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Assessing how policy and key implementers influenced gender outcomes of the community led total sanitation approach in selected counties in western Kenya

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Abstract

Kenya applied the Community-Led Total Sanitation (CLTS) approach to increase access to sanitation and hygiene. This paper assessed how policy and key implementers influenced the gender outcomes of the CLTS approach in three sub counties. The study sought to investigate if there were gender considerations in the implementation of the sanitation and hygiene policy for gender sensitive impacts through CLTS implementation. The Moser Framework was applied. A literature review, 3 Focus group discussions and 12 key in depth interviews were carried out. Quantitative data was analysed by SPSS 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 and concerns adequately yet CLTS was considered a success in Kenya. That the PHOs mandated to deliver CLTS were gender blind and made decisions not based on gender disaggregated data. The study concluded that CLTS in Kenya was not gender sensitive leading to unequal outcomes. The study recommends a review of the KESH policy and the CLTS manual to integrate gender responsive impact assessments and initiate gender critical enablers. All PHOs should be trained on gender mainstreaming which is integrated into CLTS intervention for flexible gender strategies.

Keywords: Gender Outcomes; Sanitation; Kenya

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1. Introduction

It is estimated that about 2.4 billion people in the world have no access to any form of improved sanitation services (WHO, 2015). Therefore, 2.2 million people in developing countries, most of them children, die every year from diseases associated with inadequate sanitation and poor hygiene conditions (WHO, 2014). Adequate sanitation is the foundation for social development. In most societies, women have the primary responsibility of managing household water supply, sanitation and health because of their productive role in the communities (USAID, 2014). 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 was hampered by cultural barriers and traditional gender roles. A gender analysis was applied in this study to the Community Led Total Sanitation (CLTS) approach, which lent an opportunity to interrogate an assumption that equal opportunities meant equal results and benefits to both men and women. The Moser Framework as a gender analysis approach was applied to draw out the key issues in relation to division of labour and access and control to resources and benefits of the CLTS approach.

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 designed to persuade communities to realize that residents "eat their own faeces" because of poor hygiene and sanitation. After the triggering, communities would usually decide to create a formalized sanitation committee and aim to become ODF, leading to latrine building and waste management improvements (Kar et al., 2008). Importantly, these decisions emerged from within the community itself, where the public health officers would encourage the communities to take up the decisions rather than impose it on them. There was considerable evidence of CLTS's success in rural areas, and its reputation amongst national governments, national and international agencies and donors was strong (Myers et al., 2016).

Kenya was one of the countries listed that had 68% of the rural population practising open defecation (JMP, 2013). However, there were no specific gender disaggregated data. As a result of the JMP statistics, the Ministry of Health in Kenya launched an Environmental Sanitation and Hygiene (KESH) policy in 2007 to improve its status. An implementation framework was designed as a basis of a campaign in 2009 to drive the Kenyan rural community to be Open Defecation Free (ODF) by December 2013 through the CLTS approach. The ministry carried out a pilot in some sub counties that were considered cholera hotspots and a year later, this was considered a great success in Nyando, Siaya, Bondo, Kisumu West, Rachuonyo and Busia (MOH, 2010). This result of over 100 villages open defecation free led to the adoption of the CLTS approach as a national strategy to accelerate access to sanitation.

This paper interrogates the policy and implementation environment that would have ensured a gender equitable CLTS approach. The study was carried out in 2015-2016, seeking to assess the role played by policy and key implementers that influenced the gender outcomes of the CLTS implementation process in Siaya, Nambale and Teso North sub counties. It also sought to establish the possible policy and implementation

strategies that would reduce gender inequalities of accessing the sanitation and hygiene facilities and services in the study areas. The paper presented suggested strategies that would ensure a gender equitable outcome of the CLTS approach.

1.1. Research questions

The study sought to answer the following questions;

1- What were the gender needs and concerns that were addressed in the Environmental Sanitation and Hygiene Policy and CLTS approach documents?
2- What kind of data was used to influence the successful implementation of the Community Led Total Sanitation approach?
3- What suggested strategies would ensure a gender equitable outcome of the Community Led Total Sanitation approach?

