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**DELIVERING WATER, SANITATION AND HYGIENE SERVICES  
IN AN UNCERTAIN ENVIRONMENT**

**Addressing water and sanitation needs of  
displaced women in emergencies**

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*Mainstreaming gender in an emergency Water and Sanitation (WatSan) response can be difficult as standard consultation and participation processes take too much time in an emergency. To facilitate a quick response that includes women's needs, a simple Gender and WatSan Tool has been developed that can also be used by less experienced staff. It is a step-by-step guide on how to collect required data to define design parameters based on ad-hoc consultations with women who will be the users. In 2012 the tool was tested in South Sudan within the context of a regular MSF emergency intervention. Using the tool allowed for a quick and easy way to consult women about the design. Consequently, an increased usage of facilities was observed in the intervention group compared with a control group where the tool was not used.*

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**Gender sensitive water and sanitation response in emergencies**

Meeting WatSan needs of displaced people in emergencies is a top priority if outbreaks of diarrhoeal and other hygiene related diseases are to be avoided. Gender-specific considerations are needed when developing and adapting WatSan facilities and services. Specifically, women require more privacy than men, especially when dealing with their menstruation, more space when taking care of the children and increased security to avoid gender-based violence (GBV). There is no lack of guidance on how to design and build appropriate facilities for the users. Larger agencies such as ACF, OXFAM, MSF, IFRC, UNHCR and others have their own handbooks and manuals. Other books such as "Excreta disposal in Emergencies" by Peter Harvey provide excellent guidance.

But the reality in an emergency is that there is limited time to read a 200-page manual. Additionally, agencies have to work with the staff they have or can get in a very short time, whether they have emergency WatSan experience or not. The pressure to get it all done in a short time, difficulties in finding qualified staff, and problems with funding or supply issues, can all result in what is frequently seen in emergencies: inadequate facilities set up without planning to clean or maintain them, as well as inappropriate for the needs of users, especially women. Gender issues are regularly overlooked.

As sanitation programs in emergencies fail, women and girls opt to go outside of camps to defecate, wash themselves and do other chores, like washing clothes. This takes up a lot of energy, affects their dignity and puts them at much greater risk for GBV. Equally for men, their dignity is affected by having to use dirty or poorly constructed latrines and therefore choosing to defecate in the open.

**The Gender and Watsan Tool**

One can acknowledge that in an emergency there is little opportunity to carry out a full participatory consultation process. However, skipping that step entirely is also not an option, as this input in program design is essential to success.

To address this requirement a 7-page step-by-step tool has been developed that incorporates these basic but essential consultations. The tool addresses initial priorities (prior to targeting specific women's needs) like emergency water supply, containing open defecation, and the need for coordination. Following that, a

step-by-step guide addresses basic data collection: where to find this data, who to talk to and what type of questions need to be answered. This includes ad-hoc consultations with displaced women and checklists with questions to be asked. This process should not take more than a few days, after which the design parameters will be known and the facility plans can be created. During that time technical data at the intervention site is collected as well.



**Photograph 1 and 2. Newly built latrines in a small IDP camp near Jacobabad, Pakistan 2011.” There is little privacy, no cleaning organized and as a result they were not used. Thousands of these types of latrines were built in the Sindh and Baluchistan provinces after a flooding disaster.**

It can be used in emergencies with displaced populations and provides even the less experienced WatSan practitioners enough guidance to implement a successful emergency WatSan intervention in a very short period of time. The Gender and WatSan tool is focused around the needs of women. The rationale is that women should have proper WatSan facilities, as they are more vulnerable without facilities, as they are the principal users, and usually the ones that will be cleaning them. And if the facilities work for them, then likely it will also work for men.

The tool is meant to collect the minimal information required to make a decent program design that will cover the most urgent and basic sanitation needs and is appropriate for the users, especially the women. It reduces the risk of building facilities that will not be used because they are inappropriate. For technical details such as how to line a pit under certain soil conditions, the WatSan practitioner will have to consult technical manuals since the tool is geared towards process, not the construction details.

## Using and testing the Gender and Watsan Tool in Jamam, South Sudan

The tool was tested in a refugee camp in Jamam, South Sudan in July and August 2012.

