Strengthening gender and social inclusion in Lao PDR's sanitation and hygiene programmes

Ensuring that potentially disadvantaged people have voice, influence, and leadership roles in decision-making spaces is critical to achieve the Government of Lao PDR's goal for universal access to sanitation and hygiene by 2030. This learning brief presents insights from an SNV baseline survey undertaken in 2019, in partnership with CARE to inform equitable, universal, and sustainable sanitation and hygiene service delivery in Lao PDR.

In 2019, SNV in Lao PDR engaged in a baseline study to understand the current status of sanitation and hygiene, gender equality, and social inclusion, and existing capacity for inclusive WASH governance by local government agencies in three districts. The study was conducted as part of SNV's Beyond the Finish Line - Sustainable Sanitation and Hygiene for All (SSH4A) programme, a collaboration with ISF-UTS, which is supported by the Australian Government's Department of Foreign Affairs and Trade's Water for Women Fund.

With an outreach projection of 200,000 people, SNV in Lao PDR works district-wide in Atsaphone, Champhone and Phalanxay in Savannakhet province. A high proportion of households (55%) in these districts do not have, or do not use, toilets. Income levels are closely correlated with toilet availability and use, with a number of other variables also impacting availability.

Research method and data collection

This learning brief summarises key gender and social inclusion insights gained from surveys of 1,945 households (HH), 158 schools and 30 health care facilities (HCF); 44 self-guided assessments; 25 stakeholder discussions; 18 focus group discussions (FGD); and 16 interviews with private companies.

Household survey data was disaggregated by district, gender,[1] disability,[2] ethnicity, and wealth.

[1] Gender data are limited in that the study was not able to gather data on sexual and gender minorities.
[2] The Washington Group Short Set Question tool was used to identify people with functional difficulties.

Table 1: Household access to sanitation in SSH4A programme districts in Lao PDR, 2019

District	% of HHs practising open defecation	% of HHs in the poor and poorest income quintile
Atsaphone	64%	51%
Champhone	35%	27%
Phalanxay	79%	57%

Specific indicators were collected to determine the household division of care work, women's role in household decision making about WASH, and women's leadership in improving WASH activities and services. Accessibility and the safety of toilets and availability of menstrual hygiene management facilities were assessed in schools and health care centres. The capacity of line agencies – in different functional government departments at national, provincial and district level – to support gender equality and social inclusion was assessed using self-guided assessments and a score-card system.

Findings of the baseline study

Wealth, gender, ethnicity, and location influence the availability of sanitation at household level

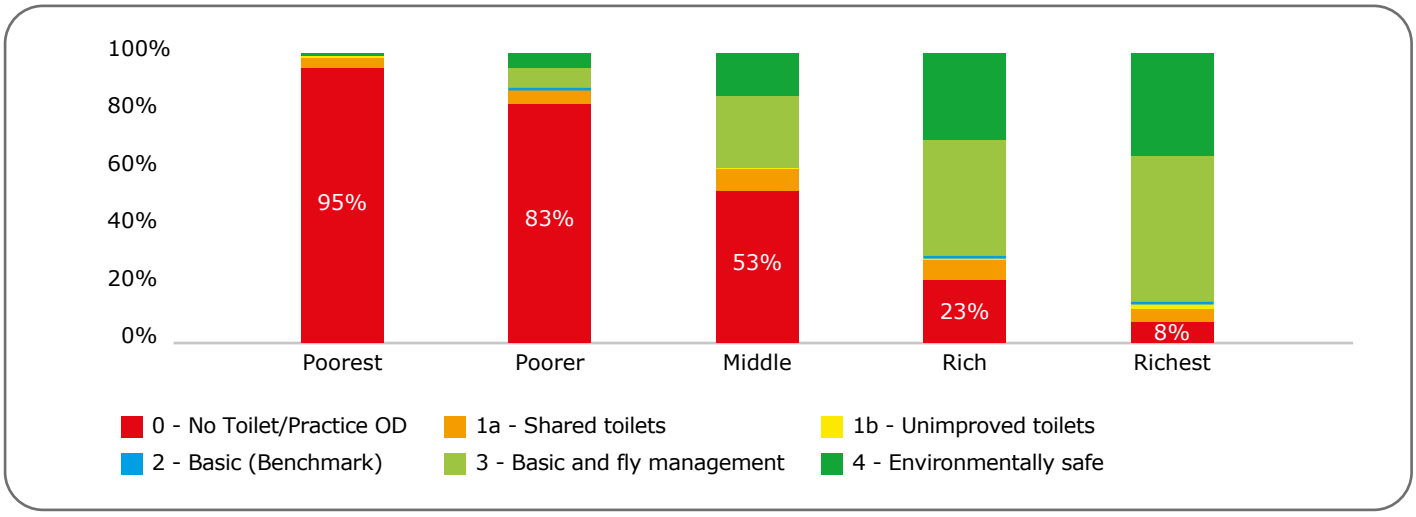
Lao-Tai households in higher income quintiles living in Champhone were most likely to have toilets and handwashing facilities. Often, these toilets were functional, clean, private and environmentally safe. In these households, most users had access to a handwashing facility with permanent water. Soap use was low across all wealth quintiles.

