Appendix 2

Where Are the "Ladies"?
Sanitation, Hygiene Improvements and Gender

A Key Note Address at the South Asian Conference on Sanitation (SACOSAN)
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Distinguished guests, ladies and gentlemen.

On behalf of the Gender and Water Alliance (GWA), it gives us great pleasure to be present in this very significant conference to address gender issues, which are of considerable importance to achieve sustainable and effective hygiene and sanitation improvements. These are not only challenging issues pertaining to the Asia region but to the world as a whole.

At the turn of the century, according to WHO and UNICEF's Global Water Supply and Sanitation Assessment 2000 Report, some 2.4 billion people had no access to any form of sanitary means of excreta disposal. This is a major cause of the 4 billion cases of diarrhoea reported each year between 1990 and 2000, and an annual toll of 2.2 million deaths. Most of those deaths are infants and young children, which makes prevention an important gender concern. Sanitation is one of the issues that clearly demonstrates the problems caused by gender inequality in human society. As traditional water bearers and custodians, women shoulder a huge burden in coping with the lack of basic sanitation services. The lack of sanitary facilities faced by women contribute to keeping their hands dirty and poor hygiene behaviours. All these factors play an important role in the poor health and the conditions of indignity that families suffer. Yet societal barriers continually restrict their involvement in the improvement of programmes intended to alleviate their situation.

What do we mean by Gender?

Gender is not about women and girls only. Gender is all about men and women, not in the sexual difference but in the socially and culturally determined differences between women and men. These differences are made by people and therefore they can, and do, change. Particularly in personal hygiene and sanitation habits, needs and demands, women and men, adolescent boys and girls differ. Therefore, gender mainstreaming involves assessing all the implications that any sanitation and hygiene intervention can have for women and men. These differences need to be reflected in relevant policies, strategies and approaches that promote improved sanitation and hygiene behaviour.

In 2002, the coverage statistics showing the awful 40% of the global population without any form of hygienic sanitation, led world leaders meeting in Johannesburg, South Africa, to demand action by governments. The target to reduce by half the proportion of people without satisfactory sanitation services by the year 2015 gives a big impulse to the sanitation cause. However to effectively address hygiene and sanitation, factors affecting the different genders become of supreme importance.

KEY SANITATION AND HYGIENE ISSUES AND GENDER IMPLICATIONS.

It is important to note that various gender groups have divergent interests, which need to be taken into consideration while developing policies, strategies, approaches and planning for hygiene and sanitation services for the poor. A gender approach recognises the social and cultural differences and inequalities between men and women, boys and girls. In a gender approach, these differences and inequalities are applied to:

- *knowledge and skills*, e.g. women know better what an hygienic latrine design is;
- *needs and demands*, e.g. women and girls face more problems with privacy and safety around latrine use, and on hygiene promotion men and boys need also to be included in the education campaigns;
- *types and division of sanitation-related work*, men know usually better how to dig a pit, how to construct the latrine with what local materials;
- *types of decisions, and who makes what decision*, are socially and culturally determined but ideally men and women must share information and make jointly key decisions to ensure sustainability and impact;
- *financing and other inputs*; men often control the finances, so convincing men for sanitation improvement is important; and
- *benefits and negative impacts*, apart from improved health, a sanitation programme may create job opportunities. In many sanitation programmes, women were effectively trained as masons and plumbers.

Such a gender approach with all these aspects mentioned is a requirement for the development of policies and strategies to achieve more effective, equitable and sustainable sanitation and hygiene behaviour.

In India it has been observed that women from minority groups have no access to the latrines in collective sanitation bocks because they simply have no right to use the shared installations. Widely reported problems with communal latrines also include the high incidence of attacks on women using them and difficulty of ensuring they are kept clean and hygienic (D. Allely et al 2000).

Sanitation interventions have strong social, economic and environmental implications that should be considered in any type of national plan. Some of these key considerations that we would like to bring to your attention are the following:

SOCIAL

Health or convenience

Evidence shows that the provision of adequate sanitation services, safe water supply and hygiene education is an effective health intervention. It not only reduces the

mortality caused by diarrhoeal diseases by an average of 65 percent and the related morbidity by 26 percent, but it results in a high reduction for governments on health cost related to poor sanitation and hygiene, lower worker productivity, lower school enrolment and lower retention rates amongst girls. It also contravenes the rights of all people to live in dignity. (WHO/UNICEF, 2000)

In South Asia women and girls in their puberty complain that if there is no toilet in the house or plot they cannot relief themselves during the day because they can only go to the sanitation field before dawn and after sunset. This forces them not to drink too much during the day, and creates great problems when they have diarrhoea. Better sanitary conditions provide real benefits to women in the form of greater privacy, convenience, safety and dignity and safe hygiene practices in the family. This means potential release of women's time and energy, much of which is invested in care of the family. Despite these apparent benefits demand for improved sanitation from poor women and men appears to be relatively low. Household sanitation usually does not have a high priority compared with other livelihood needs. For sanitation promoters, a key challenge is that those lacking good sanitation facilities are rarely convinced by the potential health benefits to make an investment for sanitation improvements. Social marketers find that convenience, privacy status and peer pressure are the areas more persuasive in motivating communities towards improved sanitation and hygiene. More and more poor farmers realise the benefits from decomposed human excreta or urine as a fertiliser for poor soils and good crops. Here men and women appreciate the livelihoods benefits: food for their family and surplus crop for potential market to generate extra family income.

