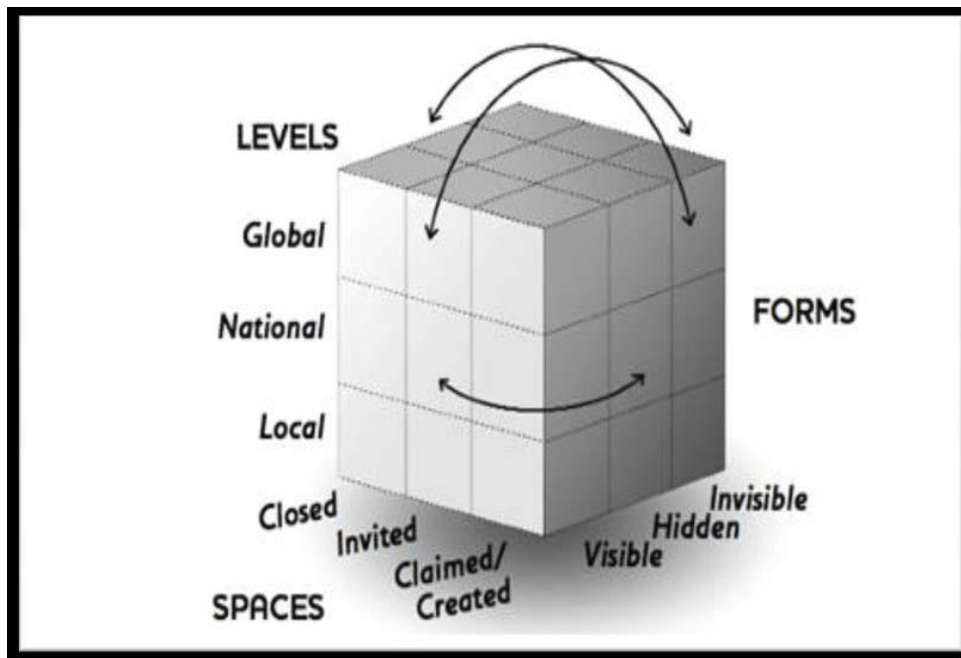


Figure 2.1 The Gaventa power framework showing the Levels, spaces and forms of power (Gaventa, 2006)

This Power framework was introduced so as to interrogate the theory of change of the CLTS approach of empowering the communities to manage their sanitation issues. This framework tested perceptions, assumptions or beliefs about the process or pathway through which presumed social change happened post ODF. Two realizations of the CLTS outcomes were reviewed - unequal power dynamics that were at the centre of relationships, practices and policies as well as unequal power balances that were sustained through a complex and ever-shifting nexus of visible 'power over', hidden mechanisms of domination and effects of internalized oppression.

The Power framework explored how powerful actors controlled the agenda through and the ability of less powerful actors to build their awareness and action for change. It was also used to think about the openings, levels and strategies to exercise agency, e.g. to strengthen the power to act. By looking at how alliances are formed with actors working on each dimension and aspect, there was constant interrelating of the facets, constantly changing the synergies of power affecting participation and engagement. The framework sought to provide some answers to the gap between CLTS theory and ODF practice. Understanding power in ODF communities indicated if any real change had occurred strengthening peoples' participation in decisions that affected their lives.

The framework interrogated the CLTS focus on quick wins and results, whilst not appreciating the complexity of social relations and how these are measured. This drew attention to power relations and how CLTS addressed or challenged underlying issues of power, that were not linear and simplistic, yet recognizing that changes in power can be measured, especially through involving the perceptions of people themselves.

There were two major limitations to the Gaventa Power framework which meant that on its own, it could not be used. In cases of sanitation and hygiene work, there was non-linearity of power dimensions when it came to linking them to theories of change. The framework assumed power as a linear framework where building power ‘within’ would lead to power ‘to’ and power ‘with’. In some cases, collective action and support in sanitation and hygiene may be a vital source and precursor to individual agency. Such pathways to change may sometimes reflect reality, it is important to engage with the complex dynamics of change. The expressions of power have been used for shaping definitions of women’s empowerment, but additional frameworks for gender analysis, such as the ‘public, private and intimate realms’ of power, conceptualization and sources of power have been used to expand the levels and spaces of power from a gender perspective.

A combination of the Moser Gender planning framework, the Gender Socialization concept and the Gaventa Power Framework provided a basis for developing the following conceptual framework to interrogate the gender outcomes of the CLTS approach in Teso North, Nambale and Siaya Sub counties in Kenya.

The conceptual framework provided an illustration of the various independent factors that directly contributed to the CLTS approach, these included the political, social, economic factors as well as the results of the CLTS approach. With the introduction of the intervening variables that included gender responsive impact assessment and gender mainstreaming contributed towards progressively achieving an equitable CLTS approach. The framework presented the impact of introducing the intervening variables which meant reprogramming



towards a dependent result which was an equitable community led total sanitation approach ensuring that the intervention highlighted the gender aspects of programming.

## 2.10 Conceptual framework

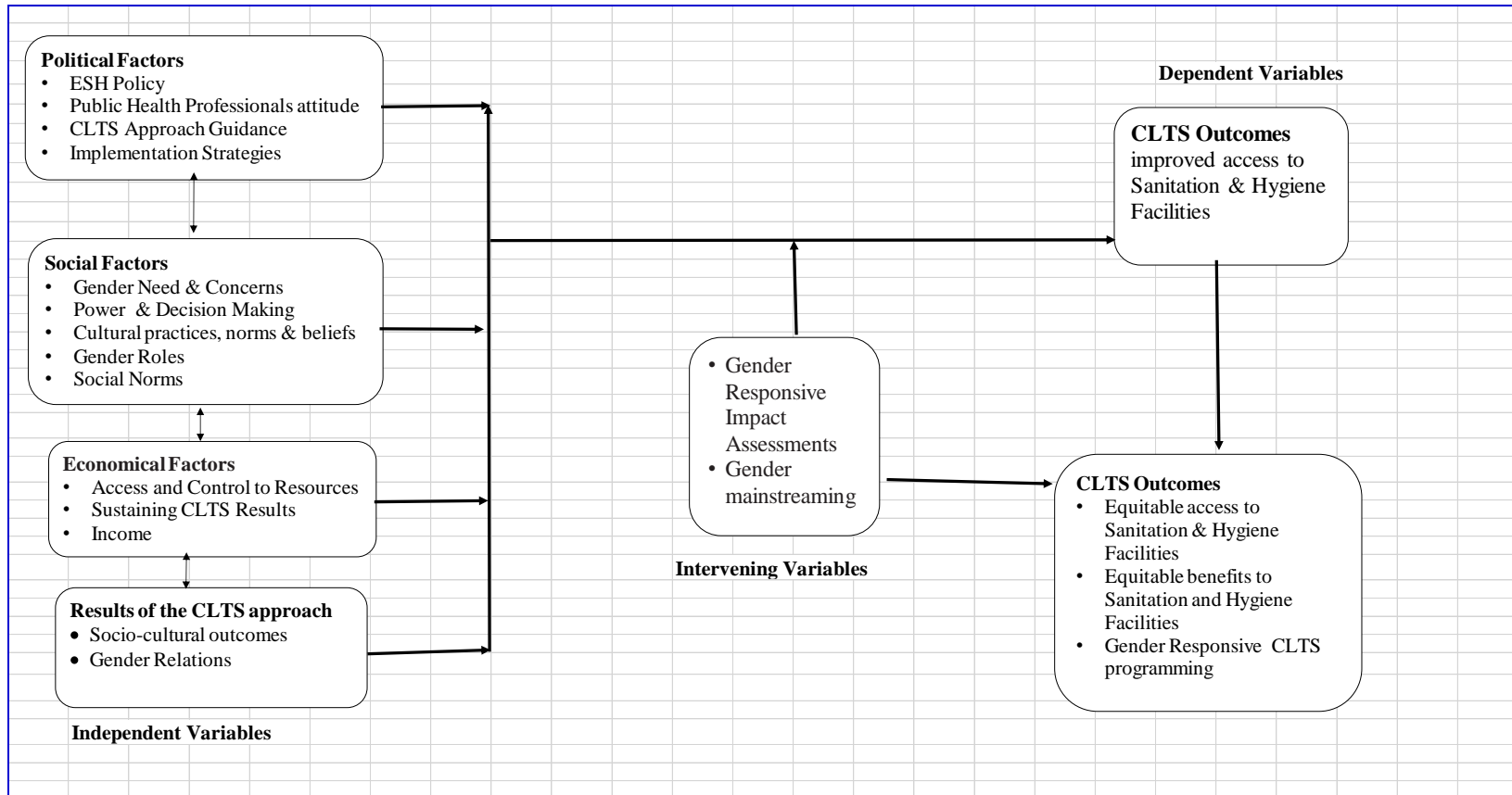


Figure 2.2: Gender Outcomes of the CLTS process

## **2.11. Summary**

The chapter reviewed literature in various forms and presented the following; the gender needs and sanitation, factors that contribute to the CLTS adoption, environmental sanitation and health policies, protocol and programs that address sanitation provision in the following countries – India, Tanzania, Zambia, Madagascar and Kenya. Gender related factors that influenced successful implementation of the CLTS approach and gender roles in implementing successful CLTS approach were reviewed. The effects of the CLTS approach to men and women and the strategies that could ensure gender equitable impacts of the CLTS approach were reviewed. A theoretical and conceptual framework was also reviewed and presented through interrogating the Moser gender planning framework, the gender socialization concept and the Gaventa power framework. Despite all these literatures reviewed, there was limited literature on evidence indicating the gender outcomes to the CLTS approach. This led to the researcher to proceed to carry out further research which is laid out in chapter three which indicated the research methodology employed in the research.

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter presents the procedures and techniques that were used in the collection, processing and analysis of data. The following subsections were included: research design, categories of analysis, site of study, target population, sampling technology and sample size, research instruments, pilot study, data collection procedures, data analysis, data management and ethical considerations.

#### **3.2. Research Design**

The research was carried out through a comparative study design that identified, analysed and explained similarities and differences (Hantrais, 1996) across the 3 sub counties in relation to CLTS implementation and took into account the socio-cultural settings of the different contexts in implementing the programme that had contributed to the sanitation status of the sub counties.

A comparative research design was considered appropriate as it enabled comparison of varied contexts that influenced the results of the CLTS programme as well as its sustainability. The CLTS program was initiated in these 3 sub counties at the same time, with the same resourcing of personnel and finance. The results of the CLTS process was not the same despite having the same inputs. Nambale reported being 100% open defecation free (ODF) in a time period of 18 months of implementation. Siaya became 85% open defecation free after implementing for 18 months and Teso North was only at 45% open defecation free after the implementation period of 18 months. Nambale remained open defecation free 1 year after being certified ODF and Siaya became ODF

after 24 months of implementation, while Teso North was at 70% after 24 months at the onset of the study.

### **3.3. Variables, Categories of Analysis and Presentation**

The independent variables included:

*a) Political factors*

These included the analysis of the Kenya Environmental Sanitation and Hygiene policy, the public health officers, the CLTS guidance provided and implementation strategies that were employed for successful CLTS implementation in Kenya.

*b) Social factors*

These included the interrogation of the gender need and concerns, power, decision making, culture, gender roles and social norms and how they impacted on the CLTS implementation.

*c) Economic factors*

These included the determining of access and control of resources and sustaining CLTS results to ensure that the CLTS approach benefits all the community members according to their needs.

*d) Results of the CLTS approach*

These included the interrogating the socio-cultural outcomes and the impact on gender relations of the CLTS process to the communities.

The intervening variables included:

- a) Gender responsive impact assessments – this included assessing what activities and strategies would contribute to ensuring that the CLTS approach is equitable to all.
- b) Gender mainstreaming – this included establishing the various strategies that would ensure that the men and women contributed towards an approach that they both benefited from equitably, without entrenching insubordination of one gender.

The dependent variable was an equitable CLTS approach

### **3.4. Site of the Study**

The study was carried out in 3 sub counties; Teso North, Siaya and Nambale. Teso North Sub County is part of Busia County and is home to the Ateso. It is located at the border between Kenya and Uganda. It has 2 divisions, 6 wards. The Teso were known to have been pastoralists since time immemorial, however, they have now embraced farming and are the most successful farmers in both Western Kenya and Eastern Uganda where they engage in subsistence farming and trade in agricultural produce. In recent years, the people have changed much of their lifestyle (UBS, 2006). Nevertheless, sanitation behaviour had not changed as this sub county by the time of the study and was yet to be declared ODF. Teso North had low sanitation coverage at 40% with only 148 villages out of 370 villages being ODF. Teso North had a population that constituted 56% women and 44 % men. The sub-county was considered a hard to reach area (WSSCC, 2015) and prone to cholera and diarrhoea outbreaks due to open defecation and limited safe water. It is a Sub County in Busia that was considered to be difficult to carry out the sanitation

interventions because of the nature of the homes being far flung from each other (MOH 2015), thus posing a challenge of having inclusive community meetings.

Siaya Sub County is part of Siaya County, is home to the Luo, which is the third largest community in Kenya and makes up close to 13% of the entire population. The Luo reside in the regions around Lake Victoria. Siaya has 3 divisions and 6 wards. Siaya was the most cholera prone district in Kenya since 2003-2011 (MOH 2013). It had limited sanitation coverage and poor access to safe drinking water that led to severe cholera outbreaks and deaths at least twice a year. By the time of the study it had sanitation coverage of 85% having 425 villages out of 501 villages being ODF. Siaya had a population that constituted 58% women and 42 % men.

Nambale Sub County is part of Busia County located along the Lake Victoria; it has 1 division and 4 wards. Nambale is home to the Luhya, Kenya's second largest ethnic community that accounted for 14% of the Kenyan population, living in the agriculturally fertile western region. Traditionally, the extended family and the clan were at the centre of the Luhya culture. Nambale had sanitation coverage of 100% by the time of the study with all the 296 villages having been declared ODF by 2011. Nambale had a population that constituted 66% women and 34 % men. Nambale was known as one of the districts in Busia that had a high prevalence of cholera and scabies (MOH, 2013) due to faecal contamination especially out of open defecation in the sugarcane plantations during the rainy season that would drain into the unprotected water points.

All the 3 sub counties were located in the Western part of Kenya and were chosen for the study due to the various results after the same period of CLTS implementation with

Nambale being at 100% Open Defecation Free (ODF), followed by Siaya at 85% and Teso at 40%.

### **3.5 Target Population**

The target population for the study was all the households in the 3 sub counties.

Teso North Sub County had 2 divisions and 6 wards as follows; Angurai North, Angurai South, Angurai East, Malaba North, Malaba Central and Malaba south, with total area population of 142,058 with 20,294 households. Siaya Sub County had 3 divisions with 6 wards as follows; Usonga, West Alego, Central Alego, Siaya Township, North Alego, South East Alego, with a total population of 212,386 with 27,350 households. Nambale Sub County had 1 division with 4 wards as follows; Bukhayo Central, Bukhayo East, Bukhayo North / Walatsi and Matayos North, with a population of 113,983 with 16,283 households.

Other study participants included PHOs, village elders and Community Health Workers and sampling was done for the households due to the large number in the 3 sub counties where the study took place.

### **3.6 Sampling Techniques**

The study employed the clustered sampling technique wherein the entire population in the 3 sub counties was sub-divided into clusters, which were the divisions, from which random samples were drawn. The information on the entire population was found through the county offices and the Kenya Bureau of Statistics census data of 2009. The cluster were formed on the basis that the populations shared attributes and characteristics of CLTS interventions in the 3 sub counties.



### **3.7 Sample Size**

In the cases of Siaya and Teso, the divisions were further sampled randomly for every second random sample and Nambale had just one division, so no division samples were drawn for Nambale. The ward samples were drawn randomly on every 2<sup>nd</sup> ward. The random sampled wards were further sampled for sub locations as follows;

- a) The following wards were randomly selected in Teso North sub county; Angurai North, Malaba Central and Angurai East. Then the following were the sub locations randomly selected; Katotoi, Amagoro and Kolanya sub locations.
- b) The following wards were randomly selected in Nambale sub county; Bukhayo and Nambale. Then the following were the sub locations randomly selected; Musokoto and Nambale sub locations.
- c) The following wards were randomly selected in Siaya sub county; South Alego, Siaya township and Usonga. Then the following were the sub locations randomly selected; Bar Osimbo, Nyandiwa and Sumba sub locations.

The sampling of households was drawn based on the list of households that was generated as a part of monitoring for CLTS that was kept by the Public Health Officer at the sub location level. Households were randomly picked for every 10<sup>th</sup> household. It was planned that in case the 10<sup>th</sup> household had no adult available to take part in the study, then the nearest household would be visited for the same purpose, to ensure that there was minimal bias in the study.

The most effective sample size of a large population is between 10 - 30% to ensure proper representation of social issues (Krejcie & Morgan, 1970). In the case of this study,

there were a total of 63,927 households in the 3 sub counties, these were many households and if 10% of the households were considered, it would have been high. Due to this fact, the researcher used the Z-score for the three sub counties to determine the number of respondents as follows;

$$\text{Necessary Sample Size} = (Z\text{-score})^2 * \text{StdDev} * (1 - \text{StdDev}) / (\text{margin of error})^2$$

With a 95% confidence level, .5 standard deviation, and a margin of error (confidence interval) of +/- 5%.

$$((1.96)^2 * .5(.5)) / (.05)^2$$

$$(3.8416 * .25) / .0025$$

$$.9604 / .0025$$

$$384.16 = 385 \text{ respondents were needed}$$

### **3.8. Inclusion and exclusion criteria**

The clustered and simple random sampling was chosen because the population was large consisting of entire populations of 3 sub counties. Respondents comprised of both male and female members of households. Further, the sampled respondents were above the age of 18 years and had capacity to be involved in communal activities in relation to hygiene and sanitation issues. All the households in the wards that were sampled had participated in the CLTS implementation process.

The only exclusion in the study was that people below 18 years would not participate in the study, whether they had participated in the project in different forms.

### **3.9 Research Instruments**

Secondary and primary data were collected for the study. Secondary data included information collected from policy documents, library books, journals, articles, electronic sources and reports from various development agencies and government departments.

Primary data was collected by the use of Structured interview guides (Appendix 2.1), observation checklists (Appendix 2.2), key informant interviews (Appendix 2.3) and focus group discussions (Appendix 2.4).

#### **3.9.1 Structured Interview Guides**

Structured interview guides were used to collect data from the households. The Structured interview guides were divided into sections to collect demographic data and programmatic data. The Structured interview guide was considered as the most convenient method to collect data from households through research assistants who were required to guide respondents to answer the questions whilst the research assistants filled them in. This ensured that all the information given by the respondents was recorded on the Structured interview guide and since the researcher was not able to cover the entire study area in the planned period of time, she enlisted the research assistants. Administering Structured interview guides took 4 months because it involved booking appointments with the community health workers who mobilized households to participate in the study and ensure that the respondents were available to meet with the researcher or research assistant to respond to the Structured interview guides. Explanation and clarity were provided to the respondents as to why the study was being conducted.

### **3.9.2 Key informant Interview Guide**

Key Informant Interview guides were used as a method of primary data collection amongst the government officials at the Ministry headquarters, at the county, sub county levels and for the heads of non-governmental organizations that implemented CLTS in the areas of study. Data was sought from these key informants as they were considered individuals with specialized knowledge on CLTS interventions. The Interviews begun with a set of baseline questions, but the researcher probed to elicit more information by requesting that the key informant expanded their answers on the initial questions. This method was ideal for obtaining in-depth descriptive data on beliefs and practices, including procedural and administrative information on programming.

