Addressing rural health and poverty through water sanitation and hygiene: Gender perspectives

ESTER NGORIMA, ZAMASWAZI NKUNA AND GIFT MANASE
CSIR Built Environment, P. O Box 395, Pretoria, 0001
Email: Engorima@csir.co.za

Abstract:

Women play a crucial role in providing care and support, and also in the use and management of the water resources and sanitation at the household level. In addition, voluntary community care work is done mostly by women,rather than men, thus as caregivers women experience further pressures brought on by the spread of HIV/AIDS in rural communities. While HIV/AIDS is not a direct water related disease, it is important to recognise that people living with this disease are much more vulnerable to infections or diseases such as diarrhoea, cholera and other diseases linked to poor water supply and sanitation, thus it is essential that such diseases are prevented. Having acknowledged this fact, it is important to note that there is still a low level of participation of women, particularly in decision-making and as a result, women still suffer the consequence of poor water and sanitary facilities, poverty and poor health and the spread of disease still prevails in spite of all attempts. It is for this reason that it is essential to empower women in all aspects of water and sanitation, through proper hygiene education and service provision. Using the case study, the aim of this paper is to present a case for factoring in gender perspectives in water and sanitation provision, by highlighting challenges women face in accessing water and sanitation, and how these can be improved to empower women to address rural health issues whilst also contributing towards poverty alleviation.

Keywords: Water, sanitation, hygiene, gender, poverty, rural health, HIV/AIDS,

1. Introduction

Africa is facing a water and sanitation crisis that hampers and kills in large numbers, limiting economic growth, educational access, and life opportunities especially for rural communities. Water and sanitation is key in ensuring that one is healthy. Unsafe water supply, poor sanitation and hygiene together constitute the third most significant risk factor for poor health in developing countries with high mortality rates (WSSCC, undated). Diarrhoea alone is responsible for the deaths of 1.8 million people every year, 90% of whom are children under five. Yet today, 2.6 billion people or 40% of the world's population still do not have access to basic sanitation, and some 1.1 billion people or 18% of the world's population lack access to safe drinking water (UN Water, 2005).

1.1 Gender, Water and sanitation provision

These health and social consequences of poor water supply and sanitation are especially harsh for women and girls who pay a high price in terms of loss of dignity where there are no latrines, compelling them to wait until dark to defecate and exposing them to harassment and sexual assaults. The girls fail to fully participate in education due to the absence of school sanitation facilities... Specifically for rural communities, women are the ones responsible for finding water, educating children in hygiene matters and understanding the impact of poor sanitation on health. At the same time, women and girls are often obliged to walk many hours every day fetching water, while men are rarely expected to perform such tasks.

With an additional burden of HIV/AIDS, this becomes even more pronounced as it is mainly women who are mostly affected. As caregivers in households, they have to ensure adequate water supply and proper sanitation for HIV-infected people to remain healthy as long as possible and for people with AIDS to reduce their exposure to infections.

While the need to mainstream gender perspectives into water and sanitation has been recognised, gender inequality still prevails.

Taking into consideration the special position of women as water collectors, managers and providers of health entails mainstreaming gender perspectives into the planning process to ensure that the specific needs and concerns of women and men from all social groups are taken into account in development, use and management of water resources and sanitation.

1.2 Gender, Water and Sanitation Policies in South Africa

In South Africa a number of policies and agreements have been established to inform gender equality processes; some of these, the White Paper on a National Water Policy for South Africa (1997), Strategic Framework for Water Services (2003), the DWAF Gender Policy and South Africa's National Policy Framework for Women's Empowerment and Gender Equality, have been deemed to be the most important policy positions that inform the strategy and action plan.

According to the White Paper on a National Water Policy for South Africa (1997),
"Women are the traditional custodians of natural resources in rural areas and they are also the people who suffer the most from degradation of water and other natural resources. It is important that women are represented at all levels and in all spheres of water management activities. The State must make sure that rural women have equal access to economic opportunities and enjoy adequate living conditions in relation to water supply and sanitation".

In addition to this statement DWAF has a comprehensive Gender Policy which affirms that the Minister and the Department of Water Affairs and Forestry "have committed themselves to the promotion of gender equality in the supply and management of water ", It further states: " In order to follow the Constitutional policy of gender equality, the Department commits itself to recognising and addressing the current conditions that mitigate against women taking their full part in society. Therefore the Department is committed to a programme of action which recognises present gender roles, and works to counteract the gender inequities of the past. The Gender Policy sets out the principles, goals and actions to ensure gender equality'.

