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Strengthening gender and social inclusion in Bhutan's sanitation and hygiene programmes

Ensuring that potentially disadvantaged people have the voice, influence, and leadership roles in decision-making spaces is critical to achieve the Government of Bhutan's goal of universal access to sanitation and hygiene by 2023. This learning brief presents insights from an SNV baseline survey undertaken in 2019 to inform equitable, universal, and sustainable sanitation and hygiene service delivery in Bhutan.

In 2019, SNV in Bhutan 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 government agencies. 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.

SNV in Bhutan works across eight programme districts, applying a phased approach. Phase 1 districts – Chhukha, Dagana, Punakha, and Zhemgang – are new district areas where the focus is on building the capacity to increase coverage, access, and use for all. Phase 2 districts – Lhuntse, Pemagatshel, Samtse, and Trashigang – are ongoing programme districts in which SNV's focus has been to transition beyond

the achievement of full coverage (the 'finish line') to the realisation of sanitation sustainability and regulation, environmental health surveillance, responsive behavioural change interventions, and development of new sanitation service arrangements suitable for post-full coverage.

Research method and data collection

This learning brief summarises key gender and social inclusion insights gained from surveys of 5,240 households (HH), 139 schools, 44 monastic schools (including nunneries), and 71 health care facilities; self-guided assessments; stakeholder discussions with officials from the Government of Bhutan's Public Health Engineering Division (PHED) and Ability Bhutan Society (ABS) – a Disabled Peoples' Organisation (DPO); and 22 focus group discussions.

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

District	Phase (1 = New, 2 = Ongoing)	% of HH access to basic sanitation (or higher)	% of HHs in the poor and poorest income quintile
Zhemgang	1	38%	58%
Punakha	1	53%	21%
Dagana	1	61%	39%
Chhukha	1	73%	43%
Lhuntse	2	87%	20%
Pemagatshel	2	68%	53%
Samste	2	82%	47%
Trashigang	2	81%	31%

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.

Household survey data was disaggregated by district, gender, disability,¹ and wealth. 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 and district level – to support gender equality and social inclusion was assessed using self-guided assessments for individuals and a score-card system.

Findings of the baseline study

Inequities in access to sanitation and hygiene improvements are growing

In Phase 2 districts, where SNV rural sanitation programmes had been ongoing for several years, sanitation and hygiene standards had improved for many households. However, improved hygiene and sanitation was still not accessible to all. Male-headed households in higher income quintiles were more likely to own environmentally safe, functional, clean, private, and improved toilets and a handwashing station with soap with permanent water, in comparison to other

households. Female-headed households in lower income quintiles or that had a member living with disability had lower standards of sanitation and handwashing stations.

Only one person from most households attends health trainings and meetings in their community

Community participation was largely limited to one member per household, with the gender of household representatives varying per district. Only 14% of households in three of the Phase 2 districts attended community health-related trainings or meetings with all household members. 'Total participation' of all household members in community sanitation and hygiene trainings or meetings is likely to be difficult, particularly in the mountainous context of Bhutan. At the minimum, more than one household member and members at risk of being excluded require access to information, training and leadership opportunities. Their voices also need to be heard to prevent marginalisation in household and community decision-making.

Entire households in higher income quintiles were more likely to participate in community events compared to households in lower income quintiles, in which only one member usually participated. Work, cultural norms, leadership,

¹ The Washington Group Short Set Question tool was used to identify people with functional difficulties.

Figure 1: Barriers faced by people with disability to participating in WASH meetings at community level



and other factors influenced the ability of individuals and households to attend meetings. Better understanding of district-level differences in participation of women or men in community level activities will assist in tailoring multiple outreach strategies.