There were 12 Key In-depth interviews that were carried to, namely with; the Director of Sanitation and Chief Public Health Officer at the Ministry of Health in Nairobi, County Executive of Health Officers, the County Public Health Officers of Busia and Siaya Counties were interviewed. Also, the Sub County Public Health Officers from Nambale, Teso North and Siaya sub counties, Non-Governmental Organizations (NGOs) and International agency executives that worked in the 3 sub counties in CLTS interventions were all interviewed after booking appointments and engaging directly with the respondents.

### **3.9.3 Focus Group Discussion Guide**

Focus group discussions were considered as the most effective way to understand the views, beliefs and opinions of representative members of the Community Health Committees that comprised of Community Health Workers who were involved in the implementation of CLTS approach in the communities as volunteers or natural leaders. A

focus group guide was developed to facilitate discussions that were held with a small number of between 10-15 individuals, on the implementation of CLTS and its outcomes.

There was a total of 3 FGDs held, namely; in Majiwa A in Siaya Sub County, Alupe in Teso North Sub County and Mundika in Nambale Sub County, all in Kenya. The FGD participants indicated that they had approximately 50-100 households with an estimated population of approximately 1000 in their catchment areas. The discussions were initiated by asking initial questions and structuring the subsequent discussion, to generate more information and views of the community volunteers. Focus group discussion participants were drawn from the same samples of wards that had been drawn, but a further random sample was drawn to acquire the 10-15 individuals as opposed to having all the volunteers taking part in the focus group discussions.

#### **3.9.4 Observation Checklist**

An observation checklist was designed to facilitate the collection of primary data by the research assistants as they carried out the household interviews. The research assistants were trained to observe specific measurable aspects of the CLTS interventions. The observation provided extra information which was used to cross check respondents' responses and triangulate the information provided by the respondents in relation to observable indicators. Some of the observable indicators included the distance of latrines from the household, the state of the latrine, the presence of functional hand washing facilities, presence of water and soap at the hand washing station, frequency of utilization of the hand washing facilities and the hand washing techniques.

### **3.10 Validity and Reliability**

Bless and Higson-Smith (2000) advice that it is important to have a small study conducted prior the main research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate. Samples were drawn from the 3 sub counties, which included Teso North, Siaya and Nambale in the study area, for testing for validity and reliability of the instruments developed. 10 households for every sub county were considered as a pilot. The results of this process were useful in determining whether the respondents understood the Structured interview guides, key informant interviews as well as if the observation checklist captured all the ODF parameters. The sampled households and the key informants did not take part in the main research activity to reduce prejudice of the respondents.

### **3.11 Data Collection Procedures**

The researcher set up appointments through community health workers for the sampled households to meet with respondents so that they can fill the Structured interview guides in the presence of the researcher or research assistants. Appointments were set up with the various key informants for the Key Informant Interview (KIIs) to ensure that the respondents had enough time to answer all the questions in the interview guide. An observation checklist was used in the households to indicate the presence of the basic criteria for considering a household an open defecation free area. Appointments were also sought for the focus group discussions of the sampled community health workers and health committees to provide ample time and space for properly held focus group discussions.

Accessibility to secondary data was a constraint due to limited studies that have focused on gender impacts or outcomes assessments on sanitation approaches globally, regionally and nationally. This was minimized by relying on general water and sanitation published annual reports of the ministry of health and education, both in the print and electronic media, within Kenya and beyond.

### **3.12 Data Analysis Procedures and Presentation**

The study generated both quantitative and qualitative data. The data sources were both primary and secondary. Responses to each question during primary data collection were assigned a numeric value so that the information was entered into an electronic database (Orodho, 2003). After the data collection was done, it was entered into a computer programme and then inspected for any errors that could have been due to coding or entry, this was done to eliminate errors and facilitate the data analysis.

Qualitative data was analysed through developed themes and categories (Ratcliff 2002), that facilitated content analysis from the focus group discussions. This was done through the inductive approach considering the analysis framework. These included coding and indexing as well as transcribing of the key informant interviews. Focus Group Discussions as well as presentation of the observation checklist provided more information for triangulation. A computer software known as Atlas t 6.0 and Open Code 3.4 were used for analysis.

Quantitative data was analysed by employing descriptive statistics and inferential analysis using statistical package for social science version 16.0. This technique provided simple summaries about the sample data and presented quantitative descriptions in a

manageable form. The Structured interview guides were coded and edited for completeness and consistency, together with simple graphics analysis. Descriptive statistics form the basis of virtually every quantitative analysis of data (Kothari, 2005). These were presented in tables to indicate the relationship of the identified variables.

The qualitative data analysed was presented in narrations and verbatim to indicate the relationship of the identified variables to the successful implementation of the Community Led Total Sanitation approach in the 3 sub counties.

### **3.13 Data Management and Ethical Considerations**

The researcher sought a permit from the National Commission of Science Technology and Innovation (NACOSTI) and acquired letters of permission to carry out the study in the targeted sub counties from the Kenyatta University to enable her to proceed with the study. Permission was also sought from the County Executives of Health and County Public Health Officers in Busia and Siaya Counties this was through seeking appointments to go and discuss with them the purpose of the study and possible contribution to a body of knowledge that would improve lives in the county.

Consultative meetings were also held with the local authorities and village elders to obtain consent from the leadership for the study to take place, ensuring that confidentiality was upheld. There was a plan drawn on how give feedback information once the study was complete. Before the actual data collection, informed consent was sought from the participants in the study to ensure that they understood the study and its implications on their lives.



### **3.14. Summary**

The chapter discussed the research design, variables, categories of analysis and presentation. It also presented the study site, the population, sampling techniques and sample size. The inclusion and exclusion criteria, the research instruments were presented. Validity and reliability of the instruments was presented as well as the data collection procedures. Data analysis and presentation procedures were discussed, and the data management and ethical considerations were outlined.

## **CHAPTER FOUR**

### **DATA ANALYSIS, INTERPRETATIONS AND DISCUSSIONS**

#### **4.1 Introduction**

The chapter presents the analysis, interpretations and discussions of the study data. This chapter is organized into six different sections; the first section focused on the bio data of the research participants in the three sub counties (Nambale, Teso North and Siaya). The subsequent five sections focus on findings and discussions on each of the objectives of the study. There were 3 Focus Group Discussions held, 12 key in depth interviews and out of 385 household Structured interview guides administered, 348 were returned and considered adequate for analysis.

#### **4.2.1 Demographic Characteristics of the Respondents at the Households**

The respondents in the study were a sample from households based in Nambale, Teso North and Siaya Sub Counties in Kenya who were of different categories. The variables that were considered include: gender, age, years lived in the village and education level. They are presented in Table 4.1.

**Table 4.1: Demographic characteristics of the respondents at the households**

Demographic Variables of the household respondents	Sub counties						No.	%
	Nambale		Siaya		Teso			
<b>Gender of Respondent</b>	<b>Nambale</b>		<b>Siaya</b>		<b>Teso</b>			
Men	52		52		84		188	54
Women	70		60		30		160	46
<b>Total</b>	<b>122</b>		<b>112</b>		<b>114</b>		<b>348</b>	<b>100</b>
<b>Age (Yrs)</b>	<b>Nambale</b>		<b>Siaya</b>		<b>Teso</b>			
	<b>M</b>	<b>W</b>	<b>M</b>	<b>W</b>	<b>M</b>	<b>W</b>	<b>No.</b>	<b>%</b>
Below 30	20	24	15	31	30	9	129	34.2
30-45	18	23	20	16	20	11	108	32.4
45 - Above	14	23	17	13	34	10	111	33.4
<b>Total</b>	<b>52</b>	<b>70</b>	<b>52</b>	<b>60</b>	<b>84</b>	<b>30</b>	<b>348</b>	<b>100</b>
<b>Length of stay in village (years)</b>	<b>Nambale</b>		<b>Siaya</b>		<b>Teso</b>		<b>No.</b>	<b>%</b>
Below 5 yrs	0		0		0		0	0
Above 5 yrs	122		112		114		348	100
<b>Total</b>	<b>122</b>		<b>112</b>		<b>114</b>		<b>348</b>	<b>100</b>
<b>Level of Formal Education</b>	<b>Nambale</b>		<b>Siaya</b>		<b>Teso</b>		<b>No.</b>	<b>%</b>
	<b>M</b>	<b>W</b>	<b>M</b>	<b>W</b>	<b>M</b>	<b>W</b>		
Adult literacy	8	5	7	4	5	5	34	10
Primary level	10	15	10	15	45	10	105	30
Secondary level	35	20	30	25	21	15	146	42
Tertiary/University	15	14	15	6	10	3	63	18
<b>Total</b>	<b>68</b>	<b>54</b>	<b>62</b>	<b>50</b>	<b>81</b>	<b>33</b>	<b>348</b>	<b>100</b>

### ***a) Gender of Household Respondents***

Sanitation issues in Kenya are considered a household issue. Knowing who was interviewed at the household contributed to understanding how sanitation was viewed in the community. The summary of the household's distribution by gender was given according to the sub counties in Table 4.1, where it indicated that 188 (54.0%) the majority were men while 160 (46.0%) were women. It also indicated that there were more women respondents in Nambale at 70 and Siaya at 60 households and Teso had 84 men respondents at the household level. The findings also indicate that most of the respondents in the study area were women, but the Teso had a high number of men respondents at the household level by a very big margin. The data corroborates the findings from the demographic Health Survey of these sub counties that indicated that the male headed households were at 73% as opposed to female headed households at 27% (KDHS, 2009).

### ***b) Age of Household Respondents by Gender***

The age of the respondents to the household structured interview guides had to be determined before the structured interview guides were administered to ensure that the household respondents were of a consent age of 18 years and that these were men or women who would ideally be involved in communal activities on their own free will. The distribution of household respondents by age given in Table 4.1 indicated that, majority of the household respondents were aged below 45 years at 66.8% while 33.2% were above 45 years. It also indicated that Nambale and Siaya had more women below 30 years as compared to men in the same age group, whilst there were more men in both sub counties in the age bracket of 30-45 years than women. In Teso, there were more men

above 45 years as compared to women or any other sub counties in the study area and it was also noted that there were more women above 45 years in Teso compared to the other study areas. These findings indicated that the majority of the households' respondents were an age group that was open to ideas and quick to adapt. According to the social learning theory this is a period when most experiential learning takes place in the community as young adults settle down into long term relations. Additionally, adults also interact with people who are not socially close to them, such as health care workers, neighbours, religious and communal gatherings (Fingerman, 2009).

***c) Length of Time Respondents had resided in the Villages***

Any community intervention requires time for it to be implemented to completion and the outcomes of the intervention to be felt. In the case of CLTS, from community triggering to declaration of ODF varies from 3 weeks up to six months depending on various factors in the communities. Individuals adapted a learned behaviour in sanitation and hygiene, and they practised it for 28 days for it to be completely engrained. It also required at least application for another 3 years before completely integrating it or dropping it (Dreibelbis et al., 2013). Based on this, the study involved respondents who had lived in the villages for more than 3 years. The findings in Table 4.1 indicated that all the household respondents had lived in the village for over 5 years. This made the study questions very viable to the households in the study area as they sought to assess the outcomes of the project. Siaya had been declared ODF in 2010 followed by Nambale in 2011 and Teso was declared 80% ODF in 2012. This data also indicates that the household members interviewed had been living in the same land over the years, confirming that these were

rural households that had been indicated in the KDHS 2009, as most of them occupied ancestral land, with minimal migrations.

***d) Highest Level of Education by Gender***

Determining the level of education of the household respondents enabled them to engage and respond to the Structured interview guides without any challenges of understanding the concepts of the study on sanitation and hygiene and also pre-empted their participation levels of the CLTS intervention in the community. Table 4.1 indicated that, majority of the households at 90% had attained formal education while 10% of the respondents underwent adult literacy. The data notes that most of the respondents at 42% had secondary education with majority being men from Siaya. It was also noted that 30% of the respondents had primary level education with 45 men from Teso North being the majority. 8 men from Nambale formed the majority of the 10% of the respondents who had taken adult literacy classes. This data also indicated that only in one incidence there were 15 women in Siaya who had primary education more than the men at 10. On average most women interviewed had a lower level of education than the men. This was evident in that the majority of the household respondents who were men, were literate. UNFPA (2016) notes that the level of literacy is a critical enabler that determines the level of participation in various communal activities. This data indicated that women's participation in the study could have been affected due to their literacy levels.

Overall, these presented data indicated that there were 348 household members that were interviewed of which, 122 households were from Nambale, 112 from Siaya and 114 from Teso North. 54.0% of the households were men headed, with 84 households being the majority from Teso North. All the 348 household heads were considered literate as they

had been exposed to some form of education. These heads of households had lived in the area for the past five years and had a good understanding of the area of study in relation to any sanitation and hygiene development initiatives that took place.

#### **4.2.2 Demographic Characteristics of the Informants in the Key In-depth Interviews**

The informants in this section of the study were from the Public Health Officers of the Government of Kenya forming different categories. The variables considered included: gender, age, position and number of years in service as indicated in Table 4.2 below.

**Table 4.2: Demographic Characteristics of the Informants in the Key In-depth Interviews**

Demographic Variables of the Public Health Officers	Gender			Total (%)
		Men (%)	Women (%)	
Public Health Officers Interviewed	<b>12</b>	<b>83.3</b>	<b>16.7</b>	<b>100</b>
Age (years)	Below 30	9	0	9
	30-45	42	8	50
	45 - Above	33	8	41
<b>Total</b>		<b>84</b>	<b>16</b>	<b>100</b>
Length of service (years)	Between 1-3	33.3	16.7	50
	4-10	8.3	8.3	17
	Above 10	20	13	33
<b>Total</b>		<b>62</b>	<b>38</b>	<b>100</b>
Levels of positions held	Training Institutions	8	0	8
	National	25	0	25
	County	8	0	8
	Sub County	25	8	33
	Ward/Location	17	9	26
<b>Total</b>		<b>83</b>	<b>17</b>	<b>100</b>

***a) The Gender of the Public Health Officers (PHOs)***

The gender of informants may contribute to the way they view an issue being discussed in line with their technical expertise. In this case the public health officer's gender impacted on how they implemented the CLTS approach. Table 4.2 indicated that of the 12 Public Health Officers who participated in the study, 83.3% were men while 16.7% were women. According to APHOK (2015), 80% of the registered trained public health officers were men, whilst only 20% were women. This data confirms the male domination in the public health sector.

***b) The Distribution of the PHOs According to Government Positions***

Most of the decisions made in government are determined by the officers in charge of a department, a division, county or sub county. These positions also determine how CLTS is implemented through the Ministry of Health in the department of environmental sanitation. Table 4.2 indicated that the informants held offices mostly at the Sub County and locational levels at 33% and 26% respectively. Of these informants, women represented 8% and 9% of the informants at these levels. There was a representation of the national office at 25% and training institutions and County levels at 8% each of informants whom were all men. This indicated that the key informants to this study held strategic offices within government and were trained in Public Health and the CLTS approach, which the government promoted to increase access to sanitation. This data also indicated that there was only 17% of PHOs interviewed who were women.

***c) Period the PHOs Served in the Positions Held***

The government of Kenya transfers public servants due to various reasons, such as promotions or need. The ministry of health was affected by the transfer of personnel due



to devolution that took place in 2013 (MOH, 2014). As shown in Table 4.2, majority of the key informants had worked as public health officers in the current position for a period between 1-3 years at 50% with the majority being men at 33.3%, and 4-10 years at 17% with 8.3% of them being men while 10 years and more were at 33% with 20% being men. The data showed that the women PHOs who were informants had been in the service mainly for less than 3 years at 16.7%, indicating an increase in the women joining the PHO profession. Despite devolution the public health officers continued to serve in their capacities in their regions carrying out CLTS work. This provided for increased experience in CLTS and understanding of the cultural dynamics of the communities, for they had been working there for a considerable period of time. This aligns with the Gender socialization concept that indicates culture as a key pre-determinant at the centre of any intervention, creating consistency and predictability of human behaviour (Stockard 1999).

#### ***d) Distribution of PHOs by Age***

The age of informants determines the experience of the informant in the various issues that the study sought to interrogate. This is closely linked to the period served in the position held as well. Table 4.2 shows that, majority of the PHO informants were aged 30-45 years at 50% with only 8% of these being women. There were PHOs below 30 years who were at 9% and were all men and those that were above 45 years were at 41% of whom 33% were men. This means that the majority of the PHOs interviewed were in their 30s and 40s with women comprising 8%. This data presents majority of PHOs who were within a dynamic age bracket and at the peak of their careers (KDHS, 2009). This data confirmed Myers' (2016) argument, that flexible government agencies play a critical

role in verification and certification of ODF and monitoring progress of the ODF community.

Overall, the data collected presented the Public Health Officers who were mostly men at 83.3% and held strategic positions within the government. The PHOs made decisions on CLTS implementation as they had a form of training. Most of the informants were below 45 years, flexible and open to new ideas required for carrying out post ODF follow ups and embrace emerging ideas to maintain ODF status. The data also indicates that there were only two women who were in the age bracket of 30- 40 years and had served as public health officers for less than 4 years, which presented mature professional women.

The demographics generated showed that 93% of the Structured interview guides administered were filled. Majority of the heads of households were men who had been in the study area during the project time. All heads of households had some form of education and most of them were below 45 years. This data presents respondents who were considered the average Kenyan citizen (KBS, 2009). The key informant interviews showed that majority of PHOs were men, who served in various positions in government as public health officers. Also, majority of the PHOs were below 45 years and at mid-level in their careers. This data established that the households in the study areas and the PHOs had been responsive to the researcher and that, there were more men respondents than women both within the households and among the PHOs.

#### **4.3. The Gender Needs that are addressed in the Environmental Sanitation and Hygiene Policy, and the CLTS Approach Trainers' Handbook.**

The first objective of the study established how the gender needs are addressed in the KESH policy and the CLTS approach Trainers' Handbook. The researcher carried out a desk review of both documents to identify areas that had clear indications of gender disaggregated needs, provisions, plans or data. A further triangulation was sought by carrying out in depth interviews with PHOs to determine if the gender needs were addressed in the KESH policy and the CLTS Trainers' handbook. The objective also sought to establish the PHOs capacity to implement an equitable CLTS approach. The Moser planning framework was applied to establish these aspects.

PHOs have the mandate to implement the sanitation programmes in Kenya through the KESH Policy using the CLTS approach. The PHOs were interviewed on various aspects such as; If they had read through the policy documents, the CLTS handbook; if there were specific mentions of boys, girls, men, women in these documents or if there were any specific gender provisions in these documents. The following are the findings:

Kenya is one of the countries in Africa that has a detailed stand-alone sanitation and hygiene policy that was enacted in 2009 and reviewed in 2016. In East Africa, Uganda, Tanzania, Ethiopia, Burundi and Rwanda have health policies that provide for sanitation and hygiene issues within the main health policies. It was through the Kenya sanitation and hygiene policy by the Ministry of Health that the Community Led Total Sanitation approach was recommended to be used to improve access to sanitation among the rural communities in Kenya. This led to the launching of the ODF Roadmap in Kenya in 2011.

These documents in my view ought to be well understood by the Public Health Officers in charge of sanitation. These documents guide, advice and provide for ways to increase access to sanitation to the Kenyan citizens (MOH, 2013).

#### 4.3.1 The Kenya Sanitation and Hygiene Policy (KESHP)

The analysis of the KESHP revealed recognition of various aspects of gender gaps as indicated in the Table 4.3.

