



Hygiene Strategy 2021 - 2025



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SADC Hygiene Strategy 2021-2025

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Southern African Development Community (SADC) Secretariat

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About SADC

The Southern African Development Community is an organisation founded and maintained by countries in Southern Africa that aims to further socio-economic, political, and security cooperation among its Member States and foster regional integration, in order to achieve peace, stability, and wealth.

The Member States are:

- Angola
- Botswana
- Union of the Comoros
- Democratic Republic of the Congo
- Eswatini
- Lesotho
- Madagascar
- Malawi
- Mauritius
- Mozambique
- Namibia
- Seychelles
- South Africa
- United Republic of Tanzania
- Zambia
- Zimbabwe

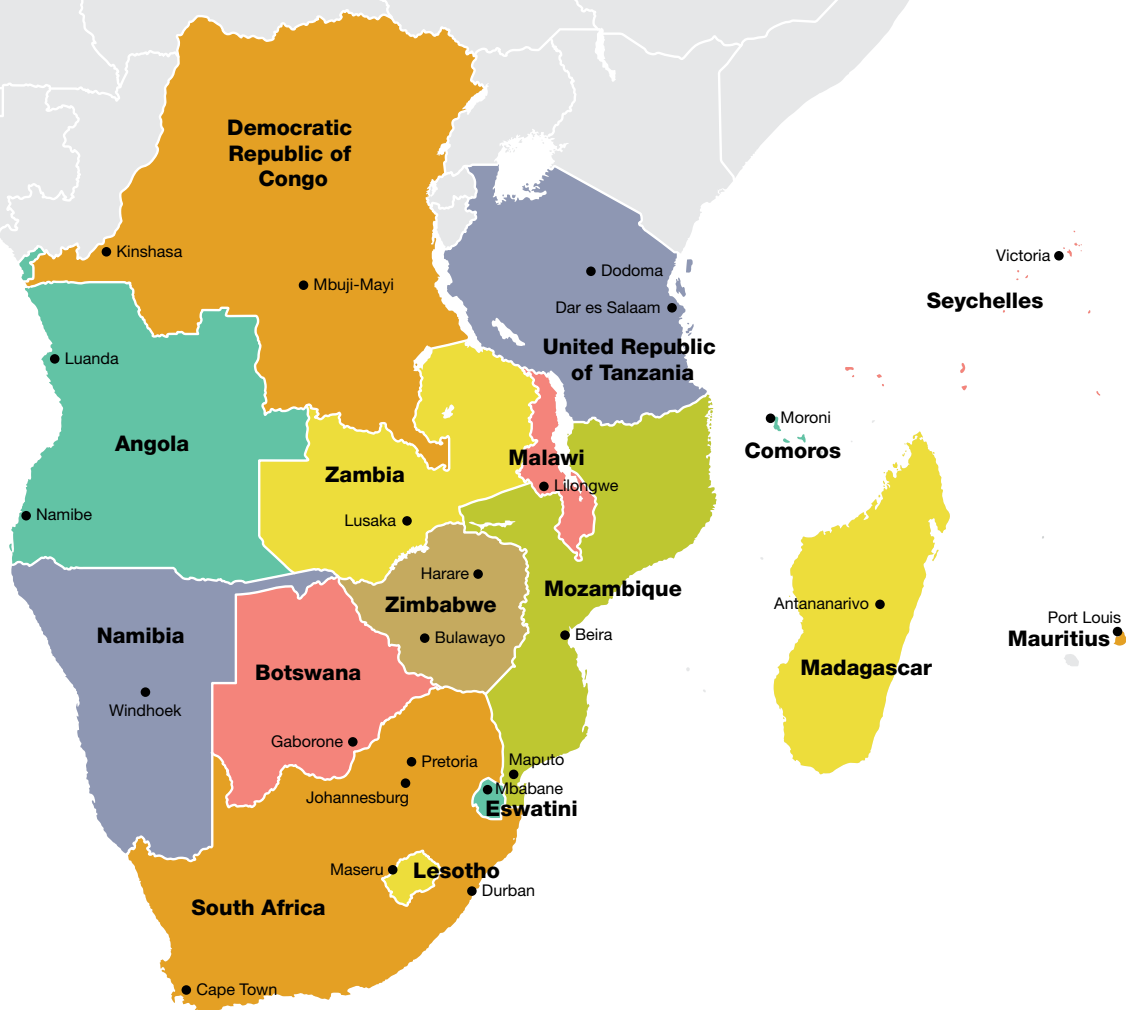


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Executive summary

This document provides a strategic framework for the Southern African Development Community (SADC) response to the hygiene challenges. The primary objective of this strategy was to provide SADC members states [Angola, Botswana, Comoros, Democratic Republic of Congo (DRC), Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe] with the opportunity to cast hygiene issues [conditions and practices that help maintain health and prevent spread of disease by promoting multiple behaviours including handwashing with soap, menstrual hygiene management and food hygiene] in a medium-to long-term perspective in order to be able to effectively plan for and assess the impact or outcomes of strategic interventions. The goal of the strategy is for SADC Members States to significantly increase hygiene coverage and behaviour change across all settings (including households/communities, schools, healthcare facilities, workplaces, public places and institutions) for improving the quality of life of people in the SADC region.

Investment in hygiene is essential to managing the current challenges presented in this time of Covid-19, and is expected to be essential in the long-term management of future pandemics. Handwashing with soap is the single most effective prevention against many diseases including diarrhoeal diseases, acute respiratory diseases like Covid-19 and many disease outbreaks. The focus on hygiene is essential for the achievement of the Nutrition Action Framework that the SADC secretariat has been mandated to implement. The current and future pandemics call for the SADC and its member states to strengthen national systems that would make much more resilient WASH services where government programmes create consumer demand and a robust private sector that can respond to these needs across all markets. In this regard, SADC wants to build on the opportunities that Covid-19 brings and use its current partnerships to support member state initiatives. In view of these challenges, it

is clear that there is an urgent need to scale up hygiene in general and hand hygiene in particular in health care facilities, schools, public places and homes/communities in order to help prevent the current pandemic and reduce the risk of future outbreaks, while improving health across all population groups, especially the most vulnerable.

The purpose of the Strategy is for SADC and the Members States to implement coordinated and concerted actions that effectively support hygiene behaviour change in the region as well as support Member States to create enabling policy environment to sustain people's changed hygiene behaviours. The Regional Hygiene Strategy is an essential tool to provide member states the necessary political backing and push for change. It is also a mechanism through which the region and Member States will implement coordinated actions that will have sufficient impact for donors to channel support to hygiene behaviour change in the region. The strategy also seeks to develop communities of practice that brings together diverse stakeholders to discuss innovations and best practices on both expanding and sustaining access and hygiene behaviour change in various hygiene settings.

The strategy focuses on promoting hygiene behaviour in key hygiene settings which include household and community settings, health care facilities (HCFs), schools and day care centres, people with disabilities (PWDs), workplaces and commercial buildings, refugee, under emergencies, migrant and other camp-like settings, prisons and jails, markets and food establishments, transport hubs, places of worship and other public spaces, and institutional settings responsible for policy making. The key hygiene behaviours include handwashing with soap, safe drinking water management, faecal disposal, food hygiene, menstrual hygiene, and waste management.

The strategy development process entailed an extensive literature review of relevant global, regional and country hygiene policies, strategies, frameworks and publications related to hygiene.



Special consultative meetings were organised with the Regional Hygiene Strategy Committee and key informant interviews with key Hygiene Sector stakeholders from a number of the SADC Member States. The strategy development process was guided by the SADC Regional Strategy Steering Committee which consisted of experts from the SADC Secretariat, WaterAid, UNICEF and World Vision International (WVI). The output of these consultations and reviews led to the eventual drafting of the Strategic Plan which was put through a peer-review process through the Regional Strategy Committee. The final version of the Strategy was produced after the process of validation by experts from SADC Member States.

The overall analysis of policies and strategies showed that policies on health, water, sanitation, environmental health, and to some extent nutrition provided enabling environment for implementation of hygiene practices in the region. However, there are still huge gaps on strategies in most of the countries. There is still need to mainstream and integrate hygiene in most of national policies in order to broaden the enabling environment base for effective and sustainable promotion of hygiene practices. There is need for broad-based policy action to strengthen the enabling environment for hand hygiene programming, including the five building blocks promoted by Sanitation and Water for All (SWA): policies and strategies; institutional arrangements; financing; planning, monitoring and review; and capacity development.

Another important step in the planning of the implementation of the strategy was to identify existing initiatives across the globe, in the region and in Member States that are being implemented to promote hygiene and, hence, will help deliver the strategic goals. A number of initiatives which are being implemented to promote hygiene were identified. There are those international and national initiatives which have long been implemented to support hygiene practices and services and have already made great impact on hygiene in the region. There are other initiatives which have just been introduced and have potential for making an impact in the hygiene sector in the region.

In order to meet SDG target 6.2 and other regional priorities, the Framework situates the regional response to hygiene challenges in the context of the following three strategic priorities identified in the Ngor Commitments on Sanitation and Hygiene as needing urgent attention. The three identified strategic priority areas are:

Strategic Priority Area 1:

Political leadership, commitment and accountability;

Strategic Priority Area 2:

Strengthening the enabling environment for hygiene practices;

Strategic Priority Area 3:

Increasing supply and demand for hygiene services and focus on behaviour change

The strategic objectives which address the three strategic priority areas are:

- To secure strong leadership, commitment and accountability in creating a culture of hygienic behaviour and practices across all levels of government and society;
- To create an enabling policy environment for hygiene services and practices;
- To promote evidence-based hygiene behaviours and basic sanitation services and practices;
- To develop and implement monitoring and evaluation systems for hygiene.

Strategic Objective 1 calls for the high-level leadership at policy level to promote hygiene behaviour change and embed the culture of hygiene practices across all levels of government and society. Strategic Objective 2 calls for action to implement the four building blocks promoted by Sanitation and Water for All (SWA), which are:

- Integration of hygiene in all sectoral policies, strategies and programmes;
- Institutional arrangements for the hygiene sector;
- Financing hygiene; and
- Capacity development for the hygiene sector.

Strategic Objective 3 calls for action to enhance hygiene products and services and focus on



promoting hygiene practices in all settings. It also includes making hygiene behaviour change programme evidence based such as conduction of formative research to understand behavioural determinants, motives, barriers and designing innovative, attractive and context specific behaviour change programme package through a creative process to implement in all settings. Strategic Objective 4 calls for actions to monitor and evaluate/review all hygiene interventions.

At the top of the implementation hierarchy, the Strategy calls the Political Leaderships of SADC Member States to embed a culture of hygienic behaviour and practices across all levels of society, to champion hygiene as key part of national development plan and to demonstrate strong government leadership that integrates hygiene behaviour change with nation building. At SADC Secretariat level, the implementation of the Strategy will require that a Hygiene Strategy Action Plan Sub-Committee be established which will be responsible for coordinating and facilitating the implementation of the Strategy. The HSAP Sub-Committee will comprise coordinators of Health from all the Member States and key partners. Strong government commitment to provide leadership, establish supportive administrative mechanisms, and formulate, monitor and evaluate the Hygiene Strategy is necessary from Member States to ensure the development of satisfactory and comprehensive hygiene policies and strategies. A National Hygiene Coordination Group will be established in each MS to provide strategic, technical and operational guidance to hygiene partners for effective planning and delivery of hygiene behaviour change programmes. The Group will be responsible for coordination and harmonization of hygiene interventions involving all relevant partners – and sharing outcomes widely, both within the hygiene sector and to the wider community.

Other relevant key partners including the private sector and civil societies should be included in all strategies. A Hygiene Partnership Forum will provide a platform for the participation of the private sector and international and national Non-Governmental Organisations (NGOs) and Community-Based Organizations (CBOs) in the

implementation of the Strategy. A Research and Training body will coordinate the generation of new hygiene technologies, conducting of formative research to understand what hygiene behaviours are being practised and why, and the training of hygiene professionals.

The minimum budget required for each Member State to implement the strategy is USD3.90 million, while the SADC Secretariat requires a budget of at least USD1.80 million to implement the strategy. Each Member State will be required to domesticate the HSAP and develop National Action Plans (NAPs) a priority of HSAP. The SADC Secretariat will assist in mobilizing International Cooperation Partner (ICP) financial and technical support for MS to develop their NAPs. Either International Cooperation Partners (ICPs) can support MS bilaterally or SADC Secretariat can have a coordinated funding strategy using ICPs support. Private sources will play an increasingly important role in financing hygiene products and services projects when the investment environment is more attractive, mature and secure. Another funding approach is where both MS and SADC can create special purpose investment funds particularly for small projects (currently without adequate access to financing, due to their inherent high transaction costs) involving both national and regional development banks.

Annual monitoring and reporting [*information on reliable data for analysis and financial support*] on the implementation of the Strategic Action Plans to produce a performance assessment report which will show the baseline scenario should be considered. This yearly assessment is needed to review the progress made against milestones, assess the adequacy of the adopted strategy to meet the targets as planned and take any corrective action, if needed.



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List of acronyms

AIDS	Acquired Immune Deficiency Syndrome
BoP	Base of the Pyramid
CBOs	Community-Based Organisations
CFS	Child Friendly Schools
CHAST	Children's Hygiene and Sanitation Training
CHC	Community Health Clubs
CLTS	Community-Led Total Sanitation
DHIS2	District Health Information Software 2
DRC	Democratic Republic of Congo
ECD	Early Childhood Development
EED	Environmental Enteric Dysfunction
ESARO	Eastern and Southern Africa Regional Office
GAM	Global Acute Malnutrition
GDP	Gross Domestic Product
GHD	Global Handwashing Day
GHP	Global Handwashing Partnership
GLASS	Global Analysis and Assessment of Sanitation and Drinking-Water
HBC	Hygiene Behaviour Change
HBCC	Hygiene Behaviour Change Communication
HCFs	Health Care Facilities
HH4A	Hand Hygiene for All
HIV	Human Immunodeficiency Virus
HSAP	Hygiene Strategy Action Plan
HWFs	Handwashing Facilities
HWWS	Handwashing with Soap
ICPs	International Cooperating Partners
JMP	Joint Monitoring Programme
KPA	Knowledge, Attitudes, and Practices
LGAs	Local Government Authorities
M&E	Monitoring and Evaluation



MH Day	Menstrual Hygiene Day
MHH	Menstrual Health and Hygiene
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, New-born and Child Health
MS	Member State
MSs	Member States
NAPs	National Action Plans
NBS	National Bureau of Statistics
NSHCT	National Sanitation and Hygiene Coordination Group
OD	Open Defecation
ODA	Official Development Assistance
ODF	Open Defecation Free
OECD	Organisation for Economic Co-operation and Development
PHAST	Participatory Hygiene and Sanitation Transformation
PHHE	Participatory Health and Hygiene Education
PLHIV	Person/People Living with HIV
PNVEA	Le programme national Village et Ecole Assaini
PPE	Personal Protection Equipment
PWDs	People with Disabilities
RISDP	Regional Indicative Strategy Development Plan
RTM	Real Time Monitoring
SADC	Southern African Development Community
SARAR	Self-esteem, Associative strength, Resourcefulness, Action planning and Responsibility
SBCC	Social Behaviour Change Communication
SDG	Sustainable Development Goal
SHD	Social and Human Development
SHMIS	Sanitation and Hygiene Management Information System
SLTS	School-Led Total Sanitation
SPME	Strategy Development, Planning, Monitoring and Evaluation
SWA	Sanitation and Water for All
SWOT	Strength, Weakness, Opportunities and Threats
UNICEF	United Nations Children's Fund
VEA	National Program for Healthy Villages and Schools
WA	WaterAid
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization
WinHCF	WASH in Health Care Facilities
WinS	WASH in Schools
WTD	World Toilet Day
WVI	World Vision International



Acknowledgements

The SADC Secretariat would like to express its gratitude to all the stakeholders who contributed to the successful completion of the Hygiene Strategy and Action Plan (HSAP) 2021-2025. The development of this strategy comes at a time when our region is in need of innovative thinking in order to address increasing challenges resulting from limited access to clean and safe drinking water, low coverage of sanitation facilities and unpredictable hygiene behaviours and practices.

The SADC Secretariat also commend Member States for their interest and participation in the process of developing this strategy by providing country level data whose analysis informed the setting of strategic priority areas for this framework. We particularly thank all partners who contributed to this process, including; International Cooperating Partners (ICPs), the Private Sector, Civil Society Organizations, Academia, as well as Research Institutions for their participation in stakeholder consultations and report review.