2. Literature review

Some regional and global studies have been carried out in relation to the outputs and outcomes of the CLTS approach, but no studies were found in Kenya (Robinson, 2016, UNICEF, 2014). There were no studies that had been carried out on the gender outcomes of the CLTS approach in Kenya. In order to indicate the major contribution to lack of these studies stems from the policy environment, the study reviewed existing literature globally and regionally. The study also interrogated the sanitation and hygiene policy and CLTS implementation documents in Kenya.

2.1. 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 (Mitlin, 2011). 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 CLTS programmes, at national and global levels (WHO/UNICEF, 2014). Addressing gender aspects in sanitation and hygiene means 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, 2012).

CLTS emerged as an effective way of initiating the process of behaviour change in relation to sanitation and hygiene. Proponents of CLTS (Kar and Chambers, 2008; Bongartz, et. al, 2010) argued that it was effective and sustainable because it empowered local communities to adapt long-term sanitation behaviours. Some argued that CLTS was highly effective because it was widely participatory, class-neutral and engaged both men and women in the whole of the community action. In addition to the positive sanitation outcomes for the whole community such as improved health, proponents also indicated that the CLTS process led 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 (Plan Uganda, 2012; Water Aid, 2009; Mehta, et.al., 2017). However, it was argued that even though benefits of interventions for women and men were clear, the lauded goals of women's empowerment and gender equality were far less evident in the CLTS approach. While CLTS did not necessarily have explicit gender equality objectives (Roose, et.al., 2015), several authors argued that women's empowerment was necessary for more sustainable sanitation and hygiene programmes for both sexes (UN Women, 2015; Plan International, 2013).

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

Table 1. Principles of CLTS

Principles of CLTS	**Assumptions**
Participation	It is expected that the community members are at the heart of the process and should drive the agenda.
Empowerment	It is expected that the communities make their own decisions and are encouraged to take their own actions.
Collective behaviour change and collective action	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.
Community ownership	This is achieved through the communal consultations to attain community buy in directly and symbolically.
Triggering	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.
Natural leaders	These people are considered activists and champions who emerge and take lead of the process.
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

Equity of access and participation, including by age, gender, and other social groupings were all factors to be considered in CLTS. Studies by Robinson (2016) and UNICEF, (2014) indicated that 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 and did not lead to changes in the CLTS programs. There was no evidence of systematic and regular monitoring of gender aspects at the national CLTS knowledge hub in Kenya that generates reports for the Ministry of Health.

2.2. Sanitation and health policies, protocols and programmes

The various sanitation and hygiene policies that were reviewed were mostly gender neutral and did not provide specific provisions for the various genders. These kinds of documents used as guidelines for governments to offer service to homogenous rural communities as they implement the work aiming to attain homogenous outcomes like open defecation free (ODF). Some governments incorporated the CLTS approach in their government policies to improve access to sanitation and hygiene, these include; India, Tanzania, Zambia, Madagascar and Kenya.

2.2.1. India

The government of India had an equity and inclusion strategy in the Gramin guidelines in the Swachh Bharat Mission. Unfortunately, the guidelines targeted various groups as beneficiaries and not implementers, curtailing any power or space to influence programming. Provisions in the guidelines 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 (Sahoo, et.al., 2015). These committees worked on a full-time basis although there was no permanent cadre and were only given a minimal honorarium. There was a lack of monitoring to ensure that the state governments adhered to this provision for women's participation.

2.2.2. Tanzania

The Government of Tanzania did not have a specific sanitation policy, but through the Ministry of Health and Social Welfare were running a four-year National Sanitation Campaign (NSC). The campaign was designed to accelerate the proportion of people with improved access to Sanitation in Tanzania. There was mention of gender in the campaign documents, under the section marked as a *"cross cutting issues",* 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 documents. 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 further indicated that the CLTS implementation did not have gender sensitivities. The report also presented a finding that public health officers who oversaw implementing the CLTS approach had not been trained on equity issues and that 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. The report recommended that the public health officers in Tanzania should be trained on equity issues to improve on the CLTS implementation. Despite these recommendations, the government did not review the policy or

implementation documents to include any gender or equity issues in their national sanitation campaign that runs up to 2020.