### Research strategy and methods

The research strategy followed was that of “action research”. The purpose was to solve a practical problem and produce guidelines for best practice.

The principle research questions was:

- Will the use of the Gender & WatSan Tool result in an uptake by women of the WatSan facilities?

An intervention and a control group were identified. In the control group an MSF WatSan had implemented a latrine program in two villages that were part of the refugee camp. 69 latrines were built using standard MSF procedure for a population of about 1800 people. The intervention group was represented by a population of about 3300 people from six other villages in the camp where already existing emergency latrines needed to be replaced with 147 new latrines.

The tool was tested in the intervention group. Experiences using the tool were recorded on forms and a researcher’s diary to allow for future improvements. Usage and satisfaction levels regarding facilities were compared between the two study groups. For two and a half weeks, monitors counted the usage in female-

designated latrines in both the intervention and control group to measure the uptake of latrine use when designed with the Gender & WatSan Tool. Separate focus group discussions (FGD's) with women and with men in both groups were held to gauge satisfaction levels. To measure a potential epidemiological impact of using the tool, clinic staff filled in line lists to record diarrhoea cases in the control and intervention group.

## Results

Following guidance from the tool, seven ad-hoc consultations were held to determine how women prefer to use latrines, showers, manage menstrual hygiene, and wash their laundry. Camp leaders, the sheiks in the villages, were consulted first before the discussions with women in the camp took place.

The first women's group involved MSF kitchen staff who were living in the refugee camp, followed by small groups of women who would be approached in the intervention area. In the latter case an international staff member had to also hold simultaneous talks with the men, who would follow the MSF team around, in order to allow his assistant and a translator to hold the consultation with the women only. Checklists with questions, included in the tool, were used to gather the information on needs and habitual behaviours around sanitation issues.

**Table 1. Latrines in the study groups<sup>1</sup>**

Group	Households	Total population	Females > 5 years	All latrines	Female designated latrines
Intervention	820	3325	1396	147	73
Control	374	1754	737	68	32

## Uptake of usage

The uptake of usage was calculated in women and children (between 5-12 years of age) in the control and intervention groups. There was very little difference in the number of visits observed per latrine in each group, 13.2 visits per observation period in the control group versus 13.5 in the intervention group. But as each female designated latrine in the control group had to be shared among 23 women versus 19 in the intervention group, there was actually almost a 25% increase in usage in the intervention group, calculated as usage per woman. The number of visits per latrine per observation period per women in the control group was 0.57 versus 0.71 in the intervention group ( $p < 0.001$ ). A limitation is that the population data for the intervention and control groups was difficult to verify and the real difference in uptake of latrine usage may be lower than what we demonstrated.

**Table 2. Observed visits to female-designated latrines**

Group	Observation periods	Number of visits		Number of females >5 years of age per latrine	Visits per female and child per latrine per observation period
		Females and children	Men >12 years of age		
Intervention	66	888	66	19	0.71
Control	58	763	46	23	0.57

## Feasibility of the tool

Using the tool was a quick and easy way to gather design criteria for the facilities. Once a female translator was found, it took one expatriate staff and two regional staff one afternoon to consult with six small groups

<sup>1</sup> Population numbers in this table are based on data from UNHCR, Acted and MSF.

of women and hold, simultaneously, talks with men. Ambiguities in the results of those consultations were easily addressed by going back and asking for clarification. After ad-hoc consultations with groups of women, it was determined to cancel the plans for a menstrual cloth washing station once it was clear that the women wouldn't use it, as they preferred to wash their cloths in the shower instead.

Not all issues identified while using the tool were resolved. In all consultations with women, the issue of having no torch to go to the latrine at night came up, but was never resolved. The desire for lighting in this case had nothing to do with GBV but rather with the fear of stepping on a snake in the dark.

Eventually, 147 latrines were built that had slightly higher material costs (7.5%) than the latrines in the control group, but total costs per latrine were lower as labour and transport costs were lower. Using the tool had no influence on the speed of construction, as supply issues in this particular emergency were the main determining factor.