People with disabilities were found to be at risk of exclusion from sanitation improvements. In households with a member living with disability, the presence of a toilet did not necessarily translate to access for all household users. Less than 1% of these households modified their toilets to facilitate access for people with disabilities.

There was huge disparity in access to sanitation between the two wealthiest-quintile and the two poorest-quintile categories; 8% of the richest and 23% of the rich did not have a toilet.

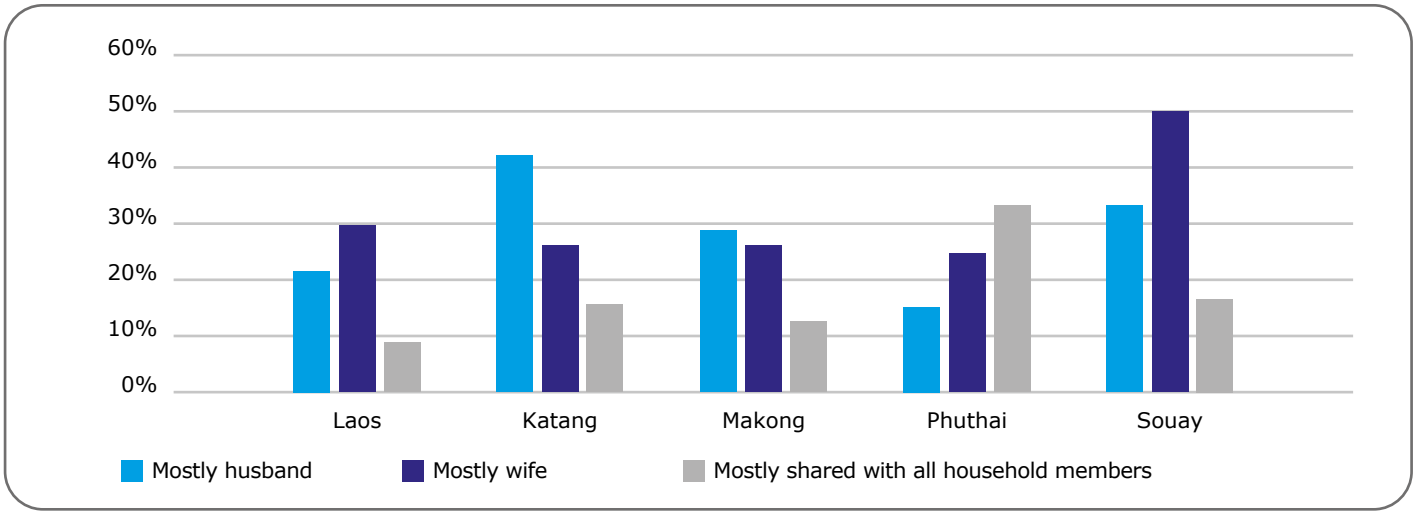
By contrast, 95% of the poorest and 83% of the poorer did not have a toilet. Similarly, 99% and 94% of the poorest and poorer, respectively, did not have a handwashing facility; while 56% and 57% of the richest and the rich, respectively, had access to a facility.

Figure 1: Access to sanitation by wealth quintile, 2019



BENCHMARK: Household toilets are assessed on a scale from no toilet to environmentally safe toilets. Toilets below the baseline include unimproved toilets, shared toilets or no toilets. Benchmark covers basic toilets. Above basic are toilets with fly management or environmentally safe toilets.