School children suffer from poor sanitation facilities

A survey carried out in India among school children revealed that half of the ailments found are related to unsanitary conditions and lack of personal hygiene (UNICEF and IRC 1998). In India out of the more than 600,000 primary schools on average over all states, half of them have a safe drinking water source while only 1 out of 10 have sanitary facilities.

In many countries, schools have become unsafe places where diseases are transmitted rapidly due to poor hygiene behaviour and dirty sanitation environments. Poor sanitation in schools impairs children's growth and development, limits school attendance and retention of student's ability to concentrate and learn. About 40 percent of the about 1 billion school age-children are infested with intestinal worms. Girls do not drink during daytime as they do not want or their parents do not allow them to use dirty school latrines if any latrine is there at all. These girls may develop kidney problems. About 1 in 10 school-age Asian girls do not attend school during menstruation or drop out at puberty because of lack of clean and private sanitation facilities.

Improved sanitation and water supply in schools directly benefits girls' education. It is already harder for girls to attend and finish school. The presence of adequate sanitation facilities that can be kept clean, offer privacy and safety for older girls, are separate from those of boys, help parents send girls to school rather than stopping their education when they reach puberty. Sanitation at schools contributes to the reducing of inequalities between boys and girls. When planning the facilities the preferences of boys and girls

should be taken into account. Urinals may be constructed for boys and more latrines and urinals for girls, all with proper hand-washing facilities.

Schools provide an excellent opportunity to create lifelong changes in behaviour. Childhood is the best time for children to learn hygiene behaviours. Children are future parents and what they learn is likely to be applied in the rest of their lives. Children often have important roles taking care of younger brothers and sisters and, depending on the culture, they can also question and influence existing practices in the household.

Building new sanitation and water facilities is not enough. It is critical that these facilities are properly used and maintained. Simply giving hygiene lessons in class will not necessarily change children's hygiene behaviour. Good organisation of cleaning and maintenance of the water supply and sanitation facilities is of utmost importance. Badly maintained sanitation facilities may cause an even bigger health risk than scattered defecation.

Growing recognition of the importance of quality of primary education has inspired UNICEF, WHO, UNESCO and the World Bank to create a partnership to Focus Resources on Effective School Health (FRESH). The issues addressed in FRESH are water and sanitation facilities in all schools, life skills-based on health and hygiene education, the establishment of school policies for health promotion, and the establishment of school nutrition and health services.

Meanwhile Vision 21, an initiative of the Water Supply and Sanitation Collaborative Council and part of the Action of the second World Water Forum, has set specific school hygiene and sanitation goals for 2015:80 percent of primary school children are educated about hygiene and all schools equipped with facilities for sanitation and hand washing.

ECONOMIC

Costs of inaction

As well as the serious health consequences, the high diarrhoeal incidence and related deaths represent large economic losses due to non-productivity of men and women, health expenditures and negative publicity for countries and governments. The cholera epidemic in Latin American cities, deteriorated water supply and hygiene conditions spurred into action politicians and administrators who had thought the disease long overcome. The cholera epidemic in Peru, which lasted 15 months in 1991-1992, cost the country $200 million in lost lives, decreased production, exports and tourism (Suarez. R and B Bradford 1993). The annual cost of gastro-intestinal disease in the USA is estimated to be as high as US$900 million, whilst noting costs in developing countries could be higher (Payment, 1997).

Imbalanced investment

The current low sanitation coverage is partially explained by the low level of investment in sanitation compared to water supply. Of the total annual investment in water supply and sanitation (WSS) sector, approximately US$16 billion, only one fifth seems to be directed towards sanitation (WHO/UNICEF 2000). It is important that while designing

improvement interventions in hygiene and sanitation the local disease patterns are well understood. Reviews by Esrey et al. (1985-1991) demonstrate that median reductions in diarrhoeal disease incidence are greater from sanitation interventions than from those in water supply only. Subsequent reviews of the impact of hand washing and household water treatment show very significant reductions in diarrhoeal disease in the absence of engineering intervention. Funds for behavioural aspects form only a small percentage of investments, despite the fact that human behaviour and specifically addressing gender dynamics is one of the key determinants for impact of public health. Often the women are the only target group of hygiene education while to make an impact, a critical majority of at least 80%, including the poor men and boys, in the community needs to practise on a continuous basis improved sanitation and hygiene behaviour. Investment strategies aiming to achieve maximum benefit must consider this gender aspect.