2.2.3. Zambia

The Ministry of Health in Zambia had a National Health Policy (NHP) based on situation analysis done in 2010, that provided statistics of population divided only into two categories; urban and rural. There was no disaggregation of data by gender in any of the text in the policy document. The NHP further indicated that lack of access to basic safe water and sanitation were some of the gender issues affecting negatively the women and girls, among other issues. However, there was no laid-out plan how that discrepancy would be addressed. 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 (Morris-Iveson, et.al 2011). The term *'engender power play'* is not further explained or qualified in the policy as to what it actually means, and how to achieve it. The NHP listed sources of data including different special groups and only listed elderly and disabled in this category, with no sex disaggregation as a critical point for data collection, only mentioning the general population categorized into urban and rural data sets.

The Ministry developed national guidelines for CLTS, to be used for verification and certification of Open Defecation Free (ODF). The targets were set based on an assumption that if a household had a latrine, both men and women would benefit equitably.

2.2.4. Madagascar

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. The literature reviewed indicated that CLTS was applied without a policy framework and without clear indications of gender sensitive outcomes of the process.

A CLTS study carried out by Buchy et al. (2014) 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 regarding 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. A study by Davies (2015) indicated that there were positive ODF outcomes for both women and men, but there was no evidence that primary outcomes differed by gender, due to lack of gender disaggregated data. This revealed the absence of a universal gender strategy for CLTS and recommended development of a context specific gender strategy and guidelines.

2.2.5. Kenya

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. 90% of the Public Health Officers in Kenya are male with only 10% being women (APHOK, 2013), 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 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. Due consideration was required to given concepts and to the recognition and understanding of gendered concepts (EIGE, 2014). The KESHP presented a perspective that completely ignored the gender dimension, or differences between men and women, 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.

The policy documents of India, Zambia, Tanzania, Madagascar and Kenya that were 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.

Studies also carried out in Sierra Leone and Bangladesh indicated that the empowerment of women was evident due to facilitated new roles for women and improved relationships in the village with the men. The women's voice was increasingly improved in village meeting formats where the women enjoyed a mutual level of trust and felt safer and more empowered to voice their needs and preferences in relation to sanitation. (Plan, 2013, Mehta et al., 2017; Mahbub, 2008). This met the CLTS objective of empowering people to act to improve their circumstances in a range of community-determined problems. However, 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, especially for the women (Wamera, 2016). 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.

3. Theoretical application

The Moser gender planning framework conceptualises planning as aiming to challenge unequal gender relations and support women's empowerment. The study sought to investigate if the policy or guidelines that were used in Kenya provided for proper planning and ensured equitable access and benefits to improved sanitation and hygiene facilities. The Moser Framework recognized planning as critical for successful implementation of programmes, and further highlighted the transformative potential of gender planning that was best captured by disaggregating data. It further distinguished between practical gender needs and strategic gender needs. This framework provided a premise that unless a program had gender planning on the onset, the program ran a risk of potentially exacerbating existing social problems and increasing the burden of work for one gender (Mehta et al., 2017; Roose et al., 2015).

3.1. Methodology

This study applied the comparative research design which was considered appropriate as it enabled consideration of varied contexts that influenced the results of the CLTS programme as well as its sustainability across Kenya. The study was carried out in 3 sub counties; Nambale, Teso North and Siaya, all located in the Western part of Kenya. These are patriarchal communities (Plan, 2014). The study considered both secondary and primary data. The total populations of the sub counties were considered at 468,369 people in 63,927 households. Stratified random samples were drawn and then a *z score* applied to get to 385 respondents for household questionnaires. 12 keys in depth interviews were carried out based on public health officers (PHOs) who had the mandate to formulate the KESH policy and implement CLTS at national and sub county levels. 3 focus group discussions (FGDs)were held with the community health volunteers (CHVs).

4. Findings of the study

4.1. Gender needs and concerns addressed in the Kenya Environmental Sanitation and Hygiene Policy (KESHP) and CLTS approach documents;

4.1.1. The Policy

The KESHP targeted children under five years of age and further indicated sanitation as a human right, highlighting various groups as having various needs – women, older members of society, persons with disability, children, youth, members of minority and marginalized communities. The terms equity, equality, non-discrimination was mentioned under the guiding governance principles and values of the policy. It also mentioned participation to provide equal opportunity, equity targeting the poorest and gender responsiveness and social inclusion among the guiding principles of the policy. The section on water and sanitation intervention in schools mentioned menstrual hygiene, and further mentioned women out of the school environment as well.