Figure 2: Division of hygiene- and sanitation-related care work across households and ethnicity, 2019



Household-disability data on access to sanitation are underreported

The baseline captured a very low prevalence rate of disability in the three districts when measured at household level. Applying the Washington Group Short Set methodology,[2] only 1% of household respondents indicated that some of their members experienced difficulties in accessing the toilet. The actual population of people with disabilities in Laos, however, is likely to be significantly higher than reported.[3] Reasons for the low reporting of disability vary.

- Disability is believed to be caused by bad karma in some areas or is a subject that is not talked about in public. Families often hide or do not declare members with disability to outsiders.
- The survey methodology was applied at household level. Whilst it was complemented with FGDs, the methodology may have obscured individual barriers to accessing toilets.

Of the 167 households who fell within the category of 'having a disability', only three households reported that they had modified their toilet to make it more accessible. This may be due to a general lack of awareness in the population that toilets can and should be accessed by all people, or that technologies are not available to assist with access. In addition to difficulties accessing toilets, people with disabilities may have also faced challenges in accessing water stations, receiving behaviour change messages, or getting involved in and listened to during home and community based decision-making processes regarding sanitation and hygiene.

Gendered division in maintaining and promoting hygiene and sanitation standards within households are apparent

Women and girls were found to be primarily responsible for maintaining and promoting hygiene and sanitation standards in 43% of households, compared to men and boys (21%). Toilet cleaning responsibilities were mostly assumed by individual women (47%) compared to individual men (2%). This gender division was also apparent in the greater proportion of girls and women collectively taking responsibility for cleaning (17%) compared to boys and men (3%). Less than a third of households (32%) indicated that toilet cleaning was a shared responsibility for all household members.

Ethnicity was found to have an important influence in the household division of care labour. While men in Katong households did the majority of work to promote hygiene and sanitation, in Makong communities, baseline data was almost split. Makong communities' men and boys were responsible for the most work in 32% of households, and women and girls in 36% of

[2] These questions are part of a rapid screening tool to identify people with self-reported functional difficulties – which may include people with disabilities, elderly people or those with health problems. Within the analysis of baseline data, 'people with disabilities' have been taken to include those who reported having 'a lot of difficulty' or 'cannot do it all' in relation to one or more of the six functional domains measured by this tool.

[3] World Health Organization and World Bank, *World report on disability*, Geneva, WHO, 2011, https://www.who.int/disabilities/world_report/2011/report/en/ (accessed 27 June 2020).

Figure 3: Barriers faced by people with disabilities to participating in WASH meetings at community level

households. Rates of shared care work differed significantly between the two largest ethnic groups; 33% of Phutai households share in care labour, compared to 9% in Lao-Tai households.

At district level, rates of gender division in hygiene and sanitation showed a mixed picture. Astaphone households had the highest rates of shared care work. Phalaxay households had the highest percentage of households where men are the primary care workers. In Champhone households, women were the primary care workers. Data point to the importance of ethnicity-specific cultural norms and practices at district level, and how these need to be considered when creating behaviour change campaigns to promote shared caring responsibilities.

Men may have more flexibility to redistribute care work that relates to sanitation and hygiene

Men were found to play a greater role in care work in poorer households; 29% of households in the poorest income quintile, compared to 15% of the richest households. Women's contribution to care work did not change with income. Across the wealth spectrum, women did the majority of care work in 27% of all households. Shared care work in the household, however, increased with income; 13% of the poorest households, compared to 22% of the richest households. Data suggest that women's care roles were less flexible than men's, and women were less able to redistribute care work as a household's income increases.

Women's unpaid work burden may increase as quality of toilet improves

Nationwide, consumers' preferred pour-flush toilets, which are perceived to smell less and attract fewer flies than a pit toilet. As such, 99% of all toilets in the three districts were pour-flush models. However, water requirements for this model (including some handwashing facilities) are great. High demand for water by some sanitation options is likely to increase a household's workload to collect water. It may also present challenges in the promotion of sanitation facilities in water-scarce locations. Most households with a toilet had access to piped water in their premises. For those households without access to piped water, data showed the women collected water for toilet use and handwashing facilities in 89% and 94% of these households, respectively.

Wealth and gender influence perceptions of participation in community health training and meetings

Women's presence was perceived to be the highest in community events or meetings to promote hygiene and sanitation over the last two years, followed by families as a unit, and then men. Around 8% of respondents said that other groups of people, such as households with a member living with a disability, were unable to participate in community activities.

