



Australian Government
Department of Foreign Affairs and Trade



Baseline Report Sustainable Sanitation and Hygiene for All BHUTAN



Rural WASH, Netherlands Development Organisation (SNV)

June 2015

Acknowledgements

This baseline survey for the Sustainable Sanitation and Hygiene for All Programme (SSH4A) in Samtse district, Bhutan was conducted by LNW Consulting, with technical support from the Netherlands Development Organisation (SNV) and administrative assistance from the Public Health Engineering Division, under the Ministry of Health's Department of Public Health and District Administration of Samtse. Sincere appreciation goes to all such agencies for their invaluable contributions to this successful baseline survey.

The International Water and Sanitation Centre (IRC) is also thanked for its support during the preparatory phase to design the survey methodology, data analysis and Akvo Flow to introduce the data collection on the android smartphone application. This survey would not have been possible without the valued contributions of all survey enumerators and respondents, as such their roles are warmly acknowledged.

Finally, the survey team offers its deep appreciation to all those who participated and supported the completion of baseline survey on time.

SNV Bhutan's SSH4A Programme is supported by the Australian Government and the Ministry of Foreign Affairs of the Netherlands (DGIS).

Executive Summary

Introduction

The Sustainable Sanitation and Hygiene for All (SSH4A) project aims to accelerate progress in sanitation and hygiene in Bhutan by strengthening professional and organisational capacity of local governments, the private sector and other sector stakeholders (*change agents*) for more effective service delivery in rural sanitation and hygiene to achieve full coverage in respective district areas. At district level, the Public Health Engineering Division (PHED), under the Ministry of Health (MoH) and SNV Bhutan will implement the SSH4A Programme in Dagana and Samtse districts from 2014 to 2018. Interventions have commenced in Samtse district and Dagana district will follow in 2016. To measure performance and progress over the programme's duration, a baseline survey was commissioned in June 2014 for Samtse district. Its major objective is to establish a benchmark for implementation of SSH4A and contribute to a better understanding of sanitation and hygiene in the study area as well as understand the capacities of key stakeholders to manage processes and deliver services.

Methodology

The SSH4A project measures performance by employing four impact indicators to gauge access to sanitation and hygiene facilities at household level and eight outcome indicators to assess qualitative aspects related to the capacity of change agents and other aspects, such as private sector engagement and involvement of disadvantaged groups¹.

To measure access to sanitation and hygiene facilities at household level as part of this baseline survey, 370 households from five Gewogs were included in the sample size. Data was collected by trained enumerators with use of the Akvo Flow mobile application software. Analysis was conducted, including disaggregation by wealth quintiles.

Key findings

Access to sanitary toilets

This indicator measured the design and construction quality of toilets. The status as found at the time of the baseline survey is depicted in the infographics from the following page. Of the households with some form of toilet (53% improved and 35% basic), about half have a pour-flush toilet considered the best option available in Samtse district villages.

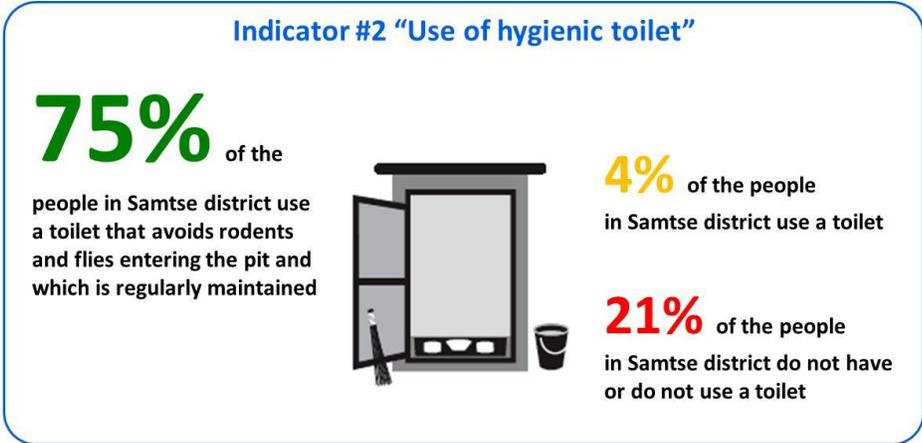
¹ Refer to SNV SSH4A Performance Monitoring Guidelines, revised 2014.



About 12% of total households do not have a toilet. Of the 35% with access to basic sanitation, approximately one-third use shared toilets, which account for 9% of access overall. The baseline data revealed noticeable differences between different wealth quintiles. More than three-quarters of the two lowest wealth quintiles fall below the benchmark in terms of either not having a toilet or meeting basic toilet standards. Only 12% of the two highest wealth quintiles do not have access to a sanitary (improved) toilet.

Use of hygienic toilets

This indicator measures the use and hygienic conditions of toilets. Some 79% of all households in Samtse district use a toilet, of which 4% is below the benchmark in terms of unhygienic usage. This means that residents from one-in-five households defecate somewhere other than a toilet. Three-quarters of households meet or exceed minimum requirements for a hygienic toilet, of which 40% meet the highest standards.



Similar to the findings for indicator one, the higher wealth quintiles outperform (92% at or above benchmark) than the lowest two wealth quintiles (66% at or above the benchmark).

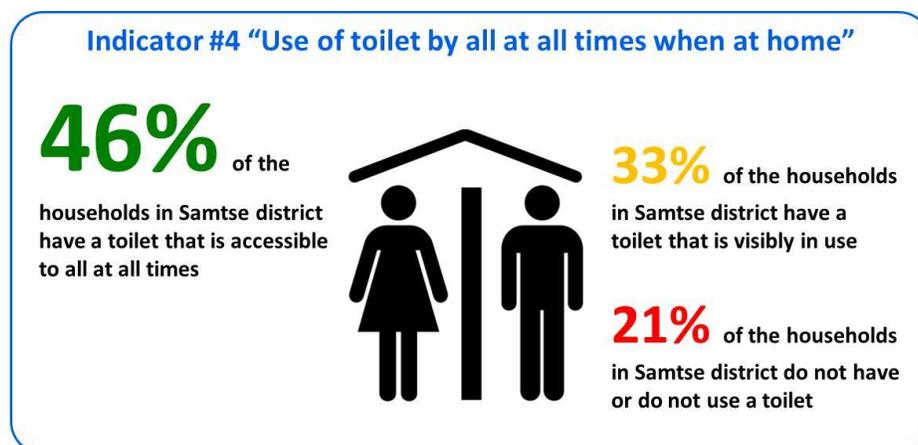
Access to handwashing facilities in or near the toilet

This indicator measures the existence and quality of handwashing facilities in or near the toilet as a proxy indicator for safe practice handwashing with soap at critical junctures. Three-in-10 households had a handwashing facility with soap in or near the toilet, of which 77% were at the highest level of access where the handwashing facility uses running water to avoid contamination. Five-in-10 households do not have a handwashing facility in or near the toilet and two-in-10 (20%) households do have a handwashing facility, but without soap. About 4% households did not have soap.



Use of toilet at all times when at home

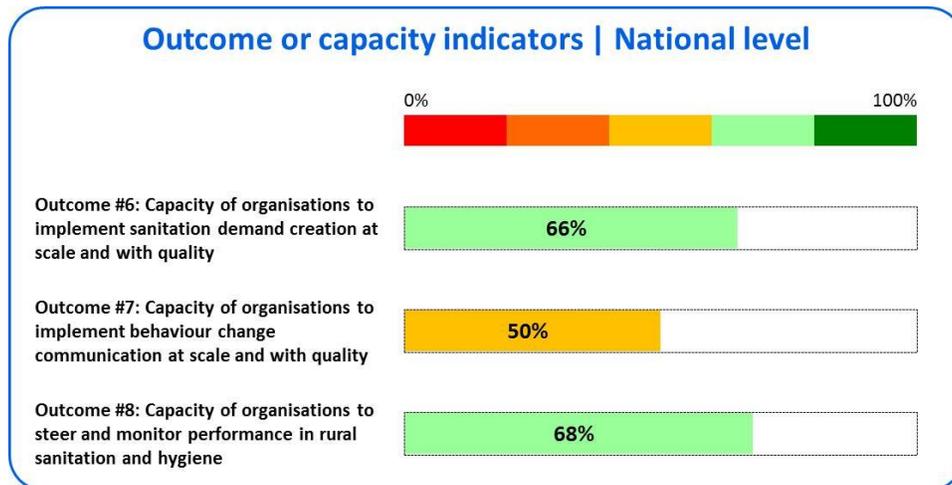
This indicator assesses toilet accessibility, convenience and privacy as a proxy indicator for toilet use by household members at all times when at home, including disposal of children’s faeces. The results for this indicator were similar to those observed for the first indicator dealing with access to a sanitary toilet. Just under half of households have a toilet accessible to all family members at all times, of which 80% were at the highest level where the toilet offers convenience and privacy as well as is used to dispose of children’s faeces when applicable.



Of note, almost 6% of households reported people with special needs in terms of access. Of this percentage, 57% were at level one below the benchmark in that they were not able to use the existing toilet facility. Households representing the three highest wealth quintiles performed better than households in the two lowest wealth quintiles, with almost half of households at the highest level of access.

National level capacity assessment result

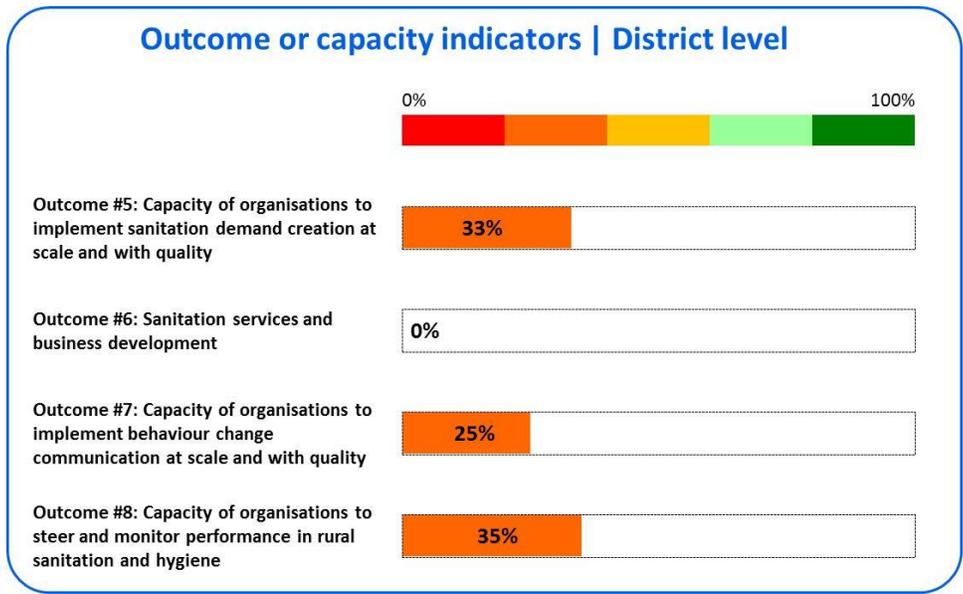
The PHED, under the MoH, is the lead WASH agency at national level in Bhutan. following this baseline study assessment, it was found to have “acceptable” levels of capacity (above 50% score) for three relevant outcome indicators: i) lead coordination and implementation of sanitation demand creation at scale with quality, ii) implement behaviour change communication (BCC) at scale and with quality and iii) steer and monitor performance in rural sanitation and hygiene. The PHED acquired these capacities through close engagement with the SNV WASH team in programme development and implementation in the earlier districts, Lhuentse and Pemagatshel.



District level capacity assessment result

This district level capacity assessment was carried out for Samtse district. It was found to have a “very limited capacity” (below 35%) in terms of all four outcome indicators relevant at district level: i) take the lead in coordination and implementation of sanitation demand creation at scale with quality, ii) sanitation services and business development, iii) implement BCC at scale and with quality and iv) steer and monitor performance in rural sanitation and hygiene.

This limited district-level capacity was anticipated as it had no prior experience in implementing large-scale sanitation and hygiene programmes. With regards to sanitation services and business development, the level of suppliers’ involvement was non-existent (0%). No marketing activities were apparent, as customers were expected to initiate contact.



Sanitation and hygiene context

The number of households (324) with a latrine accounted for 88% of all households surveyed (370), with no relevant differences between sub-districts. Observations of common toilet technologies, basic pit toilets (36%) and pour-flush toilets (64%), indicated a number of common technical errors in latrine construction as well as in use and maintenance. From the 370 households, about 75% met or exceeded the minimum requirements for a hygienic toilet. As for handwashing, only three-in-10 households had a handwashing facility with soap in or near the toilet.

Conclusions and Recommendations

Based on the findings of this baseline survey, the following recommendations are made for the programme:

1. The immediate focus of programme activities should be to elevate households up to the benchmark level for access to sanitation, hygienic usage and handwashing with soap.
2. During one-day Gewog or sub-district meetings, when targets are set and action plans drawn up, specific attention should be given to mobilise, motivate and inspire households to build, improve and/or upgrade toilets.
3. During Community Development for Health (CDH) workshops, regular follow-up and masonry trainings should discuss different technology options, advantages, affordability and applicability for differently abled people with options offered to households. Information and guidance on availability and access to sanitary hardware materials and services should also be shared with households. Since households in the two lowest wealth quintile rankings have a significant proportion (61%) of toilets not accessible to all household members, particular emphasis on location and design of toilets to suit all household members, including those with children or living with a physical disability, should be stressed during technology discussions at CDH workshops.
4. Identification and development of support mechanisms to address barriers to improved sanitation for the poorest and most vulnerable households must be

considered (44% of the lowest wealth quintile do not have access to hygienic toilets, with 10% unlikely to ever afford a latrine). Pro-poor support mechanisms and financing could be discussed, designed and debated at local government level.

5. With one-fourth of the population below the hygienic quality of toilets benchmark and two-thirds below the benchmark in terms of access to a handwashing facility near a toilet, strategic BCC approaches and activities must be developed based on focus behaviours for different target groups. Emphasis should be placed on the poorest households who are overrepresented in both. Communication materials could focus on motivations, not necessarily information or knowledge, for households and schools.
6. Targeted interventions and support should be provided to potential suppliers (SMEs and masons, in particular) to encourage and demonstrate new business strategies to respond to consumer needs and preferences.
7. The RSAHP must ensure the poorest in each Gewog are included in WASH awareness interventions and during CDH workshops, as their toilets are largely below the benchmark.
8. The capacity of PHED at national level must be enhanced in terms of to:
 - a. Provide guidance, coaching, motivation and support to district facilitators during programme implementation and regularly assess the performance of district facilitators responsible for demand creation and follow-up activities
 - b. Develop and test the effectiveness of messaging and approaches to target audiences and regularly assess the performance of facilitators or others responsible for BCC interventions as well as review approaches based on monitoring or lessons learned
 - c. Ensure monitoring includes data that assesses inclusion of all groups in villages, including people with disabilities
 - d. Ensure capacity exists to review the status of villages with regards monitoring universal access and sustained changes in sanitation and hygiene behaviour and practices.
9. Design and implement capacity strengthening initiatives for stakeholders in Samtse district and build capacity in terms of to:
 - a. Implement sanitation demand creation and follow-up activities
 - b. Implement a specific BCC strategy and action plan
 - c. Guide and monitor performance in the rural sanitation and hygiene programme.