However, the KESHP addresses people, beneficiary, Kenyans and communities but did not provide disaggregated data. The vision, mission and policy goal did not indicate disaggregated data but provided general terms such as *"Kenyans"* or *"beneficiaries".* Under the section on governance and institutional capacity building; there was no mention of what would be done to ensure that both men and women accessed equitable opportunities. Under the responsibility of household and individual sanitation; there was no mention of the various roles of men, women, boys and girls, but general statements which often entrenched existing gender inequalities.

4.1.2. The Handbook

The CLTS approach handbook listed some success factors such as the "*Natural leaders"* being men, women or youth. It indicated the emergence of volunteers and traditional midwives being active towards hygiene issues would be considered a successful CLTS intervention. It also indicated that one of the key social-cultural condition that determined if a village was favourable to intervene included women having a voice. It was noted that the absence of people from all categories might weaken the collective power of the *"triggering"* decision. It was also highlighted that young girls and women suffered most due to lack of latrines. And the handbook promoted the involvement of children as a critical step to ensuring success in triggering communities.

However, the CLTS approach handbook did not provide guidance on gender division of labour. Triggering was considered a success when communities committed to construct latrines, yet the same publication indicated that the men constructed and then the women took over the maintenance of the latrines. It encouraged the users to use the handbook with flexibility according to their culture (Plan, 2008). 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 did not provide sex disaggregated data.

The Moser framework conceptualised planning as aiming to challenge unequal gender relations, support women's empowerment and recognized the transformative potential of gender planning that is best captured by disaggregating data. Unfortunately, the generalist attitude taken by the KESHP did not categorize policy approaches that appreciate the different roles of men and women in providing sanitation, so there was no data disaggregation at any point in time in the KESHP. The framework distinguished between practical gender needs and strategic gender needs, which KESHP did not factor in the capacity building plan for equal opportunities, thus promoting inequitable labour division in CLTS implementation. The CLTS approach handbook did not challenge any systemic biases, but continued to entrench them, presenting unequal gender power relations ultimately contributing towards insubordination of the women according to the Moser framework. The framework promotes planning that makes all work visible and valuable to planners and implementers, yet CLTS promotes voluntary unpaid service and relies on it for success (Wamera, 2016), relying on cultural supremacy that is biased against one gender in division of labour and benefits.

The content of the two documents indicated that the policy and the trainers' hand book 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.

4.1.3. The Policy Implementers

In depth knowledge of the KESHP by Public Health Officers (PHOs) was imperative as they held the mandate of disseminating and implementing it. The study found that 75% of the PHOs had read through the KESHP, only 50% indicated that there was some form of gender disaggregation, referring to the mention of men and women. 67% of the PHOs had no knowledge of gender considerations in the KESHP such as menstrual hygiene, separate latrines for men, women, boys and girls and their recommended ratios. This 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. 67% of the PHOs did not recognise the need for disaggregation of data, while 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 hindered proper planning for resources and set the stage for unequal interventions and benefits in implementing the KESHP.

4.1.4. The Approach Implementers

The PHOs used the CLTS Trainers' Handbook as the main resource to lead the implementation of the CLTS process. Therefore, understanding of the CLTS documents was pertinent. 100% of the PHOs indicated that they had read the handbook and 83% of them indicated that there had been mentions of men and women in the handbook. 75% of the PHOs had no knowledge of the gender specific provisions in the trainers' handbook, while 25% indicated some form of provision, but 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.

The study found that despite the keen application of the CLTS approach and KESHP, 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 reflected that despite CLTS being

a sanitation intervention that aimed 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.

4.2. What was the kind of data used to influence the successful implementation of the CLTS approach?

The quality of CLTS implementation relies on the data gathered at the pre-triggering stage, the facilitators triggering, follow up, verification and certification (Plan UK, 2008). Disaggregated data provides a basis for proper planning on the various group's needs. Literature linking gender and CLTS highlights the need for guided gender sensitive assessments. These could be used as a practical framework to discover ways to increase the effectiveness of sanitation programmes in an equitable manner (Dreibelbis, et.al., 2013). According to a UN report in 2013, only 39% of countries reported sex-disaggregated data on access to sanitation and Kenya was not on that list of countries. The study found that Post triggering follow ups were critical activities for the long-term sustainability of ODF behaviour (Wamera, 2016). Follow up entailed reporting on the progress on access and use of sanitation facilities and this data was collected through various government designed forms, provided by the counties and compiled to provide national level sanitation statistics;

Form "A": The Household Register for documenting progress in CLTS triggered villages. Did not have any sex disaggregated data but only required "Number of people" and "head of household" to be filled in among other fields.