1.3 Study Objectives

Using the case study, the aim of this paper is to present a case for factoring in gender perspectives in water and sanitation provision, by highlighting challenges women face in accessing water and sanitation, and how these can be improved to empower women to address rural health issues whilst also contributing towards poverty alleviation.

2. Methodology

As part of the WASH project undertaken by DWAF and CSIR of using water, sanitation and hygiene to address poverty and job creation, the study pays particular attention to issues affecting women and children as part of marginalised inhabitants in water and sanitation services, in one of the rural communities in South Africa.

The study uses both qualitative and quantitative instruments to gather data for the case study including focus group discussions, physical observation of the condition of water and sanitation infrastructure and services, and interviewer-administered questionnaire surveys. Researchers also visited one of the homes for orphans.

3. Study Findings and Discussion

3.1. The study area

The study area is located approximately 35km south of Vryheid, in KwaZulu-Natal. The area consists of six villages which fall under Ward 14 of Hlahlindlela Tribal Authority, which has the majority of the population in Abaqulusi Local Municiapality of the Zululand District Municipality. The population is estimated at about 14 501(Stats SA, 2001). The villages are described as deep rural areas – these are isolated former homeland areas with fairly high population densities and poverty levels, and historical backlogs in service provision. According to AbaQulusi Local Municipality's IDP this is the rural community with the highest population.

3.2. Socio-economic factors

The population in the area is also slightly imbalanced with females out-numbering their male counterparts as indicated in Figure 1.
The decrease in the number of males could be attributed to the migration of males to urban centres in search of employment opportunities

and the decline in employment opportunities in the region over the last two decades due to the closure of coal mines (IDP, 2002). This inevitably increases the burden on women to head households and manage the homesteads in their partner's absence.

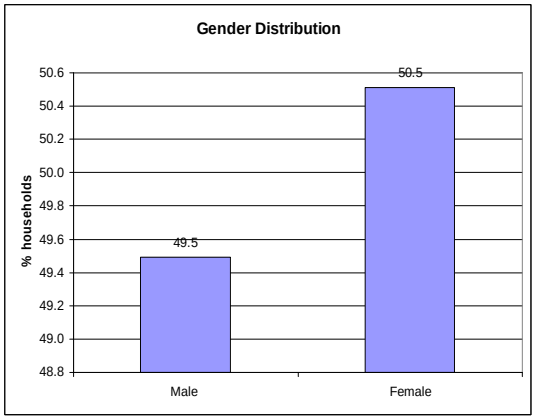

Figure 1 : Gender distribution in the study

The population in the study area is relatively young, as indicated in Figure 2, with the majority of the population (84.5%) between the ages 1 to 40 years. About 45.2% (21-60yrs) of the population fall within the economically active group and burden the economy of the area to create sufficient employment opportunities. However, it is also this part of the population that is most under the potential threat of HIV/AIDS infection.

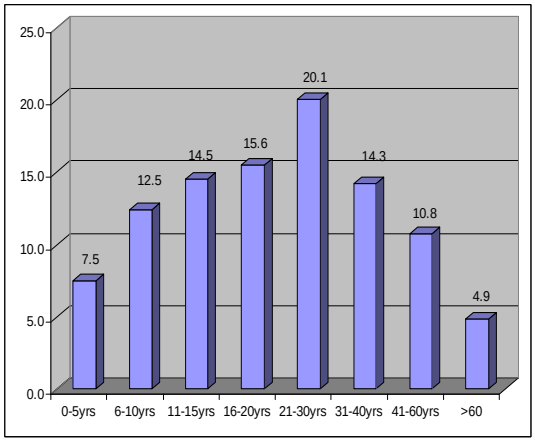

Figure 2 : Age distribution in the study area

Data also shows that household income in the study area is very low. About 45% of the household heads generate an income of less than R1000 per month with no additional source of income. About 65% of households live below the poverty datum line of R462 per person per month. Low-income levels are indicative of low affordability levels for basic services, housing and health services.