The SADC Secretariat is grateful for the financial and technical support provided by WaterAid Southern Africa, which enabled the retention of the technical expertise that supported data collection, stakeholder engagement, data analysis and drafting of the hygiene strategy. We extend our gratitude to UNICEF-ESARO and other collaborating organizations for the technical support they provided throughout this process as well as their support in the engagement with Member States.

The SADC Secretariat calls upon all partners and stakeholders who participated in the development of the SADC Regional Hygiene Strategy to continue providing support to Member States during the implementation phase in order to translate the recommendations of this strategy into actionable, change driving programmes.

Dr Stergomena L. Tax
Executive Secretary



1 Introduction

Beatriz, 9, washes her face with water from the unprotected water source in Nacoto Village, Mossuril District, Nampula Province, Mozambique.

WaterAid/ Eliza Powell



1.1 Background

Poor hygiene practice is a major contributor to several endemic and epidemic diseases in Southern Africa. The SADC region continues to report recurrent diarrhoea and cholera outbreaks, and outbreaks of typhoid and Hepatitis E (SADC, 2020a), amebiasis and Ebola virus disease (UNICEF, 2020a). In some parts of the world there is little or no awareness of good hygiene practices and their role in reducing the spread of disease. However, it is often the case that even when people do have knowledge of good hygiene behaviour, they lack the soap, safe water and washing facilities they need to make positive changes to protect themselves and their community.¹ Indeed, a large financing gap has been identified as one of the greatest barriers to achieving hygiene

targets of sustainable development (UN-Water, 2017). Handwashing with soap has been proven to be the single most cost-effective intervention to prevent the diarrhoeal diseases up-to 48%, reducing acute respiratory diseases such as Coronavirus by 36%, and contributing in reducing top causes of under-5 mortality.² Investment in hygiene is essential to managing the current challenges presented in this time of Covid-19, and is expected to be essential in the long-term management of future pandemics. As experience demonstrates, however, these quick gains can be short-lived if the enabling environment is not nurtured. The focus on hygiene behaviour change is essential for the achievement of the Nutrition Action Framework that the SADC secretariat has been mandated to implement.

1.2 Rationale for and purpose of the Regional Hygiene Strategy

1.2.1 Rationale for the strategy

Presently, a large proportion of the population in SADC countries do not have a handwashing facility with water and soap at home. Nearly three quarters of the people lack basic handwashing facilities with water and soap at home, and 2 out of 5 people in SADC countries have no handwashing facility at all (WaterAid, 2018). Moreover, field reports show that even in settings where access is not an issue, people do not clean their hands when they should. Data from the UNICEF and WHO Joint Monitoring Programme³ (JMP) shows that only 10 of the 16 SADC countries had data on hygiene. The World Health Organization⁴ estimates that a new-born in low- and middle-income countries dies every minute from infections related to lack of clean water and an unclean environment. Providing water, adequate toilets and hygiene in homes and health centres would help support these new-borns to survive and thrive. Sepsis and other infections due to unhygienic conditions are also a leading cause of preventable maternal deaths. Hand washing with soap has, for the first time, been included as a key indicator of progress of 2030 sustainable development agenda. Sustainable Development Goal (SDG) 6. Target 6.2.1b on hygiene tracks the proportion of population with a handwashing facility with soap and water on premises.⁵ This means governments need to demonstrate commitment to leaving no one behind in achieving this ambition for hygiene behaviour change.

1.2.2 Purpose of the strategy

Investment in hygiene and basic sanitation is essential to managing the current challenges presented in this time of Covid-19, and is expected to be essential in the long-term management of future epidemics and pandemics. Handwashing with soap is the single most effective prevention against many diseases including diarrhoeal diseases and acute respiratory diseases like Covid-19. Hygiene, more importantly handwashing with soap, has been a first line of defence to prevent the spread of COVID19. The focus on hygiene behaviour change is essential for the achievement of the

Nutrition Action Framework that the SADC secretariat has been mandated to implement. The current and future pandemics call for the SADC and its member states to strengthen national systems that would make much more resilient WASH services where government programmes create consumer demand and a robust private sector that can respond to these needs across all markets. In this regard, SADC wants to build on the opportunities that Ebola Virus Disease (EVD) and Covid-19 bring and use its current partnerships to support member state initiatives. In view of these challenges, it is clear that there is an urgent need to scale up hygiene in general and hand hygiene in particular in health care facilities, schools, public places, and communities/homes and specific environments (prison, refugee camps, people with disabilities, old people's homes, under emergencies) in order to help stop the current pandemic and reduce the risk of future outbreaks, while improving health across all population groups, especially the most vulnerable.

The purpose of the Strategy is for SADC and the Members States to implement coordinated and concerted actions that effectively support hygiene behaviour change in the region as well as support Member States to create enabling policy environment to sustain people's changed hygiene behaviours. The Regional Hygiene Strategy is an essential tool to provide member states the necessary political backing and push for change. It is also a mechanism through which the region and Member States will implement coordinated actions that will have sufficient impact for donors to channel support to hygiene behaviour change in the region. The strategy also seeks to develop communities of practice that brings together diverse stakeholders to discuss innovations and best practices on both expanding and sustaining access and hygiene behaviour change in various hygiene settings.

1.3 Process for the development of the Regional Hygiene Strategic Plan

This strategic plan derives from the SADC Protocol on Health adopted in Maputo in 1999, which states that a healthy population is a pre-requisite for the sustainable human development and increased productivity in



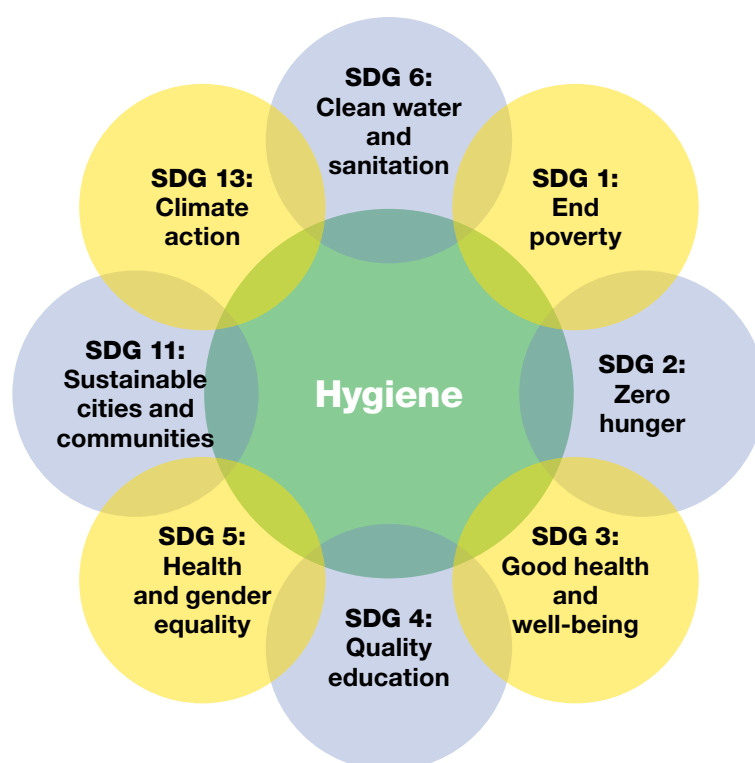
a country. Although the Protocol makes no mention of hygiene, the first of its objectives is to “identify, co-ordinate, promote and support those activities that have the potential to improve the health of the population within the region”. SADC recognises that close co-operation in the area of health is essential for the effective control of communicable and non-communicable diseases. In that respect, the development of the Regional Strategic Plan benefited from the range of virtual consultations with a diverse range of the stakeholder community from Member States including the conduct of a situational analysis on hygiene in the SADC region. The list of key experts consulted is resented in Annex 1. Special consultative meetings were also organised with the Regional Hygiene Strategy Committee and key informant interviews with key Hygiene Sector stakeholders from a number of the Member States. The strategy development process was guided by the SADC Regional Strategy Steering Committee (Annex 2) which consisted of experts from the SADC Secretariat, WaterAid, UNICEF and World Vision International (WVI). The strategy development process entailed an extensive literature review of relevant global, regional and country hygiene polices, strategies, frameworks and publications related to hygiene.

The output of these consultations and reviews led to the eventual drafting of the Strategic Plan which was put through a peer-review process though the Regional Strategy Committee. The final version of the Strategy was produced after the process of validation by experts from SADC Member States.

1.4 Hygiene and Sustainable Development Goals

Good hygiene practice is central to the achievement of Sustainable Development Goal 6 (clean water and sanitation for all), as well as other development goals including health, nutrition and education (WaterAid, 2018). Sustainable Development Goal Target 6.2 seeks to achieve access for all to sanitation and hygiene. Target 6.2.1a on sanitation tracks the proportion of population that is using an improved sanitation facility, which is not shared with other households, and where the excreta produced is either treated and disposed in situ, stored temporarily and then emptied and transported to treatment off-site, or transported through a sewer with wastewater and then treated off-site. According to the WHO, improved sanitation facilities include flush/pour flush to

Figure 1:
Hygiene-related
SDG indicators



piped sewer system, septic tanks or pit latrines; ventilated improved pit latrines, composting toilets or pit latrines with slabs (WHO and UNICEF, 2017). Target 6.2.1b on hygiene tracks the proportion of population with a handwashing facility with soap and water on premises. Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and jugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water. Apart from SDG 6, a number of SDGs have hygiene imperatives that need to be addressed to attain the goal. These include hygiene targets for SDG 1: End poverty, SDG 2: Zero hunger, SDG 3: Good health and well-being; SDG 5: Health and Gender Equality, SDG 4: Quality Education; SDG 11 Sustainable Cities and Communities and SDG 13: Climate Action (Figure 1).

Sustainable Development Goal (SDG) 1, SDG 4 and SDG 11 have targets specific to WASH (i.e., Target 1.4; Target 4.a and Target 11.1). The explanation of the hygiene criteria for the SDG target is summarised in Table 1.

1.5 Conceptual framework of hygiene

Hygiene is a set of practices performed to preserve health.⁶ According to WHO., hygiene refers to conditions and practices that help to maintain health and prevent the spread of diseases.⁷ There are different hygiene settings and pre-requisite conditions (such as access to safe water and sanitation services and cleaning commodities). Hygiene includes such personal habit choices as how frequently to wash hands with soap, where to defecate and dispose faeces, drinking safe water, eating safe food etc. It also includes attention to keeping surfaces in the home and workplace including bathroom facilities, clean and pathogen free.

1.5.1 Key hygiene settings

There are different society settings where hygiene issues are important. The major hygiene settings include, but not limited to:

Household and community settings

The households and community settings include home in rural, urban, slum, hard-to-reach areas

Table 1: Normative interpretation of hygiene in SGD target

Source: UN Water, 2015

By 2030	Normative interpretation
Achieve access and equitable hygiene for all paying attention to the needs of women and girls and those in vulnerable situation	Implies facilities close to home that can be easily reached and used when needed
	Implies progressive reduction and elimination of inequalities among population subgroups
	Hygiene refers to behaviour change to keep people and environment clean. The hygiene condition and practices that help maintain health and prevent spread of disease and improve dignity. Hygiene includes multiple behaviours including handwashing with soap, menstrual hygiene management and food hygiene
	Suitable for use by men, women, girls and boys of all ages, including people with disabilities
	Implies enabling women and girls to manage hygiene needs with dignity. Special attention should be given to the needs of women and girls in high-use settings such as schools and workplaces, and high-risk settings such as health-care facilities and detention centres
	Implies paying attention to specific hygiene needs found in special cases including in refugee camps, detention centres, mass gatherings and pilgrimages

and in emergency settings. Hygiene at home pertains to the hygiene practices that prevent or minimize the spread of disease at home. This includes a range of actions in order to protect household members from infectious diseases. It covers areas such as food and water hygiene, handwashing with soap, using the toilet and disposing child's faeces, covering when coughing and sneezing, care of pets, safe disposal of domestic wastes, caring for family members who are infected or who are at greater risk of infection such as immuno-compromised individuals, babies, pregnant mothers etc. Drinking water quality remains a significant problem in many homes. Point-of-use water treatment is part of the approach of self-supply of water for households and ensures that household water is safe for consumption after treatment and safe storage (UNICEF, 1999).

Health care facilities (HCFs)

According to WHO (2019), health care facilities (HCFs) encompass all formally recognized facilities that provide health care, including primary (health posts and clinics), secondary, and tertiary (district or national hospitals), public and private (including faith-run), temporary structures designed for emergency contexts (e.g., cholera treatment centres) and mobile units. The importance of hand hygiene in preventing infection in health care facilities is that 80% of nosocomial infections are hand-borne (Calmeiane and Dauffy, 2013).

To provide quality care, healthcare facilities need to have a safe and accessible water supply; clean and safe sanitation facilities; hand hygiene facilities at points of care and at toilets; appropriate waste disposal systems and environmental cleaning. Infrastructure that supports hygiene and healthcare waste management practices helps prevent the spread of diseases within the healthcare facility and to the surrounding community.

BabyWASH

BabyWASH integrates water, sanitation and hygiene (WASH) interventions into maternal, new-born and child health (MNCH), early childhood development (ECD) and nutrition, to have a more profound impact on child health outcomes in the first 1,000 days of life.⁸ Key



Zione Petulo, 20, bathes her daughter Flora Mwamulima, 2 years 8 months, using clean water at home in the village of Chandaka, Salima, Malawi.

WaterAid/ Alexia Webster

WASH interventions focus on hotspots in the first 1,000 days, including pregnancy, delivery, the first week of life, the onset of complementary feeding, and throughout a child's mobility. It is reported that in our world, 159 million children under 5 face stunted growth in which poor hygiene and sanitation causes about 15% of that stunting. 45% of all child deaths are due to undernutrition and 50% of underweight status in children is due to poor water, sanitation and hygiene (Urich, undated). Urich (undated) further reports that WASH interventions during child birth aid overall recovery and reduce maternal and new-born mortality, sepsis, and tetanus. Research findings support the theory of environmental enteric dysfunction (EED), a condition caused by poor hygiene that leads to chronic inflammation and low nutrient absorption. (Urich, undated) The effects of poor hygiene during the first 1,000 days of life can determine whether or not a child will reach his or her developmental potential. Hence, hygiene for babies is one of the important hygiene settings which are considered in this Strategy.

Schools and day care centres

School settings include all types of schools (public and private) at various level which unique



issues involved in creating adequate conditions of water supply, sanitation and hygiene. They also include day care centres catering for young children. These centres provide academic and, in many cases, recreational activities for children who return home every day, but who may often eat at or near the school. Access to safe water, sanitation and hygiene (WASH) in schools (WinS) is integral to the well-being of children and their right to quality education. This includes provision of water, sanitation facilities, handwashing facilities, promotion of hygiene behaviour change intervention.

Hygiene for people with disabilities (PWDs)

Disability directly and indirectly affects a significant proportion of the world's population. The World Health Organisation estimates 15% of people worldwide are affected by disability (over 1 billion people), and one household in four includes a person with a disability (WHO and World Bank, 2011). People with disabilities (PWDs) include people with long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.⁹ People with disabilities are likely to experience increased health risks because of a lack of access to sanitation and hygiene services. Amokwandoh et al., (2020) reported that people living with disabilities do not benefit fully from WASH delivery due to the design and management of the facilities at the community level. The lack of inclusive facilities means disabled people often engage in unhygienic and dangerous practices; for example, wheelchair users are forced to crawl on the floor of latrines, others defecate in the open to avoid the discrimination associated with using public toilets, and disabled people may also restrict their intake of food and water to avoid needing to go to the toilet (Collender et al., 2011).

The SDGs explicitly include disability and persons with disabilities, so it is imperative to promote disability inclusion to ensure access to safe water and sanitation for all, including people with disabilities, by 2030 (UNICEF, undated). The 2030 Agenda for Sustainable Development clearly states that disability cannot be a reason or criteria for lack of access to development

programming. SDG 6 (Ensure availability and sustainable management of water and sanitation for all) requires governments to pay special attention to the needs of people in vulnerable situations, to achieve adequate and equitable sanitation and hygiene for all (World Bank, 2017). Hence, one of the main priorities of this Strategy is to improve the lives of PWDs including their access to sanitation and hygiene services. This will be achieved through provision of adequate specifically-designed WASH facilities (drinking water, toilets, handwashing, waste disposal) that meet the needs of PWDs in all hygiene settings, among other things. This requires that MS promote hygiene disability inclusion practices in all settings.