Numerous barriers exist in promoting voice and participation in sanitation and hygiene trainings and meetings

Focus group discussions (FGDs) with women from male-headed households and women from female-headed households, poor women and men, and women and men with disabilities highlighted low levels of engagement in community meetings overall. Men with disabilities and men from poorer income quintiles had the lowest engagement levels. Personal confidence was found to be a key factor that kept potentially disadvantaged individuals from speaking up in community meetings. Attendance increased when invites were extended directly. In addition, provision of transport, accessible location, and communication tools² were recommended by people with disabilities to facilitate their participation.

During the FGDs, people with disabilities spoke of being embarrassed by their disability or hygiene.

Hence, a welcoming and non-judgemental meeting environment would improve participation. Neither women nor men who spoke up in community meetings, regardless of disability, felt that their input influenced meeting outcomes.³

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

Both men and women promoted better sanitation and hygiene in their household while caring for children or elderly. However, income played an important role in how care work was distributed. Poorer households were more likely to designate one (primary) care worker: either the husband or the wife. In richer households, by contrast, women as primary care workers outweighed men. Shared responsibilities for care work occurred in both wealth quintiles, with a higher percentage for richer households. Overall baseline results suggested that women's care roles were less flexible than men's, i.e., women were less able to redistribute care work when household incomes increased.

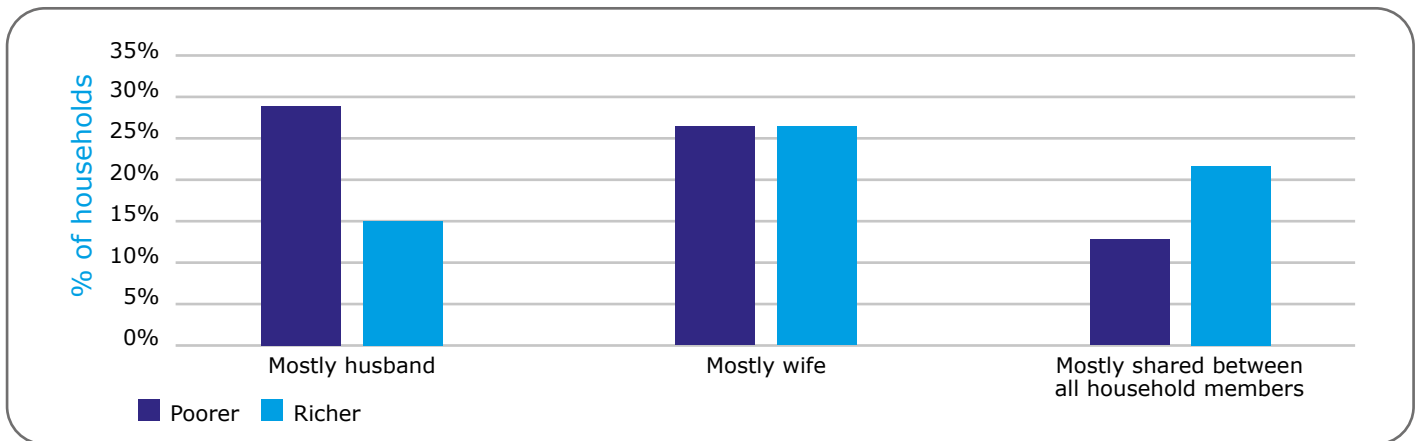
Behaviour change campaigns need to also target men

Efforts are needed to ensure that men are not overlooked as care givers. Women are commonly

² For example, through the use of simple (non-specialist) language, sign language, and pictures and charts to visualise information.

³ Data on sexual and gender minorities are considered underreported, and are likely to be higher than those reflected in this survey or national censuses. Underreporting is due to cultural norms, social stigma and/or a lack of clear definition on disabilities.

Figure 2: Care work distribution in households, 2019 (Who does most of the care work?)



assumed to be the care givers. This assumption can reinforce inequitable care arrangements and redistribution. Sanitation and hygiene behaviour change campaigns must promote men's caregiving role alongside women, and shared care work arrangements. Enlarging men's role in unpaid care work, alongside women, normalises the equitable distribution of care work within households. It creates more flexibility and openness – for both women and men – to support each other, engage in healthy conversations or negotiations in co-managing care work, and pursue productive or reproductive interests without fear or prejudice.