According to Abaqulusi IDP, 2002 the provision of basic health services is poor, and as a result the area is characterized by poverty-related diseases such as tuberculosis (TB), diarrhoea related diseases, acute respiratory illnesses and nutritional problems (Zululand Regional Plan, 1998 sited by Abaqulusi IDP, 2002). Furthermore KZN has the highest HIV/AIDS prevalence in the country, which averages 20.2% women and 11.7% men in the sexually active age group of 15- 49years (Sexually Transmitted Infections, 2006).

3.3. Gender, Water, Sanitation and Health & Hygiene

One of the sector visions detailed in the Framework for Water Services for South Africa, (2003), is that " All people lving in South Africa have access to adequate, safe, appropriate and affordable water and sanitation services….", Furthermore, one of the key principles informing this vision is gender mainstreaming, However, to date, challenges in the study area show it is still a long way until this goal is achieved

3.3.1. Access to water supply

Research undertaken reveals that access to basic water in the area is a major challenge. Figure 3 clearly shows the amount of water used per household is appallingly less than the minimum requirement by Department of Water and Forestry (DWAF) of 200l per household. About 65% of households use less than 75litres of water per day.

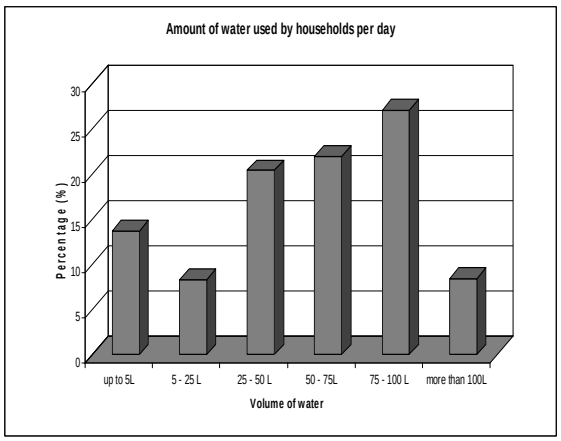

Figure 3 : Amount of water used by households per day

This community receives its water from boreholes with no prior treatment. This water could be contaminated and thus of poor quality. Almost 90% of households have yard taps, but these are illegally connected from the once-operational communal taps. These communal taps were operated with a token system.

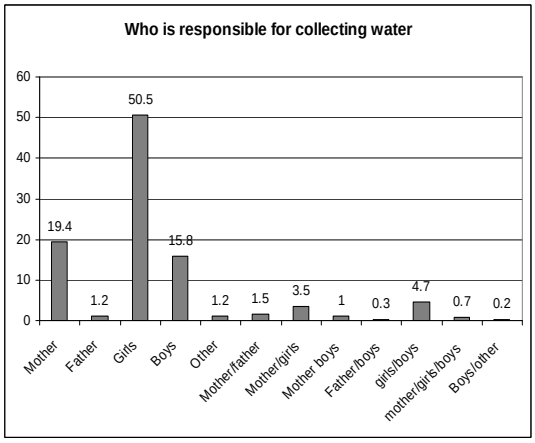

Figure 4 : Household members responsible for water collection

Furthermore, due to the unreliability of the water pumps, not enough water is pumped to the storage tank, the community goes for up to 3 weeks without water, forcing the community to travel to collect water where they buy it. This process puts further stress especially on women and children as they are the main collectors of water in this community as indicated in Figure 4. About 70% of water collectors are women and girls, and only about 30% are fathers and boys. The effects of inadequate water supply - disease, time and energy expended in daily collection, high unit costs of water, etc. - exacerbate the poverty trap. Families, especially women and children, struggle to get water to care for the sick members of the household. Women and children have to invest more time (Figure 5) and effort (Figure 6) to carry more water over longer distances for household consumption while men are away from home.

The community goes for up to three weeks without water from the illegal yard taps and communal taps. During this period it takes more than 45% of households anything from 30mins to over an hour to fetch water as indicated in Figure 5. Cutting down the time women spend collecting water could unlock the productive potential of women's time and energy. This means that more time becomes available for food production, childcare, nutrition, hygiene and health, and enhances the participation of women and girls in education, income generating activities, as well as their labour productivity (IRC International, 1998).