Hygiene during emergencies

Water, sanitation, and hygiene (WASH) are critical needs for populations affected by emergencies such as natural disasters, outbreaks, and violence.¹⁰ Emergency settings include natural disasters (i.e., earthquakes, hurricanes, flooding events, disease outbreaks or droughts), conflict and disease outbreaks. In almost all emergency contexts there is a basic need to establish access to safe water, sanitation and hygiene. Water and sanitation are critical determinants for survival in the initial stages of a disaster, and people affected by disasters are generally much more susceptible to illness and death from disease, which to a large extent are related to inadequate sanitation, inadequate water supplies and inability to maintain good hygiene (Sphere Project, 2011). Emergency WASH interventions are needed to provide access to safe water and sanitation and promote good hygiene practices with dignity, comfort and security under emergency conditions. The overall aim of all emergency hygiene interventions is to promote safe practices that reduce hygiene and sanitation-related preventable waterborne and communicable diseases (Sphere Project, 2011). In emergency settings, handwashing is critical to preventing the spread of disease and has high potential to reduce the health impact of disasters.¹¹

Ensuring proper handwashing with soap in emergency settings can also protect the progress made before an emergency. Handwashing infrastructure and behavioural



programs in emergencies often require different approaches compared to non-emergency contexts. Contexts requiring tailored approaches may include natural disasters, outbreaks and other public health emergencies, as well as conflict or post-conflict settings. The pace, scale, and temporality of emergency settings may render some standard approaches ineffective or unfeasible (Yates et al., 2017). Emergencies that cause flooding or displacement are particularly associated with health outbreaks, and handwashing's potential to prevent disease can be even more critical when health services are disrupted (Lantage, 2014). Research has identified handwashing as a major gap in emergency WASH interventions (Yates et al., 2017). Handwashing with soap must be a key consideration in emergency planning, response, and recovery programs.

Workplaces and commercial buildings

At workplace, people spread germs in countless ways, from sneezing without a tissue to leaving coffee cups unwashed, and shared facilities and equipment can soon harbour high levels of harmful bacteria. The threat for infectious disease is high in workplaces simply because employees work in close proximity and share eating areas, workstations, and restrooms that harbour a broad spectrum of microorganisms (Hewitt et al., 2012). Hygiene in workplaces is about access to hygiene facilities and services within all workplace and commercial settings – for example, construction, agriculture.

Good workplace health, safety, wellbeing and hygiene practices reduce the risk of injury and ill-health including the incidence of transmittable disease and the associated cost of absenteeism. They can help to improve productivity and keep workers, customers and organizations safe.

Refugee, migrant and other camp-like settings

Refugee camps are temporary settlements built to receive refugees and people in refugee-like situations. Refugee camps usually accommodate displaced persons who have fled their home country. Due to crowding and lack of infrastructure, refugee camps are often unhygienic, leading to a high incidence of infectious diseases and epidemics. Common infectious diseases include diarrhoea from

unhygienic conditions, malaria, viral hepatitis, measles, meningitis, respiratory infections such as influenza, and urinary/reproductive tract infections. These are exacerbated by malnutrition (UNHCR, 2013).

Prisons

Detention homes such as prisons and jails, including temporary arrest facilities, must be hygienic. The transmission of communicable diseases such as diarrhoea, relapsing fever, scabies, trachoma, and typhus fever could be possible due to crowding and poor sanitation in prisons. Unhealthy conditions such as overcrowding and poor hygiene are common in many prisons (WHO, 2014). It is important that all prisoners are educated about the importance of personal hygiene and that they must have regular access to decent toilets, toilet paper, sanitary napkins, clean water, soap and clean laundry. In addition to dealing with the health needs of individual prisoners, those responsible for prison health are also recommended to inspect the general conditions of detention, including food hygiene, water, handwashing facilities, hygiene condition, sanitation, heating, lighting and ventilation, as well as the suitability and cleanliness of the prisoners' clothing and bedding (WHO, 2014).

Markets and food establishments

Markets often represent a health hazard because foodstuffs may not be stored properly and because the markets may lack basic services, such as water supply, sanitation, handwashing facility, solid waste disposal and drainage. Ideally, markets should have several taps to provide traders and customers with ready access to safe water for drinking and washing (UNICEF, 1999). Many vegetable and fruit sellers regularly sprinkle their produce with water, and it is important that they have access to clean water for this. The sanitation facilities should also be appropriate for the number of people who will visit the market, with separate facilities for men and women and handwashing facilities with soap and water need to be available.

Transport hubs

Transport hubs are important hygiene settings as large number of people pass through public transport hubs such as metro/underground



stations, bus, tram and train stations, ferry terminals and airports channel many people into confined spaces. As passengers pass through these places, they have to stand or sit close together in concourses, pass through stairways, doorways and checkpoints, and will touch many surfaces to access the different stages of the transport service, including: ticket machines; ticket offices; escalators; handrails; door handles; washrooms — handles, taps, toilet seat, soap and tissue dispensers; shops and restaurants; waiting areas and seating; queue barriers; and waste bins. There are numerous areas and surfaces where infection can be spread in the different modes of public transport.

- **Work vehicles:** door handles, steering wheels, dashboard controls, handbrakes, window controls, seats, armrests, flooring
- **Buses and trams:** handles, handrails, seats and armrests, windows, tables, luggage racks, waste bins, floor areas, toilets
- **Overground and underground trains:** handles, handrails, seats and armrests, windows, tables, luggage racks, waste bins, floor areas, toilets, buffet cars, sleeper cars
- **Aircraft:** seats and armrests, window blinds, light switches, air vents, tables, luggage compartments, floor areas, toilets, cabins and crew areas
- **Ferries:** handles, handrails, seats and armrests, windows, tables, luggage racks, waste bins, floor areas, toilets, cabins and crew areas, gaming/arcade machines, children's play areas, restaurants and shopping areas

Institutional settings

These are public and private institutions. In public institutions, the hygiene focus is on changing the behaviours of government stakeholders and key decision-makers to support a positive policy and regulatory environment for hygiene.

Places of worship and other public spaces

Religious institutions such as churches and mosques house large number of people in one place. Just like school settings, there is need to provide adequate water, sanitation and hygiene facilities within the church premises in order to minimise risks of spread of hygiene related diseases. Strict observance of personal



Momade Buana, Imam and teacher, 46, performs ablutions before attending prayers inside his mosque in Chicoma Village, Mossuril District, Nampula Province, Mozambique

WaterAid/ Eliza Powell

hygiene is very important as worshipers interact with each other and are exposed to items and surfaces that are touched by everyone.

1.5.2 Key hygiene behaviours

Hygiene behaviour plays an important role in the prevention of diseases related to water, hygiene and sanitation. Water supply and sanitation make hygiene easier to practice, but the mere provision of facilities only has proven to be less effective. The main hygiene behaviours include:

Personal hygiene

Personal hygiene is comprehensive approach to bodily hygiene. This practice includes bathing, washing your hands, brushing your teeth, and more. You encounter millions of outside germs which can linger on your body, and in some cases, they can make you sick. Personal hygiene practices can help you and the people around you to prevent illnesses. They can also help you feel good about your appearance.

Hand hygiene

Hand washing with soap, also known as hand hygiene, is the act of cleaning one's hands with soap and water to remove microorganisms, dirt, grease, or other harmful and unwanted substances stuck to the hands.¹² Handwashing prevents diarrhoeal diseases, cholera, coronavirus and many outbreaks.



Safe water management

This entails safe domestic water management from source to the point of consumption (including collection, transportation, storage, household water treatment, and consumption). It involves managing drinking water in homes by treating water and preventing and/or minimizing risks of contamination.

Faecal disposal

This entails safe use (including cleanliness) and hygienic management of human excreta (including children's faeces). Safe disposal of excreta, so that it does not contaminate the environment, water, food or hands, is essential for ensuring a healthy environment and for protecting personal health. The safe disposal of human faeces is one of the principal ways of breaking the faecal–oral disease transmission cycle.

Food hygiene

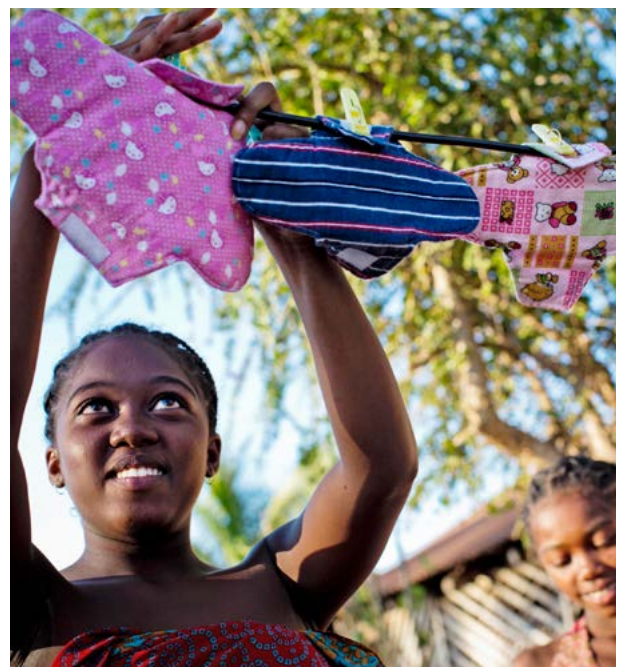
Food is one of the critical pathways through which faecal pathogens are ingested into people's gut. 70% of diarrhoeal episode are caused by pathogens transmitted through food and weaning food are a major contributor for diarrhoeal diseases in many low and middle-income countries. Community based food hygiene intervention can change multiple food hygiene behaviours (Gautam et al, 2017)¹³. Food hygiene is all the measures that must be undertaken in order to ensure the safety of food at all stages of the production chain in the food industry.¹⁴ It is concerned with the hygiene practices that prevent many diarrhoeal diseases, gastrointestinal infection and food poisoning. Proper food hygiene and handling is essential to avoid different illnesses and alterations in food from the moment of production or harvesting to the consumption of food, as it is exposed to contamination by microorganisms or other substances harmful to health.

The World Health Organization regards illness due to contaminated food as one of the most widespread health problems in the contemporary world, a situation which can be fatal for immunocompromised people, pregnant women and the elderly. The WHO "golden rules" of food hygiene are: choose food processed for safety; cook food thoroughly; eat cooked

foods immediately; store cooked food carefully; reheat cooked food thoroughly; avoid contact between raw foods and cooked foods; wash hands repeatedly; keep all kitchen surfaces meticulously clean; protect foods from insects, rodents and other animals; and use safe water.¹⁵

Menstrual hygiene

Menstrual Hygiene Management (MHM) is defined as *"women and adolescent girls are using clean menstrual management materials to absorb or collect blood that can be changed in privacy as often as necessary for the duration of the menstruation period, using soap and water for washing the body as required, and having access to facilities to dispose of used menstrual management materials"*.¹⁶ Effective menstrual hygiene is vital to the health, well-being, dignity, empowerment, mobility and productivity of women and girls. On the other hand, menstrual health and hygiene (MHH) encompasses both MHM and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment, and rights. UNICEF (2019) report that MHH is important for the fulfilment of girls' and women's rights, a key objective of the



Julianna, 16, hangs up her cotton sanitary towels to dry after washing them, these are given to young girls and women in the community as part of a hygiene awareness project in Morondavo, Madagascar.

WaterAid/ Kate Holt



Sustainable Development Goals (SDGs). Women and girls' access to MHH is a component of gender-responsive WASH services; SDG 6.2 acknowledges the right to menstrual health and hygiene, with the explicit aim to, *"By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation (OD), paying special attention to the needs of women and girls and those in vulnerable situations"* (UNICEF, 2019). Hence, menstrual hygiene entails focusing on improving awareness, challenging taboos, improving facilities, promoting the use of products and managing waste in household, community and institutional settings (WaterAid, undated).

Environmental cleaning

Environmental cleaning involves prevention, monitoring, treatment, safe handling, re-use, and residual disposition of solid and liquid wastes. The common practice for household refuse disposal in rural areas is to dump solid wastes openly in backyard gardens or in an open space. Such indiscriminate disposal is an environmental hazard and can threaten human health and safety. Solid waste that is improperly disposed of can result in a number of problems. Poor waste disposal and management of household waste in communities is becoming a huge challenge related to hygiene, especially where 3-R's (Reduce, Reuse and Recycling) are not practices. The use of disposable nappies is becoming a problem, as nappies are disposed in open space, water catchment and other water bodies that could contaminate drinking water. This practice could lead to outbreak of communicable diseases such as cholera and other faecal related diseases.

1.5.3 Hygiene behaviour change (HBC)

Hygiene behaviour change (HBC) is a systematic approach to encourage the widespread adoption of safe hygiene practices, in order to keep people and their environments clean (WaterAid, 2019).¹⁷ Sustaining improved sanitation and hygiene is first and foremost about **behavioural change**.¹⁸ Sustained hygiene behaviours enhance dignity, prevent spread of diseases, reduce under-nutrition and maintain health (WaterAid 2019). The ultimate goal of behaviour change is to inculcate a new norm whereby,

once people have made a change, they will keep doing it (Unilever, 2015). Michie et al (2011) define behaviour change interventions as coordinated sets of activities designed to change specified behaviour patterns.

One of the opportunities of promoting HBC is that there is overwhelming evidence showing that handwashing with soap (HWWS) is one of the most cost-effective interventions to prevent top causes of under-5 mortality in developing countries. Evidence shows that handwashing with soap can reduce diarrhoea by almost 48% and respiratory infections (including pneumonia) by almost 25% (WaterAid, 2018). Another opportunity is that national governments in the region have developed policies and programmes to support good hygiene practices. Another opportunity is to apply hygiene behaviour change communication (HBCC) approach which is an interactive process with individuals and communities to understand and establish communication modalities to identify and promote hygiene behaviours appropriate to their setting. This provides an environment through which people can initiate, sustain and maintain positive hygiene behaviours (Australian Aid, 2017).

There are physical and social barriers that limit hygiene behaviour change in Southern Africa (WaterAid, 2020). There are physical barriers to handwashing with soap (HWWS), including a lack of handwashing facilities (HWFs), or existing facilities not being located where they are needed. Limited availability of soap and water also negatively impacts the practice of good hand hygiene, as soap is an expensive commodity and therefore not always available at the HWF. Another barrier is that some latrines are not user-friendly to all members of the community. Young children, the elderly and people with disabilities experience physical and economic barriers to latrine use.



2 Situation analysis



Caregivers helping a young boy to wash his hands at Ngwalangwa Early Childhood Development Centre (ECDC), Binali, Zomba, Malawi.

WaterAid/ Dennis Lupenga

2.1 Overview

The Southern African Development Community (SADC) is a Regional Economic Community comprising 16 Member States which includes Angola, Botswana, Comoros, Democratic Republic of Congo (DRC), Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia and Zimbabwe. The demographic landscape of the SADC region is also expected to have implications for the implementation of the Hygiene Strategy.

Between the 2009 and 2019 intercensal period, the regional population grew from 273.72 million to 360.34 million representing an increase of 86.62 million people (31.6%) (SADC, 2020b) and the percentage of urban and rural populations

were 42.5% and 57.5%, respectively (Table 2).

The data show that most of the population lives in urban areas, in most of the countries, large proportions of national populations are rural. The state of the African Cities (2010) shows that rates of urban population growth in most countries in the SADC region were much higher than those of rural population growth. The implications of the large proportion of national populations living in rural areas are that water, sanitation and hygiene (WASH) services need to be expanded in those countries to cover these people, especially in rural areas.

The economic landscape of the region is dominated by South Africa which is the largest economy. SADC comprises some of the poorer countries in the region. Table 3 presents national gross domestic product (GDP), GDP



Table 2: Population in SADC in 2019

Source: *SADC, 2020b; ‡World Bank, 2020

Country	Population ('000)*	Proportion of urban population‡ (%)	Proportion of rural population‡ (%)
Angola	30,175	66.18	33.82
Botswana	2,339	70.17	29.83
Comoros	851	29.16	70.84
DRC	97,356	45.05	54.95
Eswatini	1,134	23.98	76.02
Lesotho	2,125	28.58	71.42
Madagascar	26,969	37.86	62.14
Malawi	18,629	17.17	82.83
Mauritius	1,266	40.77	59.23
Mozambique	29,318	36.53	63.47
Namibia	2,459	51.04	48.96
Seychelles	98	57.12	42.88
South Africa	58,775	66.86	33.14
Tanzania	55,891	33.50	66.50
Zambia	17,381	44.07	55.93
Zimbabwe	15,573	32.21	67.79
SADC Total/Average	360,339	42.50	57.50

Table 3: GDP, income classification and unemployment rate in SADC in 2019

Source: SADC, 2020b

Country	GDP (US \$ million)	GDP (US \$ per capita)	Income classification	Unemployment rate (%)
Angola	92,753	3,074	Lower middle	6.9
Botswana	18,331	7,837	Upper middle	22.2
Comoros	1,154	1,356	Lower middle	4.3
DRC	47,318	486	Low income	4.2
Eswatini	4,526	3,991	Lower middle	22.1
Lesotho	2,377	1,119	Lower middle	23.4
Madagascar	14,105	523	Low income	1.8
Malawi	8,016	430	Low income	5.7
Mauritius	14,011	11,067	High income	6.7
Mozambique	15 296	522	Low income	3.2
Namibia	12,366	5,029	Upper middle	20.3
Seychelles	1,699	17,406	High income	2.9
South Africa	351,393	5,979	Upper middle	28.2
Tanzania	61,127	1,094	Lower middle	2.0
Zambia	23,046	1,326	Lower middle	12.5
Zimbabwe	26,816	1,722	Lower middle	16.4
SADC Total/Average	694,336	1,927		



per capita, the income classification of the countries according to the World Bank, and the unemployment rate in 2019. The GDP of the country could indicate its capability of providing water, sanitation and hygiene services to its citizen. This is confirmed by the GDP in Seychelles and Mauritius with nearly 100% of people with access to safe water and sanitation (WHO and UNICEF, 2019a).