**Table 4.3 Positive recognition and gaps of gender issues in the Kenya Sanitation and Hygiene Policy**

<b>Position of the KESHP on gender issues</b>	<b>Pages</b>
<b>Positive recognition of gender issues</b>	
Targets children under five years of age but does not disaggregated beyond this aspect.	5, 16, 27, 39
Indicating sanitation as a human right, various groups are listed as having various needs – women, older members of society, persons with disability, children, youth, members of minority and marginalized communities.	16
The terms equity, equality, non-discrimination are mentioned under the guiding governance principles and values of the policy.	28, 34, 59
Participation to provide equal opportunity, equity targeting the poorest and gender responsiveness and social inclusion are mentioned among the guiding principles of the policy.	42, 52
The section on water and sanitation intervention in schools mention menstrual hygiene, and this is further discussed for the women out of the school environment as well.	54, 58
<b>Gaps in the KESHP on gender issues</b>	
The policy addresses people, beneficiary, Kenyans and communities but does not provide disaggregated data.	1, 4, 8, 24, 29, 38, 49
The vision, mission and policy goal do not indicate disaggregated data but has general terms such as Kenyans or beneficiaries.	8, 9
Under the section on governance and institutional capacity building; there is no mention of what will be done to ensure that both men and women access equitable opportunities.	18, 27
Under the responsibility of household and individual sanitation; there is no mention of the various roles of men, women, boys and girls, but general statements which often entrench existing gender inequalities.	58, 60

The KESHP recognizes sanitation as a human right, even further mentioning equity, equality, non-discrimination under the guiding governance principles and values of the policy. It further lists gender responsiveness and social inclusion as guiding principles. However, there was a clear lack of specific mechanisms to ensure the aforementioned are addressed. The Moser framework conceptualises planning as aiming to challenge unequal gender relations and support women's empowerment. The generalist attitude taken by the KESH policy does not categorize policy approaches that appreciate the different roles of men and women in providing sanitation. The Moser Framework recognizes the transformative potential of gender planning that is best captured by disaggregating data, which is not done in the KESH policy. The framework distinguishes between practical gender needs and strategic gender needs, which KESH does not factor in the capacity building plan for equal opportunities, thus promoting inequitable labour division in CLTS implementation.

#### **4.3.2 The CLTS Trainers Handbook**

The analysis of the CLTS Trainers handbook indicated various gender recognition and gaps as indicated in the Table 4.4.

**Table 4.4 Positive recognition and gaps on gender issues in the CLTS trainers' handbook**

<b>Position of the CLTS documents on gender issues</b>	<b>Pages</b>
<b>Positive recognition of gender issues</b>	
The Natural leaders could be men, women or youth	5
One of the key social-cultural condition to determine if a village was favourable to intervene included women having a voice. It was considered challenging if the women did not have a voice in that community, thus categorized as a difficult community to introduce CLTS.	12
It was noted that the absence of people from all categories might weaken the collective power of the “triggering” decision.	28
It was indicated that young girls and women suffer most due to lack of latrines.	30
Involving children is considered a critical step to ensuring success in triggering communities.	32, 58
One of the key indicators noted as a sign of progress in ODF communities was the emergence of Natural Leaders who could be men, women or youth. And also, it was noted that the emergence of volunteers and traditional midwives being active towards hygiene issues would be considered a successful CLTS intervention.	50
<b>Gaps in the CLTS documents on gender issues</b>	
Triggering is considered a success when communities commit to construct latrines. But this same publication indicated that the men construct and then the women take over to maintain the latrines	36, 51
The handbook authors indicated that they had carried out hands-on training for over 1400 trainers, practitioners and field extension staff from at least 50 different agencies in 150 countries but does not provide sex disaggregated data.	62
The Handbook indicated some form of unfair division of labour. Women natural leaders tended to be less visible than their male counterparts in latrine construction but more active and responsible in their maintenance, establishing usage norms and sustaining hygienic behaviour change. Women usually took over the latrines as soon as they were constructed. They trained children on how to use the latrines hygienically.	51

Table 4.4 shows that the CLTS trainers' handbook recognizes women's voice, as part of natural leaders and in participating in community meetings, which are critical. However, the handbook does not factor in the triple roles and how they impact on the women and men. The women were also expected to serve as natural leaders, despite the handbook not providing considerations for the triple roles of women. The handbook did not elaborate how the women would serve as natural leaders (NLs) in spaces where they had minimal influence and opportunity for decision making in the community, adding to their burden in the communal role. Moser framework makes all work visible and valuable to planners and implementers, through the concept of triple roles, yet the handbook did not elaborate how this would be achieved for both men and women in consideration of the triple roles they played.

The content of the two documents indicated that the policy and the trainers' handbook had instances that recognized gender concerns and needs. The documents also introduced gender issues as part of human rights and social cultural issues presenting gender responsiveness and social inclusion. Both documents did not provide any forms of enforcement or mainstreaming strategies of the general statements of intent made, whilst many of the instances could have benefited from a gender sensitive consideration to improve the outcome of the actions from the policy makers and CLTS trainers to ensure that the KESH policy and subsequent CLTS implementation were gender responsive.

#### **4.3.3 Knowledge of Environmental Sanitation Hygiene Policy by PHOs**

The KESH policy is disseminated and implemented by PHOs. The study sought to establish how many PHOs had an understanding of the policy, through reading it.

Additionally, the study also probed the PHOs knowledge of gender related provisions in the policy. Table 4.5 below presents responses from the PHOs as follows:

**Table 4.5 Knowledge of Environmental Sanitation Hygiene Policy by PHOs**

S/No.	Variables on the knowledge of the Kenya Environmental Sanitation Hygiene Policy	Responses (%)		
		YES	NO	DON'T KNOW
a.	Knowledge of the KESH Policy	75	25	
b.	Gender disaggregation in the KESH Policy	50	25	25
c.	Gender specific provision in the KESH policy	33	42	25

Findings on Table 4.5 indicate that 75% of the PHOs had read through the KESH Policy. Some of the PHOs who had not read the policy indicated that the document was too big to read and they knew what needed to be done.

*I know what I need to do as a PHO in my sub county. We have annual work plans where we draw our work from, so reading the policy is not important as such! (PHO – Teso Sub County)*

The findings also reveal that 50% of the PHOs agreed that there were places where there were specific gender disaggregation within the policy, with mentions of women and men specifically. Other PHOs felt that it was not necessary as all the people required sanitation and hygiene facilities and services.

*Mentioning men and women in the policy is not that important, because all the people need sanitation and hygiene services anyway. (PHO – Siaya Sub County)*

On further probing, 67% of PHOs had no knowledge of gender specific provisions in the KESH Policy in relation to sanitation. These gender specific provisions include: menstrual hygiene management, gender sensitive/related sanitation facilities, gender



responsiveness and inclusion, separate latrine for boys and girls and latrine ratios for boys and girls in schools.

This data implied that majority of the PHOs did not know exactly what was expected of them when implementing the KESH policy in relation to planning for the various genders and the provisions that are set in the policy. The Moser framework emphasizes the importance of planning according to gender needs. In this case, majority of the PHOs were not aware of the gender provisions in the KESH policy, it was a challenge to plan adequately for all Kenyans according to their needs. The framework challenges unequal gender relations, which can only be defined when planning with disaggregated data. In fact, some of the PHOs did not recognise the need for disaggregation of data which would initiate women's empowerment through sanitation and hygiene. The framework emphasizes the importance of recognizing various roles and different needs of men and women that mark the starting point of challenging unequal gender relations and insubordination of one gender during planning. A majority of PHOs not recognizing specific roles of men and women in sanitation intervention would hinder proper planning for resources and set the stage for unequal interventions and benefits in implementing the KESH policy.

#### **4.3.4 Public Health Officers Knowledge on CLTS Trainers' Handbook**

The PHOs were responsible for leading the implementation of the CLTS process. Therefore, understanding of the CLTS documents was pertinent. It was important to establish if the PHOs had noted any gender specific issues within the CLTS Trainers' Handbook. The Table 4.6 below presents responses from the PHOs as follows;

**Table 4.6 Public Health Officers knowledge on CLTS documents**

S/No.	Variables on the CLTS documents awareness	Responses (%)		
		YES	NO	DON'T KNOW
a)	Knowledge of the CLTS Trainers' handbook	100	0	
b)	Specific gender mentions in the CLTS Trainers' handbook	83	17	
c)	Gender specific provisions in the CLTS Trainers' handbook	25	67	8

Findings in Table 4.6 reveal that all the PHOs (100.0%) had a chance to read through the CLTS Trainers' Handbook, and that the majority of the PHOs at 83.0% agreed that there were places where there were specific mentions of women and men while 17.0% disagreed. The data shows that the PHOs interviewed had undergone the CLTS training and most of them noted the gender disaggregation in specific instances of the CLTS process as they implemented their work. Further probing indicated that 75% of the PHOs had no knowledge of the gender specific provisions in the trainers' handbook, while 25% indicated some form of variation only in schools and not in the community. Majority of the PHOs had no knowledge of the intricacies of the CLTS intervention and the triple roles that would be impacted on. The Moser framework draws attention to the complexity of how women's lives and roles may interact with programme interventions. If the CLTS trainers' handbook was gender responsive, it would provide opportunities for more nuanced analysis and mapping of sources of power and potential constraints or opportunities in implementing the intervention, in this case, the handbook failed to do this.

In an effort to interrogate the KESH policy, the CLTS Trainers' Handbook and the PHOs who implemented the CLTS approach; the following was established:

The study indicated that the KESH policy's mission, vision and policy goals did not indicate any gender responsiveness in page 25. It was also noted that there was a lot of generalization of the population in the document, making it more gender blind, and in instances where there was disaggregation, there was no specific critical gender enablers or enforcement strategies outlined. However, the policy recognises gender issues under the human rights perspective and indicated equality, equity, non-discrimination as part of the guiding and governance principles of the policy. Moreover, the policy indicated participation, gender responsiveness and social inclusion as some of the values of the policy and indicated a need for special attention in relation to menstrual hygiene for the women in schools and community. The challenge that still emerged was that the policy did not go beyond these mentions to indicate how the gender issues would be addressed in page 28, or who was tasked with this responsibility (MOH, 2016). As indicated, the PHOs have the mandate to implement the KESH policy, nonetheless, it does not make any provisions for capacity building on gender issues, budgetary provisions for gender specific variations, but instead addresses general sanitation.

The authors of the CLTS Trainers' Handbook underlined the importance of recognizing the different roles played by men, women, boys and girls, but did not disaggregate the data of those that they had trained to implement CLTS. They recognised women as natural leaders, who were considered community consultants (Pg. 16, 26, 45). Additionally, the importance of having both men and women as natural leaders is mentioned in the handbook. It further emphasized that communities in which women had

a voice met the requirement for CLTS engagement and would be ranked highest for intervention. The authors also expected “powerful triggering” in cases where there are various population categories represented, conversely, those that did not display involvement of all the sectors of the population were considered weak. The handbook indicated that young girls and women suffered the most in instances where there was absence of proper sanitation and hygiene, but they did not indicate the reasons for suffering, neither did they disaggregate data to address the varied needs for the women and girls. They also did not indicate clearly the variance in access and benefits for the genders in communities apart from the school environment (Pg 41. Handbook).

The study revealed that PHOs were in charge of implementing the CLTS approach which the majority at 75% had knowledge of the KESH policy and all of them, had knowledge of the CLTS trainers’ handbook. It was further revealed that majority of the PHOs did not have the knowledge of gender provisions in either the policy or the trainer’s handbook, although both documents had minimal provisions on gender specific needs. Despite the keen application of the CLTS approach and KESH policy, if the lead implementers were not gender aware, most likely the gender issues in relation to sanitation would not be recognized and addressed extensively. In applying the Moser framework in this objective, it reflects that despite CLTS being a sanitation intervention that aims to empower the communities to manage their social well-being, it failed to plan to achieve both the practical and strategic needs, which would aim for gender equality.

#### **4.4 The Gender Related Factors Influencing the Successful Implementation of the CLTS Approach**

The second objective set out to interrogate gender related factors that contributed to the successful implementation of the CLTS approach in the study areas. The objective considered power and decision making at various levels on CLTS and availability of sex disaggregated data. It also considered access and control of resources for CLTS, cultural factors and social norms that affected CLTS implementation.

Gender was identified as an important issue in sanitation, but it was not well covered in the sector research literature (Mitlin, 2011). A lack of sex disaggregated data at the program, national and global levels was indicated as a major contributor to the GLAAS and JMP reports indicating that they had stopped gathering sex disaggregated data due to limitations at national level (WHO/UNICEF, 2014). The Gaventa power framework was applied on this objective to draw out the power dynamics in CLTS implementations at various stages.

##### **4.4.1 Gender Representation at Decision Making for CLTS Implementation**

Representation of both gender in decision making facilitates the quality of implementation of programming, especially in sanitation as the needs vary (WSP, 2014). The study interrogated various levels of decision making as indicated in Table 4.7.

**Table 4.7 Gender representation at decision making for CLTS implementation**

S/No.	Areas of decision making for CLTS implementation	Responsibilities (%)						Totals
		Nambale		Teso		Siaya		
		Men	Women	Men	Women	Men	Women	
a)	CLTS decision making by PHOs at County Level on CLTS introduction	20	15	17	6	27	15	100
b)	CLTS decision making by PHOs at Sub - County Level on CLTS introduction	25	5	20	2	40	8	100
c)	CLTS decision making by the community on taking part in CLTS intervention	20	10	40	2	20	8	100
d)	CLTS decision making at the household level on taking part in CLTS intervention	20	10	30	5	20	15	
e)	CLTS decision making by the Village Health Committee on ODF certification	20	20	8	16	16	20	

CLTS implementation was a national programme led by the Ministry of Health to all the counties in Kenya. The quality of CLTS implementation relied on the facilitators triggering, follow up, verification and certification. It was also affected by the quality of natural leaders involved in the work (Plan UK, 2008). The gender of PHOs who led the decision making on whether CLTS should be introduced in the counties and sub counties of the study was given in Table 4.7. The findings indicated that majority of the PHOs in the County and sub county level (64% and 85%) respectively were men as compared to

women who were at 36% and 15% respectively. The data further showed that there were averagely more male PHOs in Siaya at both the county and sub county levels who were involved in decision making, followed by a big margin by Nambale. This showed that decision making on introduction of CLTS from the government was mostly led by PHOs who were men. This corroborated a finding by UN Water (2012) that indicated only 10% of women occupied the offices that controlled financing and decision making in relation to water and sanitation, referring to the public health profession as a “man’s profession”. According to the Gaventa power framework, this indicates that there were limited spaces provided for women to be involved in decision making in relation to CLTS as an appropriate intervention, even if they were already PHOs, it was not guaranteed.

Decision making about CLTS uptake at the community and household levels was determined by the response of the community at the triggering stage. Table 4.7 indicated that 80% of the triggering attendance was by men and 70% of decision making at the household level on whether the family would be involved in the CLTS intervention was by men. In addition, decision making in relation to CLTS at both levels was mostly done by men, with Teso having the majority of men both at communal and household level leading in decision making followed a distant by both Nambale and Siaya who were at that same level. Additionally, the study revealed that 56% of the village health committees (VHCs) were women. VHCs comprised of community health workers (CHWs) and natural leaders (NLs), who spontaneously emerged after triggering, and they facilitated communities towards ODF status. The data showed that Teso had double the number of women in the village health committees, while Nambale had an equal number of men and women, whilst Siaya had a very small margin between men and women, with women being in the lead.

The village health committees contributed towards designing solutions to end open defecation, they were the tasked with the ODF certification as well. Yet the VHCs were volunteers who were also tasked with quarterly reporting on CLTS progress, this finding was also corroborated by the following authors in various reports, Kar & Chambers, 2008; Wamera, 2016; Crocker et al., 2015). During the Focus Group Discussions with the CHWs, the issue of voluntary service emerged again as indicated:

*We don't mind working for free or a minimal stipend, because it ensures that we are not eating each other faeces and we also get a lot of respect from the community when we make house visits to inspect their facilities and collect data– (FGD - Nambale)*

Working as a VHC increased the workload of the women as it required investing time and resource for follow up from triggering to post ODF, without pay or any support from the government or agencies (Wamera, 2016). The Moser framework makes all work visible and valuable to planners and programme implementers. The CLTS approach did not factor in the triple roles played by women and provided strategies to ensure that the burden on the VHCs was borne equally by both genders, even if they were not equally involved in decision making.

PHOs led the decision making on whether the areas were ready for the CLTS implementation at the County and Sub county level. 64% of the PHOs at the county level were men and 85% at the sub county level. These were the same PHOs who had been noted as gender blind at 75%, who felt that sanitation is a general issue and the majority of them had no knowledge of gender specific provisions in the KESH policy or CLTS trainers' handbook. This data indicated that the outcomes of the CLTS process would be flawed. This is corroborated by a study by Plan International that indicated that the



quality of CLTS is determined by the facilitators who trigger the communities and make follow ups until the communities become ODF (Plan UK, 2008). The study established that the CLTS implementation was gender blind because most of the facilitators did not have knowledge of the gender provisions in the KESH policy or CLTS trainers' handbook.

Decision making at the community level on CLTS uptake was led by men at 80%, from triggering to ODF status. Decision making at the household level in relation to the family taking part in the CLTS process was also mainly led by the men at 70%, because the main resource for sanitation was land, which was more entitled to men as compared to women. Household decision making and resource allocation were critical for human development including sanitation and hygiene. These decisions are influenced by culture, marriage and family dynamics, yet ultimately the men carry the decision on the behalf of the family. Women enjoy the rights to use the resources with some limitation based on the utilization. This finding was corroborated by a research in West Africa that indicated that many decisions made at the household level influence the welfare of the individuals living in the household as well as their communities (Urdinola et al., 2010). The power framework argues that change must begin more at the household or personal level, not just in the layers of decision-making found in government. Recognizing decision making at all levels is potentially significant and is considered a basis for a power balance and equitable inter-relationship.

However, the shift was noted at the VHC level, which had more women at 56% compared to men as sanitation and hygiene was considered a woman's issue, as it constituted the reproductive role of women. The VHCs played a key role in ensuring

sustainability of the ODF status, indicating that the women were the key determinants of ODF despite them not being in the majority of decision-making positions in government, community and households. This translates to women implementing what is already predominantly determined by the men. It was noted that Teso had double the number of women in this role, further entrenching gender imbalances. The study established that according to the Gaventa power framework, this scenario would be referred to as mobilization of bias. This is manifested in the hidden forms of power whereby there is vested interests to maintain power and privilege men creating barriers to participation, or by controlling resources. Participation by various groups including discriminated ones is necessary for a socially inclusive program implementation which will make it a successful sanitation intervention (O'Reilly, 2007). A study carried out in Madagascar indicated that the gender of the PHO was not important at the onset of CLTS, but the quality of follow up was affected by the gender of the VHCs (Davies, 2015).

#### **4.4.2 Sex disaggregated Data**

Disaggregated data provides a basis for proper planning on the various group's needs. Literature linking gender and CLTS highlighted the need for guided gender sensitive assessments. These could be used as a practical framework to establish ways to increase the effectiveness of sanitation programmes in an equitable manner (Brewster et al., 2006). At the national level, only 39% of countries globally, reported sex-disaggregated data on access to sanitation, and Kenya is not one of the countries listed by UN (2013). Post triggering follow ups are critical activities for the long-term sustainability of ODF behaviour (Wamera, 2016). Follow up entails reporting on the progress on access and use of sanitation facilities and this data is collected through various government designed

forms, provided by the counties and compiled to provide national level sanitation statistics.