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List of abbreviations

AHS	Annual Household Survey
BCC	Behaviour Change Communication
BHU	Basic Health Unit
CDH	Community Development for Health
DHSO/DHO	District Health Supervisory Officer/District Health Officer
DFAT	Department of Foreign Affairs and Trade
DoPH	Department of Public Health
DYS	Department of Youth and Sports, Ministry of Education
FYP	Five Year Plan
GAO	Gewog Administrative Officer
GNH	Gross National Happiness
GT	Gewog Tshogdu/Gewog Development Committee
HH	Household
IRC	International Centre for Water and Sanitation
LCB	Local Capacity Builder
LNW	Lhagyal, Norbu Wangyal (LNW) Consulting, Thimphu
MDG	Millennium Development Goal
MoE	Ministry of Education
MoH	Ministry of Health
MoWHS	Ministry of Works and Human Settlement
NHPC	National Housing and Population Census
O&M	Operation & Maintenance
PHED	Public Health Engineering Division
PPD	Policy and Planning Division
RGoB	Royal Government of Bhutan
RSAHP	Rural Sanitation and Hygiene Programme
RWSS	Rural Water Supply and Sanitation
SNV	Netherlands Development Organisation
U5	Under Five
UNICEF	United Nations International Children's Fund
VHW	Village Health Worker
VMC	Village Management Committee
WASH	Water Sanitation & Hygiene
WatSan	Water and Sanitation
WCT	Water Caretaker
WHO	World Health Organization

Glossary of Local Terms

Chiwog	Cluster of villages
Drungkhag	Sub-district
Dzongdag	District Administrator
Dzongkha	National Language
Dzongkha	District
Gewog	Block/Sub-district
Gewog Tshogdu	Gewog committee, Local government at Gewog level (GT)
Gup	Elected administrative head of a Gewog
Kidu	Destitute allowance recipients
Mangmi	Elected administrative deputy head of a Gewog, Deputy to a Gup
Tshogpa	Head of a village or a cluster of villages and representative of the same village or a cluster of villages to the Gewog Tshogdu

1. Introduction

The SSH4A project aims to accelerate progress in sanitation and hygiene by strengthening professional and organisational capacity of local governments, the private sector and other stakeholders (*change agents*) for more effective service delivery in rural sanitation and hygiene to achieve full coverage in districts. In the SSH4A approach, SNV has integrated insights in community-led sanitation demand creation with supply chain development, hygiene BCC and WASH governance to develop a sustainable service delivery model at scale. SNV works as a capacity development and knowledge-sharing organisation at national, district and sub-district levels. International Water and Sanitation Centre (IRC), as a partner, helps strengthen performance monitoring, knowledge and learning linked with SNV's wider regional SSH4A Programme in Asia².

1.1. Country context

Bhutan is a landlocked country situated in the eastern Himalayas, bordered by China in the north and by India in the east, west and south covering 38,394 square kilometres. It has 205 Gewogs (sub-districts) under 20 districts, with a total population of 737,765 (National Statistics Bureau, 2012 projection) administered by a young democratic constitutional monarchy form of government. On a population level, the average life expectancy is 68.9 years and the literacy rate is 63% (2012). The concept of Gross National Happiness (GNH), coined by the Fourth King of Bhutan in the 1970s, has been an overarching development philosophy in ensuring sustainable development takes a holistic approach towards progress with equal importance to non-economic aspects of wellbeing. The national sanitation and hygiene programme is aligned with the GNH concept.

1.2. Overview of sanitation situation

While Bhutan's Annual Health Survey (AHS 2014) reports an impressive 95% basic sanitation coverage in rural areas, the situation on the ground tells a very different story. Some toilets are not used, some do not have covers to prevent disease transmission and are unhygienic, while progress varies across and within districts. Despite the impressive physical coverage of water supply and sanitation facilities, the incidence of sanitation and hygiene (WASH)-related diseases remains stubbornly high and the under-five mortality rate is still among the highest in South Asia (11th FYP Health Sector). According to the 2010 Bhutan Multiple Indicator Survey (BMIS), only 54% of the rural population have access to improved sanitation. Unsafe sanitation and hygiene practices remain a public health risk and place whole communities at risk. More than 30% of cases of illness reported to Basic Health Units (BHU) can be attributed to poor sanitation and hygiene (11th FYP Health Sector).

² SSH4A is a multi-donor, multi-country programme implemented in Bhutan, Cambodia, Laos, Nepal and Vietnam by SNV, IRC and local and national governments (www.ssh4a.org).

1.3. Rural Sanitation and Hygiene Programme

The lack of progress on improved sanitation has been acknowledged by the Royal Government of Bhutan (RGoB) and in 2008, with support from SNV, the National Rural Sanitation and Hygiene Programme (RSAHP) was launched, based on SNV's SSH4A approach. The SSH4A approach integrates community-led sanitation demand creation with supply chain development, hygiene BCC and WASH governance to develop a sustainable service delivery model at scale. SNV works as a capacity development and knowledge-sharing organisation at national, district and sub-district levels.

Initially operating as a pilot in four Gewogs, it dramatically increased improved sanitation coverage district-wide in Lhuentse during 2010-2011 from 27% to 85% in an 18-month period, leading to its national endorsement. As a result, the approach was replicated in a second district-wide programme in Pemagatshel during 2011-2013.

In recognition of this progress, the RGoB in its 11th Five-Year Plan (FYP) for 2013-2018 prioritised sanitation and hygiene as a key sector result area. It is targeting improved sanitation and hygiene in rural areas from 54% to more than 80% and a nationwide scaling-up of the RSAHP³. This is a critical shift from a district-wide to national approach by mainstreaming sanitation and hygiene targets within the RGoB's district and Gewog five-year plans and budgets to ultimately improve the health of rural households.

This commitment presents an opportunity as well as challenges in terms of capacity and ensuring quality at scale. As a result, the current phase of SNV's technical support as part of SSH4A is centred on building the PHED's capacity to implement the national programme through employing two strategies. Firstly, an enabling environment is created to operationalise the Rural Water Supply and Sanitation (RWSS) policy and scale-up the programme at national level supported by strategies, TOTs, guidelines and tools. Secondly, the further development of the district-level SSH4A approach is supported through targeted capacity building in four priority districts at different stages. The district level approaches also allow the programme to continue to tailor and test the approaches in different contexts in terms of functional scaling and are linked to the national level in terms of knowledge processes.

Operating within a framework agreement (2014) and with support from DGIS and the Australian Government's Department of Foreign Affairs and Trade, this current phase from 2014-2018 focuses on:

³ The baseline of 54% is based on the National Statistics Bureau, Bhutan Multiple Indicator Survey, 2010.

- Provision of technical support to the PHED as the lead government agency to further develop, replicate and scale-up the national RSAHP, including technical support to focus districts Monggar and Samdrupjongkhar and 14 other districts.
- Targeted support to local government authorities in Samtse (2014-2016) and Dagana (2016-2018) as districts lagging behind in sanitation access and prioritised by the government.
- Follow-up support to the Lhuentse and Pemagatshel district programmes with a focus on behaviour change, post Open Defecation Free (ODF) support mechanisms and overall sustainability of programme successes.

Project locations

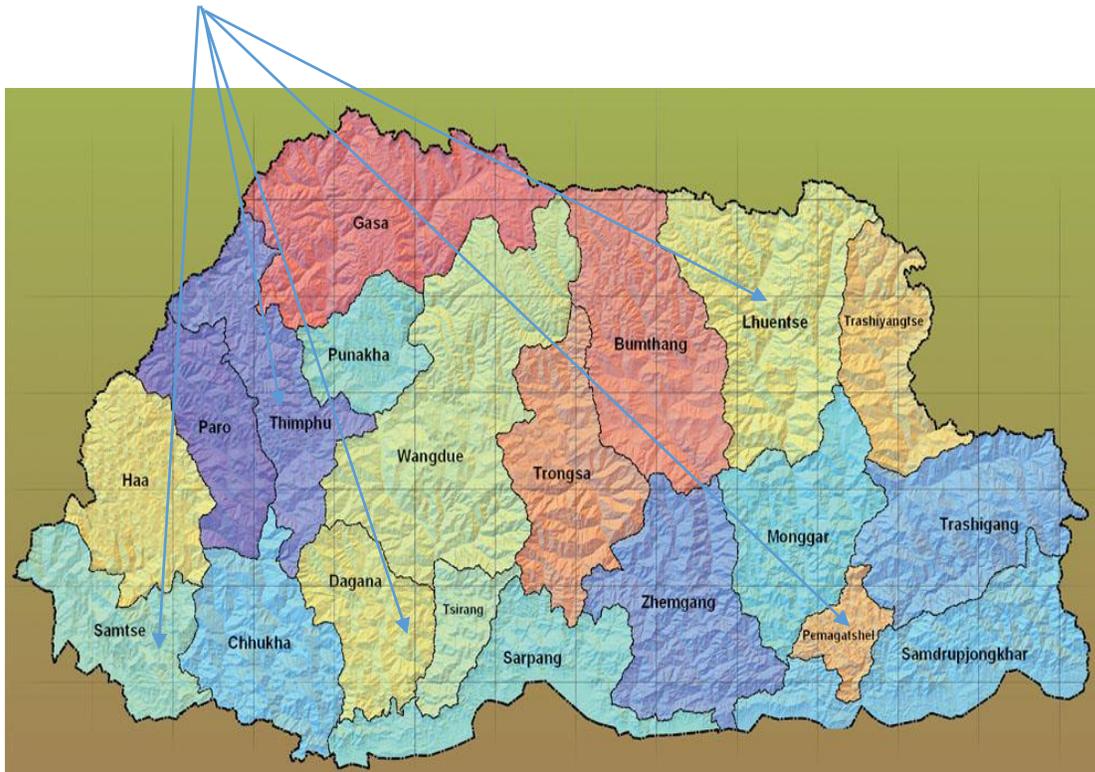


Figure 1. Map of project locations

The intended outcomes are progress in:

- Capacity of local government organisations to implement sanitation demand creation at scale with quality
- Commitment and capacity of local organisations to implement BCC at scale with quality
- Involvement of private sector actors in sanitation-related supply chains
- Capacity of local government organisations to lead and steer the sector
- Degree of influence of women/households living in poverty/socially excluded groups during planning and implementation of sanitation and hygiene programmes
- Improved performance monitoring and evidence-based learning.

This baseline report includes findings and recommendations from the household baseline survey in Samtse district conducted in May 2014 and district and national level capacity assessments subsequently conducted in January 2015. In 2016, a baseline survey will be conducted in Dagana by SNV. Chapter Two of this report describes the WASH sector institutional set-up in Bhutan, Chapter Three provides information on the targeted district of Samtse, Chapter Four describes the survey's objectives and methodologies around rural households, Chapter Five outlines all baseline information on impact indicators and Chapter Six presents all baseline information on outcome indicators.

2. Institutional set-up for the WASH sector

There are a number of government agencies in Bhutan directly or indirectly involved in the water, sanitation and hygiene sector at national and local government levels, with many communication lines and co-ordination mechanisms between such agencies. The flow chart, in Annexure-A, shows the roles and responsibilities of various agencies in relation to the sanitation and hygiene programme. The key government agencies involved in the sector are:

2.1. Central/National level

Gross National Happiness Commission leads the development of five-year development plans (FYPs), which include national targets and budget allocation for rural sanitation and hygiene, through budgeting for the health sector.

Ministry of Health is the apex national level agency responsible for rural sanitation and hygiene. It is responsible for developing and reviewing policy and associated background documents and guidelines. The MoH also has a lead role in coordinating strategies and activities across sectors and between national ministries. The process of decentralisation requires a transition in planning for sanitation and hygiene initiatives from national to local levels. Therefore, the MoH is responsible to build capacity and support districts and Gewogs to plan, budget, monitor and implement sanitation and hygiene initiatives.

Public Health Engineering Division is responsible for:

- Training and mobilisation of trained health workers to promote sanitation and hygiene practices in CDH workshops
- Capacity building and technical support on sanitation and hygiene including training health assistants in BHUs, village health workers, district engineering sections and contractors involved in construction and maintenance of toilets such as masons, plumbers and carpenters
- Technical support and training for district engineering sections to design and construct facilities in schools and other public institutions
- Producing sanitation option technical handbooks and designs for households
- Developing and updating technical and programme guidelines to support achievement of policy objectives

- Monitoring and evaluating programme approaches and on-going activities.

Health Promotion Division is responsible for developing and implementing national BCC, media and health promotion strategies, encompassing sanitation and hygiene.

Ministry of Education is responsible for planning, budgeting and coordinating construction of sanitation and hygiene facilities in schools, providing training for school health coordinators on facilities maintenance and coordinating the monitoring and reporting of sanitation and hygiene in schools and developing relevant guidelines.

National Environment Commission is responsible for establishing and ensuring compliance with standards, codes of practice and regulations on effluent discharge, septic tanks and water quality.

Dratshang Lhentshog is responsible for the planning, budgeting and construction of sanitation and hygiene facilities in monastic institutions.

2.2. District level

Districts are responsible for preparing annual targets, work plans and budgets for sanitation and hygiene that consolidate and respond to Gewog initiatives and national targets set by the MoH and GNH Commission.

Districts have a key role to play in community awareness-raising and building capacity amongst key professionals and encouraging private sector participation. This includes supporting health assistants in planning CDH workshops and awareness-raising activities to create demand and promote sanitation and hygiene. They are also responsible for monitoring and reporting of water, sanitation and hygiene facilities in schools and compiling Gewog-based RWSS MIS for annual submissions to the PHED.

The district engineering sector surveys, designs and oversees the construction of sanitation and hygiene facilities in schools, institutions and other public places. This includes directly contracting local plumbers, masons and carpenters as well as conducting training for masons and carpenters in the construction of sanitation facilities.

2.3. Gewog/community level

Gewogs have primary responsibility for engaging their communities in setting local annual targets, planning and budgeting for sanitation and hygiene initiatives. This includes the coordination of health assistants to conduct sanitation and hygiene-focussed CDH workshops and frequently discuss progress in sanitation with Tshogpas. Gewogs are also responsible for raising funds and mobilising labour to

support poor households to construct sanitation facilities. Gewog engineers provide oversight on local contractors, including those hired by districts to undertake construction of sanitation facilities in schools and other public institutions. Gewogs are required to maintain RWSS MIS and submit annually to districts.

Households are obliged to pay for construction and maintenance of their own sanitation facilities. Voluntary unskilled labour is also often provided by community members to construct public institution facilities and sanitation facilities for poor households.

2.4. Private Sector and Civil Society

Private sector actors such as suppliers, masons, plumbers and carpenters are directly employed by households to assist in the construction of sanitation facilities as well as construct and maintain school and other public institution facilities.

Civil society (including local organisations and development partners) has an important role in promoting sanitation and safe hygiene practices. National and local governments also have roles to engage these organisations in such activities.

3. Background on Samtse district

Samtse district is located in south-west Bhutan, bordered by India. It is the largest district in Bhutan with a population of 60,000 people, with one of the country's highest poverty rates (47%). It has two Drungkhags (Dorokha and Sibsoo) and 15 Gewogs, with diverse ethnic communities. The main cash crops are areca nut, cardamom, ginger and oranges. The nearest markets for these crops are the Indian State of West Bengal.

In 2011, a national level assessment was carried out by a taskforce to examine the district-level sanitation and hygiene situation taking into consideration regional representation, coverage of sanitation facilities, ratio of diarrhoeal disease cases, poverty rankings, population and access to health facilities. The assessment revealed that the most eligible districts for the next phase of the programme were Samtse in the west, Dagana in the centre and Pemagatshel in the east. The RSAH programme in Pemagatshel was implemented during 2011-2013 and is currently being implemented in Samtse. The BMIS Survey in 2010 indicated that 65% of households in Samtse used sanitary (improved) toilets, of which the majority (42%) were flush toilets without soak pits⁴. However, 35% used unimproved sanitation with pit latrines without slabs/open pits (29%) and 4% had no access to sanitation in the district. In Dagana, the programme will commence in the latter part of 2015, pending an updated assessment of its current status.

⁴ Bhutan Multiple Indicator Survey, 2010, National Statistics Bureau, RGOB, 2010.