Neither women nor men have sufficient knowledge about when to wash hands with soap

Only 7% of household respondents, of which 40% were men and 60% were women, could list all the times when handwashing with soap was important. Whilst knowledge is rarely a driver to trigger action, this does indicate a lack of knowledge for both women and men in basic hygiene practices. The most commonly reported juncture to wash hands with soap was before handling food and eating – as listed by 52% of respondents.

Only 25% of respondents considered handwashing with soap after defecation as one of the critical junctures. Out of 2,620 households interviewed, 7% had not heard of any handwashing promotion in the last 12 months. The majority of respondents were reached by handwashing messages through TV or video, radio, large gatherings, workshops, and schools.

Large gatherings and TV or video were considered the greatest sources of information.

Water collection workload increases as quality of toilet improves

Programme activities have led to 95% coverage of pour-flush toilets in Phase 2 districts. Only 1% of toilets across the four Phase 2 districts were pit toilets with a slab. Affordability was considered the main barrier to building a pour-flush toilet by these households. In Phase 1 districts, where the programme is about to commence, 66% of toilets were pour flush and 19% were pit toilets. It is expected that the programme will achieve similar rates of improved toilets using the consumers' preferred pour-flush model. The shift towards pour-flush toilets, however, has implications for water collection workload and water resource use. Water collection workload also increases as toilet cleaning and hand washing practice become normalised; two activities promoted by the programme.

Women and men collect water but roles differ between districts

Overall, water collection responsibilities were disproportionately carried out by women. Women collected water in 46% of all households compared to 36% where it was in men's remit. At district level, however, there were more striking gender roles in water collection. In Zhemgang and Dagana districts, for example, women were responsible for water collection for household consumption in 83% and 82% of households, respectively. By comparison, in Trashigang district men were largely responsible for collecting water, at 70%. In the remaining districts,⁴ roughly 50%

⁴ Data was not available for this indicator in Lhuntse during the study period.



of households assigned this task to women, and the other half to men. The reasons for the differences in division of labour and practice by district were varied, including the availability and proximity of permanent water.

Toilet cleaning is predominantly carried out by women

The programme has had success in promoting the construction and use of functional, clean, and private toilets; 79% of toilets in Phase 2 district households were classified as either 'functional and clean' or 'functional, clean and private' during the baseline study. In Phase 1 district households, only 48% of toilets were classified in the same way.

However, improvements in toilet cleanliness have had direct impacts on unpaid labour in the household, a burden mostly borne by women. Although the task of toilet cleaning is shared in 29% of households, women took on the sole responsibility in 58% of all households. Men were only responsible for this task in 7% of households.

Women are less likely to be perceived as WASH leaders than men, and in some districts their leadership opportunities appear to be curtailed

The programme aims to redress social norms around acceptance, particularly by men, of women's participation in leadership roles. Engaging with men widens safe spaces for women to participate and increases the likelihood that their participation is meaningful.