The implications of the low incomes of most of the countries in the region are that most of these have limited financial resources to fund financing hygiene practices and that they depend on substantial private sector and external support.

Average government expenditure on WASH as percentage of GDP (2000-2017) is low. There is no consolidated data on government expenditure on WASH services in Southern Africa. The World Bank BOOST programme has attempted to quantify overall government expenditure on water and sanitation and estimates that, on average, government expenditure on building, rehabilitating or improving the existing capacity

of infrastructure across the main subsectors made up 2 per cent of overall expenditure (Jones et al, 2019).

The major donors in WASH in the regions are the Official Development Assistance (ODA) to Africa from Organisation for Economic Co-operation and Development (OECD), UNICEF, WaterAid (WA), World Vision International (WVI). In many cases, donor funding surpasses MS national government expenditure allocated to hygiene. In the Global Analysis and Assessment of Sanitation and Drinking-Water (GLASS) 2018/2019 country survey, it was reported that, globally, only 4% of countries reported having sufficient finance for hygiene (WHO, 2019a).

Financing of hygiene as part of WASH in the region comes from national government financing, donor financing, private sector financing and consumer financing (Jones et al, 2019). Much of the available data on WASH financing by consumers, either via tariffs for services provided or through self-supply pertains to tariffs for urban water supplies. As these only



Yanjanani Mpalaka, Mtosa Health Centre Medical Assistant, Nkhotakota, Malawi.

WaterAid/ Dennis Lupenga

Country	Existence of national hygiene policy	Existence of national hygiene implementation plans	Developed cost estimates for hygiene plan	Conducted human resources assessment for hygiene plan	Sufficient financial resources to implement hygiene plans	Sufficient human resources to implement hygiene plans
Angola			✓	✓	✗	✗
Botswana			✗	✗	—	—
Comoros			✓	✗	✗	✗
DRC			✓	—	—	—
Eswatini			✗	✗	✗	✗
Lesotho			✗	—	✗	✗
Madagascar			✓	✓	✗	✗
Malawi			✗	✗	✗	✓
Mozambique			✗	—	✗	✗
Seychelles			—	—	—	—
South Africa			✗	✓	✗	✗
Tanzania			✓	✓	◆	◆
Zambia			✓	✓	✗	✓
Zimbabwe			✗	✗	—	—

KEY National hygiene policy: ■ Fully approved ■ Undergoing revision ■ Under development ■ None

National hygiene implementation plans: ■ Approved, fully implemented ■ Approved, partly implemented ■ Approved, not implemented

■ Under development ■ None

✓ Yes ✗ No — No data ✓ >75% of what is needed ◆ Between 50% and 75% ✗ <50% of what is needed

serve a minority of the region's population, the picture presented by the data is only partial. The significant financial (in cash or kind) contribution of households to improving water, sanitation and hygiene access is generally underestimated by sector professionals, and poor data in this area mean the sector still lacks a clear picture of household contributions (Jones et al, 2019).

2.2 National policies, strategies and resources for hygiene practices

Adequate financial and human resources are required for countries to implement successful and sustainable hygiene interventions. Policies provide enabling environments for promoting and implementing hygiene practices as well provision of access to hygiene services; while strategies are the tools for implementing policies. The summary of responses to GLAAS 2018/2019 country survey

(WHO, 2019a) on national policy, plans, financial and human resources for hygiene in some of the SADC countries are presented in Table 4.

The responses show that many of the 16 SADC countries by the 2018/2019 UN-Water Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) survey are taking steps to integrate hygiene into their policy and development plans in order to achieve SDG 6. However, a number of the countries are still in the process of developing and approving hygiene related policies and plans. The GLAAS country survey results also show that many countries in the SADC are unable to implement policies and plans because they lack human and financial resources. There is great need to improve resource base (financial and human resources) in order for countries to implementing hygiene interventions.





Water Hero Henrique Alberto Mandlate. Maputo, Mozambique.

WaterAid/ Laura Pannack

Table 5 presents the degree of support of national policies and strategies to hygiene practices in SADC countries. The white boxes indicate that either there is no such policy/strategy in the Member State (MS) or the available Policy/Strategy document could not be accessed at the time of the analysis.

The results of the analysis presented in Table 5 show that, the health policies in Lesotho, Malawi, South Africa and Tanzania provide strong enabling environment for promoting hygiene practices. Apart from the National Hygiene Policy, South Africa has a National Health Promotion Policy and Strategy which strongly support hygiene practices in the country. There is moderate support of health policy to hygiene practices in Zambia, but in Botswana, Comoros, Eswatini, Namibia and Seychelles, the support of health policy to hygiene practices is weak. Water policies in Eswatini and Malawi provide strong support to hygiene practices while the support of water policies to hygiene practices is weak in Botswana, Lesotho, Namibia, South Africa Tanzania and Zambia.

Sanitation policies provide strong support to hygiene practice in Malawi, South Africa and Zambia. The overall analysis shows that policies

on health, water, sanitation, environmental health, and to some extent nutrition provide enabling environment for implementation of hygiene practices in the region. The other policies provide either weak support to hygiene practices none at all. This analysis shows that there is still need to mainstream hygiene in most of national policies in order to broaden the enabling environment base for effective and sustainable promotion of hygiene practices. There is need for broad-based policy action to strengthen the enabling environment for hand hygiene programming, including the five building blocks promoted by Sanitation and Water for All (SWA): policies and strategies; institutional arrangements; financing; planning, monitoring and review; and capacity development.

The health strategies in most of the countries have strong linkages with hygiene practices (Table 5). In South Africa, the health promotion strategy which is part of the National Health Promotion Policy and Strategy, has very strong support for hygiene practices in the country. The other strategies that provide strong support to hygiene practices are water, sanitation, education, and environment strategies. However, there are huge gaps on strategies in most of the countries.

Table 5:
Degree of support of national policies and strategies to hygiene practices in SADC countries

Country	Angola		Botswana		Comoros		DRC		Eswatini		Lesotho		Madagascar		Malawi		Mauritius		Mozambique		Namibia		Seychelles		South Africa		Tanzania		Zambia		Zimbabwe		
Policy/Strategy	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	P	S	
National Health	🟢	🟡	🟢	🟡	🟢	🟡	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢		
National Health Promotion	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	
National Public Hygiene	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	
National Hand Hygiene Behaviour Change	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	
National Sanitation	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	
National Sanitation and Hygiene	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	
National Water	🟡	🟡	🟢	🟡	🟡	🟡	🟢	🟡	🟡	🟢	🟡	🟢	🟡	🟢	🟡	🟢	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	🟢	
National Water Supply and Sanitation	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	
National Nutrition	🟢	🟡	🟡	🟡	🟢	🟡	🟡	🟢	🟡	🟡	🟢	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟢	
National Food and Nutrition	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	
National Food and Nutrition Security	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟢	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National Environmental	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National Environmental Health	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National Gender	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟢	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National Education	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National School Health	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National School Health and Nutrition	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National Health and Hygiene Education	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National Environmental Health, Hygiene & Sanitation	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡
National Poverty Reduction	🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡	🟡

KEY ● Strong ● Moderate ● Weak ● None ● Not available or policy/strategy document could not be accessed ● P Policy ● S Strategy



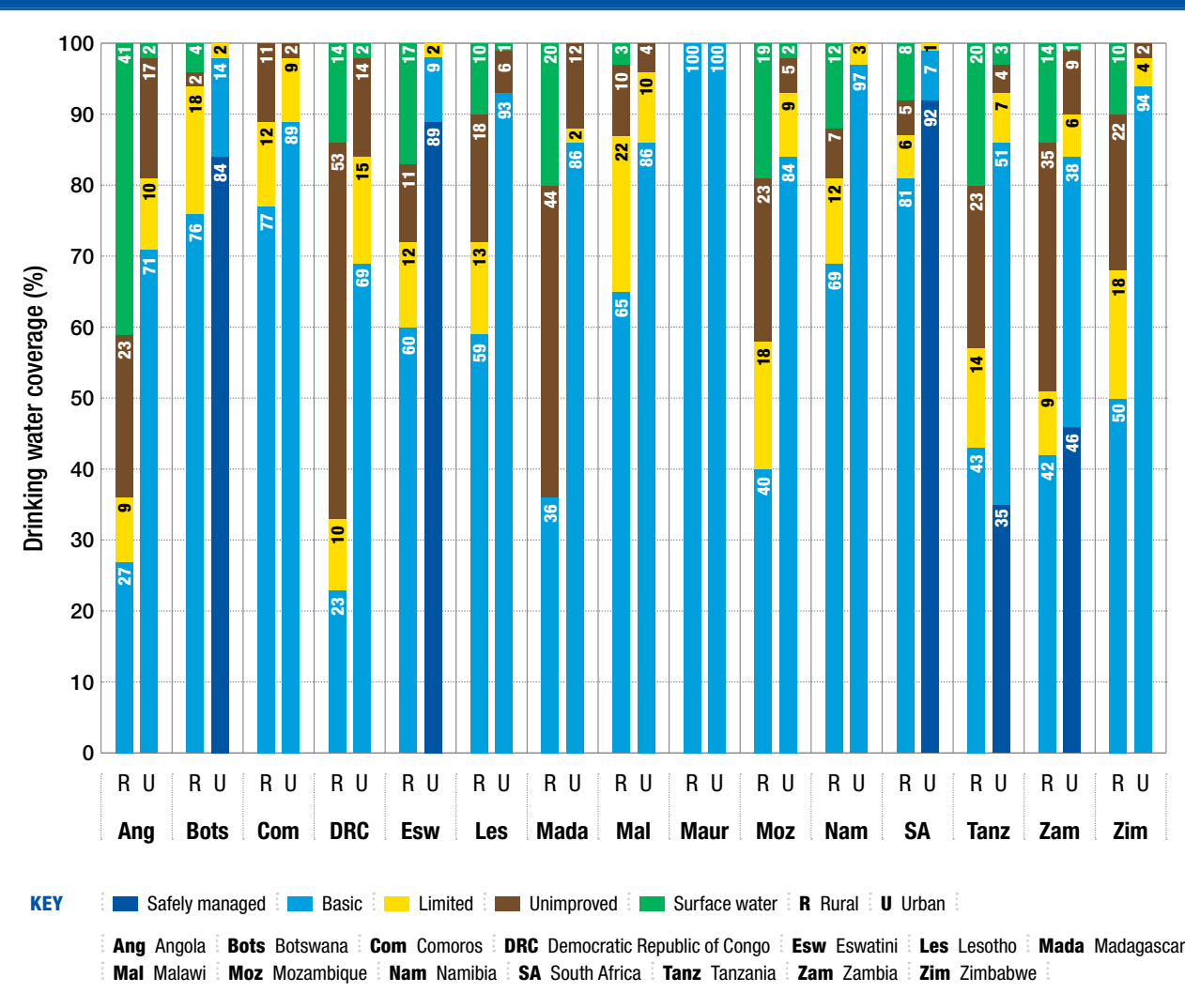
2.3 Water, sanitation and hygiene situation in the SADC region

Unsafe Water, inadequate Sanitation and poor Hygiene is the major cause of faecal infectious diseases in most poor countries. JMP (UNICEF, 2016) defined an improved drinking water source as the one which is located on premises; available when needed; and compliant with national water quality standards with respect to faecal contamination and chemical contaminants. Figure 3 presents levels of access to improved drinking water source in SADC countries as estimated by JMP in 2017. The 2017 data in Figure 4 shows that, in countries such as DRC (23%), Angola (27%), Zambia

(43%), Tanzania (43%), Mozambique (40%) and Madagascar (36%), less than 50% of the rural population have access to basic drinking water in their premises. The situation in Tanzania has since improved tremendously such that basic rural water supply coverage increased from 48% in June 2015 to 70%; and urban water supply coverage increased from 72% in June 2015 to 85% in 2019¹⁹. The figure also shows that the drinking water source of $\geq 10\%$ of the people in rural areas in Angola (41%) DRC (15%), Eswatini (17%), Lesotho (10%), Madagascar (10%), Mozambique (19%), Namibia (12%) United Republic of Tanzania (20%), Zambia (14%) and Zimbabwe (10%) is surface water. This presents high risk from polluted water as

Figure 2:
Coverage of rural and urban drinking water service level in some SADC countries, 2017

Source: WHO, 2020 <https://washdata.org/data/household#!/dashboard/new>



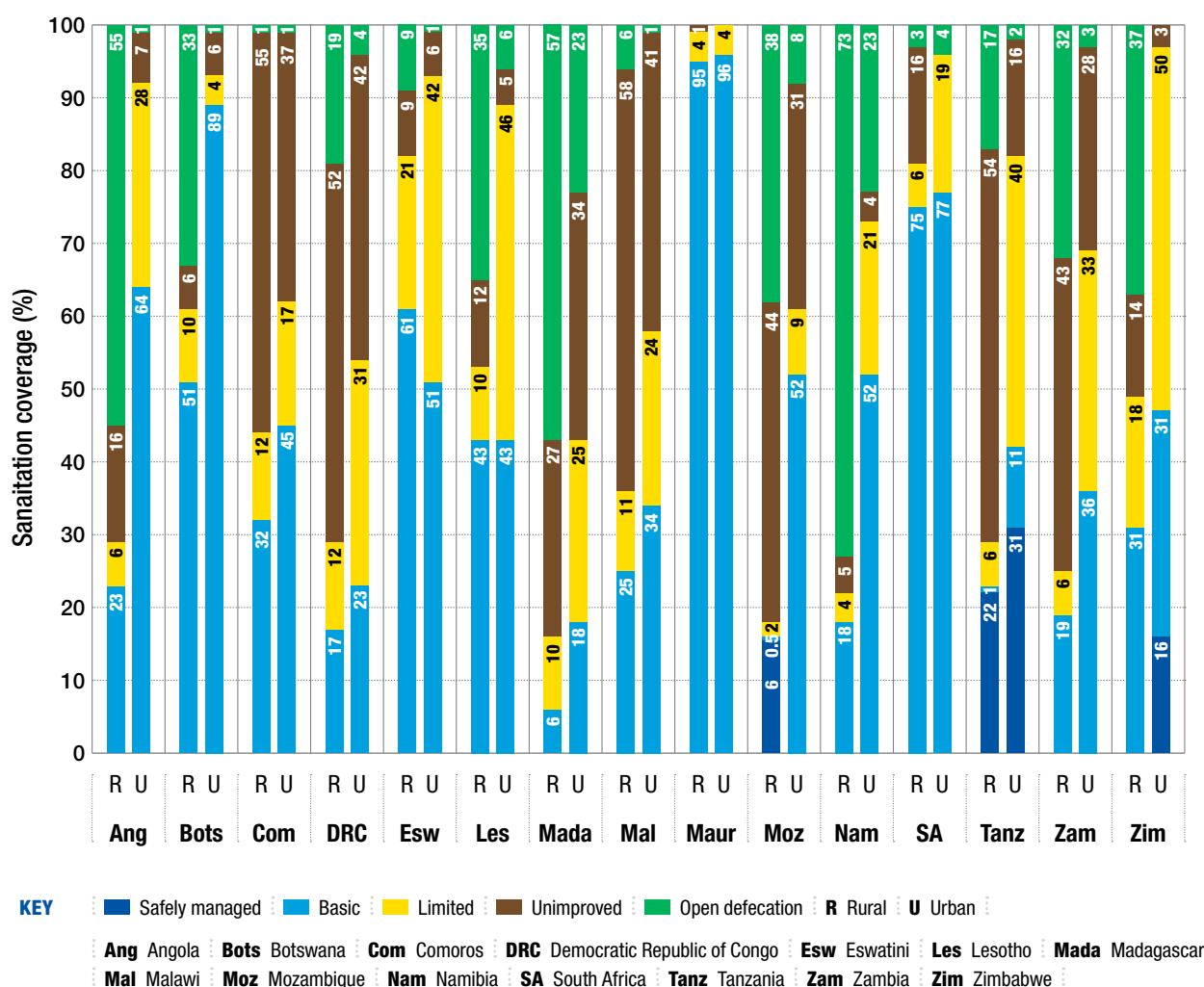
well as the risk of post-collection contamination during transportation and storage. This is further compounded by the fact that household drinking water treatment is not commonly practiced throughout the region (WaterAid, 2018). The data show that more than 50% of the urban population in the countries has access to safely managed drinking water services. Since 2017 when the JMP data given in Figure 2 were taken, there have been some improvements in Madagascar where 2018-2019 data show that basic coverage of drinking water services in rural areas is 32%, limited coverage is 2% unimproved coverage is 41% and no service is 25%, and the corresponding levels are 69% for basic, 4% for limited, 19% for unimproved and 8% for no service²⁰.