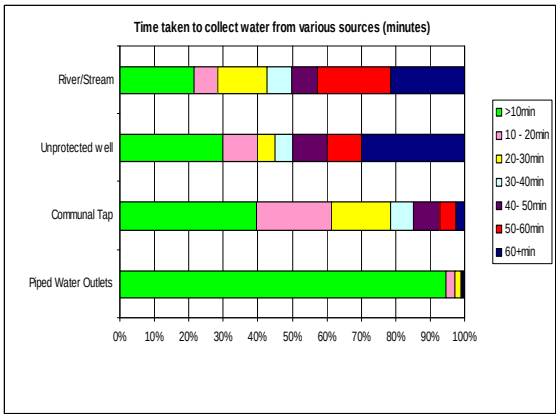

Figure 5 : Time taken to collect water from various water sources in the study area

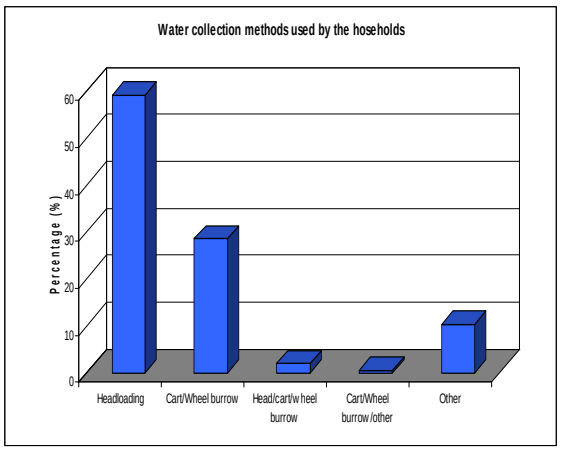

Figure 6 : Methods used to collect water by households

3.3.2. Access to Sanitation

Almost 90% of households in the community have access to sanitation through the Ventilated Improved Pit (VIP) latrine, 0.7 % with flush toilets and 1.7% with flush Ventilation Improved Pit (VIP) toilets. The remaining 9.6% lack access to basic sanitation services; 8.4% use pit latrines and 0.8% have no toilet facility at all.

However, Figure 7 shows that more than 80% of VIPs are in a bad condition and do not meet standards set by DWAF. The VIPS in bad condition are poorly ventilated, without doors and roof covers, are of poor quality, and are located further from the house. Through focus group discussions with community members it was also established that most of these facilities were constructed with no foundation and thus are collapsing, leaving households with no toilet. This means the household either has to go to neighbours or open spaces to relieve themselves.

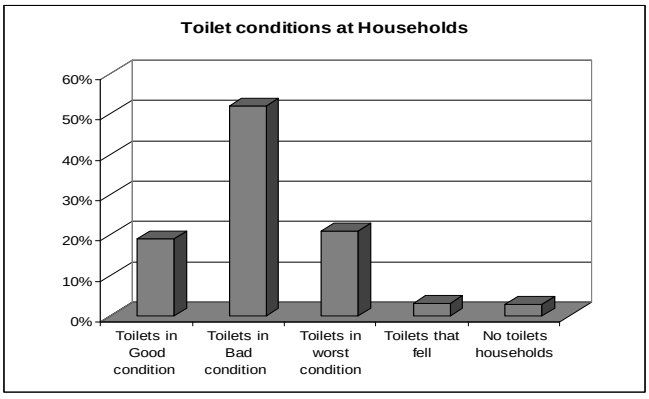

Figure 7 : Toilet conditions of VIPs used by households

The survey also indicated that 60 % of the women feel insecure using these toilets without doors because they have no privacy. This is unacceptable and violates one's human rights and dignity.

While men participated in the decision making on the type and building of the toilet, women are stuck with the responsibility of its maintenance, since cleaning the house and toilet is often not regarded as the work for men. All these issues further indicate the disadvantages of excluding women when implementing sanitation programmes.

- ***Diseases linked to poor water and sanitation***

Having no proper sanitation means that there is a vicious cycle of poverty, diseases and bad hygiene. Decomposing human waste in an open space means that people are more vulnerable to catch diseases. Sanitation related diseases experienced by households in the past 3 months are indicated in Figure 8.

While this situation might not be a significant challenge for men, it poses a serious threat to the lives of women and girls. It is more detrimental to woman, as it adds to their already heavy workload of care-giving, which means spending more time caring for sick family members and escorting them to health facilities.