Gender issues in infrastructure and technology choice

For the vast majority of the 2.4 billion non-served people and their future families, trunk sewers and centralised sewerage treatment plants may not be a viable option. It may be that low-income urban communities can be connected to central schemes subsidised from charges to better off communities. But in the meantime they need local systems that can alleviate the squalor and lack of hygiene and sanitation that threatens their lives. The aim is to adopt solutions to both the strength of the economy and the needs of the women and men with an overriding concern that they should be amenable to affordable management and maintenance, which will generally need the responsibilities of the users themselves.

Failure to account for the needs of women, men, girls and boys of the household when designing installations has been the downfall of many sanitation projects (Allely et al, 2002). Even mothers who are aware that their children's faeces are dangerous often do not let them use latrines because there is a risk of falling in. At the insistence of the villagers in Sri Lanka programmes, special children's latrines were built near the kitchens where mothers could train their children in their use (Fernando 1982). In some countries during the night women prefer to use the children latrine that does not have a superstructure, because it does not house snakes and insects (Sugden, 2003). Another example is that the raised footrests are positioned by men giving discomfort for women who usually put their feet differently than men. In situations without a piped water supply system, installing a pour-flush latrine implies extra burdens on the women and girls in the household, as there will be greater quantities of water to buy, to carry, or draw.

Cultural practices and constraints also need to be taken into consideration when planning for sanitation. Apart from personal preferences, some customs are controlled by religious or social norms/taboos. For instance women in a state in India did not want to use shared latrines as these had closed compartments while before they used to chat with each other while using the latrine. Only after holes had been made in the dividing walls allowing the women to see each other, women started using the latrines.

Because sanitation is primarily a private or household activity, motivating greater latrine usage requires promotion and marketing techniques that offer householders a choice of systems for a range of costs. The focus here should be on social, where the marketer/promoter is concerned with the correct use and sustainability rather than the commercial marketing aimed at selling the product. The 100% sanitation approach in

Bangladesh shows the success of village sanitation promoters, often women, and the wide range of latrine options offered.

INSTITUTIONAL

Institutional weakness

In spite of its importance to the health and economics of the nation, sanitation often lacks an institutional home. Frequently it is merged into the water supply and sanitation sector where the glamour jobs and investment priorities go to water supply. As a result, little support is accorded to sanitation and minimal investment committed to it. Detailed institutional, financial, implementation and operation and maintenance arrangements are well presented for water but that is not the case in sanitation and hygiene promotion; gender concerns are virtually ignored. The competing and conflicting roles and responsibilities among the subsections further complicate this. No clear regulatory frameworks are in place to guide the sanitation and hygiene promotion sector.

In contrast, where institutional arrangements have been clearly defined, more commitment is evident. For instance South Africa, which separates sanitation from water, has a clear policy focused on the provision of sanitation facilities and services. The policy aims to provide all South Africans with a basic minimum level of sanitation by 2010. The necessary institutional, implementation and financial means to achieve this goal are clearly set out in the policy, though there is still a lot that needs to be done in ensuring the different gender interests are addressed in service provision. While a multi-sectoral institutional approach is essential to hygiene and sanitation promotion, it requires addressing the gender dynamics of rich and poor women and men in the delivery of the services. Equally important is building relationships between public authorities, the private sector, for sanitation mainly the small-scale private sector, and civil society. Capacity building and an environment for learning from experiences are needed in which the aspects of both men and women, young and old are fully taken into account.

THE WAY FORWARD

1. Government departments should develop or strengthen national policies to ensure increased focus on sanitation and hygiene with specific strategies to respond to gender issues.
2. Government should establish realistic national year targets for sanitation and hygiene within the framework of the Millennium Development goals that provide a guide to investment for the delivery of hygiene promotion and sanitation services that are sensitive to gender dynamics. Gender requirements in relation to sanitation and hygiene need to be catered for in terms of the investments, planning, implementation and operation and maintenance processes/needs.
3. Government departments need to establish or strengthen inter-sectoral co-ordination and collaboration to get gender mainstreamed in sanitation and hygiene promotion. Departments should speak as *one voice for gender in hygiene and sanitation.*
4. Government departments, NGOs and donors should embark on awareness raising programmes targeted at sanitation policy makers emphasising the fact that sanitation is not just a household or social issue but rather a development program that should

be linked to gender and poverty eradication. It should be recognised that poor sanitation is both a symptom and cause of poverty and should be treated as such.

5. Government departments, NGOs and donors should develop tools for gender mainstreaming at institutional, programming and community levels that include indicators to monitor progress towards achieving gender-related goals and staff should be supported with training in gender-related knowledge and skills.
6. Hygiene behavioural change and improved sanitation should be seen as a process, not as a top-down decree. Affected poor women, men, marginalized groups and school-going boys and girls with their teachers and parents, must be consulted and involved in sanitation programme planning, implementation and follow up.
7. Participatory methods can be useful tools for encouraging involvement, developing consensus and creating commitment to action at all levels/sectors, while taking into account gender differentiated demands and preferences
8. The gender component needs reinforcement in hygiene and sanitation curricula and pre-service training for artisans, community, public health worker and teachers