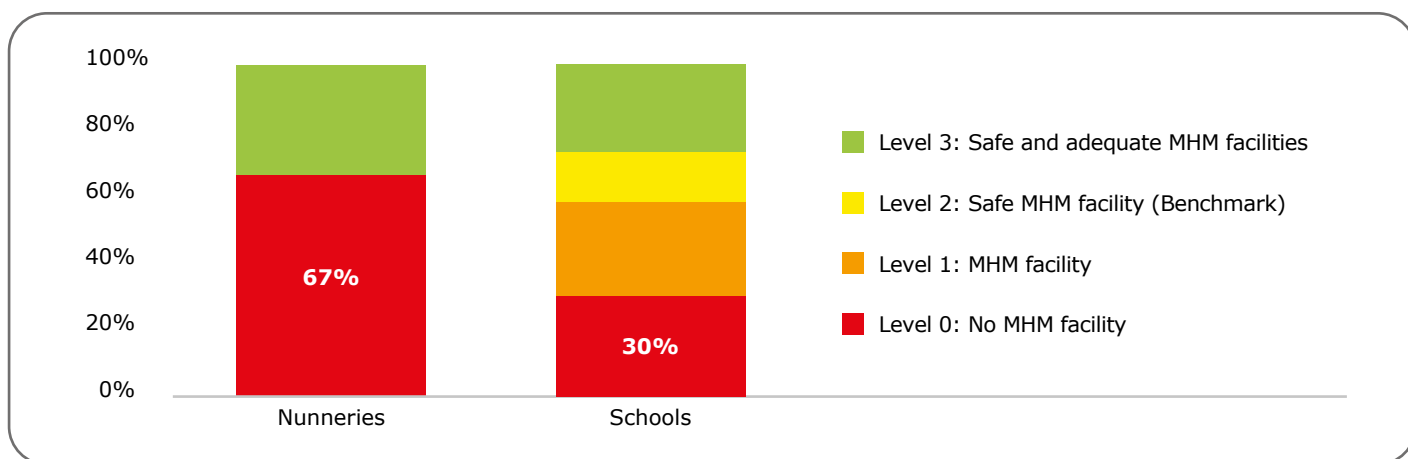
Overall, 41% of female and 39% of male respondents felt that women and men were equally engaged and influential in community leadership positions on sanitation and hygiene. Respondent perceptions of equal engagement and influence between women and men were highest in Dagana and Punakha at 67% and 68% respectively. Dagana was the only district in the country with two elected female local leaders. By contrast, 85% and 82% of respondents in the Zhemgang and Pemagatshel districts, respectively, stated that leadership positions were all held by men. Only 5% of Zhemgang respondents saw women as active WASH leaders, and 6% considered women and men to share leadership roles equally.

Household decision-making on sanitation and hygiene is hierarchical

Intra-household power dynamics can mean that some members are not consulted on toilet and washstand design and location. People at risk of exclusion include women, older people and people with disabilities.

The baseline data highlighted that most household decision-making was not inclusive or equitable; 71% of respondents said that the head of the household made the decision to invest in a toilet, selected its type and decided where to construct it. Household members in 55% of households indicated that they have 'some influence' over these decisions. Of those surveyed, 63% of households were headed by men.

Figure 3: Menstrual health and hygiene management, all districts, 2019



Menstrual hygiene facilities in schools, health centres, and nunneries are limited

Availability of safe and adequate menstrual health and hygiene (MHH) management services was low in both schools (26%) and nunneries (33%). Between 25% and 33% of Phase 1 district schools had safe and adequate menstrual health and hygiene services. Performance of Phase 2 schools was more varied, ranging from 0% in two districts to 50% in Pemagatshel. Limited to no presence of MHH services impact on girl’s school attendance, safety, comfort, dignity and human rights.

Most households that include people with disability have lower standard toilets and handwashing stations, and few have been adapted for specific access requirements

The number of households that reported having a member with difficulty accessing toilets ‘easily, conveniently and unassisted’ was a low 6%. This, however, is likely to be underreported as survey respondents may not be aware of difficulties faced by other household members, and disability is often hidden due to social stigma. Of these households, 82% did not provide any support to members with reported difficulties in accessing the toilet. Less than 8% of households modified their toilet to improve toilet access for members facing difficulties. Family members facing difficulties either practised open defecation or used the toilet unassisted.

With regards to handwashing facility access, 55% of households with disability were below the benchmark, compared to 43% of households without disability.

In schools, monastic schools and nunneries, 16%, 19% and 50%, respectively, reported that they

had students with a disability. No adaptations or modifications were observed in these educational institutions to promote the accessibility of toilets and handwashing stations.

Some districts face more challenging gender and social inclusion contexts than others

The most challenging gender norms and practices captured by the baseline were in Phase 2 district Pemagatshel in the far east. A significant majority of Pemagatshel district’s respondents (82%) believed that leadership positions were all held by men. In 79% of all households, wives did most of the care work while only 16% of husbands were reported to do this work – the lowest score across all districts. Half of all households considered women’s and men’s participation in community decision-making to be limited.