Form "B": 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.

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.

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.

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. From "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 (UNICEF, 2013). The interrogated forms provided progress reporting information to the CLTS Knowledge Hub at the Ministry of Health (MOH, 2014). Availability of quality disaggregated data at various levels facilitates adequate and effective decision making. The data determines planning and programming, where 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. This is equally emphasized by the Moser framework, which indicated 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 was not possible in Kenya, through the ministry of Health and CLTS Hub, as they did 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).

4.3. Suggested strategies to ensure a gender equitable outcome of the CLTS approach?

The study sought recommendations from literature reviews, households, voluntary community health workers and the PHOs on how to ensure that the CLTS approach implementation was equitable. The following were identified;

Gender Responsive impact assessments: These 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 captured required that the policy addressed the issues and the implementers (PHOs) were aware.

Gender analysis matrix: 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. This would have provided a unique articulation of sanitation issues through aspects of labour, time, resources and culture (Parker, 2013). The application of the matrix would have ensured that the sanitation responsibilities and benefits 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. This process 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.

Gender Mainstreaming: This 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 analyzed programme outcomes for gender equality (OECD, 2012). 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 Public Health Officers who were mandated to implement CLTS in Kenya, acknowledged that the CLTS process needed some additions to the approach to ensure equitable benefits to all. These included; targeted subsidies especially for the vulnerable households and working with sex disaggregated data to ensure equity and inclusion in sanitation and hygiene provision.

These listed 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 gender mainstreaming strategy (UNFPA, 2016) that would require the CLTS implementers to introduce complimentary aspects such as social norms, sex disaggregated data, access and control profiles, roles and vulnerability aspects, would contribute to equitable CLTS implementation.

5. Recommendations

The following were recommendations made after the study for the policy makers and key implementers to consider;

1- A policy review to the KESHP and a comprehensive review of the existing CLTS approach Trainers' Handbook to 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.

2- Hire gender specialists who would ensure that the gender strategies are applied accordingly in programming, to ensure equity in participation in decision making. They would design gender responsive CLTS programmes from planning to delivery. This would ensure that everyone's contribution is valued, both men and women.

3- Carrying out gender assessments to ensure an optimal equitable impact of the development intervention. CLTS would be used as an entry point to challenge inequalities. 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. 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. These assessments would foster an enabling environment in which to challenge gender norms and equitably increase the level of participation by both men and women whilst ensuring equitable access and benefits to the CLTS approach implementation.

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 mean re-training of policy makers and key implementers (the public health officers) to a gender sensitive CLTS approach at the onset of the programme. This would initiate a longer-term intervention targeting efficiency-focused reforms and strengthening the CLTS implementation.

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 did not exist in Kenya.

6. Conclusion

Despite Kenya being one of the countries with a standalone policy on sanitation that has been lauded across the world, the policy does not adequately facilitate equitable access and benefits of the CLTS approach. The Policy makers and the implementers needed to be aware of what it meant to have equitable access and benefits to sanitation and hygiene to ensure that the country met its target of having all Kenya open defecation free leaving no one behind. The CLTS approach was considered successful in many countries and instances, as they followed the protocols and guidance from the trainers' handbook, but this study indicated that it also perpetuated inequalities in instances whereby it would have challenged inequalities to pave way for equitable access and enjoyment of sanitation facilities and services for the communities.

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.

Kenya was noted to have human capital and goodwill from the policy makers and key influencers to ensure that sanitation interventions reach each Kenyan according to their need, these are the resources that need to be realigned to ensure that CLTS is an equitable approach in increasing access and benefits to sanitation and hygiene in Kenya.

The limitation of the study was that it only focused on 2 counties that are located in Western Kenya that have almost the same social cultural dynamics which was not representative of the other 45 counties in Kenya, limiting the possibilities of the gender outcomes of the CLTS approach.

Further research is suggested across various counties in Kenya to ensure that the outcomes provide social culturally sensitive and representative of the entire country of Kenya.

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References

APHOK. (2013), *Membership protocol for the Association of Public Health Officers in Kenya*, Government Press, Nairobi.

Bongartz, P. and Musyoki, S. (2010), *Tales of shit: community-led total sanitation in Africa Participatory Learning and Action 61,* Earth Print Ltd, London.