Furthermore, JMP (WHO and UNICEF, 2019a) define improved sanitation facility as one which is not shared with other households; where excreta (including infant and child faeces) are safely disposed in situ or transported and treated off-site; and where a handwashing facility with soap and water is present. On the other hand, unimproved sanitation entails use of the following facilities: flush or pour-flush to elsewhere (that is, not to a piped sewer system, septic tank or pit latrine); pit latrine without slab / open pit; bucket; hanging toilet or hanging latrine; shared facilities of any type; and no facilities, bush or field.

The sanitation coverage as assessed in 2017 in SADC countries (except Seychelles) is presented in Figure 3. Except for Mauritius (95%), South Africa (75%) and Botswana (51%) and Eswatini

Figure 3:
Coverage of rural and urban sanitation service level in some SADC countries, 2017

Source: WHO, 2020 <https://washdata.org/data/household#!/dashboard/new>





Melody, 13, and other female pupils washing their hands with soap at the sinks in the toilet block, Simango School, Kazungula District, Zambia.

WaterAid/ Chileshe Chanda

(61%), less than half of rural populations in Southern African countries have access to improved sanitation. The figure also shows that less than 50% of the people living in urban areas in Comoros (45%), DRC (23%), Lesotho (43%), Madagascar (18%), Malawi (34%), Tanzania (41%), Zambia (36% and Zimbabwe (36%) have access to basic and safely managed sanitation services. Therefore, safely managed sanitation services require good hygiene practices for substantial public health gain.

In Madagascar 2018-2019 data show that levels of sanitation coverage have improved such that basic coverage of sanitation services in rural areas is 16%, limited coverage is 25% unimproved coverage is 14% and no service is 45%, and the corresponding levels are 22% for basic, 44% for limited, 13% for unimproved and 21% for no service.²¹

Hygiene refers to the conditions and practices that help maintain health and prevent spread of disease including handwashing, menstrual hygiene management and food hygiene. According to JMP (WHO, 2020), the presence of a handwashing facility with soap and water on premises has been identified as the priority indicator for global monitoring of hygiene. Households that have a handwashing facility with soap and water available on premises meet the criteria for a basic hygiene facility. Households that have a facility, but lack water or soap are classified as having a limited hygiene facility, and distinguished from households that have no hygiene facility at all. In some cultures, ash, soil, sand or other materials are used as handwashing agents, but these are less effective than soap and are therefore counted as limited handwashing facilities (WHO, 2020).

Figure 4:
Coverage of rural and urban hygiene service level in some SADC countries, 2017

Source: WHO, 2020 <https://washdata.org/data/household#!/dashboard/new>

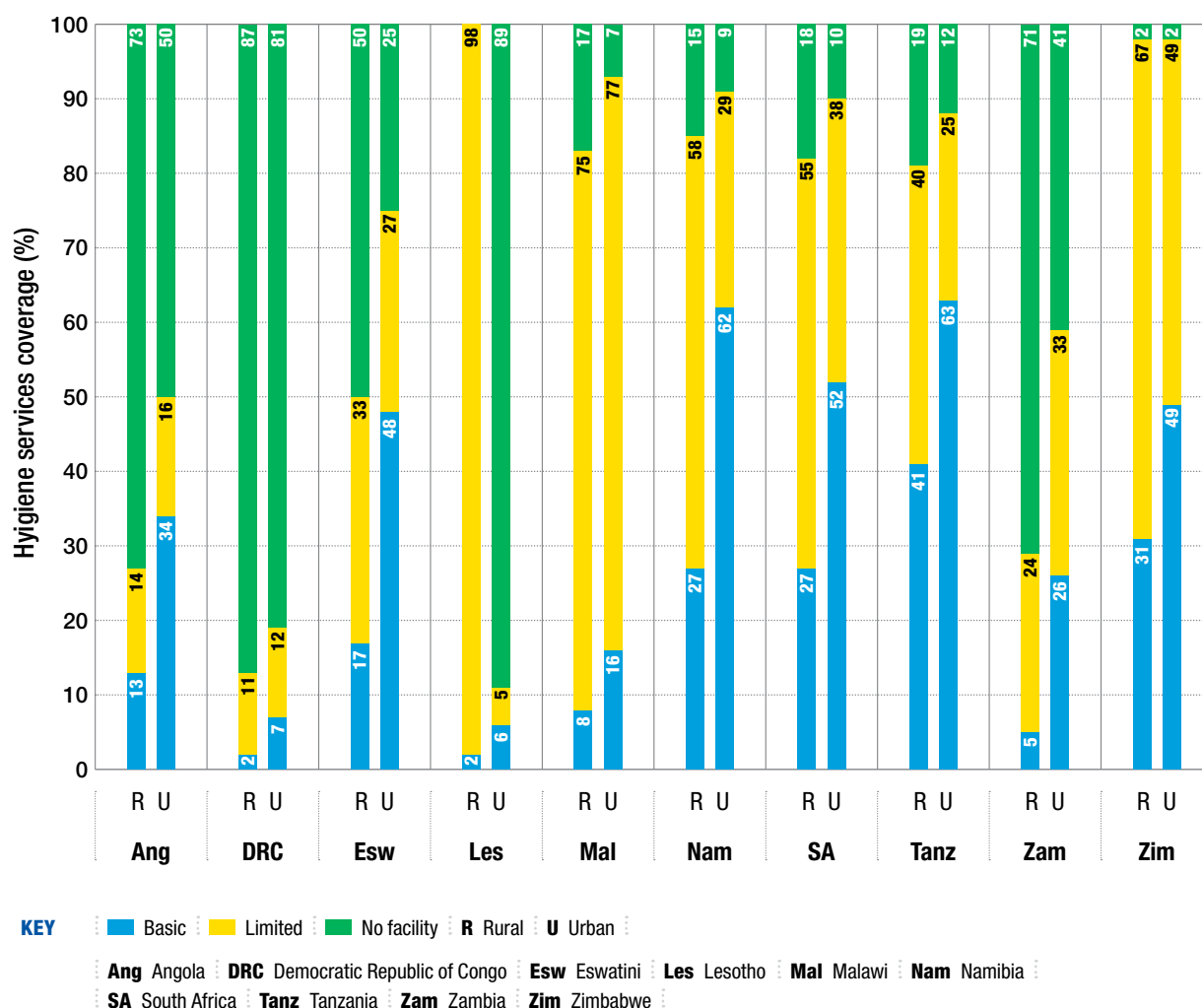


Figure 4 presents levels of access to hygiene facilities in rural and urban areas in some SADC countries as estimated by JMP in 2017. The data in the figure show that more than 70% of the population in rural areas in Angola (73%), DRC (87%), Lesotho (98%) and Zambia (71%) do have access to hygiene facilities. The data also show that, except for Tanzania (40%) and Zimbabwe (31%), less than 30% of the rural population has access to limited hygiene facilities in the region. Less than half of rural populations in Southern African countries have access to improved sanitation. The data show that more than 30% of the rural populations in Eswatini (33%), Malawi (75%), Namibia (58%), South Africa (55%), Tanzania (40%) and Zimbabwe (67%) have access to limited hygiene facilities. Less than 10% of the populations

living in urban areas in DRC (7%) and Lesotho (6%) have access to basic hygiene facilities. Subsequently access to hygiene facilities influence good hygiene practices.

In Madagascar 2018-2019 data show that levels of hygiene coverage have improved so much that basic coverage of hygiene services in rural areas is 18%, limited coverage is 45% no installation is 37%, and the corresponding levels are 38% for basic, 40% for limited, and 22% for no installation.²²

2.4 Hygiene practices in the SADC region

Good hygiene practices are important for health and social well-being. Hygiene practices include personal hygiene such as hand washing with

soap and overall cleanliness the most integral part of disease prevention.

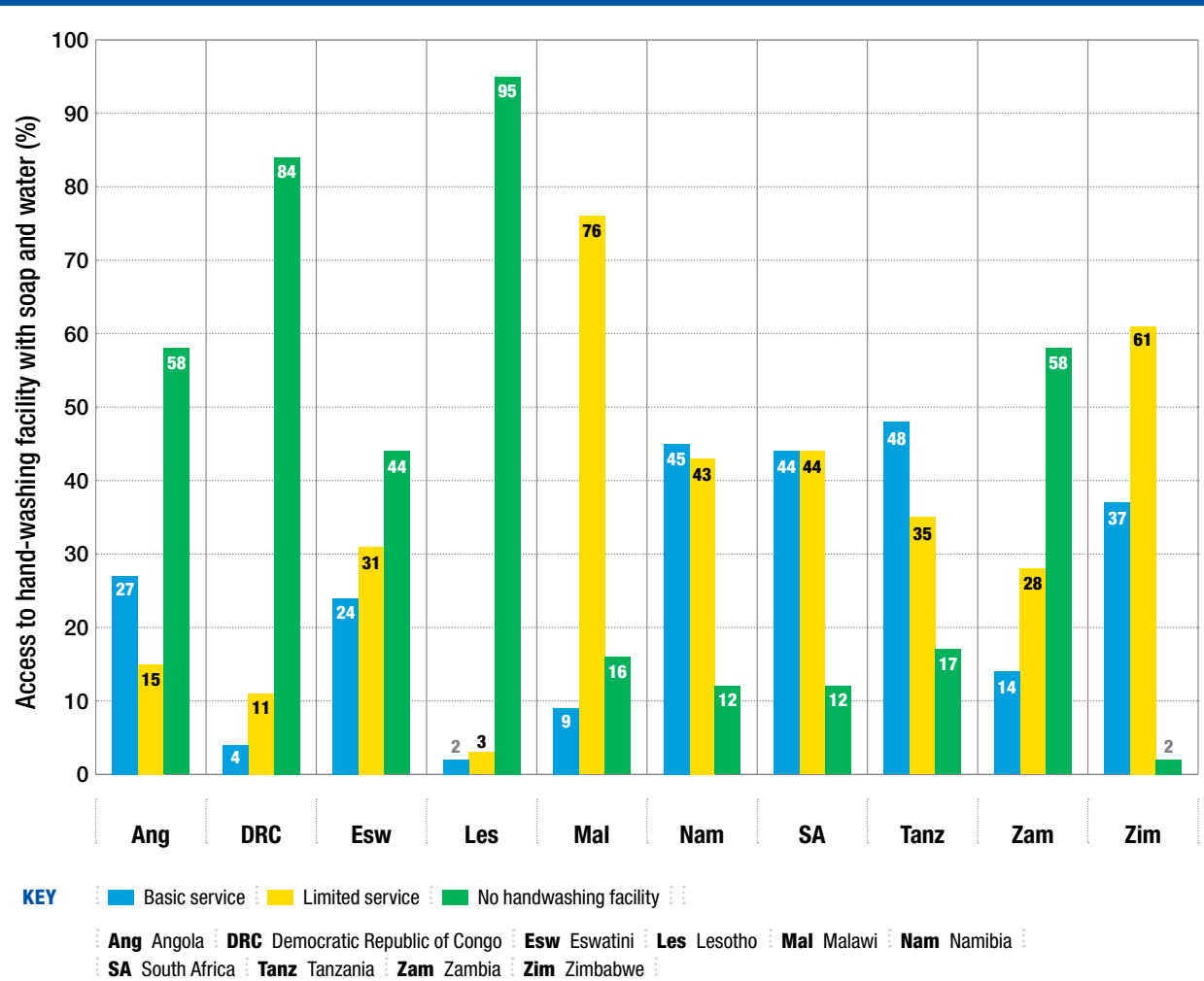
Handwashing with soap (HWWS) is one of the most cost-effective interventions to prevent top causes of under-5 mortality in developing countries. The importance of handwashing as a hygiene practices is highlighted in the Sustainable Development Goals (SDGs). The SDG target 6.2 includes an explicit reference to achieving 'equitable hygiene for all'. Hygiene comprises a range of behaviours that help to maintain health and prevent the spread of diseases, including handwashing, menstrual hygiene management and food hygiene. The indicator selected for global monitoring of SDG 6.2 is the proportion of the population with a handwashing facility with soap and water

available at home (UNICEF and WHO, 2019). A basic handwashing facility is defined as a facility with soap and water available on premises. Handwashing facilities may be fixed or mobile and include a sink with tap water, buckets with taps, tippy-taps, and plugs or basins designated for handwashing. Soap includes bar soap, liquid soap, powder detergent, and soapy water but does not include with ash, soil, sand or other handwashing agents (UNICEF and WHO, 2019).

Evidence shows that handwashing with soap can reduce diarrhoea by almost 50% and respiratory infections (including pneumonia) by almost 36%.²³ The status of handwashing with soap (HWWS) in some of the SADC countries is presented in Figure 5. The figure contains countries for which data were available and

Figure 5:
Proportion of population using a hand-washing facility with soap and water (%)
in some of SADC countries in 2017

Source: UN Water, 2019



accessible to UN Water (2019) at the time they were compiling their report. The data show that handwashing access in the region is very low especially amongst rural populations. In the five countries of Lesotho (2%), DRC (4%), Malawi (9%), Zambia (14%) and Eswatini (24%), the access to basic handwashing is less than 25% while more than 55% of the population have no access to handwashing facilities. The situation is dire in Lesotho, DRC Angola and Zambia.

The information acquired from the SADC region show gaps in relation to food hygiene, water treatment and menstrual hygiene practices. In most SADC countries where there is lack of continuous water supply, other unsafe water sources are used without any form of treatment. Water is collected and stored in dirty containers which makes it to be vulnerable to contamination. The shortage of water contributes to low productive activities and absenteeism in schools as children and girls have to walk long distances looking for water.

Maintaining improved menstrual hygiene practices in the SADC region is one of the hygiene-related challenges. Most sanitary facilities such as toilets are few as compared to

the number of school children available, facilities are not safe and do not provide privacy while hand washing facilities with soap are limited or not provided. Most of the children do not have access to hygienic sanitary products such as pads. Most of them use cloth, toilet papers and any other materials they find it working for them. It is amongst these reasons that some of the girls find it suitable not to go to school during menstrual period.

2.5 Hygiene in some settings in SADC region

2.5.1 WASH services in schools and other settings

Access to safe water, sanitation and hygiene (WASH) in schools (WinS) is integral to the well-being of children and their right to quality education (Fadda et al., 2012). The impact of WinS is multifaceted as it makes a crosscutting contribution to achievement of the Millennium Development Goals (MDGs) through impacting universal primary education, gender equality and environmental sustainability (Chatterley and Thomas, 2013). It is important that learners have secured access to safe water and adequate



Menstrual Hygiene Management training with WaterAid for boys and girls (class five) in Tsimahavaobe School. Morondava commune, Menabe region, Madagascar.

WaterAid/ Ernest Randriarimalala

hygiene and sanitation which indirectly secures their right to education, dignity, life, and equality. UNICEF have produced a *Child Friendly Schools (CFS) Manual* which underscores the notion that to be truly child-friendly a school must have accessible, gender-appropriate toilets and hand-washing facilities, access to potable drinking water and solid waste management with proper boundaries (UNICEF, 2012). It is important that the school must also teach children appropriate hygiene practices. WASH in Schools is a pathway to healthier schools and healthier, better performing children (UNICEF, 2012).