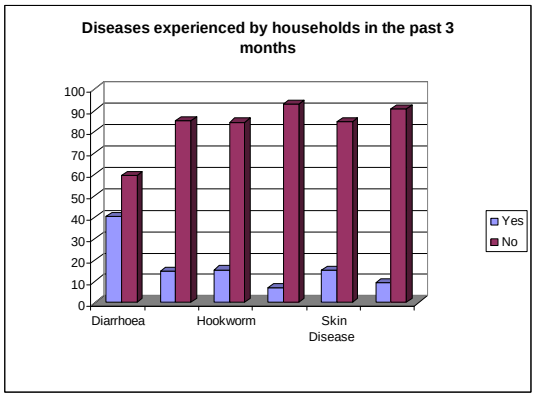

Figure 8 : Diseases experienced by the households in the past 3 months

The results also indicate that these diseases recur. Diarrhoea was the most recurring disease (37%) with skin disease, hookworms and bilharzia recurring in more than 20% of the households. At the national level diarrhoea is among the top ten causes of death, claiming 2 lives every hour (WHO, 2002).

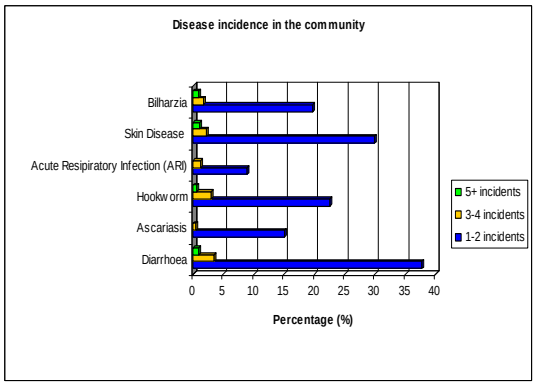

Figure 9 : Disease incidence in the community

The disease recurrence could be explained by limited knowledge of disease prevention as indicated in Figure 10. Over 50% of the households do not know how to prevent diseases linked to poor water and sanitation. Engaging women in particular in hygiene education can improve this situation as women are mainly the care givers in charge of health issues in most of the households.

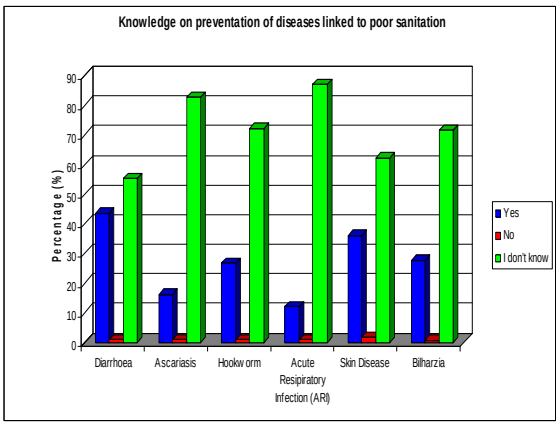

Figure 10 : Knowledge on prevention of diseases linked to poor water and sanitation

3.3.3. Poor water, sanitation and its impact on HIV/AIDS

Using indirect questioning (i.e. requesting families to list problems that they are encountering while caring for HIV/AIDS patient in the family) the results indicated that 35% of the households are directly affected by HIV/AIDS. While HIV/AIDS is not a water or sanitation related disease, adequate water supply and sanitation are of the utmost importance for HIV infected people to remain healthy as long as possible and for people with AIDS to reduce their exposure to infections.

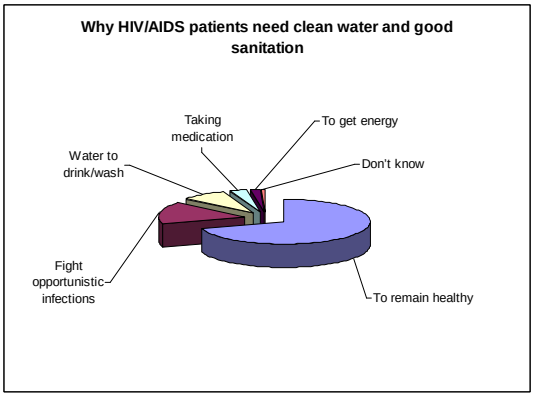

Figure 11 : Households ' perception on importance of clean water and good sanitation with regards to HIV/AIDS

The reasons given by the community on why water is important for people living with HIV/AIDS are indicated in Figure 11. 70.1% of households understand that clean water and

sanitation is important for HIV/AIDS patients to remain healthy.