4. Survey objectives and methodology

4.1. Objectives

The main objective of this baseline assessment was to document and understand the situation and status of sanitation and hygiene in Samtse district at household and institutional (schools and monastic institutions) levels at the start of the project and understand key stakeholders' capacities to steer processes and deliver services at national and district levels. The findings would then be used to inform the design of programme interventions and enable annual performance monitoring and progress against the key impact indicators (1-4A). These indicators reflect the programme's ultimate aim to increase access to safe sanitation and hygiene for all.

4.2. Methodology

The baseline was conducted using the household survey questionnaire (Annexure-B) in line with the Sustainable Sanitation and Hygiene for All Programme Performance Monitoring Guidelines updated in 2014, as part of SNV Asia's regional programme, which include 12 shared impact and outcome level indicators. In line with SNV's global programme, additional data was collected to enable wealth ranking and monitoring by wealth quintiles, using a principle component analysis. Wealth rankings were made following the DHS wealth index⁵, with details given in a separate wealth index guidance document.

Information presented in the baseline report was drawn from two distinct processes. Firstly, information was collected specifically at household level and involved quantitative (surveying) and qualitative methods (semi-structured interviews) during June-July 2014 against impact indicators 1-4a. Secondly, capacity assessments against outcome indicators (indicators 5-12) at national and district levels were conducted in January and February, 2015.

In preparation for the baseline survey, a three-day workshop was held in Thimphu from 20-22 May 2014, with technical support from IRC during which the sampling design and methodology was agreed upon and tools refined⁶.

The survey-collected data related to the household indicators is summarised as follows:

⁵ SNV (April 2014) Guidance Note: Wealth disaggregated impact monitoring in SNV's WASH sector.

⁶ SSH4A Baseline preparation workshop report, SNV Bhutan & IRC, May 2014.

Table 1. Overview of the minimum set of rural SSH4A impact and outcome indicators

PROGRAMME COMPONENTS	INDICATORS		TYPE OF INDICATOR			
			OUTCOME	IMPACT	SNV CORE INDICATOR	ASSESSMENT PLAN
IMPACTS AS A RESULT OF ALL PROGRAMME COMPONENTS	1.1	Progress in number of households and number of people (male and female) with access to a sanitary toilet		✓	✓	HH Baseline Survey, Schools in 2015
	1.2	Progress in number of schools and number of students (boys and girls) with access to a sanitary toilet		✓	✓	
	2.1	Progress in number of additional households and number of people (male and female) that use a hygienic toilet		✓		As above
	2.2	Progress in number of schools and number of students (boys and girls) that use a hygienic toilet		✓		
	3.1	Progress in number of households and number of people (male and female) with adequate hand washing facilities with soap in or near the toilet		✓	✓	As above
	3.2	Progress in number of schools and number of students (boys and girls) with adequate hand washing facilities with soap in or near the toilet		✓	✓	
	4	Progress in number of people (male and female) using a sanitary toilet when at home ("use by all")		✓		HH Baseline Survey in 2014
GENERATING DEMAND	5	Progress in the capacity of organisations (local NGO's and other implementing organisations) to deliver sanitation demand creation processes with quality at (sub)district level	✓		✓	Feb 2015
SANITATION SUPPLY CHAINS	6	<i>Progress in sanitation services and business development</i>	✓			Feb 2015
BCC	7	<i>Progress in the capacity of local organisations to implement behaviour change communication at scale with quality</i>	✓		✓	Feb 2015
WASH GOVERNANCE	8	<i>Progress in the capacity of local line agencies to steer and monitor performance in rural sanitation and hygiene</i>	✓			Feb 2015
	9	<i>Progress in rural sanitation and hygiene sector alignment</i>	✓		✓	During implementation
	10	<i>Progress in the degree of influence of women during planning and implementation of sanitation and hygiene programmes</i>	✓			During implementation
	11	<i>Progress in the degree of influence of people from poor households during planning and implementation of sanitation and hygiene programmes</i>	✓			During implementation
	12	<i>Progress in the degree of influence of people from socially excluded groups during planning and implementation of sanitation and hygiene programmes</i>	✓			During implementation
KNOWLEDGE	13	<i>Increased uptake of lessons learned and evidence</i>	✓			Ongoing

PROGRAMME COMPONENTS	INDICATORS	TYPE OF INDICATOR			
		OUTCOME	IMPACT	SNV CORE INDICATOR	ASSESSMENT PLAN
& LEARNING		<i>based approaches by wider sector and government partners</i>			

4.2.1. Sampling design and methodology

Representative sampling was the methodology used to select part of the population for data collection and analysis. It enabled the studying of a group representative of the larger targeted population. This sample was then examined to form the basis for analysis. The following steps were taken to determine sample sizes and select sample clusters and units.

4.2.2. Determining target population and survey clusters

The district was taken as the highest survey cluster. Although the rural SSH4A programme in Bhutan will be implemented in two districts, programme activities commenced firstly in Samtse district during 2014. For the rural SSH4A programme, the total target population is that expected to benefit from the programme. Therefore, the total rural population residing in Samtse district was defined as the target population.

4.2.3. Determining sample size

The sample frame was agreed upon through use of the Krejcie-Morgan table. The sampling methodology followed the stratified proportional sampling selected clusters. The required sample size for Samtse district was determined as 370 households, equal to 3% of the total rural target population as shown in Table 2.

Table 2. Sample size calculation

	Districts	# of SSH4A target villages	Total # of HH	Average HH size	Total population	Required sample size	
						In # of HH	In %
#1	Samtse	77	12,219	4.9	59,701	370	3.0 %

4.2.4. Selecting sample villages

Samtse district is divided into 15 Gewogs (blocks), sub-divided into five to six Chiwogs per Gewog. The total number of Chiwogs in Samtse district is 77, which is further sub-divided into villages. The sampling procedure involved two stages to ensure each household in the programme area had an equal chance of being

selected for the survey. The first stage was the selection of Gewogs and the second stage was the selection of households within the Chiwogs. The district health sector helped identify the Chiwogs and villages for the baseline data collection. For the selection of Gewogs included in the sample, the stratified proportional sampling⁷ methodology was used as described in the Sustainable Sanitation and Hygiene for All Programme Performance Monitoring Guidelines. This was done by carrying out a broad differentiation, such as using distance, poverty, geo-hydrologic conditions or other characteristics to select a manageable number of Gewogs with unique conditions or characteristics. Five Gewogs were selected and are presented in Table 3.

Table 3. Sample Gewogs

	Gewog	Sanitation coverage	Accessibility	# of Chiwogs
1	Dungtoe	2%	Difficult	5
2	Bara	37%	Remote	6
3	Sipsu	64%	Easy	5
4	Tading	15%	Reasonable	5
5	Lhareni	Unknown	Somewhat difficult	5

The five selected Gewogs shown in Figure 2 give a representative sample of all the different Gewogs in the district.

⁷ A **stratified sample** is a probability sampling technique in which the researcher divides the entire target population into different sub-groups, or strata, and then randomly selects the final subjects proportionally from the different strata. This type of sampling is used when the researcher wants to highlight specific sub-groups within the population.

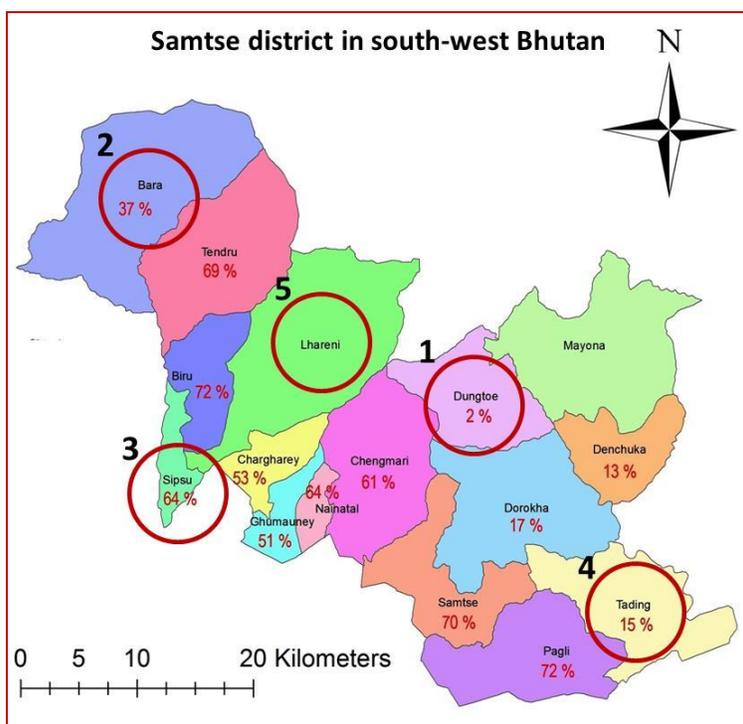


Figure 2. Five selected sample Gewogs

The sample sizes for the five Gewogs, determined proportionally on the basis of the total number of households per Gewog, are provided in Table 4.

Table 4. Sample size of five Gewogs

	Gewog	Total # of HHs in Gewog	Sample size per Gewog		As % of total sample
			# of HHs	%	
1	Dungtoe	285	33	11.6%	8.9%
2	Bara	653	76	11.6%	20.4%
3	Sipsu	921	107	11.6%	28.8%
4	Tading	824	95	11.6%	25.8%
5	Lhareni	514	59	11.6%	16.1%
	Total	3,197	370	11.6%	100.0%

The main data collection methods were:

- **Structured interviews:** Information is obtained through an interview with the respondent (interviewee) and the information is then recorded by enumerators (interviewers). Structured interviews were performed using survey forms or questionnaires with only closed-ended questions⁸.

⁸ A **closed-ended question** is a question that limits respondents with a list of answer choices, from which they select one answer. Commonly, these types of questions are in the form of multiple choice.

- **Direct observations:** Information is obtained by observing behaviour, events or physical characteristics. Observations were carried out for all impact indicators to assess the physical characteristics and conditions of sanitation and hygiene facilities.
- **Guided (capacity) self-assessments:** Information is obtained through a participatory process whereby the respondent, who is guided and supported by the interviewer, decides and rates the qualitative information system scales and/or capacity development scorecards. This methodology is particularly appropriate for capacity development indicators, as it enables an organisation to look in detail at how effectively it functions and identify priority capacity development needs.

In principle, a combination of structured interviews and direct observations are used to collect data on impact indicators and guided (capacity) self-assessments are used to collect data on outcome indicators.

Supporting data was compiled from information PHED, SNV and LNW collected over several months, including through stakeholder meetings, supply chain analysis, formative research on behaviours and gender as well as existing data.

Secondary data sources:

- Annual Household Survey Report 2010
- Health data provided by PHED, DHO and BHUs
- Bhutan Multiple Indicator Survey, 2010
- National Statistics Bureau, RGoB, 2010.

Data collection tools

Qualitative Information System (QIS)

In line with the guidelines, impact and outcome indicators were quantified with the help of progressive scales called 'ladders'. Each step on the 'ladder' has a short description, called "mini-scenario", which are factual statements that describe the situation for a particular score. Scoring is done jointly with respondents using participatory methods. Each scale ranges from the absence of the particular indicator at the lowest level (score 0) to the optimal mini-scenario at the highest level (score 4). Levels 1, 2 and 3 describe the scenarios in-between levels 0 and 4 for each specific indicator. Where there is a benchmark, it is indicated at level 2.

This system allows households, schools, enterprises and/or local government institutions at the lowest levels to climb higher on ladders developed for each indicator. The value is in analysing and visualising progressive improvements over the course of the programme. For communities and districts, performance assessments and subsequent improvement planning are based on how households and schools are distributed percentage-wise across the respective scales in the selected villages and districts/sub districts.

The experience from the previous phase of the programme highlighted the need to translate the scales into simple tick boxes, to ensure clear interpretation by enumerators as well as enhance consistency and uniformity in scoring when collecting data.

Capacity Development Scorecards

SNV distinguishes three interconnected outcome types: *capacities developed*, followed by *improved performance* and *improved enabling environment*. The scorecards are adapted to the specific capacity development outcomes of the programme. The scorecards are discussed and scored with stakeholders/clients. The scores are unweighted as they are intended to show progress and areas of further capacity to be planned for the next year and are scored from 0 (absent) to 4 (strong). Detailed explanations on the different scorecards are provided in Sustainable Sanitation and Hygiene for All Programme Performance Monitoring Guidelines.

Akvo Flow

Mobile phone-based monitoring of the survey brought together three elements: 1) an android smartphone app allowed enumerators to survey directly on their phones and send data to the database hosted in the cloud, 2) internet-based management tools allowed for the design of surveys and management of how they are distributed to people by phone and 3) maps and dashboards to create reports and show survey results online.

4.2.5. Supervisors and enumerators' training

A training programme was held in two stages. The first stage was a two-day training on 28-29 June 2014, which was attended by PHED representatives, SNV advisors and LNW facilitators. Its main content was hands-on instructions on use of Akvo Flow android smartphone data collection app. A consultant from the Akvo Flow office in New Delhi introduced the application to participants. Some of the topics covered were:

- Installing the app to tab
- Installing the GPS app
- Creating a user name
- Downloading survey questionnaires
- Exporting and cleaning data in Microsoft excel.

Unlike customary data collection methods using paper-based questionnaires, the Akvo Flow smartphone app has the following advantages:

- Bulk paper questionnaires are no longer needed in the field
- Less data collection errors due to programming among related questions within the app
- Completed household questionnaires can be submitted and uploaded whenever an internet connection is available, thus securing and backing-up completed forms
- Data entry is no longer needed

- Auto generates simple frequency tables in Microsoft excel with graphical presentation
- Harmonises household information data on Google maps with geo-coding.

Enumerators also attended a training from 30 June to 1 July 2014, which covered similar, but more relevant topics than the earlier training. In addition, roles of various team members, data collection techniques (including verbal translation of questions into local language), and field preparations were also introduced. The training programme began with theoretical sessions on Akvo Flow. Following the theoretical sessions, more practical oriented sessions on use of the app, setting GPS readings and submitting forms were briefed. Training included piloting of the household interview questionnaires and as a result, several questions were discussed in detail to make sure all team members had a good, common understanding.

Prior to fieldwork, pre-testing of the questionnaire was organised in Chengmari village. Its main objective was to familiarise questions and use of the smart phone/tablet. It also provided opportunity for enumerators to interview household members by speaking in local dialect, mainly Lhotshamkha, before data was uploaded to the online database. In doing so, inconsistent and unreliable data were highlighted by the consultant for corrective measures.

4.2.6. Data collection and quality control

A total of five teams, comprising six females and nine males in total, were engaged for just over a week to collect data through use of android smartphones. Each enumerator was provided with a smartphone to directly enter data. Further clarification was made on data collection techniques, such as different ways to ask questions, concise communication with respondents and role-plays, such as the first introduction to respondents and an explanation of the purpose of the visit. LCBs and SNV advisors guided and supported the enumerators to perform quality work in the field and provided feedback on the dashboard after monitoring.

During the field visits, logistic problems in one or two clusters were encountered where the local administration was unhelpful, possibly because the inception workshop is scheduled for later in the year.

However, the timing of the survey threatened the successful completion of fieldwork as the peak monsoon season and agricultural activities in villages interrupted the smooth data collection process. The team experienced road blockages and came across empty houses with household members busy with agricultural activities, primarily cardamom plantations, one of the main cash crops in Samtse district.

However, these teams did not encounter any technical problems, such with data collection. A random check of completed questionnaires showed appropriate and reasonable entries, aside from a small number of mistakes were shared with team supervisors and leaders for necessary corrections during the data cleaning phase.