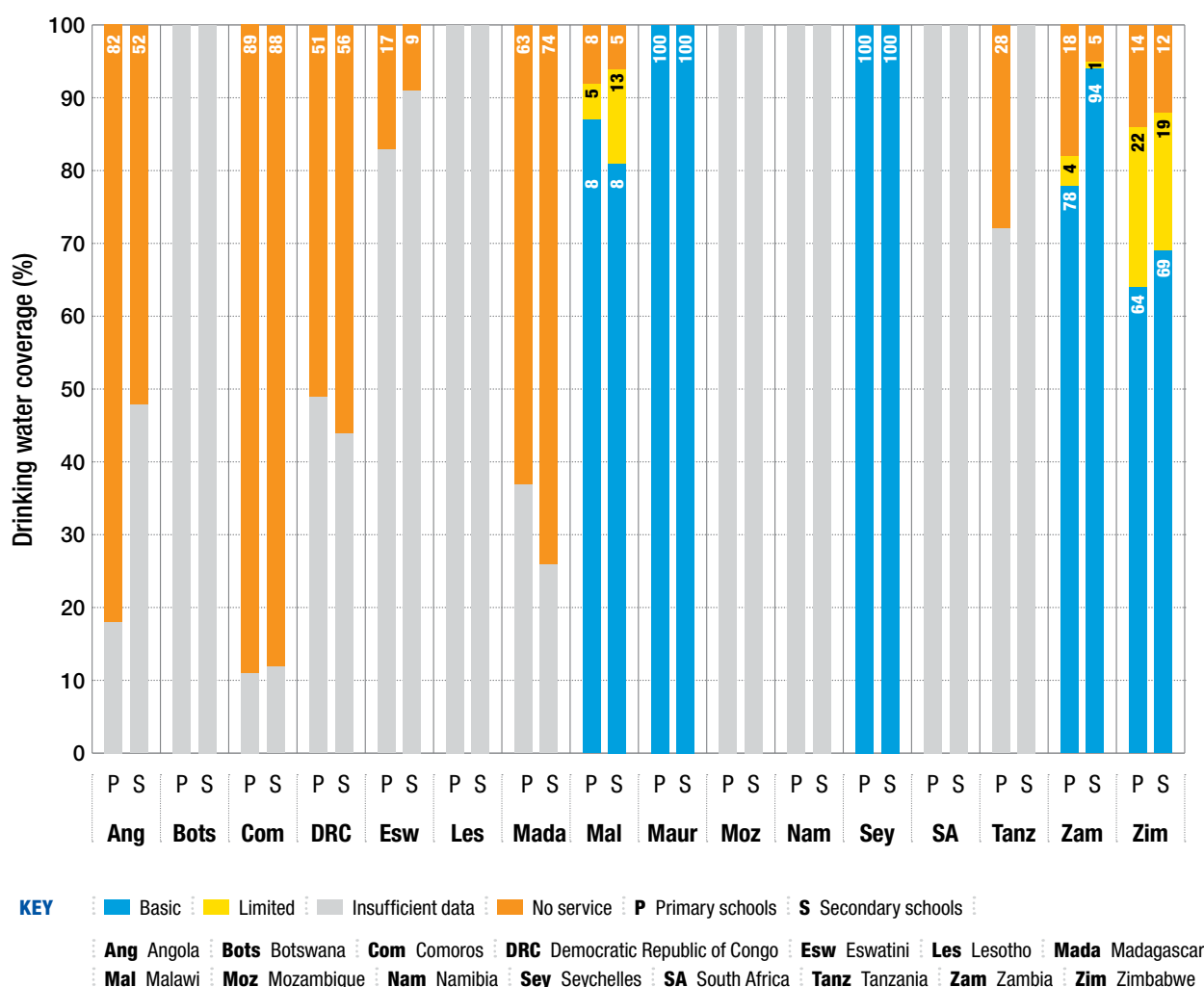
However, based on the countries where data are available, there is a lot that needs to be done to improve basic drinking water services in primary

and secondary schools in the region except for Seychelles and Mauritius (Fig. 6). In Tanzania, assessment conducted in 2018 shows that, in schools, access to basic water services is 55.3%, to limited water services is 12.3% and to no water services is 31.8% (NBS, 2020).

The availability of functional and private school toilets can positively impact health and learning outcomes, particularly for girls. A basic sanitation service means that schools have improved sanitation facilities that are usable and single-sex (UNICEF and WHO, 2018). Chatterley and Thomas (2013) reported that on average, data suggested that 45% of schools in the eastern and southern Africa have access to adequate sanitation. In the SADC region, there is general

Figure 6:
Coverage of drinking water in primary and secondary schools in some SADC countries, 2017

Source: WHO, 2020 <https://washdata.org/data/household#!/dashboard/new>



lack of availability of sanitation data in schools as shown in Figure 7. Except for Mauritius and Seychelles, there is need for improvement in coverage of basic sanitation service in primary and secondary schools in the region (Fig. 7). In Tanzania, 2018 assessment shows that, in schools, access to basic sanitation services is 30.3%, to limited sanitation services is 58.4% and to no sanitation services is 11.3% (NBS, 2020).

Handwashing has strong links to health, particularly in public or institutional settings. Despite the importance of handwashing with soap, nearly 818 million children (43%) lacked a basic hygiene service at their school in 2019 (UNICEF and WHO, 2020). A basic hygiene service means schools have a handwashing facility with water and soap available (UNICEF

and WHO, 2018). The situation in the SADC region is masked by general lack of hygiene service data in schools (Fig. 8). Once again, with exception of Mauritius and Seychelles, the available data indicate that there are limited hygiene services in primary and secondary schools in the region. The 2018 assessment in Tanzania shows that, in schools, access to basic hygiene services is 17.6%, to limited hygiene services is 27.6% and to no hygiene services is 54.8% (NBS, 2020).

Recent interviews held with some of the member states indicated major challenges related to hygiene in schools such as poor infrastructure, overcrowded facilities, lack of handwashing facilities and facilities supporting menstrual hygiene. Some of the facilities were not safe and makes girls vulnerable to sexual harassment.

Figure 7:
Coverage of sanitation in primary and secondary schools in some SADC countries, 2017

Source: WHO, 2020b <https://washdata.org/data/household#!/dashboard/new>

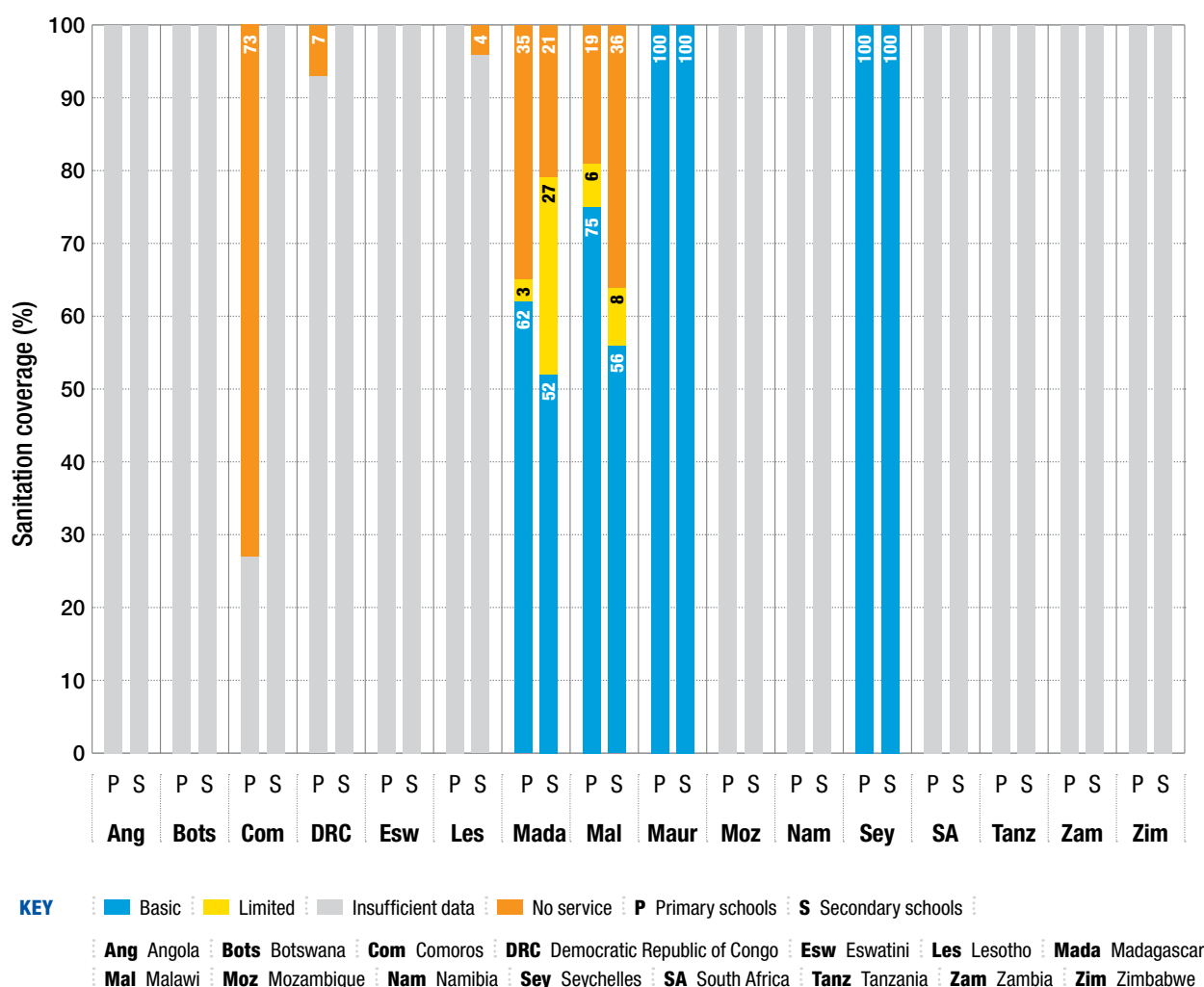
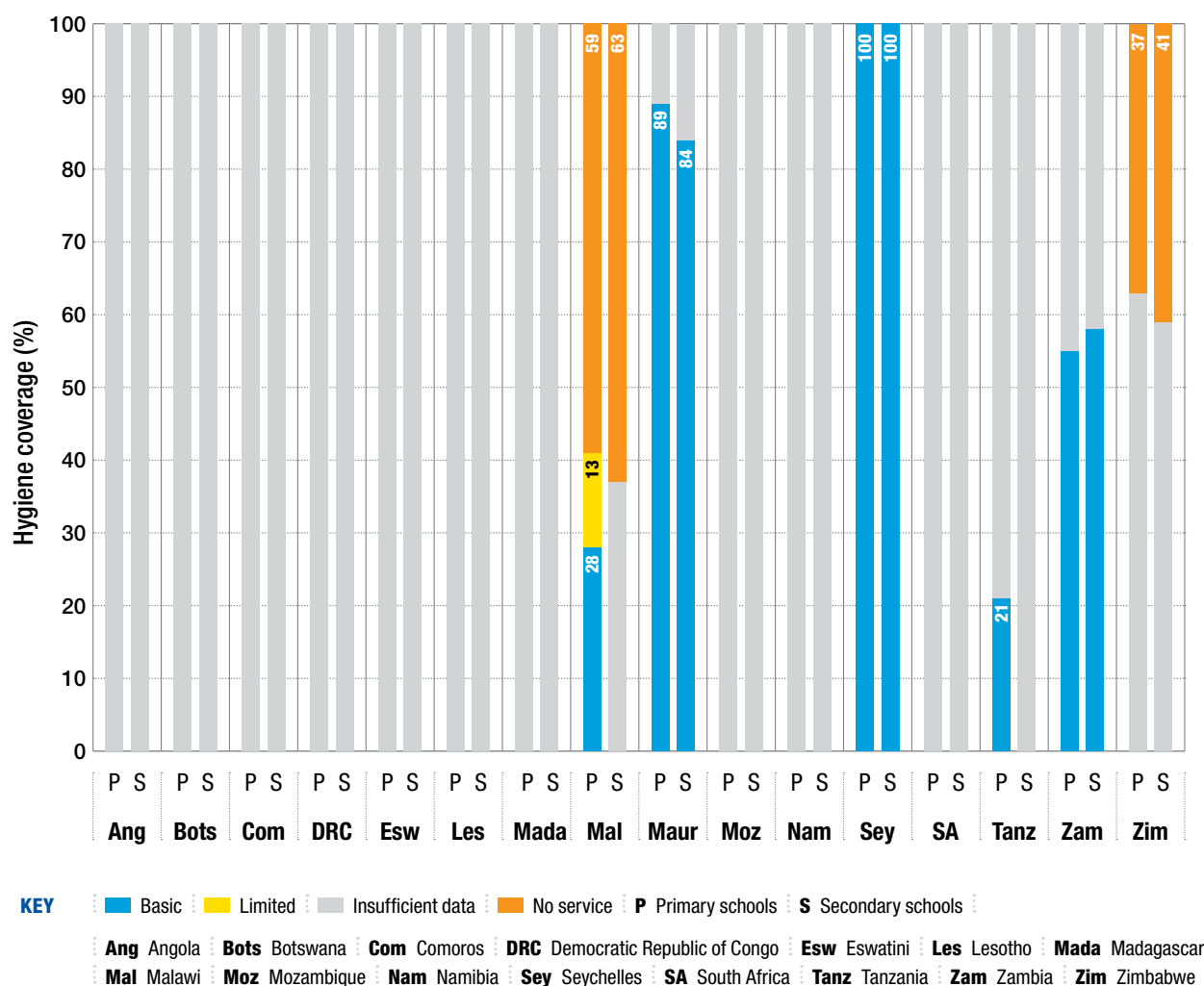


Figure 8:
Coverage of hygiene in primary and secondary schools in some SADC countries, 2017

Source: WHO, 2020b <https://washdata.org/data/household#!/dashboard/new>



2.5.2 WASH services in health care facilities

In recent times, several developments have helped strategically position WASH in health care facilities (WinHCF) as a priority on the global developmental agenda (Ofori-Kuma, 2019). Availability of sustainable water, sanitation and hygiene (WASH) services is essential to quality of care and infection prevention and control in health care facilities (Ofori-Kuma, 2019). SADC members Malawi, Mozambique, Tanzania, Zambia and Zimbabwe attended a WASH in HCF global meeting, From resolution to revolution, in September 2019 in Zambia (WHO and UNICEF, 2019b). One of the resolutions was to strengthen understanding on how to advance national efforts to improve WASH in health care facilities.

There is a well-established linkage between safe water for hygiene and handwashing in health facilities and reduction in disease transmission. Given the importance of water availability and good hygiene during childbirth, WASH is considered both a precondition and an entry point for good quality of care (Ofori-Kuma, 2019). WASH in health care facilities refers to the provision of water, sanitation, health care waste management, hygiene and environmental cleaning infrastructure, and services across all parts of a facility (WHO, 2019b). According to WHO (2019), health care facilities encompass all formally recognized facilities that provide health care, including primary (health posts and clinics), secondary, and tertiary (district or national hospitals), public and private (including faith-run),

temporary structures designed for emergency contexts (e.g., cholera treatment centres) and mobile units.

Coverage of WASH service health care facilities is rated either as basic, advanced or no service based on the criteria developed by WHO and UNICEF (2019) which are described below. Health care facilities with an improved water source on-premises with water available at the time of the questionnaire or survey will be classified as having **basic** service (WHO and UNICEF, 2019a). Health care facilities with an improved water source without water available or that is off-premises (but within 500 metres) are classified as having **limited** service, and those with an improved source that is more than 500 metres from the premises, an unimproved source or no water source will be classified as **no service** (WHO and UNICEF, 2019a). In countries where basic service is already the norm, a country-defined **advanced** service level may be appropriate based on the national context, priorities and resources. Criteria for an advanced level might include normative elements such as water quality and water quantity.

Health care facilities with improved latrines or toilets which are usable, separated for patients and staff, separated for women with menstrual

hygiene facilities, and meet the needs of people with limited mobility are classified as having basic service (WHO and UNICEF, 2019a). The term usable here refers to toilets or latrines that are accessible to patients and staff (doors are unlocked or a key is available at all times), functional (the toilet is not broken, the toilet hole is not blocked, and water is available for flush/pour-flush toilets), and private (there are closable doors that lock from the inside and no large gaps in the structure). Health care facilities with improved latrines or toilets which do not meet all the criteria for basic service are classified as having limited service. Health care facilities with unimproved or no toilets are classified as having no service. In countries where an advanced service level is appropriate, elements might include toilet cleanliness, toilet lighting, or patients per toilet ratios.

Basic hand hygiene in health care facilities is defined by two main criteria: (1) either alcohol hand-rub or a basin with water and soap are available at points of care, and (2) handwashing facilities with water and soap are available at the toilets (WHO and UNICEF, 2019a). Points of care are defined here as any location in the outpatient setting where care or treatment is delivered (i.e., consultation/exam rooms). According to WHO and UNICEF (2019), health care facilities with

Olga, 16, at a hand wash station provided by WaterAid at Mpolonjeni High School in Mpolonjeni, Lubombo Province, Eswatini.