The national CLTS implementation relies on data generated by the CHWs who relay it through the sub county to the county offices and eventually to the national level (MOH, 2010). The study further probed on the kind of data collected that was used for decision making. The Following was established;

- 1) **Form “A”** (*Appendix A4*) – This was the Household Register for documenting progress in CLTS triggered villages. It was filled by the CHW or Natural Leader. It did not have any sex disaggregated data but only required “Number of people” and “head of household” to be filled in among other fields.
- 2) **Form “B”** (*Appendix A5*) – This was the Post Triggering Progress Monitoring form. Under “Triggering information” there was data sought on men, women and children. Under “Village information” there was data sought on population (men, women, children) that was supposed to be extracted from Form “A” – which was not sex disaggregated. There was also data sought on “how many people benefitted from the new latrines and total populations from Form “A” which did not have sex disaggregated data.
- 3) **Form “C”** – This was the PHO Weekly Reporting Tool that was compiled by Divisional PHO and submitted to District PHO. It referred to “population” of the villages with no disaggregated data.
- 4) **Form “D”** – This was the monthly Status Report that was compiled by DPHO and submitted to Regional Coordinator. This form had 4 fields that did not have sex disaggregated data as follows; populations of the locations, populations in triggered villages, ODF beneficiaries per month, cumulative ODF beneficiaries.

- 5) **The ODF Certification Form** – This form was filled in by the verifying and certifying officers or organization. This form only referred to latrine coverage at triggering time, expecting the number of households to be indicated with no sex disaggregation of the household occupants.

Form “A” was the first and most critical form on data collection, which did not have sex disaggregated data, an indication that the CLTS process would only process the numbers in households with no specific gender provisions. Form B sought information on population, listing men, women and children, and this was expected to be drawn from Form “A” which did not have it. Form “B” further sought to know the numbers at triggering meetings, beneficiaries of the latrines, but there was no sex disaggregation. Form C sought numbers of the population as well, but with no sex disaggregation. Form “D” compiled monthly statistics of the populations in villages and locations with no sex disaggregation. The ODF certification form sought data on latrine coverage and numbers of households with no sex disaggregation.

The findings indicated that at no point in time was sex disaggregated data collected in the entire CLTS progress and reporting. This confirmed why Kenya was not listed as one of the countries with sex disaggregated data in relation to sanitation and hygiene (UN, 2013). The interrogated forms provided progress reporting information to the CLTS Knowledge Hub at the Ministry of Health (MOH, 2011). The data indicated that there was no available sex disaggregated data. Availability of quality sex disaggregated data at various levels facilitated adequate and effective decision making based on the needs of men, women, boys and girls. The data determined planning and programming, this was corroborated by a study that indicated that care needs to be taken with generalization, as

gender is an important indicator of status and could be associated with inequality and inequities in accessing sanitation (PathFinder, 2011). This is equally emphasized by the Moser framework, which indicates that planning could be used to challenge unequal gender relations and support women's empowerment. Creating gender-sensitive indicators presents gender dimensions leading to data management to ensure equitable outcomes for the genders (Grant et al., 2016). This is not possible currently in Kenya, through the ministry of Health and CLTS Hub, as they do not have sex disaggregated data, thus limiting their understanding of the specific sanitation and hygiene needs of households. This contributes to inequitable participation, increased outliers and contributes towards slippage (WSSCC, 2016).

#### **4.4.3 Access and Control to Resources for CLTS Implementation**

Social cultural factors are listed as one of the key determinants to engaging communities in CLTS interventions (Plan UK, 2008). Access and control of resources among other issues, could impact the use of latrines that were constructed as a result of CLTS intervention (O'Reilly, 2017). Aspects of limited access to resources like land affect other development matters in the community such as water, sanitation and agriculture (DFID, 2013). The study sought to investigate what resources were required and what levels of access and control existed to these resources in the CLTS implementation process. The researcher utilized the Harvard Analytical Framework tool 2 – access and control profile (March et al., 1999) and the following was generated in Table 4.10.

**Table 4.8: Access and Control of resources for CLTS implementation**

Resources required	Access %						Control %					
	Nambale		Teso		Siaya		Nambale		Teso		Siaya	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Land	20	15	20	10	20	15	21	3	40	2	21	3
Building materials	25	8	27	5	25	10	20	10	37	4	20	9
Maintenance tools	10	24	8	24	10	24	10	24	8	24	10	24
Finances	20	18	23	10	16	13	30	4	30	2	30	4

The study sought to understand if the women and men had equal access and control to land. Table 4.10 revealed that men accessed land at 62.4% and controlled it at 92.3%. The men in all the sub counties had the same access to land as opposed to women. The women in Teso had the lowest access to land at 15%. The men in Teso had the highest control of land at 40% against a minimal 2% for women. Control of land in the other sub counties was equally high among men with a big difference with women. This indicated that men determined the use of the land. Even though women had access at 37.6%, they had limited control on what happened on the land as they had very little control with the highest being in Siaya and Nambale at 3%. This data indicated that the women had less control of the land, this could translate to the fact that they were not able to make decisions on where latrines would be built, when they would be built and how they would be built. This translated to having Teso having more women with limited control. This results reflect that Teso had the lowest ODF coverage, and that the aspect of having less women being able to access and control land could have been a contributing factor to the ODF attainment in Teso North as opposed to Siaya and Nambale sub counties.

The quality of building materials determined the lifespan of the facilities constructed. Data showed that building materials for latrines and hand washing stations were accessed and controlled more by the men at 76.7% in both instances as compared to women. Women in Teso had the lowest access and control of building materials while the men

had double control of the building materials in Nambale. This position disadvantaged women in decision making on siting and building of the latrines unless they had express permission from the men in the family who owned the land. This confirms that men still have invisible power according to the Gaventa power framework.

As study carried out among agricultural communities in West and East Africa indicated that rural women in Africa often lack control over key farm inputs and decisions. A woman's right to own land is dependent on her relationship with her husband or male relatives. The risk of losing land rights has become a disincentive for women to invest in land (Urdola, 2010). This reflects on the fact that women have limited access to land, and yet land is one of the key resources for building toilets. This data shows internalization of powerlessness that involves the ways in which awareness of one's rights and interests are hidden through the adoption of dominating ideologies. Patriarchy is a dominating idea that affects the awareness and consciousness of potential issues and conflicts, even by those directly affected, rendering them relatively powerless in the community.

ODF requires the proper and consistent use of latrines, which requires cleaning and maintenance. Cleaning products and tools for latrines were more accessible to the women at 72% with the same amount of control in all the sub counties. The cleaning products and tools included water, brooms, ash or soap. It was also noted that men in Teso had the lowest control of cleaning equipment at 8% as compared to the other sub counties. This confirmed the aspect of women being responsible for hygiene activities as part of their reproductive roles in the home. This data seemingly indicates privileged access to the equipment and products for hygiene activities. In real sense it indicates that the work of maintaining sanitation facilities was left to the women on a daily basis, increasing their

burden. There may have been cases where the children were involved in cleaning the latrines, but there were very few instances where men did it, yet this was expected to be an activity for both men and women in the household according to the CLTS approach. The CLTS process disregards the triple role of the women according to the Moser framework, entrenching gender inequalities by increasing the work burden on women in relation to sanitation and hygiene.

Financing of sanitation services was left to the household. The study sought to determine who had access and control of finances that determined the sanitation investment in the household. According to Table 4.10, men had 90.2% control of the household finances and accessed it at 58.2% compared to women who had 9.8% control and accessed it at 41.3%. The men in Teso had the highest access to financing at 23% and there was an equal control among the men on finances across the sub counties. Teso recorded the lowest control of financial control for the women at 2% with other sub counties indicating a paltry 4% each. This is an indication that financing as one of the key sanitation resources was predominantly accessed and controlled by the men, and women had limited access and control, thus they would not have the power to make their own decisions about utilizing finances that they accessed or controlled without men being involved. The study further probed to understand the average cost of latrine construction, and it was indicated to be between KES. 10,000 to KES. 20,000. This depended on the kind of materials used for latrine construction. This scenario is seen as hidden power in the Gaventa framework, where the women may be unaware of their rights, their ability to speak out, and may come to see various forms of domination over them as natural, or at



least unchangeable, and therefore unquestioned, creating a culture of silence as a result of internalization of oppression.

The study established that resources required for sanitation and hygiene were predominantly accessed and controlled by the men, and even when women owned these resources, they would not have the power to make their own decisions about using these resources, without men being involved. As a consequence, women's economic opportunities overall were hindered as well as their ability to access resources as also illustrated by Angel-Urdinola in a study in 2011 in Nigeria, among which the use of sanitation and hygiene facilities. The data presented indicated that men had the majority of control of the key resources entrenching insubordination. The laws and/or customary practices of many countries, among them, Kenya still deny women an equal right to access land. Also, women undergo several challenges upon the death of their spouses which is compounded at the point of inheritance. Research found that in 35 of 173 countries in Africa and Asia, female surviving spouses did not have the same inheritance rights as their male counterparts (WBG, 2016). The Moser framework emphasizes on the value of the various roles played by the woman, yet this data shows that the responsibility of the woman added to the burden of her work, limiting further her empowerment opportunities.

#### **4.4.4 Social and Cultural Factors**

Inadequate access to water, sanitation and hygiene (WASH) was linked to psychosocial stress, especially among women, predisposing them to social and physical risks during their daily sanitation routines, in accessibility more than men (Grant et al., 2016). Access to facilities is in some instances determined by cultural dynamics in communities, and

this directly affects the benefits thereof of the availability of such facilities. The study sought to find out if men and women equitably accessed and benefitted from the household facilities as a result of CLTS implementation. Table 4.11 presents the findings as follows:

**Table 4.9 Access and Benefits to household facilities provided by the CLTS intervention**

Facilities	Access %						Benefits %					
	Nambale		Teso		Siaya		Nambale		Teso		Siaya	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Latrines	30	10	20	10	20	10	18	16	18	11	18	17
Hand washing stations	13	28	10	15	10	24	3	35	2	27	3	30
Bathrooms	4	35	4	23	4	30	18	20	8	18	18	20

The CLTS approach promotes the use of latrines for the entire household all the time to ensure that the communities are hygienic (Plan UK, 2008). The data in Table 4.11 indicated that access to latrines for men was at 69.3% as compared to women at 30.7%. Men in Nambale were recorded to have a higher percentage of access above all the other sub counties, while women in all the sub counties had the same level of access. Men and women in Siaya County had an almost equal access to latrines while there was a slightly larger variance in Teso among the men and women, with the men benefiting more. This indicated that the women did not use the latrines all the time even if they were at home more than the women. The researcher further probed to understand why women benefited less from latrine use at 47.7% as opposed to 50% equally with men, who most times were away from home. It was noted that most times the latrines were locked and left specially for the use of men as heads of the household and the women were not allowed to use them, especially during their menses. This corroborated a study that was carried out in Uttar Pradesh state in India, the women were vocal about not using latrines built facing

the road that afforded no privacy when coming or going to use them. They also indicated difficulties they faced during menstruation and pregnancy which contributed to limited access to latrines (O'Reilly 2017). Some of the reasons provided from FGDs were:

*There is a tradition among the Ateso that in-laws like the daughter in-law and her father or mother-in-law cannot use the same toilet. This is what has made behaviour change slow in our community. (FGD - Teso North)*

*Sometimes the toilets are built near the road and most times the doors face the road, making the women fear to use them especially at night. (FGD – Siaya)*

The Harvard analytical framework emphasises the importance of better information as the basis for meeting the efficiencies and equity goals. In the case of CLTS in the 3 sub counties, it indicated that the latrines were present, but mostly benefited men more than women, yet women accessed those, mostly to maintain them as they spent more time at home. This was a clear indication of the CLTS process not meeting its optimal efficiency and missing its equity goal by far. It also indicated that planning had not taken into account cultural practices and beliefs. The approach did not put into place an awareness creation programme on how to deal with the cultural barriers to sanitation provision.

The CLTS approach promotes proper and consistent hand washing with soap at critical times. The study sought to determine the access and benefits of men and women to hand washing. The Table 4.11 indicated that women accessed hand washing and benefited from the facilities at 66.6%, and at 92.3% respectively. In Nambale 28% of the women had access and benefited from hand washing while closely followed by those from Siaya at 35% and then Teso at 35% too. The men in all the 3 sub counties had lowest access to and benefits to hand washing facilities, indicating that men did not practice hand washing

as much as the women. This was associated with the activities that women carried out in the home that was closely associated with hand washing such as cleaning of the house, clothes, dishes and children and food preparation, that accounted for washing hands severally. A household survey carried out across 45 developing countries found that 72% of the household water and sanitation related tasks were done by women and girls (Grant et al., 2016). According to the Moser framework, attention is drawn to increased burden on the triple role of women as care givers, implying that they have to draw more water for hand washing and other household chores as part of their nurturing role.

The CLTS approach promotes personal hygiene as part of communal hygiene. This entails use of bathrooms for bathing every day. The study sought to determine the levels of access and benefits of the bathrooms to men and women. The data presented in Table 4.11 indicated that 88% of the women in Nambale had access and enjoyed the benefits of the bathroom facilities, followed by Siaya at 35% with Teso recording the lowest at 18% across the 3 sub counties. It was noted that the men had low access and benefits of the bathroom in all the sub counties of the study. Closely interrogating the data, it indicated a drop on percentage from access to benefits for women to 52%. This was an indication that the women were allowed to access the bathrooms more to clean, but not for use especially in some instances, such as during menstruation, among the household women. Further probing through the FGD, of this aspect indicated that limited benefits for the women on the bathroom utilization was due to:

*Women are not allowed to use the bathrooms especially during their “red days (menses) as it was believed that menses is a curse and the menstrual blood should not be seen by the men. So, the women bathed in other*

*designated places in the compounds far from the bathrooms and households (FGD – Nambale)*

This data presented the skewed gender dynamics whereby the women spent most time to clean and maintain the facilities, yet they did not benefit from the bathroom facilities when they required them most, during their period days. The issue of women needing to use the latrine the most during their menstruating days had not been addressed by the PHOs in any of the hygiene education forums. This also presented additional work added to the burden of the women, marginalizing them further with minimal benefits for personal hygiene. The gender socialization concept draws strongly on the aspect of ethnomethodology whereby individuals develop, refine and learn to ‘do’ gender through internalizing gender norms and roles (Wharton, 2005). In the case of CLTS, it builds on already existing aspects of doing gender and does not consider if the activities entrench any gender biases. Understanding how the gender socialization process unfolds over the life course is a necessary precursor to any efforts that aim to influence its trajectory, especially in development programming (Wharton, 2005).

Interrogating the gender related factors indicated that the PHOs, majority of whom were not gender sensitive, were in charge of decision making in relation to CLTS at the county and sub county levels. It was also noted that men led in the decision making at both the community and household levels. However, it was noted that the women led in serving as the village health committees as this was expected of them as part of their reproductive role in all the 3 sub counties. The VHC was a voluntary community role most times without or with minimal pay yet required a huge amount of their time. The data also confirmed why Kenya was listed as one of the countries with no sex disaggregated data

on sanitation and hygiene at all the levels, and most decisions were based on general data. The study further revealed that the most crucial resources for successful CLTS were land, building materials and finances that were majorly accessed and controlled by men in all the 3 sub counties. In cases where women had some access and control, the men still had a decision-making role to play in it, for example in cases where the widow had control of her late husband's land, it was her son or brothers-in-law who would decide what would be built on the land she controlled. However, it was noted that women had access and control to cleaning equipment, which meant daily maintenance of sanitation and hygiene facilities provided. The data further indicated that women had limited access and benefits to latrines and bathrooms despite being burdened with the responsibility of maintaining these facilities; in fact, they did not enjoy equal benefits as the men in all the 3 sub counties. This implies that the success of CLTS implementation was based on the availability of the sanitation facilities rather than equitable benefits for both genders in all the 3 sub counties. Consequently, it brought negative outcomes of CLTS such as the increased burden on the women in maintaining facilities as part of their reproductive role was ignored within the context of doing gender in the cultural context of the Luhya, Teso and Luo communities.

#### **4.5 The Gender Roles in CLTS Implementation**

This objective set out to establish the division of labour that ensured successful implementation of the CLTS approach and maintaining the Open Defecation Free (ODF) status. Some of the factors investigated were activity profile for CLTS implementation and sustaining ODF status and the activity profile during the ODF celebrations. This

objective was interrogated also using the Harvard Analytical framework tool 1 – Activity profile.

The involvement of the community in every step of the way is perhaps the most important predictor of the success of a sanitation and hygiene project (FEMSA, 2016). The community is made up of men, women, boys and girls. The study sought to understand the various roles played by men and women in the CLTS implementation and how these roles determined the successful implementation of CLTS.

#### **4.5.1 Activity Profile for CLTS Implementation and Sustaining ODF Status**

The CLTS approach was designed to have VHCs formed after the community triggering. Commitments made by households on sanitation and hygiene improvement activities that ensured the village became ODF, were facilitated by the VHCs. To get a village verified, certified and declared ODF, there were required basic standards to adhere to on a daily basis noted during follow up (Kar & Chambers, 2008). These requirements were also laid out in the ODF protocol that included; presence of latrines, clean environment, clean latrines, presence of hand washing stations, joint follow up structures and community dialogue days (MOH, 2012). The study sought to establish the various roles played by the men and women to ensure that the community was declared ODF and this gain sustained according to the ODF protocol. The Table 4.12 below shows the following:

**Table 4.10: Activity Profile for CLTS implementation and Sustaining ODF**

Sanitation Improvement Activities	Nambale		Teso		Siaya	
	Men	Women	Men	Women	Men	Women
Building latrines	30	4	30	2	30	4
Waste collection	13	25	9	28	5	20
Cleaning of latrines	0	34	0	33	0	33
Hand washing station maintenance	9	25	7	25	9	25
Joint follow ups	15	18	15	17	17	18
Participating in community dialogue	8	25	7	25	10	25

The ultimate goal of the CLTS approach is to ensure that every household has latrine in a clean environment. Building latrines was one of the key activities to ensuring that a community was ODF. From data generated, it indicated that the men mainly controlled the land where the latrines were built. Table 4.12 indicated that 90% of the men were tasked with building the latrines; this was noted in all the 3 sub counties equally. It also indicated that 73% women were involved in waste collection, with Teso women contributing the biggest number. The waste collection included both household waste and animal waste. It was noted that the men mainly collected waste for animals especially the big animals such as cattle and donkeys, whilst the women collected all the other household waste in addition to that of the small animals' waste such as chickens, goats and sheep. The men in Nambale were noted to collect more waste than the men in Teso and Siaya, this was due to households in Nambale having more cows and donkeys. This reflected on the reproductive roles of women as good hygiene providers. According to the gender socialization concept, internalization of certain enduring social norms shapes social structure and contribute as agents of socialization, leading to formation of gender



norms. This was a confirmation that Nambale, Teso and Siaya were patriarchal communities, with a small number of women headed households. This data was further confirmed during the FGDs such as;

*Most homes have cows for milk and for ploughing. These are the families' pride, but with CLTS, they are not allowed to defecate anywhere, but if they do, it must be collected promptly and their sleeping areas, "zizi la ng'ombe" must be cleaned every morning. This is the job for men before they set out for their day, as these are the wealth of the home (FGD - Nambale)*

The CLTS approach promoted hand washing with soap, proper and consistent use of latrines, which were well maintained. The Table 4.12 indicated that the daily cleaning of latrines was done at 100% by women in all the 3 sub counties and no men were involved at all. It further indicated that women ensured that there was water and soap for hand washing at 75% in all the sub counties equally. This was a reflection of the added burden on the daily activities that would be carried out by the women to ensure that the homesteads were clean. The role of men emerged in a different form; that men bought soap or provided the money to the household for buying the soap as noted in the FGDs:

*The men are the heads of the household, so all the money that buys the soap in the home, belongs to the man and all the other expenditure is commissioned by the man, irrespective whether the women make money or not. (FGD - Siaya)*

This data revealed that the women had a daily responsibility of ensuring clean latrines and a constant supply of water for hand washing in the homes with no help regardless of the circumstances. These tasks were considered good hygiene responsibilities as part of the women's reproductive role. This implies the increased burden on the woman without

valuing her role in contributing towards a successful CLTS approach, which the Harvard Framework highlights.