Enumerators did not report any cases of households refusing to be interviewed, but said some houses were found abandoned or empty at the time of visit. In such cases, the next households were interviewed. However, some households were revisited to obtain a total sample if short. Overall, the survey team managed to obtain the required sample size and quality data within the planned survey duration.

4.2.7. Data processing and analysis

After the fieldwork, all e-forms submitted on the Akvo Flow dashboard were checked for accuracy and completeness before analysis. The data was then cleaned and verified for consistency and any missing values and errors, after which the syntax commands were generated to ensure variables are transformed into a qualitative information system for ease of analysis.

Data processing and analysis was undertaken by an SNV WASH advisor with technical guidance from IRC. Data processing and analysis entailed the following steps: 1) downloading data from the Akvo Flow app and performing an exploratory analysis to check for accuracy, completeness, relevance and consistency of critical data elements, 2) converting the downloaded data from Akvo Flow's online dashboard to excel format and 3) performing data cleaning.

5. Limitations

Since the sample size for the poorest wealth quintile to draw conclusions was minimal (less than 2% out of 370 households surveyed), for the purposes of this report only three instead of five wealth-ranking categories were used. However, for programme intervention purposes, special attention was paid to households that fell under the poorest wealth quintile category.

6. Findings

Gender compositions

Of the total respondents, 51% were male and 49% female. Of the total households interviewed, 84% were headed by men and 16% by women.

Sanitation context

The number of households (324) with a latrine accounted for 88% of households surveyed (370), with no relevant differences between sub-districts. Common toilet technologies included basic pit toilets (36%) and pour-flush toilets (64%), with observations indicating a number of common technical errors in latrine construction, use and maintenance. From the 370 households, about 75% met or exceeded the minimum requirements of a hygienic toilet.

7. Results and findings of Impact indicators

Overall summary of findings for impact indicators 1-4

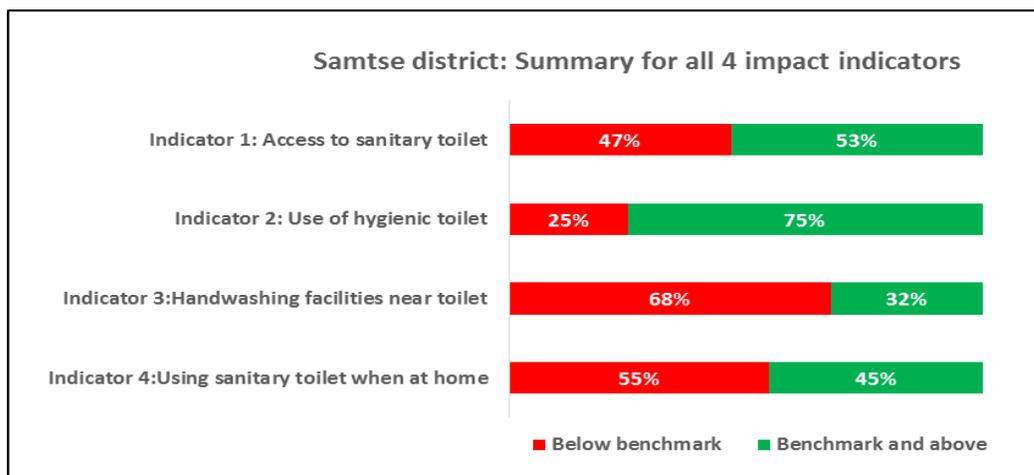


Figure 3. Overall summary of findings for impact indicators

7.1. Impact Indicator 1: Progress in number of households and people (male and female) with access to sanitary toilets

This indicator measures the design and quality of toilet construction. The status as found at the time of the baseline survey is depicted in Figure 4. Of the households with an improved toilet (53%) from levels 2 to 4, about half the population have pour-flush toilets considered the best option available in Samtse district villages. About 12% of all households did not have a toilet, but 42% of households had achieved the highest level as their toilets were environmentally safe. Of the 35% with access to a basic toilet, 9% shared other toilets (Level 1c) and 8% shared their toilet with others (Level 1b), whilst the remaining had unimproved toilets.

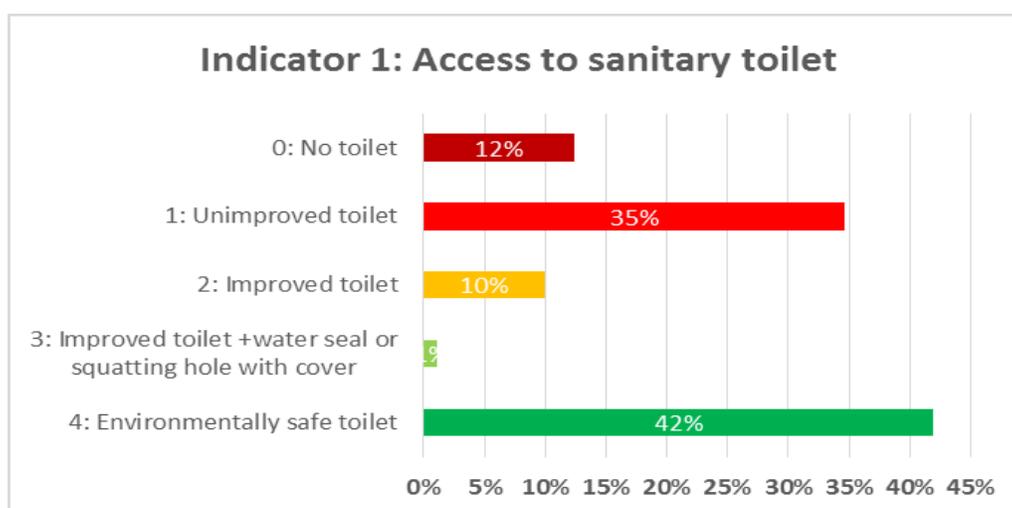


Figure 4. Access to sanitary toilets

Indicator 1a Progress in the number of households with access to a sanitary toilet

47% are below the benchmark: 35% of the households have access to an unimproved toilet and the remaining 12% of the households do not have a toilet. Part of these households without toilet may use a toilet of someone else (e.g. neighbour or relative) and part may be defecating in the open.

The baseline data revealed noticeable differences between various wealth quintiles in Samtse district. Almost three-quarters of the lowest two quintiles (75% of the poorest and 68% of the second lowest) fall below the benchmark, whereas all households of the richest wealth quintiles were above the benchmark. Only 23% of the fourth highest wealth quintiles did not have access to sanitary (improved) toilets. While households in the lowest two wealth quintiles have limited access to environmentally safe toilets, more than 56% of the two highest wealth quintiles have access to environmentally safe toilets.

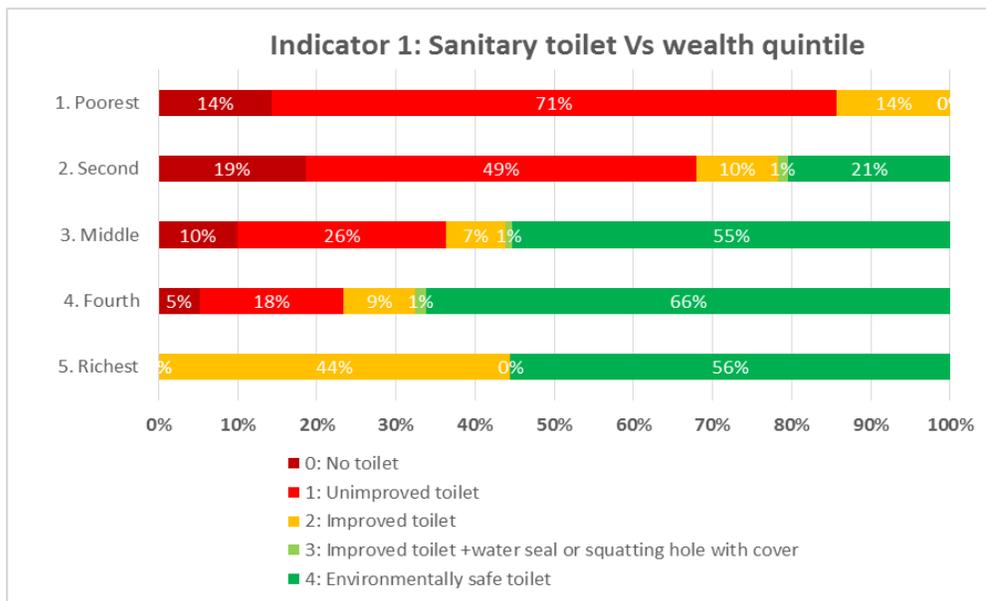


Figure 5. Sanitary toilet Vs wealth quintile

7.2. Impact Indicator 2: Progress in number of households and number of people (male and female) that use a hygienic toilet

This indicator measures the use and hygienic conditions of toilets. Some 21% of households in Samtse district do not make use of toilets. This means residents from one-in-five households defecate somewhere else other than a toilet. Almost three-quarters (75%) of total households (levels 2 to 4) met or exceeded the minimum requirements for a hygienic toilet (*toilets with functioning water seals or lids that completely cover the squatting hole, so rodents and flies cannot enter the pit or tank*). However, only 32% of households met the highest standards (*use anal cleansing materials and/or sanitary materials not exposed, as they are disposed of safely immediately after use*).

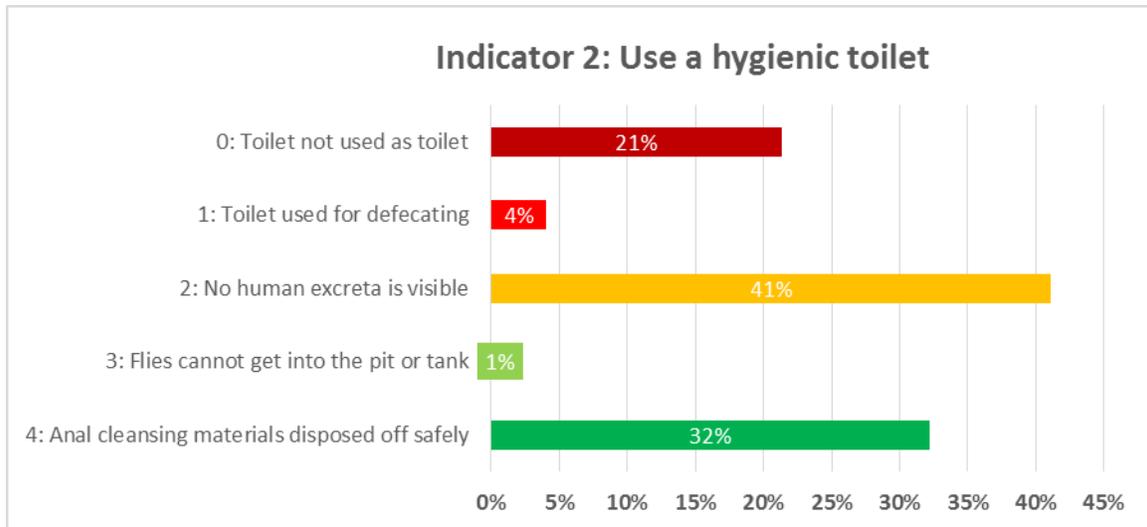


Figure 6. Use a hygienic toilet

Similar to findings for indicator one, the higher wealth quintiles performed far better than the lowest wealth quintiles in terms of making hygienic use of toilets. More than one-third of the lowest two quintiles (28% of the poorest and 38% of the second lowest) fell below the benchmark (*households either did not use toilets or use toilets, but not adequately prevent flies and rodents from entering pits/tanks*). Whereas all richest wealth quintile households were above the benchmark and only 17% of the fourth highest wealth quintile did not have access to sanitary (improved) toilets. While households in the lowest two wealth quintiles had limited access to environmentally safe toilets, more than 56% of the two highest wealth quintiles could access environmentally safe toilets, which is the highest level (*use anal cleansing materials and/or sanitary materials not exposed as they are disposed of safely immediately after use*).

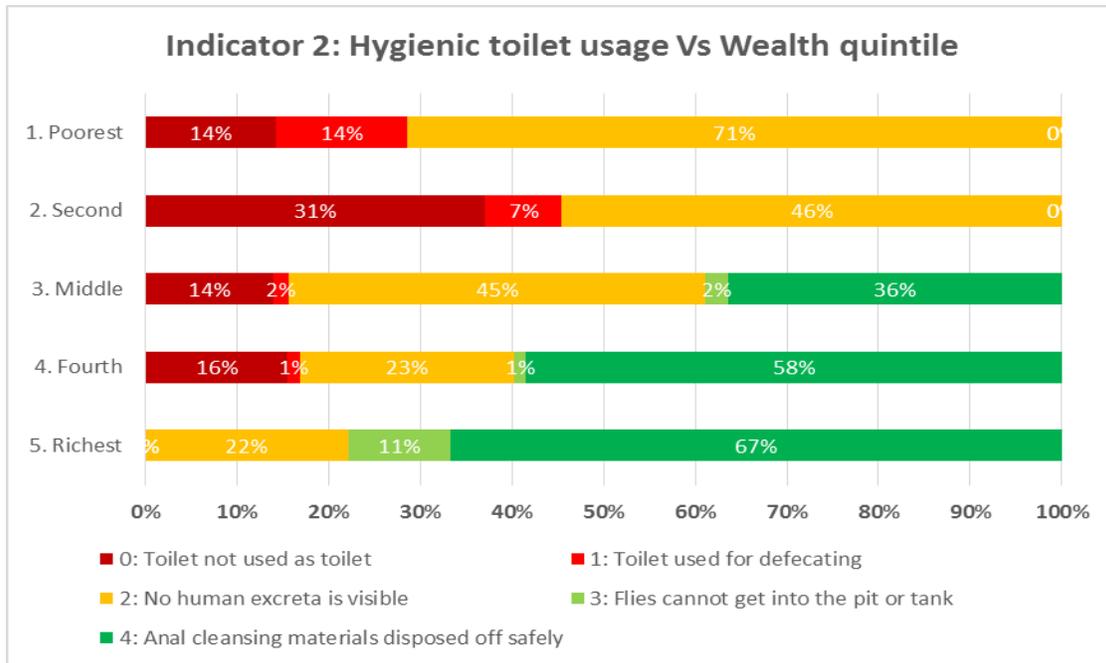


Figure 7. Hygienic toilet usage Vs Wealth quintile

7.3. Impact Indicator 3: Progress in number of households and number of people with adequate hand washing facilities in or near the toilet

This indicator measures the existence and quality of handwashing facilities in or near the toilet as a proxy indicator for safe practice handwashing behaviour with soap at critical junctures. Almost half (48%) of households in Samtse district did not have a specific place or facility for handwashing and 68% of households were below the benchmark (*household either had no specific place or facility for handwashing or had a designated place with water for washing hands located within 10 paces of the toilet, but did not prevent contamination of water*). Only 24% of households had a handwashing facility that used running piped water (that people or animals cannot contaminate) with soap. No soap was observed for 4% of households.

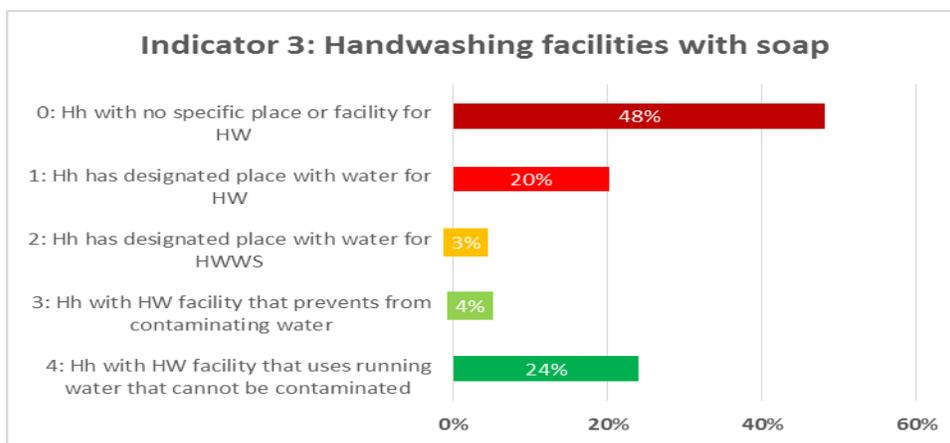


Figure 8. Handwashing facilities with soap

Indicator 3a Progress in the number of households with adequate facilities for hand washing with soap (or substitute)
 68% are below the benchmark = 1) absence of soap; 2) facility too far from the toilet; or 3) no facility at all.