WaterAid/ Nyani Quarmyne/ Panos



hand hygiene materials at either points of care or the toilets, but not both are considered to have limited service, while those with no hand hygiene stations or with no cleansing materials are classified as having no service. An advanced level for hygiene might include availability of hand hygiene promotional materials near hand hygiene stations and/or the patient waiting area, or if hand hygiene facilities are accessible to all staff and patients.

Health care facilities where waste is safely segregated into at least three bins (sharps, infectious, and non-infectious) in the consultation area, and that safely treat and dispose of sharps and infectious waste are classified as having **basic** service (WHO and UNICEF, 2019a). According to WHO and UNICEF (2019), facilities that segregate waste but do not treat

and dispose of it safely, or that do not effectively segregate waste, are considered to have **limited** service. If waste is not segregated or safely treated and disposed of, the facility is classified as having **no service**. An advanced level for health care waste management might include whether functional needle cutters or hub cutters are available near sharps bins, or if bins are out of reach of patients, particularly children. Health care facilities with basic protocols for cleaning and where all staff with cleaning responsibilities have been trained are classified as providing a **basic** service (WHO and UNICEF, 2019a). Facilities with cleaning protocols and/or where at least some staff with cleaning responsibilities have received training have **limited** service. If there are no cleaning protocols available and no staff have received training, the facility is

Figure 9:
Coverage of water services in health care facilities in some SADC countries, 2017

Source: WHO, 2020b <https://washdata.org/data/household#!/dashboard/new>

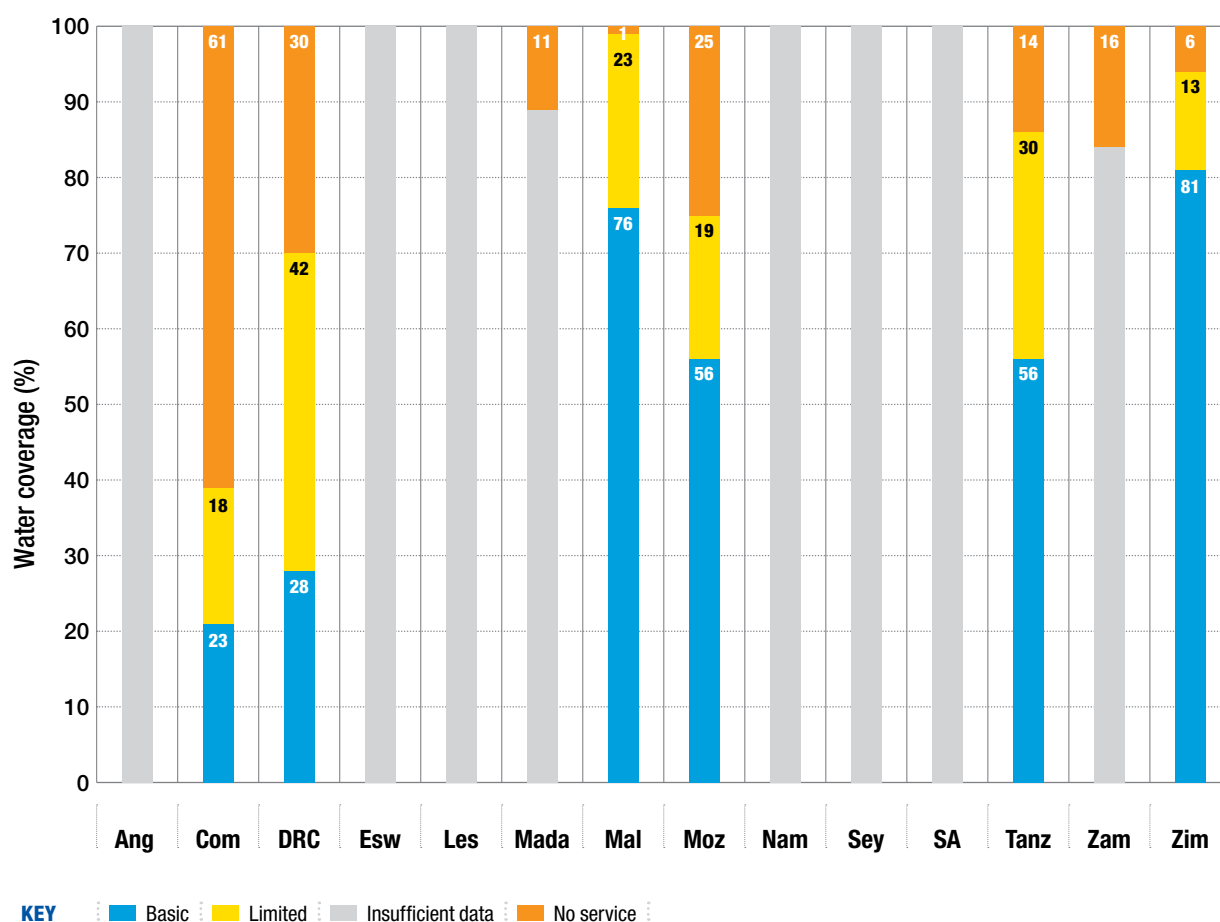
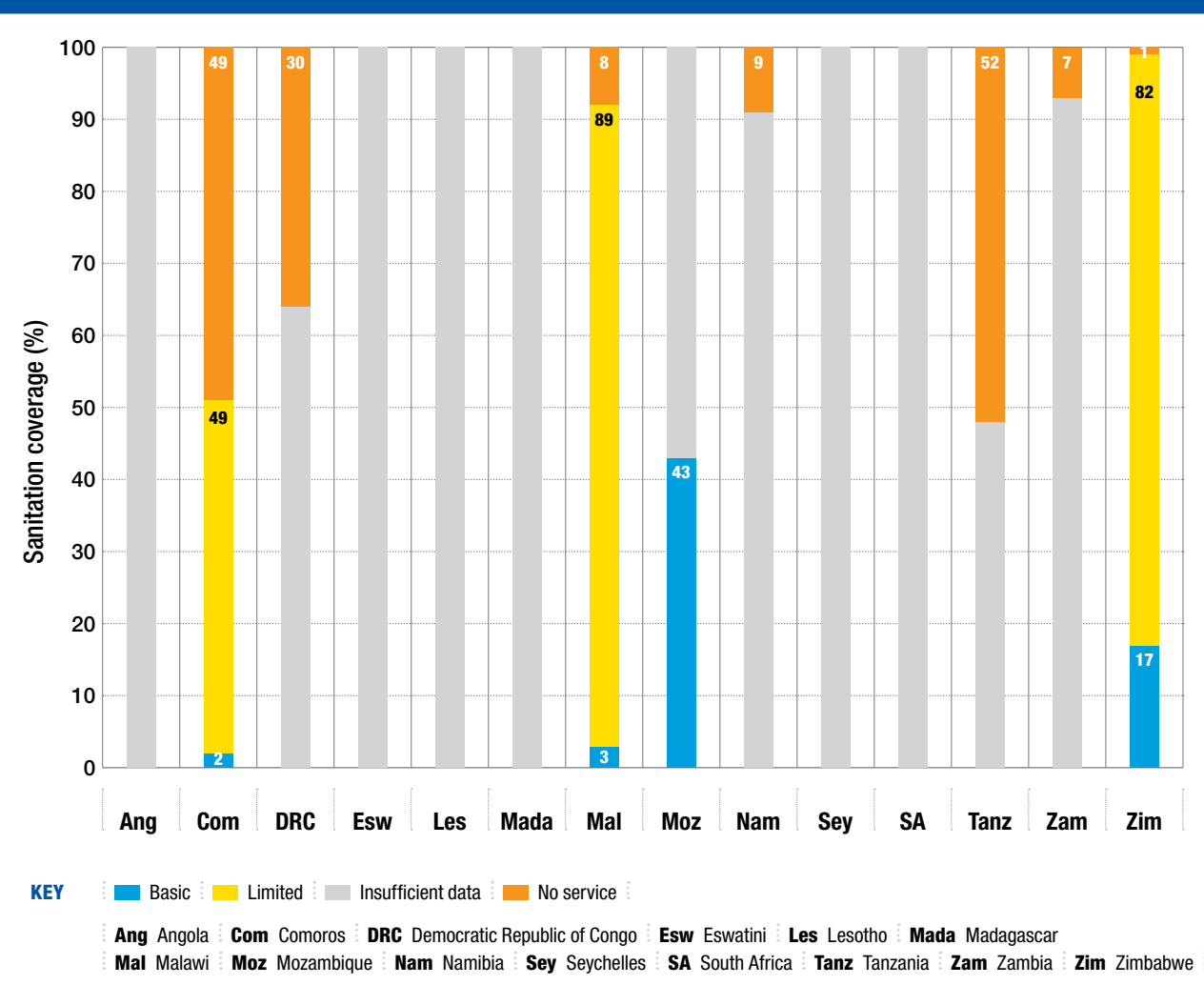


Figure 10:
Coverage of sanitation services in health care facilities in some SADC countries, 2017

Source: WHO, 2020b <https://washdata.org/data/household#!/dashboard/new>



considered to have **no service**. An **advanced** level for environmental cleaning might include whether disinfectants are available or observed cleanliness of points of care.

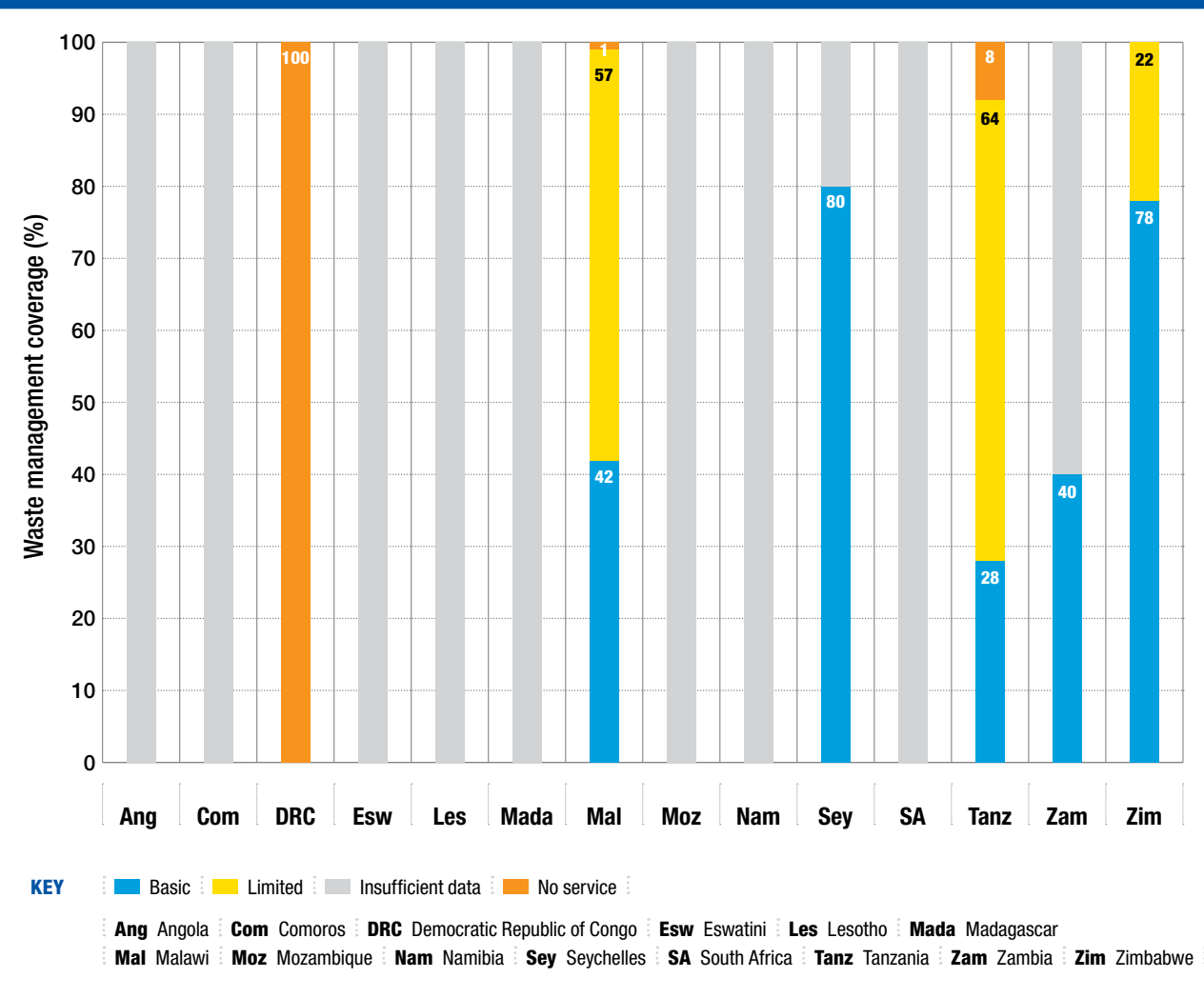
The available data shows that Zimbabwe, Malawi and Comoros are the only countries with complete coverage data across all service ladders for four out of the five WinHCF indicators. Hence, partial assessment of coverages of water, sanitation, hygiene, waste management and environmental cleaning services in health care facilities in SADC countries is presented in Figures 9 to 11. The assessment is partial because of lack of data in most of the SADC countries. The available data show that there is more than 50% coverage of basic water services in health care facilities in Malawi, Mozambique, Tanzania and Zimbabwe

while coverage is less than 50% coverage for basic water in the other countries (Fig. 9).

The available data shows that there is limited coverage of sanitation services in health care facilities in Comoros. Malawi and Zimbabwe (Fig. 10). Limited data available from countries in the region to estimate the hygiene services in healthcare facilities. Zimbabwe reported 58% and Malawi 25% basic hygiene services in healthcare facilities. Similarly, limited data available on basic waste management services in the region. More than 50% basic waste management service reported by Seychelles and Zimbabwe but limited services in DRC, Malawi and Tanzania (Fig 11). Malawi is the only country with data on environmental cleaning services in healthcare facilities reporting only 25% safely managed environmental cleaning services.

Figure 11:
Coverage of waste management services in health care facilities
in some SADC countries, 2017

Source: WHO, 2020b <https://washdata.org/data/household#!/dashboard/new>



It was noted during the recent interviews with member states that some of the health facilities share drinking water facilities with the public; whereas some access water on the street. Such facilities were reported to provide services without water, which contribute to health outcomes of the patients. Handwashing with soap was identified as one of the major challenges as some of the health facilities experience shortage of handwashing soaps.

2.5.3 WASH services in refugee camps

Refugee camps are emergency places where displaced people affected by natural disasters conflicts or wars leave their homes for safety and temporary shelter. Such places are usually not safe as they depend on unsafe water for

domestic chores. Sanitation is also a challenge as most people often practice open defecation (OD) or use unimproved sanitation facilities. Providing WASH services in such areas become more important. In SADC region many of the private agencies found internationally and locally are the ones providing WASH services. Private sectors believe that providing immediate WASH services to the camps and areas where the displaced or refugee people are living are fundamental in improving public health in those areas and their surroundings. However, security restrictions, complex operational conditions, scarce resources, understaffing, the difficulty of undertaking thorough measurements during emergency situations makes it difficult to achieve WASH in refugee settings (Cronin et al., 2008).

2.6 Cross-cutting factors related to hygiene

Hygiene is interconnected with many other sectors (health, water, sanitation, nutrition, environment, and education, among others) and cross-cutting issues (gender). So, it is important that a multi-sectoral and cross-government approach is taken to ensure that all needs are considered.

2.6.1 Burden of diseases related to hygiene

Personal and public hygiene implementation is a key step to control transmission and prevent community outbreaks of pandemics. Mortality caused by exposure to unsafe water, sanitation and hygiene (WASH) services is an indicator under SDG Target 3.9. Where there are no safe and clean toilets to go to, people are exposed to disease, lack of privacy and indignity. When communities defecate in the open, diseases spread fast and unprotected water sources are polluted. In 2012, an estimated 871 000 deaths mostly from infectious diseases) were caused by the contamination of drinking-water, bodies of water (such as rivers and reservoirs) and soil, and by inadequate hand-washing facilities and practices resulting from inadequate or inappropriate services (WHO, 2020a).