Joint follow ups were carried out by VHCs led by PHOs; these were done after the triggering to advance to ODF status. The Table 4.12 indicated that both men and women did the joint follow ups equally, cumulatively. However, it was noted that in Nambale and Siaya, the women were slightly more than the men during follow ups and only in Teso there were an equal number of men and women at 17%. The joint follow ups presented an equal representation of men and women, being led by PHOs who were the CLTS custodians and majorly men. The VHCs comprised of mainly women, who worked for free, and it is the PHOs who certified villages as ODF. The community dialogues were held on a quarterly basis for updates for sustained ODF status (Raghab et al., 2015). Table 4.12 also indicated that 75% of the community dialogue participants were women across all the 3 sub counties, indicating men from Teso with the least participation at 7%. Further probing of the data was done to understand the high participation of women during the community dialogue days as compared to men.

*It is during the community dialogue meetings where we as the VHCs report progress to the Community Health Extension Workers (CHEWs) who were part of the Ministry of Health in our Nambale dispensary. (FGD-CHW-Nambale)*

This data implied that the men majorly made the decision of ODF status, corroborated also by the ODF protocol (MOH, 2011), which stated that the PHO was mandated to certify ODF villages and not VHCs whose primary role was data collection. This showed that despite a big number of women represented in both joint follow ups and community dialogue days, the final decision was made by the PHOs who had limited knowledge on

gender provisions for sanitation. This data confirmed the critical role of women, which did not just end at the household level, but contributed towards the follow ups and reporting on ODF.

This data implied that there was unfair division of labour. According to the Harvard framework, the women shouldered the biggest burden of cleaning latrines and the environment, fetching water for hand washing, participating in follow ups and community dialogues. Even when there seemed to be equal participation of men and women in joint follow ups, the data noted that the PHOs were government employed while the VHCs were volunteers. This implied the closed spaces according to the Gaventa power framework. There seemed to be increased participation from women, but in real sense decision-making spaces were closed by men. The policy and the ODF protocol supported decision making by PHOs without any pretence of broadening the boundaries for inclusion for women, even if they served as VHCs participating in follow ups and community dialogues which entrenched gender marginalization.

#### **4.5.2 Division of Labour during an ODF Celebration**

ODF communal celebrations were considered the ultimate goal of CLTS. The entire community gathered to celebrate the attainment of ODF (Kar & Chambers, 2008). The study set out to interrogate the roles of the men and women in relation to the kind of activities that were held on the ODF celebrations and this is shown in Table 4.13.

**Table 4.11: Division of labour at the ODF celebrations**

Work responsibilities at the ODF celebrations	Nambale %		Teso %		Siaya %		Total %
	Men	Women	Men	Women	Men	Women	
Erecting community signage	27	7	27	5	27	7	100
Leading the transect walk	15	20	10	20	15	20	100
Speeches	20	15	30	2	20	13	100
Receiving ODF certificates	20	13	30	2	20	15	100
Entertaining guests (dance & food)	5	30	2	30	3	30	100

Erection of a sign board in a prominent spot to indicate that the village is ODF marks the beginning of celebrations. Table 4.13 indicated that 81% of the people across the 3 sub counties who erected the sign boards were men, with an equal distribution across the 3 sub counties. These boards acted as a sign of pride to the community upon being declared ODF (Kar et al., 2008, Plan UK, 2008). The decision regarding where the board would be erected was done by men who controlled the land, were either heads of households or PHOs and some were part of the VHCs. At the onset of the ODF celebrations, a transect walk through the village was done to showcase the cleanliness of the community. Table 4.13 indicated that 60% of the people who led the transect walk were women, equally spread out in the 3 sub counties, while only 40% were men. Teso yielded the lowest numbers of men leading the transect walk at only 10%. During the celebrations, speeches were made to congratulate the communities, encourage them to sustain ODF and to share on community dialogue days led by the village health committees. According to Table 4.13, 70% of the speeches were made by men, with the Teso men leading at 30% whilst

Nambale and Siaya at 20% each. It was also noted that the women in Teso had the most limited space to speak at the celebrations at 2% out of 30% for women.

This data showed that the men had absolute control of the land and where to erect the celebratory board. They also felt that general cleanliness was part of the reproductive role of the woman and thus they participated more in the transect walk as compared to men. While there were more women in the VHCs who could have been given an opportunity to share the plans for the community dialogue days during the ODF celebrations, the men led in the speeches. This data implies that as much as it seemed that organic spaces had emerged out of participation by women in CLTS implementation according to the Gaventa Power framework, the women could still not claim that space and participate equitably in the ODF celebration processes.

Awarding certificates to ODF households was the highlight of every ODF celebration. According to Table 4.13, certificate to households were received 90% by men, with the Teso men at 30% leading, while only 2% of the women in Teso received certificates on the behalf of their households. During the celebrations, entertainment was provided in the form of song, dance and skits to convey hygiene messaging by the village health committees. There was also food and drink for the entire community. Table 4.13 indicated that 90% of the women were involved in the entertainment, equally distributed in the 3 sub counties at 30% and only 2% of men in Teso participated in the entertainment. Moreover, data indicated that the men were openly rewarded for work that the women had done, this included ensuring that the toilets were clean for use on a daily basis and having a functional hand washing facility, these were the main activities that qualified a village to be certified open defecation free. The nurturing role of the woman

was stretched to cooking for the masses, serving and entertaining them. This implies that the woman's role is still not valued as emphasized in the Moser planning framework which conceptualises planning as it aims to challenge unequal gender relations and support women's empowerment. The framework also promotes planning to make all work visible and valuable to the programme implementers.

It can still be deduced that women participated in various CLTS activities during ODF celebrations, but they were not the ultimate decision makers nor were they recognized for their roles. The women were associated with voluntary service as VHCs, the transect walk and entertaining guests during the ODF celebrations. Participation is key to community empowerment but the actual CLTS approach does not quantify the participation levels (Plan, 2008; Angel-Urdinola, 2011). A close assessment also revealed that women took part in only the low-level activities associated with their nurturing role extended out of the home. To probe further, the researcher engaged in an FGD discussion with VHC members. The following was reported

*VHCs are highly valued and get tokens of appreciation such as; leadership roles in the community in relation to sanitation, which come with pride and status in the community. (FGD - Siaya)*

The findings imply that the actual bulk of the sanitation work was carried out by women and not men in line with the data on division of labour either at implementation or during celebrating ODF. Some of the activities were time consuming especially serving as village health committee members, this was corroborated by a study of Nambale that indicated that the VHCs did their work in a voluntary capacity with no pay or with minimal irregular stipends (Wamera, 2016). The women's role was biased and their

participation tokenistic with no intention of addressing any strategic needs. The CLTS approach handbook encouraged the users to use the handbook with flexibility according to their culture (Plan, 2008). This was an indication that the CLTS approach did not challenge any systemic biases, but continued to entrench them, presenting unequal gender power relations ultimately contributing towards insubordination of the woman according to the Moser framework. The framework promotes planning that makes all work visible and valuable to planners and implementers, through the concept of triple roles.

#### **4.6 Effects of the CLTS Approach on Men and Women**

The fourth objective of the study determined the effects of the CLTS approach on the community. This could only be after a period of time since the villages were declared ODF, it would require a time lapse of at least 12 months after ODF celebrations. In Uganda it is recommended that monitoring should be done 3 times over 3 months by which time ODF should be sustained and behaviour change ingrained (Pastuer, 2017). This variable was probed focusing on social cultural outcomes and gender relations, using household Structured interview guides, key in-depth interviews, FGDs and an observation checklist. The environment and the behaviour of the communities were probed to determine the outcomes of the CLTS approach to the community members.

##### **4.6.1 Social Cultural Outcomes**

Culture undergoes rapid change under the impact of technology as well as development interventions (Fingerman, 2009). Culture is an important socialization force throughout life and is most efficacious in shaping behaviours of adults (Pasupathi, 2001) through close interactions with people who are not socially close to them, such health care

workers, neighbours and ions with people in religious and communal gatherings (Fingerman, 2009). The CLTS approach introduced behaviour change that contributed to a general culture shift due to social practices. The study sought to determine the outcomes of the CLTS implementation in Teso, Nambale and Siaya Sub Counties which had been declared ODF between 2011 and 2012. The probing was on how the approach contributed towards social cultural shifts from; Open defecation to ODF, cultural practices and attitudes to acceptable social norms, which were probed through the Structured interview guides, Key In-depth Interviews and FGDs and how it affected the genders differently.

#### **4.6.1.1 Shift of Social Practice from Open Defecation to ODF**

Social practices in the community are determined by the way of life of the people. Behaviour is one of the parameters to determine social practices in the community. The CLTS approach was intended to create a social cultural shift for safe faecal disposal in communities where open defecation was a custom or convenient practice. CLTS set out to influence behaviour change from open defecation to ODF. The study sought to investigate if the communities and PHOs believed that there had been a shift in the communities several years after they had held the ODF celebrations. Table 4.14 indicated the results as follows:



**Table 4.12 Shift of social practice from Open defecation to ODF**

Variable of social practice shift	Response (%)					
	Nambale		Teso		Siaya	
	Yes	No	Yes	No	Yes	No
The village is considered ODF by the Community	40	2	14	2	40	2
The village is considered ODF by the PHOs	40	2	12	4	40	2

According to the data shown in Table 4.14, 94.0% of the households responded that their village was ODF, but with a paltry 14% from Teso. Nambale and Siaya felt that their community was till ODF despite the CLTS programme ending in 2012 and 2014 respectively, when they were declared ODF. Among all the three sub-counties 6% of the communities indicated that their villages were not ODF, this indicated that there were areas that the communities had gone back to practicing open defecation, but they were not of a very big number. This data indicated that there was an obvious social practice shift from open defecation to latrine use that was adopted and sustained with a high incidence in Siaya and Nambale but not in Teso. A further probe on the number that was not considered ODF, to determine the level of “*slippage*” included collapsible soils, some latrines had been swept by long rains in May 2016, but the communities were working on rebuilding. According to a study of ODF villages in West and East Africa, slippage depended on both internal and external factors over which communities had little or no influence and could be caused by a multitude of factors, either occurring separately or interacting with each other (WSSCC, 2016)

The Public Health Officers felt that there was a shift in behaviour change and that the communities were able to sustain ODF status. They felt that Nambale and Siaya were doing very well with 40% indicating their confidence in ODF but indicating that only 12% felt that Teso could still be ODF. The data indicated that 2% of the PHOs felt that Siaya and Nambale had some open defecation happening, and that 4% of the PHOs felt that there was open defecation happening in Teso. This data indicated that both the communities and the PHOs presented Teso North as the community that had not embraced the social shift of stopping open defecation despite the CLTS intervention over the years.

Some of the social practice shifts due to the ODF process were indicated during the FGDs as follows:

- i) *My sister in law and myself were not allowed to share with our parents in law a latrine in the homestead. This meant that we would go to borrow from our neighbours or use the sugarcane plantation. With the implementation of CLTS, our father in law built a separate toilet and bathroom for the women in the homestead. (FGD –Teso)*
- ii) *We the Teso used to consider women as children and would not allow them to participate in community meeting or share the facilities with us. CLTS helped us to see that we were not practical with our women, so we now have our women in meetings, and we built for them their toilets in the homestead. (FGD - Teso)*
- iii) *One of the firmly held belief among the Teso was that pregnant women were not to use latrines because the hot air in the drop hole was an evil spirit that would suck out the foetus. With CLTS implementation we actually know that using latrines is safer for everyone in the village. (FGD - Teso)*
- iv) *There are some social activities that we value in the luhya community, such as marriage and women’s merry go round. We decided to use these activities as reasons for ensuring that the people in Nambale had latrines. Without which, no merry go round meetings or dowry negotiations with in-laws would be allowed to take place by the chief in the village. This ensured that we all had latrines that were in use. (FGD – Nambale)*

- v) *Building of latrines and selling things required for sanitation such as toilet slabs, covers, hand washing stations, detergents and PVC pipes, was known to be men's work. With the onset of the CLTS process, some women were trained to be masons, which is different but good, for women are sensitive to people's needs. (FGD – Nambale)*
- vi) *There is dignity especially for visitors. When a visitor comes to a home and asks to use a latrine, you easily point it out. That person becomes happy not to go in the bush. There is respect at a home if there is a latrine. Having a toilet gives one high sense of respect and dignity. (FGD – Siaya)*

These data showed an evident social cultural shift whereby both the community and the PHOs agreed that there was a shift from open defecation to ODF as follows;

- a) In Teso Sub County, some key things emerged; that despite the cultural practice of in-laws not sharing latrines, some of the households built separate toilets to ensure everyone had access. One other factor that limited women's access to the latrines was misconceptions, such as not using latrines during pregnancy. These beliefs were openly discussed and addressed during follow up changing their perceptions and actions. Previously, women were not allowed to participate in community meetings with men, this posed a challenge to sanitation discussions during triggering, follow up and during community dialogue days. After the CLTS implementation, spaces for some participation of women in meetings and communal activities that were previously presumed to be men's domain were opened.
- b) In Nambale Sub County, two key shifts were noted that impacted their social lives. The community introduced sanctions to those households that did not have latrines by withholding social gatherings (such as weddings) in those homes. The Nambale community previously had mainly men as sanitation entrepreneurs and masons, but

they encouraged and facilitated some women groups to take up sanitation entrepreneurship. Thus, improving on overall economic productivity as emphasized by the Harvard analytical framework.

- c) In Siaya Sub County a key shift that emerged was on pride. The community did not previously consider having a toilet a priority. With the CLTS implementation, the process opened up the community to many visitors who came to learn on the approach, which the community would host the visitors and be proud to show off their toilets.

These issues presented aligned with the gender socialization rationale where the women spent more time at home, carrying out various reproductive roles, yet were rarely considered ‘real work,’ were rarely paid, and were performed primarily by women (Ludgate, 2016). The implementation of CLTS indicated that the social cultural shift was presenting opportunities for women to have improved access and benefits to facilities as opposed to before the CLTS implementation. The social practice shift also showed that there were spaces created for increased participation of women in communal decision making and economic activities such as sanitation entrepreneurs. These also showed that besides the actual shift to ODF, there were some benefits and positive outcomes to the women that were not initially intended at the onset of the CLTS programme.

The PHOs were tasked with the implementation of CLTS. Sustaining gains made by CLTS implementation is one of the challenges that faced many initial programmes. This was due to the designing of the programmes that indicated ODF attainment as the optimal success (Wamera, 2016). The study sought to investigate from the PHOs if they

felt that the villages were still ODF since the ODF declarations were done between 2011 and 2012.

The findings on Table 4.14 indicated that majority of the PHOs at 92.0% indicated that that the villages in the sub counties were still considered ODF. Teso had the lowest figure of ODF at 12% indicating that the PHOs felt that Teso had suffered major slippage compared to Siaya and Nambale. Some reasons provided by PHOs for slippage included: weak latrine structures, long rains and using locally available materials that were not durable. This finding indicated that majority of the PHOs believed that there was a social practice shift that had been brought about by the CLTS implementation. That was further confirmed through the following statements from PHOs:

- a) *Sanitation matters were considered a taboo subject in Busia, whereby human waste would not be addressed by its actual name in public or private. CLTS expected that the human waste is referred to by its actual name in public, among the women, men, boys and girls. This process took time, but eventually the community got used to the idea of calling waste by its name to bring about shame and encourage the community to deal with it. (County Public Health Officer – Busia County)*
- b) *Among the Luo community, it was the duty of a man as head of household to build any structure in the homestead. It was considered taboo for a woman to build any structure, even a toilet. Therefore, if a woman was single or widowed, and didn't have a toilet, she would keep on using her neighbour's every time she needed to use one. With the CLTS approach, the PHOs, CHWs, VHCs or Natural Leaders encouraged fellow community members to support in the provision of latrines to such people. This led to ODF villages regardless of the presence of single or widowed women. (County Public Health Officer – Siaya County)*
- c) *In Nambale, there were some people who were not involved in communal activities due to the fact that they lived away most of the times, such as civil servants or businessmen. These people would periodically visit the village and shunned building latrines, since they felt that they were only visiting for a short while and did not need to build latrines. They were persuaded to participate in sanitation activities and if they refused, sometimes the law would be invoked and they would be threatened with*

*legal action under the Public Health Act facilitated by the area chief, so as to be able to build latrines.* (Chief Public Health Officer – Afya House)

The data revealed that there was a shift, acknowledged by the PHOs. These included: in Nambale, the community calling faeces by name, which had been considered taboo before CLTS. Also, the community designed an enforcement strategy to ensure that there was total compliance to ODF by engaging the law to get stubborn people to build latrines. In Siaya, the community coming together to support women headed households to build latrines despite not having husbands, which was contrary before CLTS. These actions show that the community took up ODF seriously and made a shift in their social practices to ensure that they stayed ODF. In the CLTS process there were unintended positive outcomes especially in cases where there was support provided by the community to the women headed households to build facilities. This was captured by the gender socialization concept where generations adopt social structures and modes of social behaviour that are different, disrupting specific patterns of behaviour that have been held (Pasupathi, 2001). This provided an internalization of certain enduring social norms that were introduced within the social structure through CLTS which contributed as agents of socialization

The data implied that the CLTS implementation had resulted into a permanent behaviour change in relation to ODF, which was sustained beyond 3 years after the communities were declared ODF. It also provided evidence of change in cultural shift that saw increased space for women's participation in decision making and provided opportunities for women's economic advancement as sanitation entrepreneurs. The CLTS process also activated a social practice shift of communities discussing sanitation matters and integrating it into their social lives while before CLTS, it had been taboo.

#### 4.6.1.2 Shift in Social Norms

Social norms refer to a rule of behaviour that individuals prefer to conform to on condition that they believe that most people in their reference network conform to it and most people in their reference network believe they ought to conform to it (UNICEF, 2015). As sanitation and hygiene programmes mature, the challenge shifts from bringing communities to ODF status to sustaining this status (WSSCC, 2016). When slippage happened, what was most critical was that the communities regained their hygienic behaviour despite the disruption. The study interrogated the shift in social norms through, clean homesteads, consistent use of latrines and hand washing. This was through household Structured interview guides, the FGDs and the key in depth interviews with PHOs.