Some major differences were noticed between different wealth quintiles. The higher wealth quintiles did far better than lower wealth quintiles. While 71% and 67% of poorest and second poorest wealth quintile households, respectively lacked a specified place or facility for handwashing, only 30% and 22% of fourth and richest wealth quintile households, respectively lacked facilities. Some 78% of the richest wealth quintile had a handwashing facility that used running water with soap.

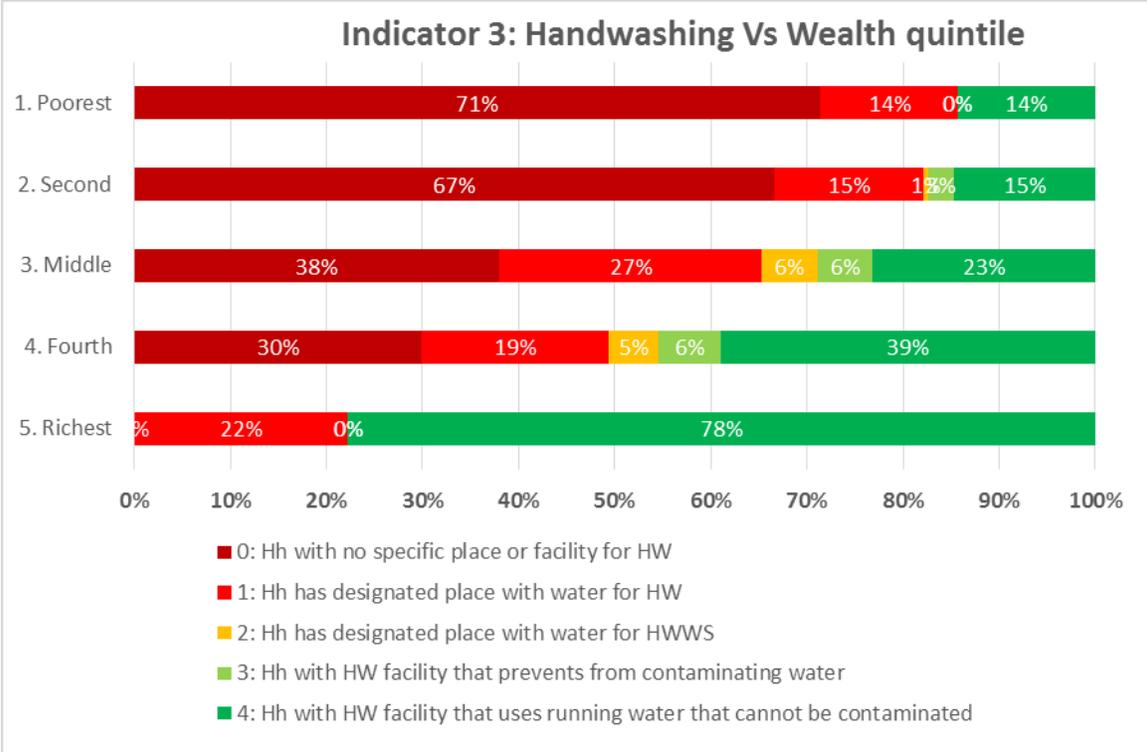


Figure 9. Handwashing Vs Wealth quintile

7.4. Impact Indicator 4: Progress in number of households and number of people (male and female) using a sanitary toilet when at home

This indicator assesses accessibility, convenience and privacy of toilet use and is a proxy indicator for toilet use by all household members at all times when at home. More than half of households (55%) were below the benchmark as they either did not use or the toilet was not accessible for all household members. It indicates the design, construction quality and location of toilets for the majority of households were not suitable for all household members.

Of note, almost 6% of households reported special needs access. Of these, 57% were at level one below the benchmark, as they were unable to use the toilet in comparison with an average of 33% for this level. A further 8% of households had

children under the age of 2 and of these, 42% were below the benchmark and 51% self-reported safe disposal of children’s faeces. However, care is needed when interpreting the latter percentage. Some 42% of households reported one or more person over the age of 50 year, but overall had higher access with 64% at the benchmark or above. Sixty of the 370 households were headed by females, of these 27% had no access in comparison to 20% for male-headed households. Some 55% of female-headed households who had toilets were at the benchmark or above in comparison to 45% of male-headed households.

Table 5: Use of toilet by all at all times

IMPACT INDICATOR 4: USE OF TOILET BY ALL AT ALL TIMES		
Level	Descriptions / mini scenarios	%
0	Toilet is not used	21
1	(i) Is visibly in use	33
2	(i) Is physically accessible for ALL at ALL times when at home including the elderly and disabled	5
BENCHMARK		
3	(i) Provides convenience and privacy for ALL at ALL times	0
4	(i) There is no visible evidence of children’s stools in or around the house and surrounding yard	40

Impact indicator 4 a: Progress in number of households and number of people (male and female) using a sanitary toilet when at home
55% are below the benchmark

8. Results and Findings of Outcome Indicators

8.1. Outcome Indicator 5: Progress in capacity of organisations to implement sanitation demand creation at scale and with quality

This outcome indicator is to be used by the lead agency responsible for implementing sanitation demand creation at district or sub-district levels, depending on which level is responsible for implementing demand creation activities.

8.1.1. National Level

Part A: General information

Table 6. Capacity scorecard for outcome indicator 5 at national level

Type of survey (✓)	Baseline	Regular annual performance monitoring	
Name of lead agency	PHED	Level	National
Name of location	Thimphu	Date of meeting	19/01/15
Participants in meeting/scoring exercise		Name(s)	Position(s)
Name of lead agency officials involved in the scoring exercise	Sonam Gyaltshen		Executive Engineer
Name of individuals (LCB and SNV) who facilitated the scoring exercise	Raj Kumar Bhattra		Advisor, WASH SNV

Part B: Capacity scorecard for outcome indicator 5

Organisational statements	Capacity scores				
	0	1	2	3	4
Your organisation					
1. Has a plan for implementing demand creation activities in their district/sub-district with attention to timing (e.g. season, other activities and when households have available cash to invest)				X	
2. Provides assessed training to facilitators in proven demand creation approaches to an adequate standard				X	
3. Provides follow-up to the facilitators after training in the form of guidance, coaching, motivation and/or support during implementation			X		
4. Regularly assesses the performance of facilitators responsible for demand creation and follow-up			X		
5. Uses the experiences and lessons learned to adjust or improve sanitation demand creation activities and/or facilitator training.				X	

Important notes:

Score 0=non-existent/absent; 1=areas of weakness; 2=acceptable; 3=positive strength; 4=fully present.

NARRATIVE PART FOR OUTCOME INDICATOR 5**Give a short summary of the main topics discussed during the meeting**

The following were topic of discussion:

- Plan for implementing demand creation activities in their district/sub-district
- Training of health assistants (facilitators) on demand creation approaches
- Capacity assessment of the facilitators

Justification for above scores

While PHED was involved in the expansion of the Rural Sanitation and Hygiene Programme in the pilot district of Pemagatshel, it was not engaged in the coordination and implementation of sanitation demand creation at scale. It plans to train health assistants and implement demand creation activities for two districts. However, PHED has acceptable levels of capacity to take the lead in coordination and implementation of sanitation demand creation at scale with quality.

8.1.2. District Level**Part A: General information****Table 7. Capacity scorecard for outcome indicator 5 at district level**

Type of survey (✓)	Baseline	
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Name of lead agency	Samtse Health Sector	Level	District
Name of location	Samtse	Date of meeting	23 Jan 2015
Participants in meeting/scoring exercise		Name(s)	Position(s)
Name of lead agency officials involved in the scoring exercise	Mr. Sonam Dorji Ms. Thinley Choden		DHO ADHO
Name of individuals (LCB and SNV) who facilitated the scoring exercise	Mr. Raj Kumar		Advisor, WASH SNV

Part B: Capacity scorecard for outcome indicator 5

Organisational statements	Capacity scores				
	0	1	2	3	4
Your organisation					
6. Has a plan for implementing demand creation activities in their district/sub-district with attention to timing (e.g. season, other activities and when households have available cash to invest)			X		
7. Provides assessed training to facilitators in proven demand creation approaches to an adequate standard		X			
8. Provides follow-up to the facilitators after training in the form of guidance, coaching, motivation and/or support during implementation			X		
9. Regularly assesses the performance of facilitators responsible for demand creation and follow-up		X			
10. Uses the experiences and lessons learned to adjust or improve sanitation demand creation activities and/or facilitator training.		X			

Important notes:

1. Additional details regarding monitoring protocol related issues are provided in a separate table on page 32 of Part 1 of the Performance Monitoring Guidelines.
2. The additional explanations and conditions for each score provided in Part 2 of the Performance Monitoring Guidelines | pages 26-28 are to be used during the scoring exercise to ensure consistency of scoring.

Narrative part for outcome indicator 5

Give a short summary of the main topics discussed during the meeting

The following were topic of discussion with the district health sector:

1. The current status of Sanitation and Hygiene Situations
2. The Baseline data
3. The CDH Workshops (demand creation) planning and execution plans
4. Working in partnership with the local government leaders and other sectors

within the districts.

Justification for above scores

Has a plan for implementing demand creation activities in their district/sub-district with attention to timing (e.g. season, other activities and when households have available cash to invest)

As this was a project initiated by SNV and PHED (national level), there wasn't a concrete plan as such initially for demand creation. However, the sanitation and hygiene promotion is a regular part of the District health sector's plans. The regular district health sector's plans were not as coordinated and organised like our project based activities. So initially, sanitation and hygiene promotion plans did exist but not as concrete and organised as we have developed after the project inception workshop in December 2014.

Provides assessed training to facilitators in proven demand creation approaches to an adequate standard

The district health sector does not provide training to facilitators in proven demand creation approaches as the trainings and courses were directly organised and coordinated by the national programmes and institutes. However, the district health sector does the assessment and nominate the relevant facilitators whenever, there is any trainings being organised by the programmes within the ministry or other agencies.

Provides follow-up to the facilitators after training in the form of guidance, coaching, motivation and/or support during implementation

The district health officers do have good working relationship with all the health assistants and always provide guidance, coaching and motivation. They also provide managerial and administrative support to all BHU health staff. But as such the demand creation activities and plans were not as coordinated and organised as stated above, specific forms of guidance and coaching and motivation and support for demand creation activities is hard to determine.

Regularly assesses the performance of facilitators responsible for demand creation and follow-up

Trainings and performance of the demand creation activities are not fully initiated and coordinated at the district level. But the sanitation and hygiene situation and status discussions do happen and there is recognition for regular follow up.

Uses the experiences and lessons learned to adjust or improve sanitation demand creation activities and/or facilitator training.

Sanitation and hygiene situation and status discussions happen and there is recognition for regular follow-ups. Annual household survey data is being compiled and presented whenever relevant. But, trainings and demand creation activities are not fully initiated and coordinated at the district level, the adjustment or improvement in

demand creation activities (as much coordinated as in our programme) did not happen.

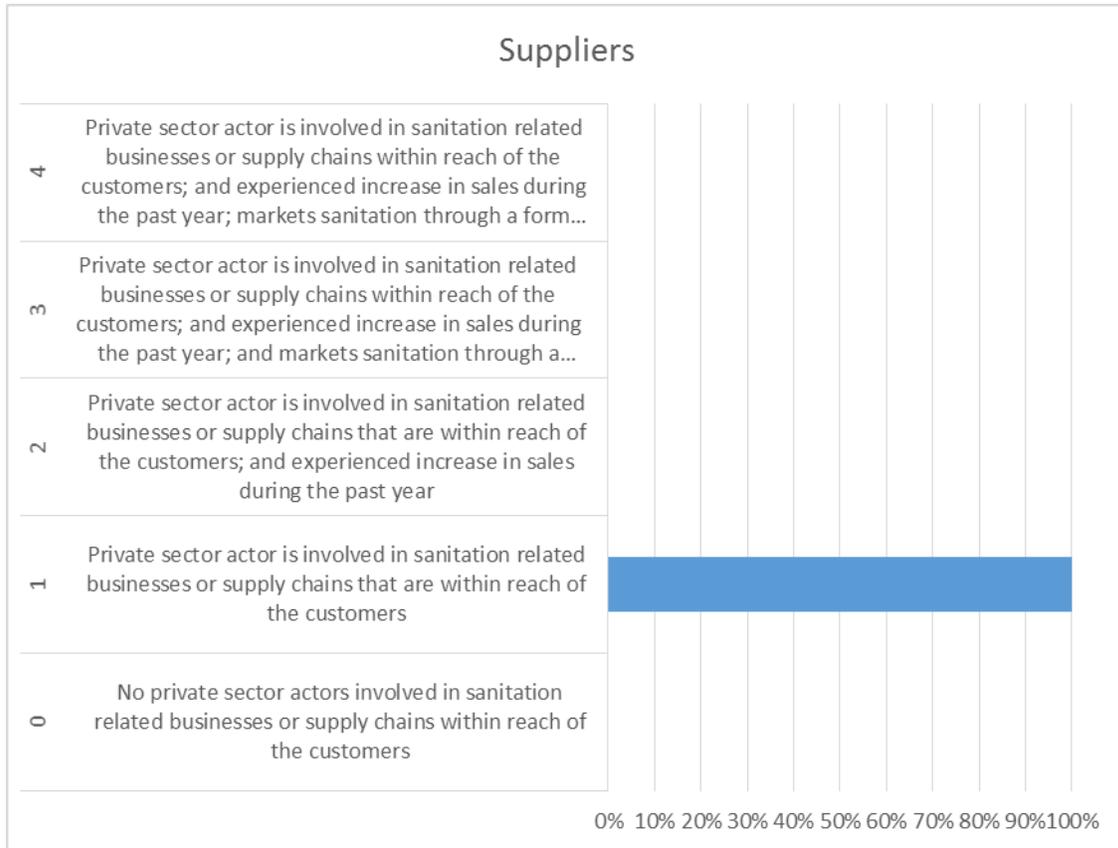
8.2. Outcome Indicator 6: Progress in sanitation services and business development

There are no sanitation hardware producers in Samtse district to produce items such as ceramic pans, fittings materials and pipes, which are all imported from India. The two existing suppliers, hardware shop and the cement agent are located in the district headquarter. The suppliers operate from the main town of the district with limited network/linkages with the rural shops/community. Transportation to rural communities is available, but at high cost. Masons and carpenters at the local level do provide construction services, though most households themselves are also active in providing unskilled or semi-skilled construction labour. Table 8 depicts the private sector actors' engagement in sanitation business in the programme area.

Table 8. Private sector actors engaged in sanitation businesses

Type of private sector actors engaged in sanitation businesses or related supply chains in the district	Total # of actors	Sex of entrepreneurs		
		Male	Female	Females in %
1. Sanitation hardware producers (#)	0	0	0	0
2. Shops/retailers (#)	1	1	1	50%
3. Cement sales agents (#)	1	1	1	50%
4. Masons/carpenters (#)	0	0	0	0
5. Pit emptying service providers (#)	0	0	0	0
6. Others, specify (#)				
Total number of private sector actors (#)	2	2	2	50%

Table 9. Scores and criteria for each of the scores of outcome indicator 6.