Phase 1 district Zhemgang, which is geographically and culturally similar to Pemagatshel, also held similar scores. Both districts have the highest rates of poverty in the country, and the lowest rates of toilets above the benchmark. The variable district results highlight the need to tailor district-specific gender and social inclusion strategies to address local contexts.

District governance capacity is a barrier to the programme’s GESI goals

The capacity of district government officers in Phase 1 districts to promote GESI is limited. Limited government capacity across a range of GESI areas was found in planning strategy, budget activities, training tools, approaches, and resources; developing sustainable social support mechanisms in sanitation and hygiene; and implementing behavioural change communications approaches in an inclusive and sensitive manner.

Recommendations and next steps

In 2018, SNV in Bhutan 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 or community members, including people with disability, as a result of programme activities. SNV in Bhutan has built partnerships with local disabled people's organisations and women's rights organisations to better understand context-specific causes of disadvantage and modify programmes, research, and staff practices to reduce harm and promote gender equality and social inclusion.

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 risk of marginalisation that limits possibilities for people to influence sanitation and hygiene choices and benefit from toilet and washstand availability.
- Complement phased approaches with tailored district-level strategies to promote gender equity and social inclusion to make sure that realities and priorities of individual districts are not obscured.
- Design WASH improvements based on the lived realities of target audiences. Without informed choice and shared caring roles, increasing the availability of pour-flush toilets may lead to increased workloads for women who are largely responsible for cleaning and maintaining toilets.
- Having an available household handwashing station or toilet does not mean that all members are able to access or use it. Accessibility considerations need to be further monitored, including in follow-up visits, and incorporated in mason training.
- Enable a robust sanitation market that is supported by strengthened private sector capacity to deliver appropriate products and services at affordable cost. And raising consumers' awareness of the availability of wide-ranging sanitation options.



Promoting greater gender and social inclusion through disaggregated data collection and mixed research methods

The collection of gender and social inclusion data during the baseline study has led to new and strengthened strategies in several programme areas.

- National and district government GESI capacity strengthening, through training provided as part of district-level multi-stakeholder meetings, coaching and mentoring. These have been supported by tailored district-level strategies that promote gender equity and social inclusion and approaches to leave no one behind.
- Pro-poor market-based approaches that deliver to the accessibility needs for improved toilets and handwashing stations. Some actions taken so far include raising stakeholder awareness on when adjustments of toilets and handwashing stations may need to be made, and strengthen skills and know-how to adapt facilities.
- The launch of a dedicated leadership for change initiative, in collaboration with the National Commission for Women and Children (NCWC), Gender at Work and BNEW in 2019.
- Campaigns on safe and private menstrual health and hygiene management with national level stakeholders for schools, health facilities and nunneries, to break the silence.
- Revised tools for more inclusive community development for health (CDH) workshops developed as part of the national rural sanitation and hygiene for all programme.
- Improved awareness of disability inclusion at all levels and within the private sector and reflected in the national sector forums.

Beyond the Finish Line - SSH4A in Bhutan

SSH4A in Bhutan aims to progress equitable, universal access to safely managed sanitation and hygiene that directly benefits more than 275,000 people in eight districts. The eight districts comprise of Chhukha, Dagana, Punakha and Zhemgang (Phase 1), and Lhuntse, Pemagatshel, Samtse and Trashigang (Phase 2).

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 Bhutan'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 Tshering Choden (SNV), and was reviewed by Asahel Bush (CBM Australia). It was edited by Anjani Abella (SNV) and designed by Crunchy Frog.

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P1: SNV-trained sanitation masons and champions in Punakha.

P5: Woman from Punakha who built a toilet attached to her house after SNV interventions.

P7: SNV WASH Advisor in dialogue with a user and health assistant in Dagana.



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

For more information

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