In conforming to what the entire community is working towards, the households worked towards having a clean homestead without any visible faecal matter or waste as proof of ODF. The study sought to verify the information provided by the households through observations as shown below:

**Table 4.13 shift in social norms**

S/No	Variable of Social Norms	Response (%)					
		Nambale		Teso		Siaya	
		Yes	No	Yes	No	Yes	No
	The Norm of a clean homestead	30	6	20	8	30	6
	The Norm of consistent use of latrines	30	6	20	8	30	6
	The Norm of hand washing	13	20	10	25	12	20

Table 4.13 indicated that 80% of the homesteads across the 3 counties were observed to be clean with no faecal matter. Teso recorded the lowest number at 20% indicating more households that had open defecation. 20% of the communities had some form of waste such kitchen or animal waste but none of it was human waste, with Teso recording a high percentage of homesteads with waste. Further probing indicated that communities were using their latrines consistently at 80%, with Nambale and Siaya leading at 30% each, with Teso at 20%. The data was consistent with the clean environment noted, with no human faecal matter. These were indicators that the social norm of consistent use of latrines had been ingrained despite having an average of 20% slippage it did not necessarily mean open defecation. For a village to be declared ODF, there had to be hand washing facilities with water and soap or ash (WSSCC, 2016). The norm of hand washing was verified by the presence of hand washing stations with water and soap. The Table 4.15 indicated that only 35% of the community washed its hands at the required times while 65% did not. This was determined by either lack of water or soap/ash at the hand washing station, or lack of the hand washing station itself. Teso was leading in number of households with non-functional hand washing stations at 25%, while Nambale and Siaya were at 20%. The data indicated that there was a shift in the social norm of people living in ODF environments whereby there is no kind of waste, more people using latrines and washing their hands. It also indicated that there was still work to be done on encouraging households to have more functional hand washing stations. This would also mean that increasing the burden of women on fetching water to ensure that the handwashing station had water and soap available when required.



A study carried out by the London school of tropical medicine noted that availability of latrines does not guarantee their optimal use (Dreibelbis, 2016). For a community to be fully ODF, it is expected that everyone in the household adopted the social norm of properly using the latrine consistently. The researcher had to verify presence and use of latrines and found it consistent with the self-reporting done. Some of the latrines were in bad condition or almost filled up, but there was evidence of use.

This data was further confirmed indicating a shift in social norms, through FGDs as follows:

*We as Africans' we are very generous people, if our neighbour has a problem, we share with them what we have, even a latrine! (FGD - Teso North)*

The FGDs further indicated that consistent use of latrines had also been facilitated by some adoption of innovative technology especially for the aged and pregnant women. Some of the latrines had wooden rumps on the sides of the toilet to facilitate wheelchairs access. Two of the households visited had a commode for the aged, pregnant and physically disabled. Another household had a toilet equipped with a rail for easy access for the physically disabled.

*The Small Doable Actions by the USAID project helped us to understand how to appreciate the different stages of our life that could change our consistent and proper use of latrines (FGD – Nambale)*

CLTS aims at reducing deaths caused by diarrhoea episodes by promoting hand washing. Data showed that women were majorly responsible for ensuring there was water for hand washing at 50%. So, in this case, it was considered that the women had failed in their duty to keep up with the social norm of hand washing with soap at the most critical times

(CDC, 2013). Further probing indicated availability of only one piece of soap in the household used for every need and kept at a central place in the home, and if the household had fully adopted hand washing as a norm, they would find the soap and wash their hands anyway. It was also noted that Teso had a big challenge with accessing water, which was the responsibility of the women. This data implied a shift in the social norm of hand washing increased the burden on the women as this was seen as part of their nurturing role.

Often ODF achievements are fragile. Over time, toilets collapse or fill up and some people revert to old behaviours. The data indicated 20% slippage in the 3 sub counties, but there was a high level of adoption of social norms. A study across four countries found that 87% of the 4,960 households surveyed more than 2 years after becoming ODF still had a functioning latrine, and 75% had hand washing with soap or ash representing a 13% slippage rate (Tyndale-Biscoe et al., 2013). The data implies that hand washing was dependent on a functional hand washing station that was maintained by the women. This indicated additional burden to the women according to the Harvard framework, yet there were no guarantees that the presence of water and soap led to hand washing. The CLTS approach considered an evident shift in social norms to ODF environments and practices and not valuing the role of the woman in ensuring a successful adoption of the social norms of latrine use and hand washing.

#### **4.6.2 Gender Relations**

Women play a central part in the provision, management and safeguarding of water and sanitation. The gender analysis principle that calls for ensuring active participation of women is critical. However, gender roles and relations can impede women's participation

(Brewster et al., 2006). There is a need to be gender aware through training for programme representatives, facilitators and communities (Global Water Partnership, 2000). The study sought to understand if the CLTS approach had been successful in Kenya and in the 3 sub counties and how it had affected the relationships between men and women and how this was reflected in their lives. This was done through having key in-depth Interviews and FGDs.

#### 4.6.2.1 Success Levels of CLTS as an Approach

The CLTS approach has been considered successful in several countries across the world since its inception (Myers, 2016). Kenya being one of the countries that adopted CLTS as an approach, the study sought to interrogate the implementers and recipients of the approach if they considered it a success and the Table 4.16 indicated these successes.

**Table 4.14 the success of the CLTS approach**

Variables on the success of CLTS approach	Response (%)					
	Nambale		Teso		Siaya	
	Great extent	Moderate extent	Great extent	Moderate extent	Great extent	Moderate extent
Success of CLTS in Kenya	18	20	8	18	16	20
Success of CLTS in the 3 Sub counties	35	2	23	3	35	2

CLTS emerged as an effective way of initiating the process of behaviour change in relation to sanitation and hygiene, through a variety of interconnected emotive factors that influence community members to construct and use latrines to achieve ODF status

(Lawrence et al., 2016). The study sought to understand the extent to which the CLTS process was considered a success in Kenya. Table 4.16 indicated that cumulatively 58% of the PHOs in the 3 counties felt that the CLTS process had been a success in Kenya to a moderate extent, with PHOs in Teso registering the lowest figure at 18%, while Nambale and Siaya PHOs felt that CLTS was moderately a success in Kenya at 20% each. The following were some reasons provided for the data on further probing; the approach heavily relied on voluntary work and the ‘non-subsidy’ approach to sanitation services was not taking the poor into consideration leading to poor quality latrines construction, that later collapsed leading to slippage.

*One can only volunteer for some time while hoping for recognition or some form of incentive, if it is not there, then we start spending time in some aspects of our work that are more paying like, TB and malaria work that we are paid a monthly stipend. (FGD – Siaya)*

This data called to attention the fact that most VHCs were women and they felt the burden of voluntary work that they performed, which in different settings would attract a pay. Rural areas sustainability depended on the voluntary engagement and contribution of communities, yet in urban areas there were more likely to be contractual obligations for service delivery through paid community consultants (Myers et al., 2016). According to the Moser framework this would be an indication of failure to plan properly to challenge unequal gender relations and support women’s empowerment through CLTS.

Also, Table 4.16 indicated that 93% of the households felt that CLTS had been a success in the sub counties, with Teso recording the lowest at 23%. The study further sought to understand the figures through FGDs, and the following emerged:

*CLTS has brought us dignity to the community; it introduced a high level of cleanliness that was not there before to the households and the community at large (FGD - Nambale)*

*The CLTS process empowered us to have our own Village Health committees that were formed to manage CLTS and other emerging socio-cultural issues in the villages as well. The process facilitated the identification of individuals with great potential in leadership, to serve as natural leaders (FGD - Siaya)*

*CLTS improved our unity and togetherness, you could see more men working together to help build latrines and compost pits in the village, leading to a sense of ownership in the community, as we do not wait for outside help to solve our problems anymore. (FGD – Nambale)*

The data revealed that the CLTS approach had been a great success in the sub counties and it had wider benefits than just CLTS. The community members felt that they had more dignity and pride that came with a clean environment. They also indicated that the programme had increased its cohesion, leading to community mobilization into social action that increased ownership that was previously not there.

The data implied that despite the CLTS approach not being considered such a great success in Kenya, it was highly considered a success in the areas of study. Despite the aspect of voluntarism that raised the question of sustainability of the gains made in the CLTS implementation, the sub counties felt that the approach had yielded more community gains that went beyond just voluntary efforts. Women's' economic resilience is undermined by the unpaid work they do to manage CLTS as indicated in the data. However, the VHCs who were mainly women, considered CLTS a success in the sub counties as they felt that the approach gave them an opportunity to participate in communal activities that yielded respect for them despite the extra burden of work. The rural women have limited access to resources and opportunities as indicated in this study and may result to women experiencing a range of negative impacts leading to limited

livelihoods and lower incomes as opposed to the men in the same communities involved in the sanitation and hygiene work. CLTS in this context was considered as an opportunity for women to access closed spaces by men according to the Gaventa power framework, even though the gains are minimal and the increased burden of work much higher.

#### **4.6.3 The Outcome of Successful CLTS Implementation to on Gender Power Relations**

Gender shapes the distribution of power at all levels of society. One of the most persistent patterns in the distribution of power is that of inequalities between women and men. Gender roles can be the cause, consequence and mechanism of power relations that shape the distribution of power (Koester, 2015). With a focus on the relationship dynamics between the genders in relation to CLTS, the Gaventa Power Framework (Veneklasen et al., 2002), was applied to assess gender relations post ODF. The forms of power and the spaces of influence for power in the post ODF communities were assessed to determine if CLTS had facilitated an increase of power to either genders, and an increase in the spaces of influence in the community of either gender.

##### **4.6.3.1 The Forms of Power**

Power manifests itself in different forms, which can either be visible, hidden and the invisible (Veneklasen et al., 2002). According to the study, visible power was based on observable decision making. The findings are presented in table 4.17, and further discussed in subsequent sub sections on forms of power among the women, among the men and between men and women.

**Table 4.17: Gender power relations in the community before and after the CLTS intervention**

Relationship	Forms of Power (%)					
	Invisible		Hidden		Visible	
	Before	After	Before	After	Before	After
Women to Women	54.3	63.5	34.8	55.4	53.4	66.8
Men to Men	49.8	69.2	39.5	45.6	51.1	62.3
Men and Women	39.5	45.6	49.9	76.3	51.1	63.3
Relationships	Spaces of influence for power display (%)					
	Closed		Invited		Claimed	
	Before	After	Before	After	Before	After
Women to Women	46.7	61.3	51.1	61.9	49.9	67.3
Men to Men	39.5	45.6	58.9	59.9	43.3	48.7
Men and Women	53.4	66.8	49.9	52.2	49.2	51.1

- i) *Among the women*; there was an increase in visible power from 53.4% to 66.8%. This meant that there was an increased number of women who participated in processes that were previously a preserve of a specific category of women, such as the CHWs. Hence, women who were previously not in leadership positions, emerged as natural leaders and served in the VHCs, thus

the CHWs had to share the decision-making power with the VHCs in the community, which the data indicated were majorly women.

- ii) *Among the men*; there was an increase of visible power from 51.1% to 62.3%. This was an indication that the CLTS process had increased the participation of some men who previously were not involved in decision making in the community. These were the men who emerged as natural leaders and served in the VHCs alongside the community leadership and PHOs.
- iii) *Between men and women* – there was a noticeable increment where there were more women involved in decision making processes that were previously dominated by men from 51.1% to 63.3%. These processes included decisions in relation to the siting of latrines, when to hold community dialogue days and when to declare communities ODF during the joint monitoring missions. The increase of women's participation was noted through VHCs who were predominantly women.

The data implied that there was substantial increase in participation of women in decision making among the women at 13% increase. It also showed that visible power increased among the men by 11%. The data also registered an increase of 12% by men to women. These findings therefore underline that the CLTS processes facilitated the inclusion of women in decision making processes in relation to CLTS.

The study found that hidden power was the most prominent through setting the agenda for CLTS, and it determined who got to the decision-making table and what was agreed upon. Table 4.15 indicated that:



- i) Among the women;* there was an increase in the women who were involved in the agenda setting that had not been consulted previously from 38.4% – 55.4%. This data reflects the increase in the visible power, even though not all the women who became VHCs were involved in agenda setting all the time amongst themselves.
- ii) Among the men;* there was a minimal increase in the agenda setting of the men who had not previously participated, from 39.5% to 45.6%. This data was a reflection of the visible power as well with minimal agenda setting as well.
- iii) Between the men and women;* there was a great increase in participation of the women in agenda setting from 49.9% to 76.3% this was noted to be the highest participation among all the groups and categories.

The findings therefore demonstrate that there was a substantial increase on participation in the setting of the agenda, between the men and women at 26.4%, amongst women with a 17% and a minimal increase amongst men with a 6.1%. This means that the CLTS process facilitated the inclusion of women in setting the agenda in relation to sanitation and hygiene in the community more than before the CLTS process was initiated in the community.

The study also sought to understand invisible power and who shaped the meaning and what was acceptable in CLTS, especially ideological boundaries of participation. Table 4.15 revealed the following;

- i) Among the women;* there was an increase of participation from 54.3% to 63.5% in setting the sanitation and hygiene social norms among the VHCs and the CHWs who had previously held the preserve of determining the hygiene parameters.

- ii) *Among the men*; there was an increase in participation of men from 49.8% to 69.2% who previously had not been consulted in the setting of social norms in the community. This reflected a big leap of getting natural leaders setting community norms with the PHOs and the village elders, who were predominantly men.
- iii) *Between men and women*; there was a marginal increase in setting norms from 39.5% to 45.6%. This data indicated that despite an increase in participation in decision making, there was limited participation of women in setting the social norms and it remained a preserve of the men.

The data indicated that there was a substantial increase among the participation of men amongst themselves in setting the socially acceptable norms at 19.4% as compared to among women at 9.2% and between men and women at 6.1%. This data implied that the setting of social norms was determined more by men and there was limited participation of women or men who were not previously involved. The leading role of men was also noted in the FGDs as follows:

*We respect our men as our leaders in the household and in the community generally, so we must let them speak up first and then we augment their answers. (FGD - Nambale)*

The power dynamics operate on many levels to exclude and devalue the concerns and representation of less powerful groups. The findings implied that the men were willing to invite more men into decision making, setting the agenda and determining social norms, but not women. The men were also flexible in increasing the power of women to participate in setting the agenda, which was very commendable but, they still set the

social norms by increasing the power of other men to participate. And as noted in the FGD, the men who are considered leaders in households speak first as a sign of respect. This curtailed women's participation by default and maintained the status quo despite increasing women's participation. This confirmed that the three sub counties were patriarchal in nature and that the CLTS process had limited positive impact on the gender relations in aspects of power dynamics. The findings established that CLTS only set out to meet practical gender needs, continue in-subordinating the women with no intention of meeting their strategic gender needs.

#### **4.6.3.2. The Spaces of Influence for Power**

These spaces consider situations where power is exercised and experienced by different actors, and how power relations can persist or change according to the particular places where they arise. This provides an understanding of the characteristics of the spaces of power relations occurrence, and how these shapes the possibilities for continuity or transformation and it is a vital step in identifying practical entry points for supporting change. These spaces are namely, closed, invited or claimed. Table 4.15 indicated these:

The study sought to understand the gender relations in the closed spaces where decisions were made behind closed doors, often without even the pretence of extending the opportunities for inclusion. The following was found;

- i) *Among the women* there was a substantial increase from 46.7% to 61.3% of more women who were included in decision making behind closed doors in relation to sanitation and hygiene. This was an indication of CHWs including the women

natural leaders and VHCs into decision making spaces that were considered exclusive.

- ii) *Among the men*; there was a minimal increase in the inclusion of other men from 39.5% to 45.6% in decision making behind closed doors. This indicated that there were instances that the PHOs made some decisions without including the natural leaders or village elders.
- iii) *Between men and women*; there was a very limited increase from 51.1% to 59.9% on decisions that were made behind closed doors that affected the communities. This focused on the community leaders who were referred to as “gate keepers”. The VHCs were not involved in the decisions that were actually made behind closed doors by the village elders, chiefs and PHOs.

The study therefore established that the decision making in the community was a preserve of the men, who only opened up to a limit of 8.8% for women’s participation. While the women opened up spaces among themselves at 14.6%, the men did not open up the spaces among themselves, only doing it at 6.1%. Hence decision making in closed spaces continued to be dominated by a specific cluster of men who also held influential positions.

Further probing by the study established to understand the dynamics in the invited spaces, where various kinds of authorities invite people to participate in decision-making processes as beneficiaries. The following was established in Table 4.15:

- i) *Among women*; there was a substantial increase in invited spaces of influence from 51.1% to 61.9%. These were instances where women who had

previously been considered beneficiaries from previous CHW interventions were invited to participate in decision making as the VHCs.

- ii) *Among men*; there was a minimal increase of invitations from 58.9% to 59.9% of men who were previously considered beneficiaries by men in authority. This was noted as the men who became natural leaders to participate in village elders decision making processes.
- iii) *Between men and women*; there was a minimal increase in invitation in spaces of influence of power by men from 49.9% to 52.2%. This showed that the men who served as community leaders minimally invited women to participate in the decision-making process in CLTS. This is because the communities considered the men's social power and authority; therefore, members argued that their decisions were best for the community.

This study, therefore, underlined that invitations into spaces of influence was limited, as decision making was left to the people with authority, who were predominantly men, there was only 2.3% increased participation of women. Women of authority opened up participation for other women at 10.8% more, while among men, there was only 1% increase.

The study probed for any created or claimed spaces as a result of CLTS. This entailed assessing for any instances of autonomous spaces created for engagement and action, (Gaventa, 2006). The following was established as shown in Table 4.15:

- i) *Among women*; there was great space claimed among the women from 49.9% to 67.3%. This data indicated that the women who were invited into decision making were able to claim the space for engagement among the VHCs
- ii) *Among men*; there was minimal claim of space created from 43.3% to 48.7%. The findings, therefore, underline that the men who had been invited or involved in various decision-making processes were not confident enough to push for any action or engagement.
- iii) *Between men and women*; there was the most minimal increment from 49.2% to 51.1%. This data indicated that despite having invitations and being included in the decision-making processes, the women were given minimal space to be able to claim any autonomy for engagement or action.

The study established that there were more women who created autonomous spaces to engage in action among themselves in activities in relation to sanitation and hygiene decision making, claiming a 17.4% increase in autonomy. This was due to the women who joined the VHCs and worked closely with the CHWs, providing the impression that there had been more spaces of power opened up for the women. In real sense there was minimal spaces created among the men with only 5.4% increase and among men and women with the most minimal claim of space at 1.9%. This means that women were provided minimal autonomy for any engagement in decision making by the men in regard to activities that contributed towards CLTS.

The study established that there was a notable power increase in participating in decision making among women in all the aspects of visible, hidden and invisible power in relation to the CLTS approach. The women easily shared power among themselves to a point

whereby the invited women were able to claim autonomy or space for action. This was on the contrary among the men who had authority who opened up minimal spaces for fellow men for decision making. There was markedly, very limited increase in all aspects of gender power relations among men and women, which contributed to very limited claims to autonomy in decision making from men in CLTS. Consequently, the study notes that the three sub counties were patriarchal and that even the CLTS processes did not provide sufficient opportunities to address strategic needs for women and empower them through sanitation and hygiene work.

The data further indicated that the level of participation on decision making for women was still low in relation to activities of CLTS intervention. This was directly affected by the gender relations that were indicative of the patriarchal system in the study areas. According to the Gaventa power framework, it was established that there had been some instances of invited spaces created through the CLTS process. However, there was no genuine inclusion as agendas were already pre-determined by the gate keepers. There were closed spaces that also seemed to have opened up to women to participate in decision making forums such as the community dialogues, but the women were not able to claim the spaces to take action that would empower them despite shouldering the burden of CLTS. These aspects were the entry points for supporting change for the women, albeit limited, starting with the VHCs. However, the study established that there was a relative increase in participation of men and women in CLTS process than witnessed before. There was an increase in inclusiveness in dialogue, consultation and decision making as compared to before, among the genders and between the genders. The opening up of spaces to the women by men increased opportunities for women to present

their practical needs to be addressed in the CLTS process. Despite the communities becoming more inclusive and progressive than before; the women did not achieve their strategic needs of empowerment through CLTS due to limited spaces created that could be claimed by women.