### User satisfaction

User satisfaction showed a significant improvement with the 147 new latrines in the intervention group, as there were more of them, they had doors with locks, a roof, and were easier to clean. Through four FGD's, two in each group, with women and men separately, it was clear that both types of latrines were appreciated and the quality was considered good. All toilets in the intervention group had locks, but none of the latrines in the control group had locks. The lack of locks in the control group was considered a problem.

Cleaning latrines and filling up handwashing buckets was done by unpaid users according to a cleaning schedule via a program supported by another NGO. This worked well in both groups, as only 9 of the 124 observations noted a dirty latrine first thing in the morning, and only 6 by the end of the morning. As for showers, there were complaints about the limited number available, and the plastic sheeting distributed to each family to make showers was often used for other purposes, aggravating the issues around washing and drying menstrual cloths. Other complaints related to sanitation included the lack of torches and an insufficient number of washing basins available to them. People were using the same washing basin for doing dishes and laundry to bathing small children.

### Epidemiological impact

Limited data made a proper comparison between the two study groups unreliable. In the intervention group, the incidence of diarrhoea decreased from 11.4 /1000 population /week in the two weeks prior to the completion of the last latrines, to 7.9 in the two weeks after. The incidence of diarrhoea in the entire camp had already stabilized a few weeks earlier and hovered between 5 and 6 cases / 1000/ week (see Figure 1). Incidence in the control group was already low with 3.8 and 4.8 cases/ 1000/ week respectively over the same two periods as in the intervention group, which could indicate the importance of simply having quality facilities and a good cleaning program.

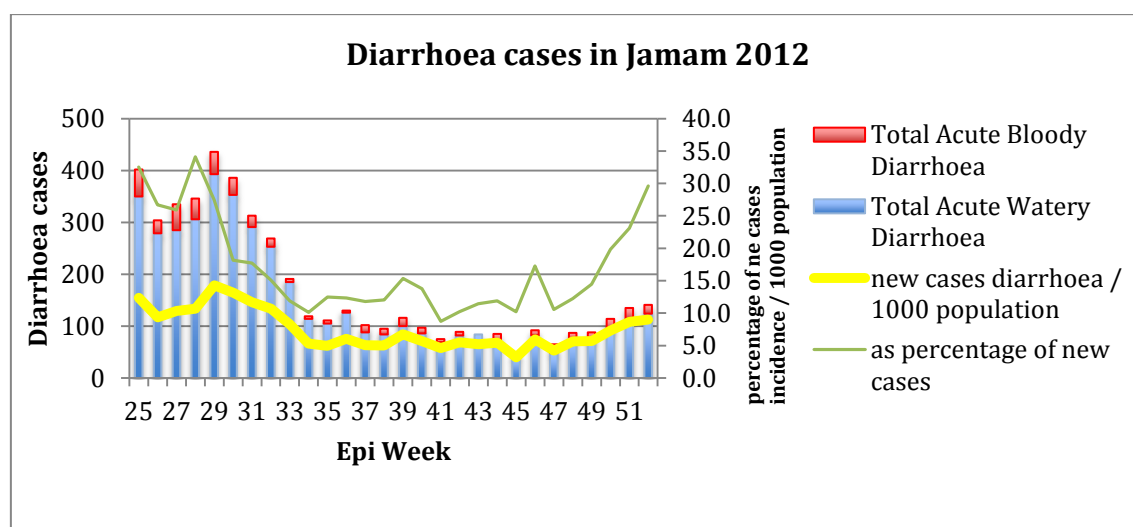


Figure 1: Diagnosed diarrhoea cases from June to December 2012

## Conclusion and recommendations

The Gender and WatSan Tool worked well to easily and rapidly collect essential data to guide the building of gender-sensitive WatSan facilities in an emergency situation. The resulting facilities were appropriate and were an improvement over those built without any consultation. No link could be established between using the tool and the incidence of diarrhoea. The tool, as a generic design, was quickly and easily put to use in the emergency in South Sudan. It is expected that it could be done again in other, and different, emergencies. Based on this experience, the tool needs some revisions and should be further used, evaluated and adapted in other emergencies.

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