Since no marketing activities were undertaken nor clear information and ideas to increase sales of materials, the level of the suppliers' involvement was scored at 1.

In Samtse, the findings showed that there were only two suppliers (hardware shop and cement agent), both located in the district headquarters. Hardware materials (such as the ceramic pans, syphons, pipes and fittings materials) sold in the shop are all imported from India. The suppliers operate and sell from the main town of the district, with no marketing and linkages with the any rural shops.

The shops do not provide any delivery services, therefore the consumer needs to arrange their own transportation such as Bolero (mini pickup trucks) to travel, which makes the product more expensive to purchase.

Some masons do provide toilet construction services in the communities while most households themselves are also active in providing unskilled or semi-skilled construction labour. However households do encounter problems and make common mistakes when themselves build the toilets especially in laying the pan and syphon, simple measurements and the layouts.

8.3. Outcome Indicator 7: Progress with regards to increased capacity of local organisations to implement behaviour change communication at scale and with quality

National Level

This outcome indicator is to be used with the lead agency responsible for designing, planning, organising and implementing behaviour change communication activities.

Part A: General information

Table 10. Capacity scorecard for outcome indicator 7 at national level

Type of survey (✓)	Baseline		
Name of lead agency	PHED	Level	National
Name of location	Thimphu	Date of meeting	19/01/15
Participants in meeting/scoring exercise	Name(s)	Position(s)	
Name of lead agency officials involved in the scoring exercise	Sonam Gyaltshen, Sonam Pelzom	Executive Engineer, Engineer	
Name of individuals (LCB and SNV) who facilitated the scoring exercise	Thinley Dem	Advisor, WASH SNV	

Part B: Capacity scorecard

Organisational statements	Scores (one tick per statement)				
	0	1	2	3	4
Your organisation					
1. Has a BCC strategy or action plan that includes sanitation and hygiene focus behaviours and target groups in line with national guidance and/or plans				X	
2. Has a clear division of roles and responsibilities to implement the strategy or plan			X		
3. Has adequate human and financial resources to implement BCC activities in line with its strategy or plans			X		
4. Develops BCC based on formative research or evidence of motivators				X	
5. Tests effectiveness of messages and approaches with the target audience		X			
6. Provides training to facilitators or other implementers in BCC approaches to an adequate standard			X		

Organisational statements	Scores (one tick per statement)				
	0	1	2	3	4
7. Regularly assesses the performance of facilitators or others responsible for BCC interventions		X			
8. Reviews approaches based on monitoring or lessons learned		X			
9. Monitors the usage and effectiveness of BCC materials			X		
10. Adapts or tailors the approaches and messages based on the changing context, lessons learned and/or specific target populations				X	

Important notes:

Score 0=non-existent/absent; 1=areas of weakness; 2=acceptable; 3=positive strength; 4=fully present.

Narrative part for outcome indicator 7

Give a short summary of the main topics discussed during the meeting

The following topics were discussed:

1. BCC Strategy
2. Formative Research and development of communication materials

Justification for above scores

Behaviour Change Communication Strategy

A draft strategy has been developed for the Rural Sanitation and Hygiene Programme and the BCC strategy will be part of it (four components of the RSAHP). Based on the experience from Lhuntse and Pemagatshel, the National strategy will contain communication objectives and messages, which will be tested. BCC strategies were developed for Lhuntse and Pemagatshel, similarly a district strategy will be developed for Samtse following the National strategy.

Formative Research and development of materials

A focal person for the BCC component has been appointed within.

PHED was part of the National study (2014) from the very beginning till the end of the study, which gave them a better insight on the formative study using the FOAM framework. In Lhuntse and Pemagatshel formative study has been carried out and based on the findings materials were developed and tested targeting different population. This will also be carried for Samtse district.

District Level

Part A: General information

Table 11. Capacity scorecard for outcome indicator 7 at district level

Type of survey (✓)	Baseline		
Name of lead agency	PHED	Level	District level
Name of location	Thimphu	Date of meeting	23/01/15
Participants in meeting/scoring exercise		Name(s)	Positions
Name of lead agency officials involved in the scoring exercise	Sonam Dorji Thinley Choden	DHO ADHO	
Name of individuals (LCB and SNV) who facilitated the scoring exercise	Thinley Dem	Advisor, WASH SNV	

Part B: Capacity scorecard

Organisational statements	Scores (one tick per statement)				
	0	1	2	3	4
Your organisation					
1. Has a BCC strategy or action plan that includes sanitation and hygiene focus behaviours and target groups in line with national guidance and/or plans	x				
2. Has a clear division of roles and responsibilities to implement the strategy or plan	x				
3. Has adequate human and financial resources to implement BCC activities in line with its strategy or plans	x				
4. Develops BCC based on formative research or evidence of motivators	x				
5. Tests effectiveness of messages and approaches with the target audience	x				
6. Provides training to facilitators or other implementers in BCC approaches to an adequate standard	x				

Organisational statements	Scores (one tick per statement)				
	0	1	2	3	4
7. Regularly assesses the performance of facilitators or others responsible for BCC interventions	x				
8. Reviews approaches based on monitoring or lessons learned	x				
9. Monitors the usage and effectiveness of BCC materials	x				
10. Adapts or tailors the approaches and messages based on the changing context, lessons learned and/or specific target populations	x				

Important notes:

Score 0=non-existent/absent; 1=areas of weakness; 2=acceptable; 3=positive strength; 4=fully present.

Narrative part for outcome indicator 7

Give a short summary of the main topics discussed during the meeting

The Following were topics that was discussed:

1. Action Plan and BCC strategy
2. Hygiene Promotion and Materials development
3. Formative research

Justification for above scores

Action Plan and BCC strategy

There is no District Action Plan and specific strategy for BCC, but there is a work plan which includes hygiene promotion. Hygiene promotion is carried out by the health assistants during the Out Reach Clinics (ORC), but this can also be seen as a challenge as ORCs are mainly for vaccinations, MCH and OPD and sanitation and hygiene promotion is given less priority. The District Health sector expects PHED and SNV for developing action plans and strategy for BCC as BCC is one of the four components for the Rural Sanitation and Hygiene Programme.

Hygiene Promotion and Material Development

Hygiene promotion is carried out during ORCs, there are no structured plans separately for hygiene promotion. Communication materials are developed at the national level and then distributed to the districts. Almost all the materials developed are knowledge-based (IEC

materials) and doesn't focus much on motivations or barriers.

Formative Research

Studies were not carried out for BCC/to understand people's motivation and barriers to certain behaviours, therefore the health officials (districts/sub-districts) will not have much idea on it. PHED along with SNV has conducted a formative study on sanitation and hygiene behaviours and Samtse was one of the study areas. The district health officials were part of it and they were introduced to the FOAM framework used for collecting the data. The district health sector is interested in the study report and request PHED and SNV to share it as soon as it is finalized so that they know the area of focus for intervention.

8.4. OUTCOME INDICATOR 8: Progress in capacity of local line agencies to steer and monitor performance in rural sanitation and hygiene

This outcome indicator is to be used with the lead agency responsible for the rural sanitation and hygiene sector at the district or sub-district level to steer and monitor performance in rural sanitation and hygiene.

National Level

Part A: General information

Table 12. Capacity scorecard for outcome indicator 8 at national level

Type of survey (✓) Baseline

Name of lead agency	Samtse Health Sector	Level	National
Name of location	Samtse	Date of meeting	19 Jan 2015
Participants in meeting/scoring exercise		Name(s)	Position(s)
Name of lead agency officials involved in the scoring exercise	Sonam Gyaltshen		Executive Engineer
Name of individuals (LCB and SNV) who facilitated the scoring exercise	Raj Kumar		Advisor, WASH, SNV

Part B: Capacity scorecard

Organisational statements	Scores				
	0	1	2	3	4
Your organisation ...					
1. Sets priorities and targets for investment in rural sanitation and hygiene in line with national policies and planning documents and on the basis of local				X	

Organisational statements	Scores				
	0	1	2	3	4
information					
2. Has a plan for implementing sanitation and hygiene activities in their district/sub-district to achieve their targets				X	
3. Ensures that there are human and financial resources to implement the plans			X		
4. Has a clear division of roles and responsibilities to implement the plan				X	
5. Gives active follow-up and enforces agreements on the above.				X	
6. Has a monitoring system that measures progress on sanitation and hygiene targets at village and district level				X	
7. Ensures that information on progress is shared, analysed and discussed with relevant village and district level stakeholders				X	
8. Ensures that monitoring includes data that assesses inclusion of all groups within the villages, including people with a disability.			X		
9. Reviews the status of villages to assess the sustainability of coverage/ access to sanitation			X		
10. Uses the data from monitoring, experiences and lessons learned to adjust or improve implementation plans when relevant				X	

Notes:

1. Additional details regarding monitoring protocol related issues are provided in a separate table on page 37 of Part 1 of the Performance Monitoring Guidelines.
2. The additional explanations and conditions for each score provided in Part 2 of the Performance Monitoring Guidelines | Pages 40-41 are to be used during the scoring exercise to ensure consistency of scoring.

Narrative part for outcome indicator 8
Give a short summary of the main topics discussed during the meeting
Same as above (Indicator 5)

Justification for above scores
<p>The reasons are same as above.</p> <p>The monitoring and assessing process is based on the annual household surveys which is technically directed by the Health Information and Management Division and Public Health Engineering Division of the ministry. As the data collection is a total census on most of the sanitation and hygiene and other health, demographic data are collected and reported.</p>

District Level

Part A: General information

Table 13. Capacity scorecard for outcome indicator 5 at district level

Type of survey (✓) Baseline			
Name of lead agency	Samtse Health Sector	Level	District
Name of location	Samtse	Date of meeting	23 Jan 2015
Participants in meeting/scoring exercise		Name(s)	Position(s)
Name of lead agency officials involved in the scoring exercise	Sonam Dorji and Thinley Choden		District Health Officer (DHO) and (ADHO)
Name of individuals (LCB and SNV) who facilitated the scoring exercise	Raj Kumar	Advisor, WASH, SNV	

Part B: Capacity scorecard

Organisational statements	Scores				
	0	1	2	3	4
Your organisation					
11. Sets priorities and targets for investment in rural sanitation and hygiene in line with national policies and planning documents and on the basis of local information		X			
12. Has a plan for implementing sanitation and hygiene activities in their district/sub-district to achieve their targets			X		
13. Ensures that there are human and financial resources to implement the plans		X			
14. Has a clear division of roles and responsibilities to implement the plan			X		
15. Gives active follow-up and enforces agreements on the above.		X			
16. Has a monitoring system that measures progress on sanitation and hygiene targets at village and district level		X			

Organisational statements	Scores				
	0	1	2	3	4
17. Ensures that information on progress is shared, analysed and discussed with relevant village and district level stakeholders		X			
18. Ensures that monitoring includes data that assesses inclusion of all groups within the villages, including people with a disability.			X		
19. Reviews the status of villages to assess the sustainability of coverage/ access to sanitation		X			
20. Uses the data from monitoring, experiences and lessons learned to adjust or improve implementation plans when relevant		X			

NARRATIVE PART FOR OUTCOME INDICATOR 8
Give a short summary of the main topics discussed during the meeting
Same as above (Indicator 5)
Justification for above scores
<p>The reasons are mostly same as above.</p> <p>The monitoring and assessing process is based on the Annual Household surveys, which are technically directed by the Health Information and Management Division and Public Health Engineering Division of the ministry. As the data collection is a total census on most of the sanitation and hygiene and other health, demographic data are collected and reported.</p>

8.5. Outcome indicator 10. Progress in the degree of influence of poor households during planning and implementation of sanitation and hygiene programmes

Outcome indicator 10 measures the progress in the degree of influence of poor households during planning and implementation of sanitation and hygiene programmes. This outcome indicator will be measured during focus group discussions in the programme target villages. It will assess the actual influence poor households have in sanitation and hygiene programmes as evidence of more inclusive decision making. From the baseline survey, a substantial percentage (44%) of sample households belonged to either poor or poorest wealth quintiles. About 12% of sample households that belonged to either poor or poorest wealth quintiles did not have a toilet. More than three fourth (77%) of the two lowest wealth quintiles fall below the benchmark in terms of access to sanitary toilet as compared to only 12% of the two higher wealth quintiles. Some 34% of sample households that belonged

to either poor or poorest wealth quintiles did not use the toilet as a toilet. 84% of sample households that belonged to either poor or poorest wealth quintiles did not have handwashing facilities near the toilet.

Throughout the programme cycle, the sanitation status and hygiene practice of the above mentioned 44% would be closely monitored for improvement. Furthermore, the participation rate and the influence on decision making during planning and implementation of sanitation and hygiene programmes of the households belonging to the poor and poorest wealth quintiles would be measured during the demand creation activities (such as the CDH workshops, one day meetings, multi-stakeholder inception meetings), BCC interventions.

8.6. Outcome indicator 11: Influence of women during planning and implementation of sanitation and hygiene programmes

This outcome indicator will be measured during focus group discussions in sample clusters of Samtse district after the initial baseline information on this collected during the community development for health workshops. After the priority Gewogs/clusters were chosen, the programme will collaborate with Tarayana Foundation to conduct focus group discussions through the existing women groups already formed by Tarayana foundation in Samtse.

Furthermore, the national formative research on gender that was conducted in August/September 2014 also included three Gewogs in Samtse district as study sites. These Gewogs were Tading, Yoseltse and Sipsu Gewogs. Findings from this study also provides good baseline on the role of rural women in rural sanitation and hygiene and more particularly on their role in household level sanitation and hygiene, their decision making influence at the household level decision making related to sanitation and hygiene, their participation and influence on decision making at the community level and their privacy, safety and mobility issues.

The study findings validate that gender relations at the household level and in the community were greatly influenced by factors such as culture and remoteness of the Gewogs. In the Lhotshampa (Nepali speaking) communities in Tading and Sipsu Gewogs, the clear division of roles between the women and men within HHs in terms of WASH-related activities was very prominent where the women and men saw women more fit to take care of HH work, as compared to Yoseltse Gewog where there is a mix of Lhotshampa and Zhi Sar (people from northern, western and eastern part of Bhutan who have resettled in the southern areas including in Samtse) communities. The belief by both women and men that HH work is the domain of the women was stronger in the more remote villages with less road accessibility (such as the villages under tading Gewog). The caste system in the Lhotshampa communities played a crucial role on persistent beliefs on gender relations with division of labour being more distinct amongst the HHs from the upper castes. Furthermore, for Lhotshampa HHs in Samtse, the change in gender attitude was not as much as in other districts. In addition, the beliefs of both women and men that women need to

serve men amongst others were strong in these HH compared to other districts and Zhi Sar HHs in Samtse.

Implications/Recommendations: Since factors such as culture and remoteness affected WASH-related division of labour in the household, it becomes imperative that the issues need to be addressed by approaches that are sensitive to culture, whatever cultural issues prevail in any community and that this work might be expected to need a more intensive and longer-term approach in locations where traditional gender roles have so far changed little, due to distance/remoteness lack of exposure to changing norms. At the same time due to the differences in relation to cultural/regional differences, we need to ensure that messages are conveyed in ways that are acceptable in local contexts, i.e. cultural and language specifics are recognisable to different audiences, that different audiences can both access the materials (i.e. are available and are not in a language they can't understand) 'see themselves' in, and identify with the messages rather than feeling that the messages relate to someone else but not to them.

In terms of decision making at the household level, the major decisions are made by men in all the three districts including in Samtse for social/cultural and economic reasons. These include decisions for toilet construction i.e. type and location of toilet. Decision-making at the HH level was linked directly with income. Whoever earned an income from the HH also had the decision making power in all the areas visited. Additionally both women and men thought that the men were better placed for decision-making as they have "more exposure, networks, know more." In terms of differences in the findings between different regions/culture, it was found that some degree of joint decision-making took place in non-Lhotshampa communities whereas in the Lhotshampa communities (such as in Samtse), it was mostly the men who made decisions at the HH level.