#### **4.7 Strategies to Ensure a Gender Equitable CLTS Approach**

The study sought to establish recommendations from the households and PHOs on how to ensure that the CLTS approach benefited everyone according to their needs and what other suggestions they had to improve the CLTS approach. This was done through the Structured interview guides, FGDs and in-depth interviews. Some of the strategies that emerged included the following:

##### **4.7.1 Households**

The study probed households through Structured interview guides for possible solutions to ensure equitable outcomes of the CLTS process, through asking the following question, “Are there things that you think could be done to ensure men, women, boys and girls were adequately reached during the CLTS process in the village? If Yes, what are these things?” The following issues were raised:

- a) Majority of the households at 60% indicated that the CLTS officials used English and Kiswahili to address them; not all the community members understood these languages well. The community recommended that programmes should be implemented in Kiswahili and local languages for easier understanding and participation. 25% of the households in Teso indicated that they preferred to have the programme implementation in mother tongue for better understanding.



- b) Some of the households at 43% indicated that the CLTS implementers should have first investigated the communities' economic capacities to have proper and durable latrines before initiating the CLTS process. This was raised on the aspect that the community felt that CLTS relied on local resources, which actually meant resources that mostly men had access to and yet sanitation work was considered the woman's domain. 18% of households in Siaya indicated that the issue of land use was critical in sanitation provision and could only be made by men.
- c) Some of the households at 32% felt that adhering to communal penalties introduced for non-compliance ensured sustaining acquired behaviour change in relation to hygiene and sanitation. However, 60% of them also indicated that designing the penalties should be a communal thing and not just the community leadership, who most of the times were men. They indicated that some of the sanctions were unfair especially to the women headed households.
- d) Few of households at 20% felt that the VHCs worked very hard to ensure that the villages stayed ODF, yet they worked for free. 60% of the households indicated that the VHCs should be given a stipend to facilitate their duties in the communities, especially the household follow up visits.

The study established some aspects of the gender impact assessments that form part of strategies to ensure that there were equitable outcomes of the CLTS approach. These include; use of local language, carrying out economic assessments, introducing communal penalties and incentivizing the VHCs. Social impact assessments are a process of identifying and managing the social issues of project development and includes the

effective engagement of affected communities in participatory processes of identification, assessment and management of social impacts. It is used as a mechanism and decision-making tool to consider the social impacts in advance before an intervention (Vanclay et al., 2015). Social assessments are processes of ensuring proactive and deliberate participation of women and gender-discriminated peoples at all stages (Grant et al., 2016). Sanitation and hygiene issues affect the genders differently and the differences need to be identified and properly understood from the onset of the CLTS process. The most effective way to ensure the needs were well understood was to include all the genders in the various stages of decision making of the CLTS process, which the findings of this study indicated did not happen.

#### **4.7.2 Communities**

The study probed the community through the FGDs for possible solutions to ensure equitable outcomes of the CLTS process, through asking the following question, “what do you suggest should be done to improve the CLTS process in the Sub County?” The following issues were raised:

- a) All the 3 FGDs held, most of the members indicated that incentivizing the work of the VHCs would have motivated them. That could be through financial tokens/stipends or supporting the VHC groups to have income generating activities, or train them to serve as sanitation entrepreneurs. The following was said:

*The CLTS process introduced the natural leaders to serve as VHCs. It's nice! But also, very demanding, as it increased their work. We need some motivation to keep working to ensure that we are ODF throughout (FGD - Siaya)*

- b) Teso and Busia FGDs indicated that training the community in mother tongue would have initiated quick gains because the community would have understood the approach faster and adopted it accordingly as opposed to having the trainings in English and Kiswahili. This was expressed as follows;

*Having CLTS training in mother tongue or Kiswahili is so effective and easily understandable (FGD - Nambale)*

- c) All the three FGDs also felt that the CLTS process did not try to understand how sanitation and hygiene work was divided among the genders and carried out in the community. They felt that understanding who did what and why, would have provided information on what roles were acceptable or a challenge to either of the genders. They felt that this was not done, and it led to women having an extra burden. And that, there was no consideration for the vulnerable households like the poor, child or women headed households who had challenges in building and maintaining latrines.
- d) All the FGDs also expressed that there should have been a triggering of school children and teachers in schools. That would have ensured behaviour change at an early age. This was perceived to be more effective as opposed to having children attending the village triggering sessions. However, it was indicated that most times the triggering happened when children were in school and they were not aware of the project but had to do what they were directed by their parents.
- e) The CHWs felt that the planning for CLTS activities was done by the community leadership which most times were men and did not factor in some gender sensitive issues. Examples were given of organizing meeting times and points

where both men and women were available to attend. They also suggested alternatively having various triggering sessions as opposed to having one general session for the village to ensure that everyone in the community was reached regardless of their gender or status. The following was said;

*Triggering meetings were mostly carried out during midmornings on weekdays when most men are away for work and only women are available. This automatically made the women to shoulder the burden of community sanitation more than the men. (FGD - Nambale)*

The study established that; a clear understanding of the division of labour, roles of men, women and children in the sanitation work, and having all-inclusive planning for activities with both genders in mind would ensure full participation in CLTS implementation. The listed issues form part of the gender analysis framework that facilitates the definition and analysis of gender issues by the communities. Using the gender analysis matrix would have provided a unique articulation of sanitation issues through aspects of labour, time, resources and culture (Parker, 2013). The framework would have ensured that the sanitation responsibilities were equitably shared among the men, women and children. Gender analysis would have ensured that all gender groups enjoyed the outcomes of the CLTS process. The framework would have created a space to speak about cultural practices that entrenched gender biases in CLTS and ensured equitable access and benefits to CLTS related resources.

#### **4.7.3 CLTS Implementation Practitioners**

The study interrogated the CLTS implementers, who were PHOs through key in-depth interviews for possible solutions to equitable outcomes of the CLTS process. The

following questions were asked; “what do you suggest should be done to improve the CLTS process in the Country?” The following issues were raised:

- a) The 2 County Public Health Officers (Busia & Siaya) and the Chief Public Health Officer admitted that the government recognized that the ‘non – subsidy’ approach that was adopted by the CLTS approach adversely affected the vulnerable households. They suggested that introducing a ‘targeted subsidy’ approach for vulnerable groups such as the poor, child and women headed households, would ensure that all genders had equitable gains of the CLTS implementation. And that this would ensure that communities became ODF quickly and there was limited slippage experienced due to vulnerable households.
- b) Both the County Public Health officers (Busia & Siaya) felt that providing structured guidance to the community in planning for post ODF would ensure a sustained behaviour change to all genders. They indicated that the project funding for CLTS ended at ODF celebrations and the responsibility was left to the women to sustain ODF. However, they recommended close follow up and monitoring, that would ensure equitable access, benefits and responsibilities of maintaining ODF.

The following emerged:

*The biggest challenge we have with post ODF is that partners do not finance follow up and it is expected that there is at least follow up for 6 months to ensure that all the households maintain an agreed sanitation standard. This has led to the women as the hygiene providers to continue in the role in and beyond the homes. This has considerably added a burden to the women. (CPHO – Siaya)*

- c) All the PHOs interviewed indicated that the data that was collected by the CLTS knowledge hub did not have sex disaggregated data, which made it difficult for

them to provide sex disaggregated data on the CLTS process. They suggested a review of the monitoring and evaluation tools by the Ministry of Health to ensure data disaggregation of people reached with the CLTS intervention. They recognized that it was with that kind of data that would facilitate reporting on equitable access and benefits to improved sanitation and hygiene as a result of CLTS.

- d) All the PHOs interviewed indicated that the CLTS implementation process took cognisance of other aspects of development such as; equity, inclusion and appropriate technologies, at the end of the process. However, they recommended that re-scheduling of various development approaches to enrich the CLTS approach were critical for sustained and equitable results. That would lead to equitable access and benefits to vulnerable households to basic sanitation and hygiene.

The study established that the PHOs acknowledged that the CLTS process needed some additions to the approach that were key aspects of gender mainstreaming. These additions would contribute towards equitable CLTS outcomes such as; targeted subsidies, planning beyond ODF, dealing with sex disaggregated data and recognizing the vulnerabilities in the community in aspects of equity and inclusion in sanitation and hygiene provision. Gender mainstreaming introduces gender-sensitive indicators that would measure gender-related aspects in the community. It would identify status, roles and needs of women and men that need to be achieved and knowing how to measure them. The gender-sensitive indicators would facilitate the understanding of how changes in gender relations happened and analysed programme outcomes for gender equality (OXFAM, 2014).

The study established key strategies that emerged from the households, the PHOs and the VHCs that could influence equitable outcomes of the CLTS process as follows: gender responsive impact assessments, gender analysis framework and gender mainstreaming. These strategies have been applied in other development interventions with success. Since 1995 gender mainstreaming was a strategy that had been implemented in all sectors with varying degrees of success. Various tools have also been developed to support the strategy (Osagi, 2006). Gender mainstreaming could be applied in CLTS as one of the additional tools to improving the CLTS outcomes, among other tools, as more innovations emerge on successful interventions in order to speed up the pace of equitable CLTS. The CLTS implementers need to introduce complimentary aspects to the gender strategy, such as social norms. Having a sustainable flexible gender strategy that has sex disaggregated data, access and control profiles, roles and vulnerability aspects would contribute to equitable CLTS implementation.

## **CHAPTER FIVE**

### **SUMMARY, CONCLUSIONS AND RECOMMENDATIONS**

#### **5.1 Introduction**

This chapter presents a summary of the major findings of this study as well as the conclusions. Suggested recommendations based on the study and areas for further research are also presented.

#### **5.2 Summary of Major Findings**

The section contains the key findings of the study based on the five objectives namely; to establish how gender needs were addressed in the Environmental Sanitation and Hygiene policy and the CLTS approach and to assess gender related factors influencing the successful implementation of the CLTS approach. Also to identify gender roles in the implementation of a successful CLTS approach, to discuss the effects of the CLTS approach on women and men, in the three Sub Counties of Siaya, Nambale and Teso.

The summary of the findings are discussed below:

The study established that all households that participated in the study had been in the areas for over 5 years. All the respondents had a form of education with majority of them being men. Majority of the respondents were below 45 years, a relatively average age according to the Kenya Demographic Health Survey (2009). The key informant interviews targeted PHOs who majority were men and who were in the peak of their careers having served on average for 10 years. FGDs were carried out among VHCs who were predominantly women who had served since the triggering of their villages. The FGDs provided insights that spanned over 5 years of CLTS experience.



### **5.2.1 Establish how Gender Needs were Addressed in the Kenya Environmental Sanitation & Hygiene Policy, and the CLTS Trainers' Handbook.**

The first objective established how gender needs were addressed in the Kenya Environmental Sanitation and Hygiene policy, and the CLTS Trainers' handbook. This was done through a literature review and in-depth interviews with PHOs. The study established that the KESHP recognized sanitation as a human right. However, there was a clear lack of specific mechanisms that ensured the realization of the human rights. The policy had a generalist attitude on the capacity building plan that lacked equal opportunities for both men and women. The policy was also not gender responsiveness and had no specific critical gender enablers or enforcement strategies outlined. As for the CLTS trainers' handbook, it recognized the women's voice, but did not factor in the triple roles and how they impact on the women and men. The authors of the CLTS Trainers' Handbook underlined the importance of recognizing the different roles played by men and women but did not disaggregate the data of those that they had trained to implement CLTS. Both documents did not provide any forms of enforcement or mainstreaming strategies of the general statements of intent made, whilst many of the instances could have benefited from a gender sensitive consideration to improve the outcome of the actions from the policy makers and CLTS trainers.

Majority of the PHOs who were mandated to implement CLTS, were not aware of the gender provisions in either the policy or the CLTS trainer's handbook. This was despite both documents having minimal provisions on gender specific needs. This made it a challenge to plan adequately for all Kenyans according to their needs. The PHOs further

did not recognise the need for disaggregation of data, which marks the starting point of unequal gender relations and insubordination of one gender during planning.

The Moser framework draws attention to the importance of recognizing various roles and different needs of men and women, and the complexity of how women's lives and roles may interact with programme interventions. If these documents were gender responsive, they would provide opportunities for more nuanced planning. They would highlight potential constraints or opportunities in implementing an equitable intervention, therefore, in this case, both documents failed.

Based on these findings, it was indicated that the KESHP and the CLTS trainers' handbook were inadequate to provide equitable outcomes of the CLTS approach. The findings also revealed that the PHOs, who were the custodians of CLTS from the national level to the grassroots were not well equipped to implement a gender responsive CLTS approach. Due to being gender blind, they had an attitude of trivializing gender matters. This is contrary to what the Moser framework emphasizes the importance of meeting both practical and strategic gender needs in any development interventions. This would yield to equitable access and benefits to all as well as yield efficient projects and improve overall productivity.

### **5.2.3 Gender Related Factors that Contributed to the Successful Implementation of the CLTS Approach**

The second objective set out to interrogate gender related factors that could have contributed to the successful implementation of the CLTS approach. The study

established that decision making on CLTS implementation at the County and Sub county level was led by PHOs who the study had established were gender blind. Decision making at the community and household level was also largely done by men. However, women seemed to participate more in decision making as VHCs. Unfortunately, the VHCs were community volunteers with no decision-making role in the official community structures. Decision making was based on the data available which the study revealed that data collection was done by the VHCs. Nonetheless, the data was not sex disaggregated in the entire CLTS progress reporting. This translated to limiting the understanding of the specific sanitation and hygiene needs of households in Kenya.

The study also established that resources required for sanitation and hygiene were predominantly accessed and controlled by the men, and even when women owned these resources, they would not have the power to make their own decisions about using these resources, entrenching insubordination. It further revealed a skewed gender dynamic whereby the women spent most of their time maintaining the facilities, yet they did not benefit from them equitably. This also presented additional work burden to the women. It was revealed also that CLTS built on already existing aspects of gender and did not consider if the activities entrenched any gender biases.

Recognizing decision making at all levels is potentially significant and is considered a basis for a power balance and equitable inter-relationship. The Moser framework emphasizes on the value of the various roles played by the woman, yet the study revealed that the programme added the responsibility of the woman burdening her yet limiting her empowerment opportunities. In addition, according to the Gaventa power framework, there is extensive evidence of mobilization of bias. This is manifested in the hidden

forms of power whereby there was vested interests to maintain power and privilege by men creating barriers thus limiting women's participation by controlling resources. Consequently, it led to negative outcomes of CLTS such the increased burden on the women.

#### **5.2.4 Gender roles in the Implementation of a successful Community Led Total Sanitation Approach**

The third objective aimed at interrogating the division of labour and how it contributed to successful implementation of the CLTS approach and maintaining ODF status. The study revealed that the women had a daily responsibility of ensuring clean latrines and a constant supply of water for hand washing in the homes with no help regardless of the circumstances. It further noted that men largely made the decision of ODF status; this was despite a big number of women represented in both joint follow ups and community dialogue days. The final decision on ODF was made by the PHOs who led in CLTS implementation, yet they had limited knowledge on gender provisions for sanitation. The study also further confirmed the critical role played by women which did not just end at the household level but contributed towards the follow ups and reporting on ODF.

The study established that there was unfair division of labour whereby the women shouldered the biggest burden of maintaining facilities at home and participating in follow ups and community dialogues. They further participated in various CLTS activities during ODF celebrations, but they were not the ultimate decision makers nor were they recognized for their roles. The men were recognized during the ODF celebrations and were served and entertained by the women, which translated to more work without recognition. This confirmed that the actual bulk of the sanitation work was

carried out by women and not men. Some of the activities were time consuming especially serving as VHCs, yet they were voluntary jobs. This was an indication that the CLTS approach did not challenge any systemic biases, but continued to entrench them, presenting unequal gender power relations ultimately contributing towards insubordination of the woman according to the Moser framework.

### **5.2.5 The Outcomes of the CLTS Approach on Women and Men in the Three Sub counties**

The fourth objective set out to determine the outcomes of the CLTS approach through household Structured interview guides, in depth interviews with the PHOs and FGDs with the VHCs. The study established that there was a social practice shift that resulted in some benefits and positive outcomes to the women that were not initially intended at the onset of the CLTS programme. Also, some spaces were created for increased participation of women in communal decision making and economic activities as sanitation entrepreneurs. These were spin offs from communities being ODF. It was further revealed that there was support provided by the community to the women headed households to build facilities.

The CLTS approach was considered a great success in the sub counties, despite having a moderate success in the country. The VHCs felt that CLTS had wider benefits than just sanitation, in that it had provided them opportunities to participate in communal activities that yielded respect for them despite the extra burden of communal work without pay. The study also revealed that despite the VHC indicating that there had been more participation, in actual sense the women participation had increased in a minimal way. There was a markedly very limited increase in all aspects of gender power relations

among men and women, which contributed to very limited claims to autonomy in decision making from men in CLTS. This confirmed patriarchy, and that the CLTS process did not challenge it to provide sufficient opportunities to addressing strategic needs for women and empower them through sanitation and hygiene work.

According to the Gavena power framework, there was no genuine inclusion of women in decision making as agendas were already pre-determined by the gate keepers. There were closed spaces that also seemed to have opened up to women to participate in decision making forums such as the community dialogues, but the women were not able to claim the spaces to take action that would empower them despite shouldering the burden of CLTS. These aspects were the entry points for supporting change for the women that were not fully utilized. However, all is not lost as the permanent behaviour change in relation to ODF provided some opportunities for women's economic advancement as sanitation entrepreneurs. Despite the communities becoming more inclusive and progressive than before, the women did not achieve their ultimate strategic needs of empowerment through CLTS. Considering the gender socialization concept, there is potential for change by adaptation of social structures, modes of social behaviour and social norms which would be an initial influencer of socialization.

### **5.2.6 Strategies that would ensure a Gender Equitable Outcome of the Community Led Total Sanitation Approach**

The fifth objective sought to generate strategies that would ensure a gender equitable outcome of the CLTS approach. Various respondents were interrogated including households, PHOs and VHCs. Households felt that sanitation and hygiene issues affected

the genders differently and the differences needed to be identified and properly understood from the onset of the CLTS process. The most effective way to have ensured the needs were well understood was to include all the genders in the various stages of decision making in the community. The study established that; a clear understanding of the division of labour, time and resources would indicate the socio-economic status of the community. Additionally, understanding the culture, roles of various genders in the sanitation work and having all-inclusive planning for activities would ensure full participation in CLTS implementation.

PHOs acknowledged that the CLTS process needed some additions to the approach that were key aspects of gender mainstreaming. Gender mainstreaming would introduce gender-sensitive indicators that would measure gender-related aspects in the community. It would identify status, roles and needs of women and men that needed to be achieved and acknowledged on how to measure them.

Gender mainstreaming with flexible aspects according to culture of the specific community is critical to a gender responsive program. The CLTS implementers needed to introduce complimentary aspects to a gender strategy that every programme must have, such as social norms. Having a sustainable flexible gender strategy that has sex disaggregated data, access and control profiles, roles and vulnerability aspects would contribute to equitable CLTS implementation. Strategies such as gender responsive impact assessments, gender analysis framework and gender mainstreaming, have been tried before in other development interventions with success, CLTS implementers should consider these too.

### **5.3 Conclusion of the Study**

The study sought to assess the gender outcomes of the CLTS approach in Siaya, Nambale and Teso sub counties. The Gender outcomes were influenced by some key factors such as the existing Kenya Sanitation and Environmental Hygiene Policy (KESHP) and the CLTS Trainers' handbook that did not provide sufficient direction and mechanism to ensure equitable CLTS implementation. The study also found that the PHOs who had the mandate of implementing CLTS did not have sufficient knowledge on gender provisions for equitable CLTS implementation. This led to PHOs dealing with data that was not disaggregated, thus limiting their decision making based on general data in relation to equitable outcomes of CLTS.