Respondents from different wealth quintiles held different perceptions about participation; 50% of the poorest saw women as the main participants in sanitation and hygiene-related activities, compared to 38% of the richest. Correspondingly, households in the richer income quintile were more likely to see men as the main participants than poorest households. Respondents in the richest income bracket perceived a greater level of 'everyone' participating in community learning events, compared to the poorest households.

Men were more likely to hear of and see a handwashing with soap campaign than women, despite the fact that women's attendance in community meetings and events about sanitation and hygiene was higher. Women were almost twice as likely as men to have not heard any campaign message. Men's recall of handwashing with soap campaigns was found to be higher than women's in every forum, but they were less likely to absorb messages communicated to them during door-to-door campaign activities. Women and men were most likely to receive handwashing with soap messages in community gatherings. More work needs to be done to understand the reasons behind women's lower recall of campaigns from TV, radio, and community activities relative to men.

Limited voice and participation in sanitation and hygiene trainings and meetings

Women and men in FGDs reported to have limited voice and influence in community WASH activities. Women heads of households and women with a disability were less likely to attend meetings than poor and elderly women. Similarly, the former were less likely to participate actively. Care work served as a huge barrier to attendance for women heads of households. Men with disabilities also had very low attendance rates.

While poorer men had high attendance rates, they were reticent to speak. Women often remained silent due to lack of confidence and knowledge, fear of being ridiculed, and the belief that meetings are for receiving information rather than seeking participants' opinions. Elderly women were more likely to speak out in meetings than other women but did not feel that they had any influence. Interestingly, poor men and men with a disability were even less likely than poor women and women with disabilities (who both reported having very limited voice) to speak out in community meetings.

Ethnicity plays an important role in shaping women's leadership opportunities in WASH

Both women and men surveyed recognised that women were leaders in WASH alongside men. However, 34% of survey respondents still believed that it was a woman's role to support male leaders.

Ethnicity played a role in shaping beliefs about women's leadership capacity. Phutai households, for example, showed the strongest support for women's leadership, with 65% perceiving women and men to be equally engaged in leadership positions, and with equal influence in WASH activities. By contrast, 83% of Souay and 45% of Katang households perceived leadership positions to be held by men, with women acting in support. Similar numbers of Lao-Tai households held the same perceptions about equal engagement of women and men in leadership positions, and saw women playing a supportive role to men.

Heads of households have the final say on toilet construction in most households

In 60% of households, the head of the household took the decision about toilet construction. As 70% of household heads are men in the programme locations, it is likely that men dominate household decision-making. Despite the hierarchical nature of decision-making, 83% of respondents felt that other household members had a high level of influence over decisions made.

Decision-making practice differed between ethnic groups. Lao-Tai households were more likely than any other ethnic group to make decisions as a family (38% of households reported to share in the decision making). Lao-Tai households also had the lowest percentage of decision-making by the household head alone, relative to the other ethnic groups. Decisions about building a toilet were mostly taken by the head of Katang households, with 80% following this practice.[5] Although Phutai households were the most supportive of women's leadership in WASH activities relative to other ethnic groups, this belief did not translate to shared decision-making at household level. Only 25% of Phutai households reported to share in the decision-making about their toilet.

Toilets and menstrual hygiene facilities in schools and health centres are limited

Overall, 26% of schools did not have a toilet, and only 9% reported to have adjusted their toilets to improve accessibility. Sanitation access and menstrual hygiene management services in schools and health centres differed between districts.

Whilst some adjustments had been made to promote the accessibility of toilets in health care centres, these did not follow national accessibility standards. For example, some health care facilities with wheelchair ramps were found to be too short or too steep to serve their functional purpose. Existing menstrual health management facilities were also below the benchmark; usually consisting of a cubicle with a bin with no lid, no soap or water, and no private facilities where girls could change, wash themselves, and dispose of or wash their pads. In rural health centres, which were small and catered to approximately ten people a day, women and men shared toilet facilities because it was considered economically unviable to build sex-segregated toilets. The study observed the urgent need to target the 23% of health care centres that do not even have basic facilities.

Capacity of local line agencies to pro-actively mainstream gender and social inclusion in rural sanitation and hygiene is low

Local line agencies' capacity to mainstream gender and social inclusion (GESI) in rural sanitation and hygiene scored the lowest across all outcome indicators measured for the baseline study, with almost every parameter scoring below average, except for one. Key barriers to capacity included lack of budget and resources to mainstream GESI in sanitation and hygiene, and the limited involvement of specialist organisations

[5] Many Katang HHs did not answer this specific question, meaning that the sample size is small and may not show the full picture.