Implications/Recommendations: Since decision making at the HH level is directly linked with income, it becomes imperative that women need to be provided with better economic generating opportunities such as giving them skills for income generation (as masons/or as sanitation suppliers) for them to have a say on decision making at the HH level which will eventually lead to women's participation in decision making at the community level.

Majority of the leaders at all levels are men and the decisions for any development activities are thus made by men. At the district, the key positions were mostly headed by the men for both the technical and administrative roles and similarly in all the villages of the three districts, there were more men compared to women in leadership posts (such as the Dzongda, Dzongrab, sector heads). All working women at the Gewog levels (such as Mangmis, Tshogpas, Community Centre Coordinators, Treasurers and Secretaries of farmers' groups and cooperatives) were working under a male boss. These women have limited decision-making power.

Implications/Recommendations: RSAHP must ensure that for any RSAHP activity discussions and decisions held at the district level, ways to engage more women participants is actively sought. Additionally, the representatives present at the discussion meetings need to represent the needs, interests and concerns of both women and men in sanitation.

In the study, the women's and men's focus group discussions were conducted separately. The study team observed that the women were more vocal and active during the women only group discussions than in the mixed-group discussions. The women were found to be quieter in the mixed groups where the men were not hesitant to give their views and opinions; the women sat at the back in the mixed group discussions; women from Lhotshampa HHs were found to be even more quieter than the women from the Zhi Sar HHs, male Tshogpas/other local leaders were dominating the mixed group discussions.

Moreover, in Lhotshampa communities in Samtse the women faced more social restrictions on their mobility. The study also brought to light so many barriers to women's participation in discussions when the meeting places were far away from their villages.

Implications/Recommendations: The RSAHP needs to be sensitive of these restrictions and need to look at addressing this issue in two ways: one, by sensitizing the men on the importance of having women participate in meetings/trainings and discussions; second, by bringing the training/meeting venues closer to the homes of the women so that they do not have to stay overnight and away from their homes (to avoid women from getting in troubles with their husbands at home).

8.7. Outcome indicator 12: Influence of socially excluded groups during planning and implementation of sanitation and hygiene programmes

Outcome indicator 12 measures the influence of poor households and socially excluded groups in sanitation and hygiene programmes as evidence of more inclusive decision-making. As there is no official wealth ranking in the Gewogs, the identification of the poor HHs would be done in consultation with the local Gewog leaders with a particular emphasis on the royal kidu/destitute allowance recipients including single female headed HHs. Socially excluded groups in Samtse will focus on the persons living with a disability (that will influence their access to sanitation and hygiene) which as per the baseline survey is about 5% of the rural population. The upcoming research on disability to better understand the impact disability has on access to safe sanitation and hygiene; the barriers to participation to development activities with a particular focus on sanitation and hygiene activities; and opportunities to address the identified barriers, will provide more baseline information to access, monitor and increase the influence of socially excluded groups (persons living with a disability) during planning and implementation of sanitation and hygiene programmes. For this research, the programme will collaborate with a relevant local CSO.

9. Discussion

9.1. Impact Indicator

9.1.1. With access to sanitary toilets

- The proportion of households with improved sanitation has increased by only 11% over four years {from 42% in 2010 (BMIS) to 53% in 2014 (Baseline survey)}. As revealed, although, the majority of households have toilets, there are still significant proportions of households who do not have a toilet (12%). During the programme implementation activities, first priority and attention have to be given to not only upgrading, but eliminating open defecation.
- The proportion of households with unimproved toilets and/or sharing (47%) needs more focus and immediate attention to upgrade and improve, otherwise the risks of slippage and public health concerns would continue despite high toilet coverage.
- Affordability and access to financing mechanism have to be taken into consideration while promoting toilet technology options. During the programme activities, needs of poorer households and households with disabled/older members have to be given appropriate guidance.

9.1.2. Hygienic use and sanitation

- The study indicated that 79% of the households in Samtse were using toilet and remaining 21% do not have toilet facility or use a toilet for defecation. Of the 79%, 4% of the households do not meet or succeed the minimum requirements of a hygienic toilet. Therefore in total 25% of the Households) in Samtse District do not have access to toilet and or do not use the toilet hygienically.
- During the cross tabulation between the Hygienic use of toilet and the wealth quintiles, interestingly there is a huge difference between the higher and lower wealth quintiles. The higher wealth quintiles were doing far better with (some 92% at or above benchmark) than the lowest two wealth quintiles (with some 66% at or above the benchmark). These means that the focus of the BCC programme interventions must be on the lower wealth quintiles.

9.1.3. Access to hand washing facility in or near toilet

- The findings show that 48% of the households had no handwashing facility in or near the toilet and 32% of the households have a handwashing facility that may or may not prevent contamination. Only 20% of the households have a basic handwashing facility. Out of the four levels of the wealth quintile, 84% (below bench mark) of the households who do not have adequate facilities for hand washing with soap belong to the lowest wealth quintile as compared to only 36% of the households from richer wealth quintiles. There is a high access to soap though. In response the BCC activities should focus on proximity to toilet facility as the first priority in conjunction with hygienic usage.

9.1.4. Use by all when at home

- There are a number of issues reflected in the data for level one. Firstly, for 33% of households the designs and or locations of the existing facilities are presenting barriers to some or all members of the households. Whilst members with special needs are over represented in this figure this does not explain the majority of responses in this level. Households with small children (10%) had comparable access to those without whilst households with members over 50 years had better access. This issue needs to be further explored as the programme is implemented. The study showed that the households that fall in the two lowest wealth quintile rankings have a significant proportion (80%) whose toilet is not accessible to all members of the household either due to the location and/or design of the toilet..

9.2. Outcome Indicators

9.2.1. Capacity of organisations to implement sanitation demand creation at scale and with quality

- The assessment at national level revealed that PHED in general has acceptable level of capacity at 65% to plan and implement sanitation demand creation at scale and with quality. However it lacks capacity in terms of providing guidance, coaching, motivation and support to the district facilitators during programme implementation. Further, it also has inadequate capacity to regularly assess the performance of district facilitators responsible for demand creation and follow-up activities.
- The assessment at district level revealed that Samtse district has very limited capacity at only 33% to plan and implement sanitation demand creation activities. It is because the structured and improved sanitation and hygiene programme is not yet introduced in Samtse district.

9.2.2. Sanitation services and business development

- The two suppliers (a hardware shop and the cement agent) that exists in Samtse are located in the district headquarter beside the Indian suppliers across the Bhutan border. They operate from the main town with no marketing activities and linkages with the rural communities and also do not provide any delivery services. Thus the consumer needs to gather information on the toilet materials required and arrange their own transportation to travel, which makes it difficult and the product more expensive to purchase. The limited access to the hardware materials, information on the materials required, and its cost and technology options appeared to be the hurdle for the consumer. Masons are available in the community and it seems most households are also active in building their own toilets though compromises are being made on the quality of the toilets built. As such, it indicates a need for further study on the barriers and drivers to SME engagement, and the nature of program support required to stimulate this.

9.2.3. Capacity of local organisations to implement behaviour change communication at scale and with quality

- At the national level, PHED has acquired acceptable level (50%) of capacity to implement BCC at scale and with quality. However it lacks capacity in terms of developing and testing effectiveness of messages and approaches with the target audience. It also lacks capacity to regularly assess the performance of facilitators or others responsible for BCC interventions and reviews approaches based on monitoring or lessons learned.
- At district level, while there is overall sanitation and hygiene work plan which includes hygiene promotion, there is no specific BCC strategy and action plan. As such, the district capacity to implement BCC is very limited at only 25%.

9.2.4. Capacity of local line agencies to steer and monitor performance in rural sanitation and hygiene

- At the national level, PHED has acquired acceptable level (68%) of capacity to steer and monitor performance in rural sanitation and hygiene. However it lacks specific capacity in terms of ensuring that monitoring includes data that assesses inclusion of all groups within the villages, including people with a disability, lacks capacity to reviews the status of villages to assess the sustainability of coverage/access to sanitation. Also one of the main challenges is ensuring adequate human and financial resources to implement the plans.
- The assessment at district level revealed that Samtse district has very limited capacity at only 35% to steer and monitor performance in rural sanitation and hygiene. It is because the structured and improved sanitation and hygiene programme is not yet introduced in Samtse district.

9.2.5. Participation and degree of influence of poor households, women and socially excluded groups in sanitation and hygiene programmes

- The assessment revealed that a substantial percentage (44%) of sample households belonged to either poor or poorest wealth quintiles. The formative research on gender showed that decision making at the household including for construction of toilets are mostly made by men while most of the household work including for sanitation and hygiene purposes are mostly done by women. The baseline assessment showed around 5% from the total sampled households living with a disability. Thus, throughout the programme cycle, ample attention will be given to monitor and improve the sanitation and hygiene status of these groups. Furthermore, emphasis will also be placed to ensure that these groups participate in and influence on decision making during sanitation and hygiene programme activities.

10. Conclusions and Recommendations

The baseline survey results presented in this report should be seen as a basis to plan and design interventions to accelerate progress in sanitation and hygiene. This can be done by strengthening professional and organisational capacity of national and

local governments, private sector and other sector stakeholders (*change agents*) for more effective service delivery in rural sanitation and hygiene to achieve full coverage in all 15 sub-districts of Samtse district.

Based on the findings of this baseline survey, the following recommendations are made for the programme:

1. Immediate focus of programme activities should be to elevate households up to the benchmark level for access to sanitation, hygienic usage and handwashing with soap.
2. During one-day Gewog or sub-district meetings, when targets are set and action plans drawn up, specific attention should be given to mobilise, motivate and inspire households to build, improve and/or upgrade toilets.
3. During CDH workshops, regular follow-up and masonry trainings should discuss different technology options, advantages, affordability and applicability for differently abled people with options offered to households. Information and guidance on availability and access to sanitary hardware materials and services should also be shared with households. Identification and development of support mechanisms that can address barriers to improved sanitation for the poorest and most vulnerable (44% of the lowest wealth quintile do not have access to hygienic toilet, out of which 10% may never be able to afford a latrine). However, care and attention needs to be ensured during the implementation of such mechanism. Since households in the two lowest wealth quintile rankings have a significant proportion (61%) of toilets not accessible to all household members, particular emphasis on location and design of toilets to suit all household members, including those with children or living with a physical disability, should be stressed during technology discussions at CDH workshops.
4. Pro-poor support mechanism and financing can be discussed, designed and debated at the local government levels.
5. With one-fourth of the population below the hygienic quality of toilets benchmark and two-thirds below the benchmark in terms of access to a handwashing facility near a toilet, strategic BCC approaches and activities must be developed based on focus behaviours for different target groups. Emphasis should be placed on the poorest households who are overrepresented below the benchmark standards to improve and enhance usage of hygienic toilets and handwashing facilities. Communication materials could focus on motivations, not necessarily information or knowledge, for households and schools.
6. Targeted interventions and support should be provided to potential suppliers (SMEs and masons, in particular) to encourage and demonstrate new business strategies to respond to consumer needs and preferences.
7. The RSAHP must ensure the poorest in each Gewog are included in WASH awareness interventions and during CDH workshops, as their toilets are largely below the benchmark.

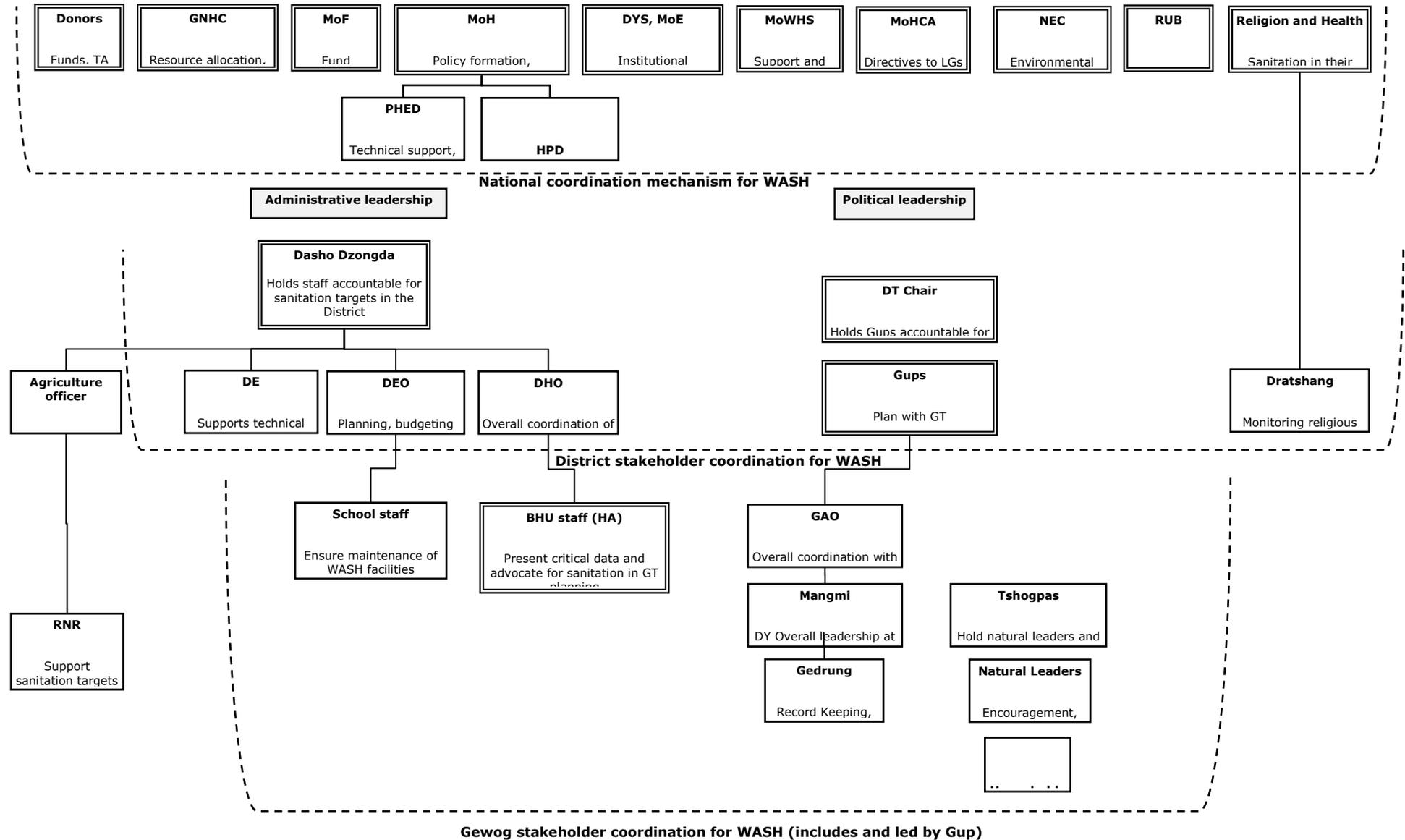
8. The capacity of PHED at national level must be enhanced in terms of to:
 - a. Provide guidance, coaching, motivation and support to district facilitators during programme implementation and regularly assess the performance of district facilitators responsible for demand creation and follow-up activities
 - b. Develop and test the effectiveness of messaging and approaches to target audiences and regularly assess the performance of facilitators or others responsible for BCC interventions as well as review approaches based on monitoring or lessons learned
 - c. Ensure monitoring includes data that assesses inclusion of all groups in villages, including people with disabilities
 - d. Ensure capacity exists to review the status of villages with regards monitoring universal access and sustained changes in sanitation and hygiene behaviour and practices.
9. Design and implement capacity strengthening initiatives for stakeholders in Samtse district and build capacity in terms of to:
 - a. Implement sanitation demand creation and follow-up activities
 - b. Implement a specific BCC strategy and action plan
 - c. Guide and monitor performance in the rural sanitation and hygiene programme.