The study also revealed that decision making in relation to CLTS was mainly led by men from the country, county, Sub County, community and household levels. This was both by default and by design. At the national, county and sub county levels, the decisions were made by PHOs, who of whom were men as the public health profession had been considered a man's profession for a long time. At the community level the men led the decision making as they were mostly found during the triggering meetings. At the household level, men made most of the decision in relation to CLTS, as this required resources from the household that the men had absolute control over. VHCs collected data and made follow ups that facilitated decision making for ODF. The VHCs positions were voluntary with no pay and were mainly comprised of women. These showed that the men held a lot of power and determined the outcomes of interventions in the community.



The study further found that there was unfair division of labour in that women shouldered the biggest burden of providing and maintaining sanitation facilities in CLTS. However, the women did not enjoy equal benefits as men to the facilities. The women managed most of the sanitation and hygiene work at the community and household level, yet, the men were recognized for these efforts during the ODF celebration. The women further took up the burden of feeding and entertaining the masses during ODF celebration and no recognition was accorded to them either as women or VHC members.

The study also revealed that the CLTS approach was considered a great success in the sub counties where the study took place. However, it also indicated that the approach provided very limited space for participation and decision making for women by men. The inclusion of women in the community processes was tokenistic and not genuine. However, there was some evidence of positive initial steps toward power relations, such as, inclusion in dialogue, consultation and decision making, as compared to before. The women were able to access some limited opportunities like, sanitation entrepreneurship and women headed households being supported to construct latrines. Despite these limited positive outcomes, the women were not able to claim autonomy in any decision-making process in regard to CLTS. This confirmed that the CLTS process did not provide any strategic benefits to the women.

The study concluded that for an equitable CLTS approach, additional gender strategies must be applied. These would include carrying out gender responsive impact assessments with a gender analysis framework at the onset of the approach. Integrating gender-sensitive indicators to the monitoring framework of CLTS would ensure measurement of

gender-related aspects, leading to equitable access and benefits of all sanitation and hygiene related activities and facilities.

#### **5.4 Recommendations of the Study**

Based on the study findings of this study, it will be important to implement gender responsive programming to enable the women and men to access and benefit CLTS outcomes equitably. The following are the recommendations made;

1. There is need to ensure that the KESH policy and CLTS Trainers' Handbook are reviewed to facilitate delivery of equitable outcomes. These would include:
  - i) Introducing a CLTS gender strategy that will facilitate delivery mechanisms and provide gender specific indicators for measuring success.
  - ii) Set up capacity building programmes for all PHOs in Kenya on gender mainstreaming as trainers of trainers of a gender responsive CLTS approach.
2. There is need for the government and agencies that work in CLTS promotion to do the following:
  - i) Hire gender specialists who would ensure that the gender strategies are applied accordingly in programming, to ensure equity in participation in decision making.
  - ii) Design gender responsive CLTS programmes from planning to delivery.  
This would ensure that everyone's contribution is valued, such as the VHCs.
3. CLTS promoters need to consider the following community aspects as they plan their interventions:

- i) That the kind of result that the CLTS programme expects to get would affect roles of the people, resources required and their lives. Acknowledging that the CLTS process would impact on the socio-cultural aspects of life. The programme would be promoted in a way that it would add value to integrating understanding of socio-structural factors for a more comprehensive culture shift and adoption of gender sensitive behaviour in relation to sanitation and hygiene.
  - ii) That CLTS may be used as an entry point to challenge inequalities. This could be an entry point to the shifting of gender norms by empowering young people (mainly girls) with information, skills, and social support to challenge norms. This would foster an enabling environment in which to challenge gender norms.
4. Besides CLTS implementers considering the numbers of toilets and hand washing stations only to determine ODF success, other issues should be considered, such as;
- i) Level of participation by both men and women to attain success of ODF
  - ii) Access and benefits of both men and women to attain ODF
  - iii) Recognition of special roles played by the various members of the community to attain ODF.
5. Some of the strategies that would improve the CLTS process would include:
- i) A policy review to the KESH policy and a comprehensive review of the existing CLTS approach Trainers' Handbook would provide opportunities to mainstream gender into CLTS. This would be achieved by carrying out a

comprehensive gender analysis. Ideally, this analysis would cover the macro, meso and micro levels. Proactive and deliberate participation of women and gender-discriminated peoples at all stages of CLTS would be facilitated by the guidance documents.

- ii) Carrying out gender assessments to ensure an optimal equitable impact of the development intervention. This would ensure active participation of women by acknowledging that sometimes the gender roles and relations may impede women's participation. Using periodic gender audits would ensure that there are equitable outcomes of CLTS.
- iii) Introducing the activity profile for men, women, girls and boys at the onset of the programs. This should appear as part of the triggering process when mapping is carried out and commitments made on the ODF roadmaps for the wards.
- iv) Initiating critical enablers would ensure that there is change of mind-sets of professionals and policy makers about the gender disparities perpetuated by the CLTS approach. These would include government, service providers and the private sector, who are not currently triggered as the community at the onset of the programme. This would initiate a longer-term intervention targeting efficiency-focused reforms and strengthening the CLTS implementation.
- v) Working with men and boys as champions of mainstreaming gender into sanitation and hygiene interventions. This would put gender equality at the heart of CLTS implementation and would be owned by men and women

alike. Facilitating a change of mind-set for boys and men would lead to the levelling of the playing field to empower girls and women. This would reduce the burden on women and girls and increase their benefits.

- vi) Designing flexible gender mainstreaming strategies that would institute gender sensitive participatory processes in stakeholder consultations. This would give women and men adequate representation and voice. In cases whereby community sanctions have been designed for those who have failed to adhere to the new social norm, gender consideration would be assessed for failure to adhere to policy or practice. This would require gender guidelines and gender sensitive frameworks that would enable continuous gender sensitive CLTS programming that does not exist in Kenya currently.

## **5.5 Recommendations for Further Research**

Based on the findings of this study, the following areas may require further research;

- i) A study to investigate the role of men in promoting sanitation and hygiene in Kenya
- ii) A study to establish the factors that determine candidate selection for public health training in Kenya.

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# APPENDICES

## A1: NACOSTI PERMIT

**CONDITIONS**

- 1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.**
- 2. Government Officers will not be interviewed without prior appointment.**
- 3. No questionnaire will be used unless it has been approved.**
- 4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.**
- 5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.**
- 6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.**

**REPUBLIC OF KENYA**

**NACOSTI**  
National Commission for Science, Technology and Innovation

**RESEARCH CLEARANCE PERMIT**

**Serial No. A 9518**

**CONDITIONS: see back page**


**THIS IS TO CERTIFY THAT**

**MS ELIZABETH KETTY WAMERA**  
**of KENYATTA UNIVERSITY 0-3240**  
**Kiminini, has been permitted to conduct**  
**research in Busia, Siaya Counties**  
**on the topic: ASSESSING THE GENDER**  
**OUTCOMES OF COMMUNITY LED TOTAL**  
**SANITATION PROGRAMME IN SELECTED**  
**COUNTIES IN KENYA**  
**for the period ending:**  
**13th June, 2017.**

**Permit No. : NACOSTI/P/16/74236/11235**  
**Date Of Issue : 16th June, 2016**  
**Fee Received : Ksh 2000**

*[Signature]*  
**Applicant's Signature**

*[Signature]*  
**Director General**  
**National Commission for Science, Technology & Innovation**



## APPENDIX A2.1: STRUCTURED INTERVIEW GUIDE FOR HOUSEHOLD

### RESPONDENTS

The purpose of this study is to assess the gender impact of the Community-Led Total Sanitation approach to sanitation in Kenya.

#### SECTION A: DEMOGRAPHIC INFORMATION

Name of Respondent (Optional): .....

Gender: Male  Female

Ward:.....

Sub County: .....

#### Age (years)

18-25.....  26-30.....  31-35.....  36-40.....

41-45.....  46-50.....  51-55.....  >55.....

#### Period of Time Lived in the area (in years)

Less than 6 months .....  6 -12 months .....  1-2 years .....

2 -5 years .....

#### Highest Level of Education

Primary School .....  High School.....  College.....

University..... Other, specify .....

#### SECTION B: ENVIRONMENTAL SANITATION AND HYGIENE POLICY and COMMUNITY LED TOTAL SANITATION APPROACH

1. Have you been involved in the implementation of CLTS in your community?  
Yes  No
2. If yes, are there any places where there are specific references to women, men, boys, and girls specifically when working in the community?  
Yes  No
3. Are there any gender specific provisions in the CLTS approach in relation to women, men, boys, and girls?  
Yes  No



4. If yes, what are they?

.....  
..  
.....  
..

5. Who and how many people constitute the health committee that oversees and makes decisions on CLTS implementation in the community?

At the locational level; Male [ ] Female [ ]  
At the sub locational level; Male [ ] Female [ ]  
At the village level; Male [ ] Female [ ]

**SECTION C: INFLUENCING FACTORS**

6. Have you ever taken part in providing information on how many people in your household require sanitation?

Yes [ ] No [ ]

7. If yes, were you required to indicate how many were men, women, boys, girls?

Yes [ ] No [ ]

8. Who asked for this kind of information from you?

..... Male [ ] Female [ ]  
..... Male [ ] Female [ ]  
..... Male [ ] Female [ ]  
..... Male [ ] Female [ ]

9. How was the information collected?

.....  
..  
.....  
..

10. What are some of the **socio-cultural** factors that affect sanitation in this area?

Positive Socio-Cultural factors	Negative Socio-Cultural factors

11. What **resources** are required for the CLTS program implementation? Who **controls** these?

Resources for CLTS Implementation	Men	Women

12. Who has **access** to the resources listed above?

Resources for CLTS Implementation	Men	Women

13. Who has **control** over the activities of latrine construction?

Activities of latrine construction	Men	Women

14. Who has **access** over the activities of latrine construction?

Activities of latrine construction	Men	Women

15. Who has **access** to utilize the latrines constructed?

Men [ ]

Women [ ]

Boys [ ]

Girls [ ]

#### SECTION D: ROLES IN CLTS IMPLEMENTATION

16. Who made the decision to have your household participate in the CLTS program in the area?

Government Officials: Male [ ]

Female [ ]

NGO Officers: Male [ ]

Female [ ]

Community Officials: Male [ ]

Female [ ]

Your Spouse: Male [ ] Female [ ]  
 Other:..... Male [ ] Female [ ]

17. Who **led** the following processes in implementing the CLTS process in the area?

Implementation phase	Men	Women
Community mobilization		
Pre-triggering		
Triggering		
Taking the pledge to change		
Latrine construction		

18. What activities are carried out to achieve Open Defecation? And who **leads** the process?

Activities leading to ODF	Men	Women

19. What activities entail maintaining the latrines for use? Who does these activities?

Activities in maintaining latrines for use	Men	Women

20. What activities entail maintaining the ODF status achieved? Who **leads** in these activities?

Activities leading to ODF	Men	Women

**SECTION E: EFFECTS OF CLTS APPROACH IMPLEMENTAITON**

21. Are there any taboos or beliefs that have been affected by the CLTS implementation in the area?

Positive effect on Taboos/ beliefs	Negative effect on Taboos/ beliefs

22. To what extent does the CLTS approach affect the way people relate in the area?

Relationship	Ignoring	Sensitive	Supportive	Challenging	Tense	Others
Women to Women						
Women to Men						
Men to Men						
Men to Women						

23. To what extent do you consider the CLTS process a success in your area?

- No extent at all..... [ ]
- Little extent..... [ ]
- Moderate extent..... [ ]
- Great extent..... [ ]
- Very great extent..... [ ]

**SECTION F: STRATEGIES :**

24. Are there things that you think could be done to ensure men, women, boys and girls were adequately reached during the CLTS process in the area?, If Yes, What are these things?

.....

25. What do you suggest should be done to improve the CLTS processes in the community?

.....

**THANK YOU FOR YOUR COOPERATION**

**APPENDIX A2.2: OBSERVATION CHECKLIST**

**VILLAGE SETTING:**

1. Are there any visible human or animal waste in the paths in the area?

Animal  Human

2. Who meets you in the area to take you to the households? Is it ;

Man  Woman  Boy  Girl

**B. HOUSEHOLD SETTING:**

3. Is there a toilet in the home visited? Yes  No

4. Approximately how far is the toilet from the house?

In the house  Less than 50m  between 50 – 100m   
More than 100 m

5. Is there a hand washing station around the toilet?

In the toilet  Below 5m  Between 50 – 100m  More than 100 m

6. Does the hand washing station have water and soap? Yes  No

7. Is the toilet built with strong and stable materials? Yes  No

8. What kind of materials are used to construct the toilet?

.....  
.....

9. During the time you were in the home, is the toilet utilized? Yes  No

10. Who utilized the latrine?

Man  Woman  Boy  Girl

11. During the time you were in the home, is the hand washing station used?

Yes  No

12. Who washed their hands?

Man  Woman  Boy  Girl

**13. Request to visit the toilet to check for the following:**

a) Is the toilet clean with no waste on the floor? Yes  No

b) Is the toilet easily washable? Yes  No

c) Is the toilet door lockable providing adequate privacy? Yes  No

d) Is the toilet easily accessible to all the people in the household? Yes   
No

e) Is there anything that has been done to the toilet to enable any person with special needs to be able to use the latrine? If yes? What?

.....  
.....  
.....

**APPENDIX A2.3 KEY IN-DEPTH INTERVIEW GUIDE**

The purpose of this study is to assess the gender impact of the Community-Led Total Sanitation approach to sanitation in Kenya.

**SECTION A: DEMOGRAPHIC INFORMATION**

**Name of Respondent (Optional):**

.....

**Gender: Male**                           **Female**    

**Position in**

**Government/Organization:.....**

**Sub**

**County:.....**

**Period served in the current position:**

.....

**Age (years)**

18-25.....      26-30.....      31-35.....      36-40.....   
41-45.....      46-50.....      51-55.....      >55.....

**SECTION B : ENVIRONMENTAL SANITATION AND HYGIENE POLICY and COMMUNITY LED TOTAL SANITATION APPROACH**

1. Have you had a chance to read through the KESH Policy?  
Yes     No
2. If yes, are there any places where there are specific mentions of women, men, boys, and girls specifically?  
Yes     No
3. Have you had a chance to read through the CLTS Trainers’ Handbook or the CLTS trainers’ manual?  
Yes     No
4. If yes, are there any places where there are specific mentions of women, men, boys, and girls specifically when referring to the community?  
Yes     No
5. Are there any gender specific provisions in the KESH policy in relation to sanitation?

Yes  No

6. If yes, what are they?  
 .....  
 .....

7. Are there any gender specific provisions in the CLTS approach?  
 Yes  No

8. If Yes; what are they?  
 .....  
 .....

9. Who and how many people constitute the public health office that oversees and makes decisions on KESH Policy implementation?

At the national level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the count level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the sub county level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the divisional level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the locational level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the sub locational level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the village level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>

10. Who and how many people constitute the public health office that oversees and makes decisions on CLTS implementation?

At the national level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the count level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the sub county level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the divisional level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the locational level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the Sub locational level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>
At the village level;	Male <input type="checkbox"/>	Female <input type="checkbox"/>

**SECTION C: INFLUENCING FACTORS**

11. Do you have access to any data on sanitation that is disaggregated according to women, men, boys and girls?  
 Yes  No

12. If yes, which data is this?  
 .....  
 .....





21. Who has **access** to the resources listed above?

Resources for CLTS Implementation	Men	Women

22. Who has **control** over the activities of latrine construction?

Activities of latrine construction	Men	Women

23. Who has **access** over the activities of latrine construction?

Activities of latrine construction	Men	Women

24. Who has **access** to utilize the latrines constructed?

Men [ ]                      Women [ ]                      Boys [ ]                      Girls [ ]

**SECTION D: ROLES IN CLTS IMPLEMENTATION**

25. Who made the decision to have the CLTS program come into this Sub County?

Government Officials:                      Male [ ]                      Female [ ]  
 NGO Officers:                      Male [ ]                      Female [ ]  
 Community Officials:                      Male [ ]                      Female [ ]  
 Other:..... Male [ ]                      Female [ ]

26. Who **led** the following processes in implementing the CLTS process in the Sub County?

Implementation phase	Men	Women	Boys	Girls
Community mobilization				
Pre-triggering				

Triggering				
Taking the pledge to change				
Latrine construction				

27. What activities are carried out to achieve Open Defecation? And who **leads** the process?

Activities leading to ODF	Men	Women	Boys	Girls

28. What activities entail maintaining the latrines for use? Who does these activities?

Activities in maintaining latrines for use	Men	Women	Boys	Girls

29. What activities entail maintaining the ODF status achieved? Who **leads** in these activities?

Activities leading to ODF	Men	Women	Boys	Girls

## SECTION E: EFFECTS OF CLTS APPROACH IMPLEMENTATION

30. Are there any taboos or beliefs that have been affected by the CLTS implementation in the Sub County?

Positive effect on Taboos/ beliefs	Negative effect on Taboos/ beliefs

31. To what extent does the CLTS approach affect the way people relate in the Sub County?

<b>Relationship</b>	<b>Ignoring</b>	<b>Sensitive</b>	<b>Supportive</b>	<b>Challenging</b>	<b>Tense</b>	<b>Others</b>
Women to Women						
Women to Men						
Men to Men						
Men to Women						

32. To what extent do you consider the CLTS process a success in your community?

No extent at all..... [ ]

Little extent..... [ ]

Moderate extent..... [ ]

Great extent..... [ ]

Very great extent..... [ ]

**SECTION F: STRATEGIES:**

33. Are there things that you think could be done to ensure men, women, boys and girls are adequately reached during the CLTS process in the county? If Yes, What are these things?

.....

.....

34. What do you suggest should be done to improve the CLTS process in the Sub County?

.....

.....

**THANK YOU FOR YOUR COOPERATION**



### A4: FORM "B" CLTS FOLLOW UP REPORTING

<b>Form B: MOPHS Community Led Total Sanitation Program for</b> _____ <b>Location,</b> _____ <b>Division,</b> _____ <b>District</b>					
<b>Post Triggering Progress Monitoring (filled by CHEW, PHO/T) for</b> _____ <b>Village,</b> _____ <b>Sub Location</b>					
<b>Triggering Information</b>	<b>Village Information (Form A)</b>	<b>Latrine Coverage at Triggering (Form A)</b>	<b>ODF Dates</b>		
Date	No. of HH	HH With	Target		
Attendance: Men	Population: Men		Actual		
Women	Women				
Children	Children				
Matchbox in Petrol Stn		HH Without			
Promising Flames					
Scattered Sparks					
Damp Matchbox					
(Tick one)					
	<b>Follow up #1</b>	<b>Follow up #2</b>	<b>Follow up #3</b>	<b>Follow up #4</b>	<b>Follow up #5</b>
	<b>Date:</b>	<b>Date:</b>	<b>Date:</b>	<b>Date:</b>	<b>Date:</b>
1. How many households have built a new latrine since the triggering? (Total from CHW Form A)					
2. How many people are benefiting from the new latrines? (Total from CHW Form A)					
3. How many households are in the process of building a latrine? (e.g. pits dug) (Total from CHW Form A)					
4. For all existing latrines (old & new), how many have handwashing facilities? (Total from CHW Form A)					
5. Inspect known OD sites. Did you find any shit?					
6. Is the community on track with its action plan?					
7. Key issues identified & suggested solutions.					
8. Is the village now ODF?					
Name of Staff					
Designation					
Signature					



**APPENDIX A5.2: NAMBALE SUB COUNTY**