(such as disabled persons' organisations) and social services. There was also no system in place to identify potentially disadvantaged groups, and to provide them with sustainable social support mechanisms for their sanitation and hygiene needs.

Recommendations and next steps

In 2019, SNV in Lao PDR adopted a Do No Harm approach in its SSH4A programme. This has involved a conscious effort to increase institutional commitment and capacity to predict and prevent or mitigate harm caused to or by staff and community members, including people with disabilities, as a result of programme activities.

Applying a Do No Harm approach to baseline results has highlighted areas requiring action.

- Address the growing sanitation gap between richer and poorer households to avoid intensifying health, economic and social challenges for people already at risk of marginalisation.
- Strengthen government capacity in behaviour change communication to avoid exacerbating harmful norms and practices, reinforcing gender, disability, and other exclusion and discriminatory factors that limit people's range of opportunities.
- Increase attention to hierarchy and power within households and community leadership approaches to reduce the risks arising from top-down decision-making approaches that limit possibilities for people to influence sanitation and hygiene choices, and benefit from toilets and washstand availability.
- Promote gender equity and social inclusion in sanitation and hygiene improvement strategies that are informed by ethnicity-specific norms and practices in each district to ensure effectiveness and avoid causing harm.
- Identify and work with people with disabilities and their households to ensure that their rights are upheld, their voices are heard, and they are able to access sanitation and hygiene with dignity through the development of respectful engagement approaches and methods that prevent harm. This includes recognising that people with disabilities can experience different forms of violence from other community members, e.g., emotional violence (relating to issues of shame, burden of caregiving responsibilities) and neglect (in the case of people who are dependent on others to support access to water, sanitation and hygiene).

Promoting greater gender and social inclusion in WASH services

The collection of gender and social inclusion data in the baseline study has led to new and strengthened programme strategies that will progress the following outcomes.

- To improve processes, national and district government capacity to understand and develop gender and social inclusion strategies and behaviour change campaigns must build on the experiences of different ethnic groups, genders, and people with disabilities. Leadership skills and governance capacity of village leaders to be more inclusive will also require strengthening.
- To realise more inclusive WASH services, improving awareness of disability at all levels is a must. This may include developing creative and sensitive ways to identify and engage people with disabilities in households.
- To encourage and strengthen the role of women as leaders, district-specific household and institutional strategies will need to address women's low participation in meetings, attitudes towards women who take leadership roles, and promote shared care work, toilet cleaning and household decision-making.
- To enlarge access to facilities and systems, pro-poor market-based approaches must be introduced to increase the availability of improved toilets and handwashing stations for people at risk of marginalisation. Training tradespeople to deliver and promote a wider range of accessible facility options is another strategy, as well as increasing consumer awareness on possibilities to modify/adjust facilities to meet the sanitation and hygiene needs of all. In schools and health facilities, menstrual hygiene facilities that are safe and private and accessible toilet designs may be considered a requirement, rather than an option.

SNV in in Lao PDR, 'Strengthening gender and social inclusion in Lao PDR's sanitation and hygiene programmes', *Learning brief - SSH4A*, The Hague, SNV, 2020.

Beyond the Finish Line - SSH4A in Lao PDR

SSH4A in Lao PDR aims to progress access and use of safely managed sanitation and hygiene by 2022 that directly benefits over 200,000 people in the three districts of Savannakhet Province: Atsaphone, Champhone and Phalanxay.

SNV

SNV is a not-for-profit international development organisation that makes a lasting difference in the lives of people living in poverty by helping them raise incomes and access basic services. Focusing on three sectors – Agriculture, Energy and Water, Sanitation and Hygiene (WASH) – SNV has a long-term, local presence in over 25 countries in Asia, Africa and Latin America.

This brief is based on baseline data collected as part of SNV in Lao PDR's Sustainable Sanitation and Hygiene for All Programme, with support from the Australian Department of Foreign Affairs and Trade's Water for Women Fund. The analysis was led by Claire Rowland with support from Gabrielle Halcrow and Le Huong (SNV), and was reviewed by Asahel Bush (CBM Australia). It was edited by Anjani Abella (SNV) and designed by Crunchy Frog.

Photos ©SNV/Bart Verweij
P1: Women collecting water from community well
P5: Sanitation demand creation in progress
P7: New toilet customer assisting mason in construction

For more information

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