11. References

1. Statistical Yearbook of Bhutan (2012), National Statistics Bureau, Royal Government of Bhutan
2. Annual Health Survey (2014), Ministry of Health, Royal Government of Bhutan
3. Bhutan Multiple Indicator Survey (2010), National Statistics Bureau, Royal Government of Bhutan
4. Gross National Happiness Commission 2012, Guidelines for the 11th Five Year Plan, RGoB, <http://www.gnhc.gov.bt/?s=11th+FYP>
5. 11th FYP Health Sector (2013), GNHC, Royal Government of Bhutan
6. SNV and IRC (January 2014) Performance Monitoring Guidelines for the Rural SSH4A Multi-Country Programme in Asia; Part 1 | Guidelines; Version 2
7. SNV (April 2014) Guidance Note: Wealth disaggregated impact monitoring in SNV's WASH sector

12. Annexure

12.1. Annexure-A: Roles and Responsibilities in Rural Sanitation and Hygiene



12.2. Annexure-B: Household survey questionnaires

RURAL SANITATION AND HYGIENE PROGRAMME (RSAHP) BASELINE STUDY

Part A: General Information

Head of Household:.....	Village name:.....
Chiwog name:.....	Geog:.....
Respondent Sex/Age.....	
Data collector's name:.....	Date of data collection:.....

Household composition

What is the household composition? In #

Number of male HH members (#)

Number of female HH members (#)

Total number of HH members (#)

Additional information

Number of male HH members with physical disabilities (#)

Number of female HH members with physical disabilities (#)

Total number of HH members with a physical disability (#)

Defecation practices

Where do you and your family members defecate? Tick

Use our own toilet (✓)

Use toilet of others (e.g. neighbours or relatives) (✓)

Use public toilets (✓)

Do not use any toilet (open defecation) (✓)

If you own a toilet, is it also used by other people on a regular basis (e.g. neighbours or relatives)? Tick

YES (✓)

NO (✓)

Access to sanitation facilities at household level

If the HH owns a toilet, what type of toilet and how many of each type? #

- Pit latrine (direct drop pit with squatting slab) (#)
- Ventilated improved pit (VIP) latrine (#)
- Pour-flush latrine with pan and water seal and direct drop pit/tank (#)
- Pour-flush latrine with pan water seal and with offset pit(s)/tank(s) (#)
- Flush toilet (with automatic flushing mechanism) (#)
- Composting toilet (e.g. Ecosan) (#)
- Other type of toilet (#)

Part B: Households assets

Source: (Bhutan Multiple Indicator Survey (BMIS))

HOUSEHOLD CHARACTERISTICS		HC
HC2. HOW MANY ROOMS IN THIS HOUSEHOLD ARE USED FOR SLEEPING?	Number of rooms	
HC2A. HOW MANY ROOMS ARE THERE IN THIS DWELLING UNIT? (Exclude toilet and kitchen)	Number of rooms	
HC3. Main material of the dwelling floor. <i>Record observation.</i>	<u>Natural floor</u> Earthen / clay floor 11 <u>Rudimentary floor</u> Planks / shingles 21 Bamboo 22 <u>Finished floor</u> Polished wood 31 Tiles / marble..... 33 Cement / concrete / terrazzo 34 Other (<i>specify</i>) 96	
HC4. Main material of the roof. <i>Record observation.</i>	<u>Natural roofing</u> No Roof..... 11 Thatch 12 <u>Rudimentary Roofing</u> Bamboo 22 Planks / shingles 23 Cardboard..... 24 Tarpaulin..... 25 <u>Finished roofing</u> Metal sheets..... 31 Tiles / slates 34 Concrete / cement 35 Other (<i>specify</i>) 96	

<p>HC5. Main material of the exterior walls.</p> <p><i>Record observation.</i></p>	<p><u>Natural walls</u></p> <p>No walls 11</p> <p>Cane / Palm / Trunks/ Bamboo 12</p> <p><u>Rudimentary walls</u></p> <p>Bamboo with mud..... 21</p> <p>Stone with mud..... 22</p> <p>Plywood 24</p> <p>Cardboard..... 25</p> <p><u>Finished walls</u></p> <p>Cement / RCC wall 31</p> <p>Stone with lime / cement 32</p> <p>Bricks..... 33</p> <p>Cement blocks..... 34</p> <p>Wood planks..... 36</p> <p>Rammed earth.....37</p> <p>Mud blocks.....38</p> <p>Other (<i>specify</i>) _____ 96</p>																
<p>HC6. WHAT TYPE OF FUEL DOES YOUR HOUSEHOLD MAINLY USE FOR COOKING?</p>	<p>Electricity 01</p> <p>Liquefied Petroleum Gas (LPG) 02</p> <p>Kerosene 05</p> <p>Coal..... 06</p> <p>Wood..... 08</p> <p>Straw / Shrubs / Grass 09</p> <p>Dung cake 10</p> <p>No food cooked in household..... 95</p> <p>Other (<i>specify</i>) _____ 96</p>	<p>01⇒HC8</p> <p>02⇒HC8</p> <p>05⇒HC8</p> <p>95⇒HC8</p>															
<p>HC7. IS THE COOKING USUALLY DONE IN THE HOUSE, IN A SEPARATE BUILDING, OR OUTDOORS?</p> <p><i>If 'In the house', probe: IS IT DONE IN A SEPARATE ROOM USED AS A KITCHEN?</i></p>	<p><u>In the house</u></p> <p>In a separate room used as kitchen 1</p> <p>Elsewhere in the house 2</p> <p>In a separate building 3</p> <p>Outdoors 4</p> <p>Other (<i>specify</i>) _____ 6</p>																
<p>HC8. DOES YOUR HOUSEHOLD HAVE:</p> <p>[A] ELECTRICITY?</p> <p>[B] A RADIO?</p> <p>[C] A TELEVISION?</p> <p>[D] A FIXED TELEPHONE?</p>	<table border="0"> <thead> <tr> <th></th> <th>Yes</th> <th>No</th> </tr> </thead> <tbody> <tr> <td>Electricity</td> <td>1</td> <td>2</td> </tr> <tr> <td>Radio</td> <td>1</td> <td>2</td> </tr> <tr> <td>Television</td> <td>1</td> <td>2</td> </tr> <tr> <td>Fixed telephone</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		Yes	No	Electricity	1	2	Radio	1	2	Television	1	2	Fixed telephone	1	2	
	Yes	No															
Electricity	1	2															
Radio	1	2															
Television	1	2															
Fixed telephone	1	2															

[E] A REFRIGERATOR?	Refrigerator.....	1	2	
[F] A SOFA SET?	Sofa set.....	1	2	
[G] A WASHING MACHINE?	Washing machine	1	2	
[H] A SEWING MACHINE?	Sewing machine.....	1	2	
[I] A POWER-TILLER?	Power-Tiller.....	1	2	
[J] A VACCUM CLEANER?	Vaccum cleaner	1	2	
[K] A RICE COOKER?	Rice cooker.....	1	2	
HC9. DOES ANY MEMBER OF YOUR HOUSEHOLD OWN:		Yes	No	
[A] A WRIST WATCH?	Wrist watch	1	2	
[B] A MOBILE PHONE?	Mobile phone	1	2	
[C] A BICYCLE?	Bicycle	1	2	
[D] A MOTORCYCLE OR SCOOTER?	Motorcycle / Scooter	1	2	
[E] A CAR OR TRUCK?	Car/truck	1	2	
[F] A COMPUTER?	Computer	1	2	
[G] A FOREIGN BOW?	Foreign bow	1	2	
[H] A CAMERA?	Camera.....	1	2	
[I] A VCR/VCD/DVD PLAYER?	VCR/VCD/DVD Player	1	2	
[J] A SERSHO GHO/KIRA?	Sersho Gho/Kira.....	1	2	
HC10. DO YOU OR SOMEONE LIVING IN THIS HOUSEHOLD OWN THIS DWELLING?	Own	1		
	Renting for pay	2		
	Rent free	3		
<i>If "No", then ask:</i>				
DO YOU RENT THIS DWELLING FOR PAY OR ARE YOU LIVING THERE RENT FREE?	Other (Not owned or rented)	6		
<i>If "Rented from someone else for pay", circle "2".</i>				
<i>If it is "Rent free", circle "3". For other responses, circle "6".</i>				
HC11. DOES ANY MEMBER OF THIS HOUSEHOLD OWN ANY LAND THAT CAN BE USED FOR AGRICULTURE?	Yes	1		
	No.....	2		2⇒HC13

<p>HC12. HOW MANY ACRES/DECIMALS OF AGRICULTURAL LAND DO MEMBERS OF THIS HOUSEHOLD OWN?</p> <p><i>If less than 1 acre, record "00" followed by the number of decimals.</i> <i>If 95 or more, record '95.00'.</i> <i>If acre not known, record '99.98'.</i></p>	<p>Acres</p>	
<p>HC13. DOES THIS HOUSEHOLD OWN ANY LIVESTOCK, HERDS, OTHER FARM ANIMALS, OR POULTRY?</p>	<p>Yes 1 No 2</p>	<p>2⇒HC15</p>
<p>HC14. HOW MANY OF THE FOLLOWING FARM ANIMALS DOES THIS HOUSEHOLD HAVE?</p> <p>[A] CATTLE?</p> <p>[B] HORSES, DONKEYS, OR MULES?</p> <p>[C] GOATS?</p> <p>[D] SHEEP?</p> <p>[E] CHICKENS?</p> <p>[F] PIGS?</p> <p>[G] BUFFALO?</p> <p>[H] YAKS?</p> <p><i>If none, record '00'.</i> <i>If 95 or more, record '95'.</i> <i>If unknown, record '98'.</i></p>	<p>Cattle _ _ _</p> <p>Horses, donkeys, or mules _ _ _</p> <p>Goats _ _ _</p> <p>Sheep _ _ _</p> <p>Chickens _ _ _</p> <p>Pigs _ _ _</p> <p>Buffalo _ _ _</p> <p>Yaks _ _ _</p>	
<p>HC15. DOES ANY MEMBER OF THIS HOUSEHOLD HAVE A BANK ACCOUNT?</p>	<p>Yes 1 No 2</p>	

Part C: Hygiene effectiveness

1. FAECAL CONTAINMENT, TOILET USE AND MAINTENANCE

How long do you have this toilet?	
	Up to two years
	More than two and up to five years
	More than five and up to ten years
	More than ten years
	Don't know
How much money was spent on construction this toilet? (initial construction costs)	
Direct costs for materials and so on	Amount
Direct costs for paid labour	Amount
HH direct contributions (material and labour)	Yes/No
	Don't know
How did you pay for this toilet?	(more options than one possible)
	Others paid for it (Pan, CGI sheet, Pipe)
	By paying cash
	By paying in instalments
	By borrowing from relatives/friends
	By obtaining a loan
	By getting a grant
	Others (specify)
	Don't know
Did you carry out any repairs or improvements to your toilet in the last 12 months?	Yes/No
	Don't know
If Yes, amount spent on repairing and or improving the toilet	
Direct costs for materials and so on	Amount
Direct costs for paid labour	Amount
HH direct contributions (material and labour)	Yes/No
	Don't know
Did you spend any money on pit emptying in the last 12 months?	Amount
	None
	Don't know

2. Hand washing with soap

How long do you have this hand washing facility?	
---	--

	Up to two years
	More than two and upto five years
	More than five and up to ten years
	More than ten years
	Don't know
How much money was spent on the hand washing facility?	
	Nothing (paid by others)
	Amount
	Don't know
What type of soap is used for hand washing?	
	Lux
	Nepal sabun
	Lifebouy
	Dettol
	Surf (detergent soap powder)
	Others
Number of this type of soap purchased per month?	
How much does it cost each time you buy this soap?	Amount

3. Safe Water Handling

Which water source do you use for drinking, cooking, washing dishes and washing yourself?

Improved drinking-water sources
According to JMP: source that, by nature of its construction or through active intervention, is protected from outside contamination, in particular from contamination with faecal matter.

<i>Do not use the words improved/unimproved in the questionnaire!</i>	<ul style="list-style-type: none"> Piped water into house or into yard 	
<i>Indicate for which activity piped water, protected spring, surface water, etc. is used: for drinking? For bathing? Etc.</i>	<ul style="list-style-type: none"> Piped water to public place (tap or standpipe) 	
	<ul style="list-style-type: none"> Tubewell or borehole 	
	<ul style="list-style-type: none"> Protected dug well 	
	<ul style="list-style-type: none"> Protected spring 	
	<ul style="list-style-type: none"> Rainwater stored in a container or tank until used 	
	<ul style="list-style-type: none"> Other, specify 	

“Unimproved” sources of drinking water

Drinking water from either an unknown source (e.g. tanker truck or water vendor) or from a known source which is unlikely to protect the water from contamination.

- Tanker truck or cart with small tank/drum

	<ul style="list-style-type: none"> • Unprotected spring, unprotected dug well, surface water from river, reservoir, lake, rainwater stored in an open container or tank 	
	<ul style="list-style-type: none"> • Other, specify 	
Did you pay for connection or installation of the water source/system?	Yes: [] amount	
	No	
	Don't know	
How long do you use this water source/system?	Years	
	Don't know	
Do you pay for the water?	Yes	
	No	
	Don't know	
How much do you normally pay each month for the water that the household uses?	[] amount (fill in amount spent p/m) (payment for care takers)	
How is <u>drinking</u> water collected?		<u>Key issue to observe here:</u> is it a clean pot with cover where hands cannot touch the water during transportation
	Open container, not covered, e.g. open pot or bucket	
	Closed container, covered, e.g. bucket with lid, jerry can	
	Don't know	
Do you treat your <u>drinking</u> water?	Yes, always	
	Yes, sometimes. Only when (specify)	

	No	
	Don't know	
How do you treat your <u>drinking</u> water?	Boiling	
	Put chlorine into it	
	Sodis	
	Use (ceramic) filter	
	Other, specify	
	Don't know	
Do you store <u>drinking</u> water in or near the house?	Yes	
	No	
	Don't know	
How is <u>drinking</u> water stored? (<i>observe</i>)	Open container, not covered, e.g. open pot or bucket	
	Closed container, covered, e.g. bucket with lid, jerry can	
	Don't know	
How is <u>drinking</u> water taken from the container (<i>observe if there is a tap or dipper</i>)		<u>Key issue to observe here:</u> can it be done without touching the water with hand(s). (is a designated ladle /utensils used, or does it have a tap)
	Pour water	<i>To be discussed. Can 'pouring' be observed by asking the interviewee to give a glass of water? If 'pouring water' cannot be observed, we may need to remove this option.</i>
	Tap	
	Dipper / ladle	
	Other, specify	
	Don't know	

IV. Additional questions to include are related to hygiene promotion activities

Have you or other household members participated in any type of hygiene promotion activities within the last 6 months?	Who? And how often?		Attended By:
	Yes, once		
	Yes, times	Number of times	

	No		
	Don't know		
If YES, what type of hygiene promotion activities did you or other household members participate in?			
	Household visits	Number of times	Female(Specify) Male(Specify)
	Group meetings	Number of times	Female(Specify) Male(Specify)
	Community meetings	Number of times	Female(Specify) Male(Specify)
	Others (Specify)		Female(Specify) Male(Specify)
If YES, what was the content of the hygiene promotion activities?			
	Toilet construction		
	Toilet hygiene and use		
	Hand washing with soap		
	Safe drinking water handling		
	Others (Specify)		
	Don't know		
If YES, how much time did you or the other household members spend on participating in the above activities?			
Gender disaggregated info	[] persons [] times [] hours [] persons [] times [] days		