Buchy, M., Adams, J. and Rafalison, J. (2014), *Madagascar Country Report: Mid-Term Evaluation 2010 – 2013 WSSCC Global Sanitation Fund,* International Organization Development Ltd, London.

Davies, I. (2015), *A gender case study of the experience and outcomes of the Fonds D'Appui pour l'assainissement (FAA) Community-Led Total Sanitation (CLTS) Interventions in Madagascar,* WSSCC, Geneva.

Dreibelbis, R. and Winch, P. (2013), "The integrated behavioural model for water, sanitation, and hygiene", *BMC Public Health,* Vol.13 No. 10, pp. 15-25.

EIGE. (2014), *Effectiveness of institutional mechanisms for the advancement of gender equality: review of the implementation of the Beijing platform for action in the EU member states,* European Institute, Lithuania.

Grant, M., Hugget, C. and Willets, J. (2016), *Gender & SDG 6: The critical connection – A framing paper for the high-level panel on water*, AWP, Australia.

JMP. (2013), *Comfort, cleanliness and convenience: the social organization of normality,* Bloomsbury Academic, North Carolina.

JMP. (2015), *Progress on drinking water, sanitation and hygiene: 2014 update and Sustainable Development Goal baselines,* UNICEF, New York.

Kar, K. and Chambers, R. (2008), *Handbook on community-led total sanitation*, Practical Action. London.

Mahbub, A. (2008), "Social dynamics of CLTS. Inclusion of children, women and vulnerable", paper presented at the CLTS Conference, 16-18 December 2008, IDS Sussex, available: https://www.communityledtotalsanitation.org/resource/social-dynamics-clts-inclusion-children-women-and-vulnerable (accessed 23 February 2017).

Mehta, L. (2017), "Hygiene, sanitation, and water: forgotten foundations of health", *PLoS Medicine*, Vol. 7 No.11, pp. 10-36.

Mitlin, D. (2011), *Equity and gender*, *Pathfinder report*, SHARE, London.

MOH. (2010), *Protocol for implementing CLTS in Kenya,* UNICEF, Nairobi.

MOH. (2014), *Annual report 2013-2014*, WASH Hub, Nairobi.

Morris-Iveson, L. and Siantumbu, B. (2011), *Ministry of Local Government, Housing, Early Education and Environmental Protection Community Led Total Sanitation in Zambia: An Evaluation of Experiences and Approaches to Date*, UNICEF, Zambia.

Plan International. (2013), *How CLTS has contributed to changing gender roles in sanitation,* IDS, London.

Plan Uganda. (2012), *Research on the impact of gender on community led total sanitation processes*, Plan International, Canada.

Robinson, A. (2016), *Challenges and opportunities for inclusive and sustainable WASH,* IDS, London.

Roose, S., Rankin, T. and Cavill, S. (2015), *Breaking the next taboo. Menstrual hygiene within CLTS*, IDS, London.

UN Women. (2015), *Progress of the world's women 2015-2016, transforming economies, realizing rights*, UN, USA.

UNICEF. (2013), *Progress on sanitation and drinking water, 2013 Update*, UNICEF, New York.

UNICEF. (2014), *Progress on sanitation and drinking water, 2013 Update*, UNICEF, New York.

USAID. (2014), *Sustainable water and sanitation in Africa (SUWASA). A tool for mainstreaming gender in water supply and sanitation services,* USAID, Burlington, USA.

Wamera, E. (2016), "Who is managing the post-ODF process in the community? A case Study of the Nambale sub-county in western Kenya" in Bongartz, P., *Sustainable Sanitation for All,* Practical Action Publishing, Rugby, London, pp. 181-197.

WaterAid. (2009), *Seen but not heard? A review of the effectiveness of gender approaches in water and sanitation service provision*, *WaterAid in Nepal*, WaterAid, London.

WHO. and UNICEF. (2014), *Progress on sanitation and drinking water. 2013 Update*, UNICEF, New York.

WHO. and UNICEF. (2015), *Progress on drinking water and sanitation. 2014 update*, WHO, Geneva.

WHO., UNICEF., JMP. and WHO. (2013), *Progress on drinking water and sanitation. 2012 update,* UNICEF, New York.

World Bank. (2012), *World development report 2012, gender equality and development,* World Bank, Washington.