They also indicate that taking medicine, washing of patients and fighting opportunistic infections need clean water. Taking treatment without clean and healthy water can be counter-productive to the intended reasons of taking treatment, which is mostly in a pill form. Thus clean water and water points should be easily accessible to reduce the burden of walking for caregivers and those who are weak. Furthermore, it is important that latrines are easily accessible and close to where they are needed. When people are approaching or are at a terminal stage it means that they will frequent toilets to relieve themselves. The study shows that 96.1% of households have their latrines located outside the household. For HIV/AIDS patients, access to sanitation facilities like toilets becomes more important. He/she must not have to travel any distance to access a toilet, as this will drain him or her.

3.4. Empowering women in Water and Sanitation

Recognising women's role in the management, provision and safeguarding of water and sanitation is essential to achieving rural health and fighting poverty. A focus on gender differences is of particular importance with regard to sanitation initiatives. Gender balanced approaches should be encouraged in plans and structures for implementation (UN Water, 2005)

3.4.1. Community care

The study also shows that it is mostly women that play an important role in the health and well-being of this community. There are 20 voluntary care workers, 13 of whom are women and only 7 men. They take care of the vulnerable members of the community as indicated in Table 1. This clearly shows the commitment by women in community issues and further illustrates the need to empower women through improved water and sanitation provision in the area.

Vulnerable group	Number
HIV Patients	105
TB Patients	140
Disabled Children	21
Orphans	98
Total	384

Table 1: Vulnerable members cared for by voluntary care-givers.

3.4.2 Operation and maintenance of water infrastructure

Through a focus group it was also established that women's empowerment and water advocacy at village level are crucial to continued operation of the water supply. In one of the villages it is a woman who, without any training and in addition to household activities, took over the water pump operation after the death of her husband, ensuring continuous water supply for the community. Thus it is necessary that not only men receive training on operation and maintenance but also women. This will ensure a viable maintenance system which will guarantee continued water supply to the community.

3.4.3 Mainstreaming gender

Gender mainstreaming is the process of assessing the implications for women and men of any planned action, including legislation, policies and programmes in all areas and at all levels.(UNDP, 2006) People-centred approaches need to ensure that gender perspectives are taken into account. Thus, a deliberate strategy of gender mainstreaming can be useful to ensure that these issues that effect women and men are part of analysis, programme and project planning, implementation, and evaluation. More importantly, gender mainstreaming can assist in bringing about institutional and organisational change necessary to ensure gender equality as an on-going commitment.(UNDP, 2006)

4. Conclusion

Despite gender being included in water and sanitation, it is not addressed in project planning and implementation levels. Consequently women still suffer despite the

promulgation of gender policies. This situation is further complicated by the spread of HIV/AIDS, since South Africa has the highest number of people living with HIV and AIDS. It is recommended that simple step-by-step guidelines are formulated to address
gender at all levels of the project cycle in addition to national gender policies.

5. References

Abaqulusi Local District Municipality 2002. Integrated Development Plan Situational Analysis, Vryheid, South Africa.

Abaqulusi Local District Municipality, 2007/8. Integrated Development Plan, Vryheid, South Africa

Department of Water Affairs and Forestry, 2003.Strategic Framework for Water Services. (September 2003). http://www.dwaf.gov.za

Department of Water Affairs and Forestry, 2003. White Paper on a National Water Policy for South Africa (April 1997). http://www.dwaf.gov.za

IRC, International Water and Sanitation Centre, 1998. Gender in Water Resources Management, Water Supply and Sanitation: Roles and Realities Revisited, The Hague, Netherlands. http://www.irc.nl

National population based HIV prevalence surveys in sub-Saharan Africa, 2006. Results and implications for HIV and AIDS estimates", Sexually Transmitted Infections, Volume 82 Supplement iii.

Statistics South Africa. 2001. Census 2001, Census in Brief. [Online]. Available: http://www.statssa.gov.za

United Nations (UN) Water, 2005. Gender, Water and Sanitation: A Policy Brief

United Nations Development Programme (UNDP), 2006. Mainstreaming Gender in Water Management, Gender and Water Alliance (GWA)

Water Supply and Sanitation Collaborative Council (WSSCC), 2000. Vision 21; A shared vision for hygiene, sanitation and water supply and A framework for action, Geneva, Switzerland.

World Health Organisation (WH0), 2002. Cholera, 2001. Weekly epidemiological record 31 (l77): 257-268.