Steady progress is being made against mostly from infectious diseases) were caused by the contamination of drinking-water, bodies of water (such as rivers and reservoirs) and soil, and by inadequate hand-washing facilities and practices resulting from inadequate or inappropriate services (WHO, 2020a). Overall access to essential health services improved globally from 2000 to 2017, with the strongest increase in low- and lower-middle-income countries (WHO, 2020a). Yet, service coverage in low- and middle-income countries remains well below coverage in wealthier ones. Due to the serious inadequacy of service coverage in low-resource settings, the overall access to essential health services is still way below optimum. The situation in the SADC regions reported by WHO (2020a) that there were some improvements in the quality of health and wellbeing. However, there were worrying trends of increasing mortality, incidence and prevalence infectious and non-infectious diseases and low levels of

immunization coverage and health services in some countries in the region. The report further indicates that WASH mortality rate in Comoros and Democratic Republic of Congo was more than 50% while it is between 40% and 50% in Angola and Lesotho. WASH mortality rates in Madagascar, Tanzania and Zambia are between 30% and 40% and those of Eswatini, Malawi, Mozambique and Zimbabwe 20% and 30%.

HIV and Aids burden

People living with HIV/AIDS are susceptible for opportunistic infection such as diarrhoea, cholera, skin diseases etc. Access to services and key hygiene practice help to protect from opportunistic infection and improve quality of life. Diarrhoea caused by poor hygiene remains a leading cause of death across southern Africa – particularly for children under five years old and for person/people living with HIV (PLHIV), whose risk of serious illness and death through faecal to oral disease, such as diarrhoea, cholera, cryptosporidiosis (disease caused by *Cryptosporidium parvum*), typhoid, dysentery and hepatitis A and E is very high (WaterAid and SAfAIDS, 2015). Improved access to sanitation and safe water, combined with improved personal hygiene, can dramatically improve the health of communities. SADC countries have the highest morbidity of human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS), with approximately 26 million people living with the disease in 2015 (IHME, 2020). Against the challenges of low accessing to water, sanitation and HWWS,



A girl doing laundry in a riverbed in Ka-Ben, Lubombo Province, Eswatini.

WaterAid/ Nyani Quarmyne/ Panos

most of some of the countries in the region also grapple with the burden of HIV/AIDS. Eswatini, Lesotho, South Africa are the worst hit countries in the region. HIV/AIDS impacts negatively on hygiene practices and systems. Hence, countries that have high burden of HIV/AIDS require support to develop their hygiene infrastructure.

COVID-19 and future pandemics in the context of hygiene

The Southern African Development Community (SADC) recorded its first case of COVID-19 in early March, and since then, the numbers increased exponentially so that by 15th April, 2020, fourteen (14) of the sixteen (16) SADC Member States had been seriously affected by COVID-19 – Angola, Botswana, Eswatini, Democratic Republic of Congo, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, United Republic of Tanzania, Zambia and Zimbabwe (SADC, 2020c). Hygiene behaviours including handwashing with soap are seen as first line of defence to COVID-19. Covid-19 has brought hygiene into the spotlight which include personal, hand and home hygiene as well as hygiene in public

place, businesses and all other facilities. The provision of safe water, sanitation and waste management and hygienic conditions were proven to be very essential for preventing and for protecting human health during COVID-19 and all infectious disease outbreaks (COVID-19) (UNICEF, 2020b). Sustainable hygiene behaviour change programmes (including hand hygiene) should be integral to any development agenda, including containing COVID-19 and preventing future pandemics.²⁴ COVID-19 pandemic could form a baseline for management and prevention of other hygiene related future pandemics. Ensuring evidenced-based and consistently applied WASH and waste management practices in communities, homes, schools, public places, and health-care facilities will help prevent human-to-human transmission of pathogens including SARS-CoV-2, the virus that causes COVID-19 (WHO and UNICEF, 2020b). The statistics of COVID-19 cases and deaths in the SADC region as of September 2020 are presented Table 6. The cases per million show that the situation was very serious in South Africa, Eswatini and Namibia.

Table 6: Situation of COVID-19 in the SADC region as of September 2020

Source: SADC, 2020d

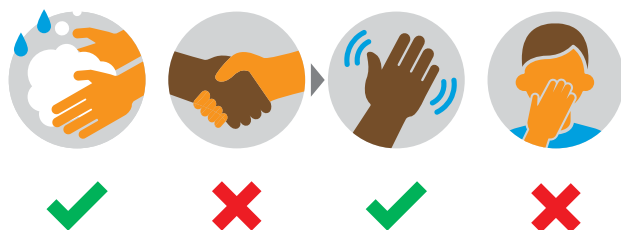
Country	Confirmed cases	Total deaths	Recoveries	Active	Cases per mil
Angola	2,654	108	1,071	1,475	80
Botswana	1,724	6	493	202	731
Comoros	423	7	399	17	485
DRC	10,097	258	133	706	112
Eswatini	4,577	91	3,529	957	3,938
Lesotho	1,085	31	528	526	506
Madagascar	14,863	192	13,832	839	535
Malawi	5,566	175	3,160	2,231	290
Mauritius	355	10	335	10	279
Mozambique	3,916	23	2,170	1,721	125
Namibia	7,550	75	3,327	4,148	2,963
Seychelles	136	0	127	9	1,382
South Africa	627,041	14,149	540,923	71,969	10,551
Tanzania	509	21	183	305	9
Zambia	12,097	288	11,469	340	655
Zimbabwe	6,497	202	5,221	1,074	436
SADC	699,090	15,636	586,900	86,529	2,137



Figure 12:
Basic personal and public hygiene practices

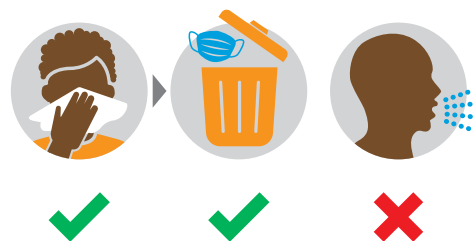
Adapted from: Chawla and Saxena, 2020

Good hand hygiene



- Wash hands with soap-water for at least 20 seconds or use alcohol-based sanitizer.
- Avoid handshakes – wave or say ‘hi!’
- Don’t touch your eyes, mouth or nose without sanitizing.

Good respiratory hygiene



- Cover your nose/mouth while sneezing/ coughing with a tissue.
- Use a medical mask.
- Discard used tissue/mask in a bin with a lid.

It is clear that the COVID-19 pandemic not only draws into focus the need to rebuild resilient health systems with increased access to quality health services, lowered financial cost and a strengthened health workforce, but also calls for the provision of services such as routine vaccinations and basic hygiene and sanitation (WHO, 2020a). The global response to COVID-19 has also underlined the importance of WASH, especially hygiene, in households, schools and health care facilities for reducing the transmission of infectious diseases and protecting global health (UNICEF and WHO, 2020). The WHO has aggressively promoted good hand hygiene and respiratory hygiene practices (Figure 12) which have shown to be very effective in limiting the spread of COVID-19 pandemic infections. These basic personal and public hygiene practices are certainly key to containing the spread of any future similar pandemics.

2.6.2 Nutrition status

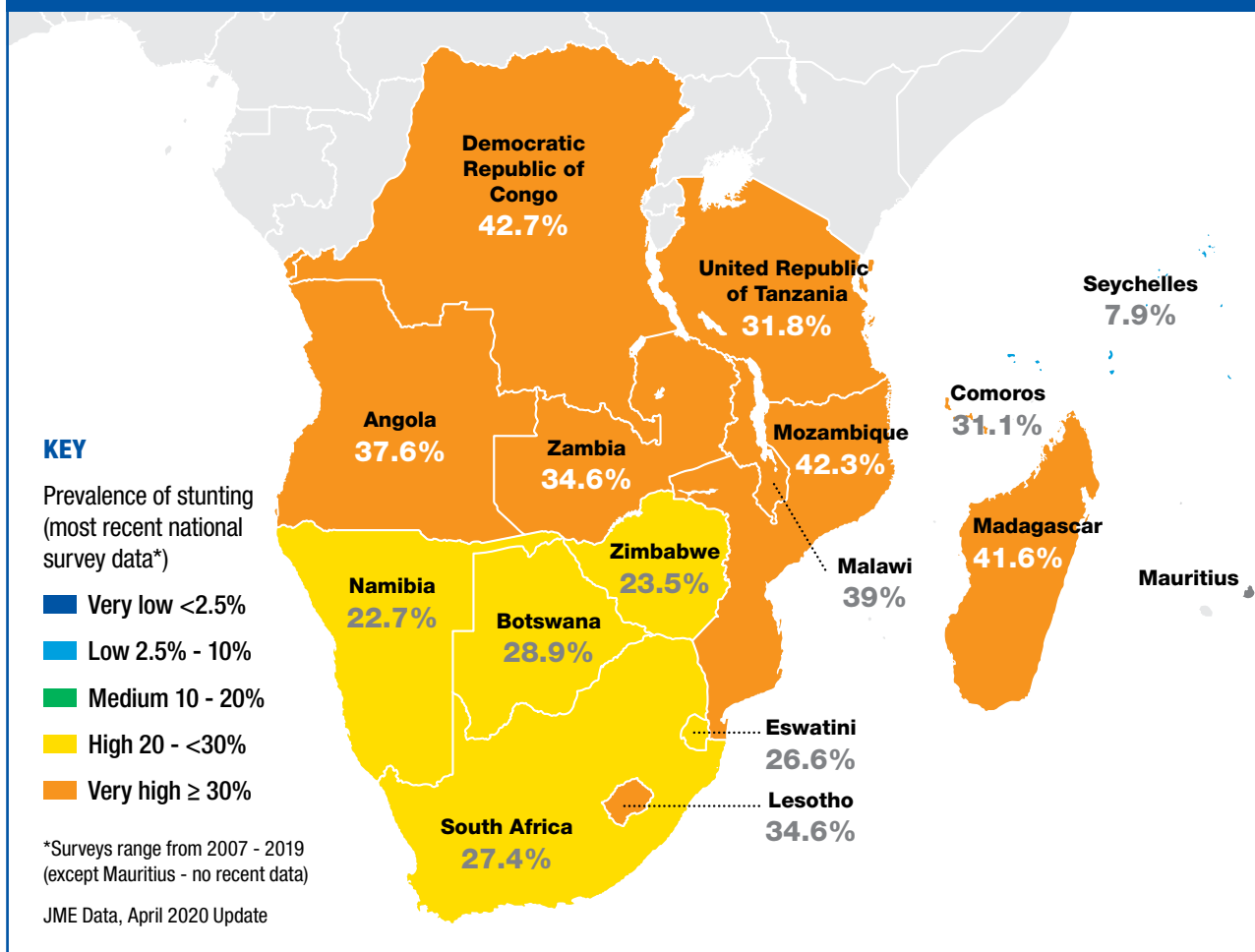
Malnutrition is the result of a complex set of interacting factors that are multi-sectoral, related to health, sanitation and care practices as well as consumption and access to food (SADC, 2018). Lack of access to safe water

and inadequate sanitation as well as poor food hygiene practices could lead to diarrhoea infection which could lead to poor adsorption of nutrients and increase the chance of infants and young children to be malnourished. The trend of early termination of breastfeeding and substituting with other forms of food and milk could lead to infection due to unhygienic meal preparation and improper mixing of such milk. Inability to practice hygiene during meal preparation could lead to diarrhoea infection, which could lead to death. Sometimes this could be due to lack of education and poor environmental health practices.

The SADC region is faced with a triple burden of malnutrition characterized by under-nutrition (stunting and acute malnutrition); over-nutrition (overweight/obesity); and micronutrient deficiencies. The SADC region has more than 18.7 million stunted children (being too short for your age). The stunting prevalence is above 30% – classified as very high in 9 of the 16 SADC Member States (SADC, 2020e). Reduction in stunting is occurring too slowly to meet the World Health Assembly (WHA) 2025 or the Sustainable Development Goals (SDGs) 2030 targets (see Figure 13).

Figure 13:
Prevalence of stunting in the SADC region

Source: SADC, 2020e



The COVID-19 pandemic of 2020 has further increased the risk to malnutrition due to the containment measures taken by various Member States to curb the spread of the virus, resulting in reduced access to food. As restrictions were put in place during the year by Member States, diverse varieties of food have become unavailable, inaccessible and unaffordable to the most vulnerable households. With COVID-19 cases persisting in 2021 and more restrictions measures adopted, there is a risk that households will be forced to adopt negative eating practices, including reducing frequency, quantity and quality of foods, to adapt to the lockdown measures.

Available current data shows that the prevalence of global acute malnutrition (wasting – being too thin for your height) among children under age 5 is above 5% in 5 Member States (Botswana, Comoros; Democratic Republic of

Congo, Madagascar and Namibia). Additionally, prevalence of overweight in three countries in the region is 10% or higher (Botswana, Seychelles and South Africa), revealing an emerging problem in the region.

Nutrition counselling and social behaviour change communication (SBCC) on the recommended feeding practices, together with access to basic WASH services at household level, can improve caregiver knowledge of the recommended hygiene and sanitation behaviours and decrease faecal contamination of complementary foods. Evidence shows that community-level sanitation access has a greater impact on nutrition outcomes than household level access. As such, community-wide WASH-nutrition approaches may be critical to significantly reduce environmental contamination to improve children's diets. It is vital to understand which of the faecal-oral routes are

most relevant in a given context and ensure they are adequately targeted in programme design.

2.6.3 Hygiene in the context of gender issues in the SADC region

The Southern African Development Community (SADC) has a vision of durable peace, freedom and social justice, equitable development and sustained economic prosperity for the people of Southern Africa. SADC Member States undertook, in the SADC Treaty Article 6(2), not to discriminate against any person on the grounds of inter alia, sex or gender.²⁵ SADC Member States have committed to mainstreaming gender into the SADC Programme of Action and Community Building initiatives as a prerequisite for sustainable development. The goals to deepen regional integration and strengthen community building can only be realised by eliminating Gender inequalities and marginalisation of women throughout the SADC region.

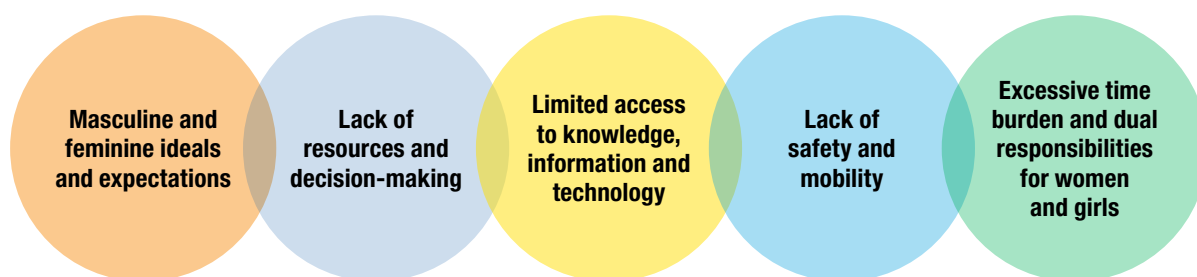
Women and girls face challenges in accessing hygiene and related services in the region. Women and men have different exposure to hygiene related diseases because of their gendered roles within society. For example, women's gendered roles may place them at an increased vulnerability to water-borne diseases due to their water-collection and cleaning duties. In secondary schools, inadequate provision of menstrual hygiene facilities can prevent menstruating girls from attending school (UN Water 2006). Within households, water

distribution may be gendered, with men given preferential access over women and girls. As an adequate quantity of clean water is essential for prevention of diarrhoeal diseases, women may be at increased risk (Moshabela et al. 2012). These gendered structural determinants may mean that women are unable to enjoy and exercise their rights. For example, the prevalent gendered norm that women and girls (and not men and boys) are responsible for water collection and for the cleaning of hygiene and sanitation facilities of the family means that women expend considerably more time than men on these domestic tasks, often at the expense of schooling and economically productive activities (UN Water 2006). In the SADC region, women are largely responsible for household water, sanitation and hygiene management; they bear a disproportionate burden when these basic services are lacking, and face health, security and psychological vulnerabilities due to inadequate access and decision-making control.

To effectively implement the hygiene strategy, it is important to incorporate a gender lens at each stage of the hygiene programme cycle. Tsetse (2017) suggests that one needs to use a gender lens in identifying gender-related hygiene barriers and bottlenecks. According to Tsetse (2017), the common gender-related barriers and bottleneck are those presented in Figure 14. For all barriers and bottle-necks, it is important to make sure the most marginalized women and girls are identified, including analysis by income, disability, and ethnicity.

Figure 14:
Common gender-related barriers and bottlenecks

Source: Tsetse, 2017



2.7 SWOT analysis of the hygiene sector in the SADC region

The analysis of strengths, weaknesses, opportunities and threats (SWOT) made it possible to link the opportunities and threats of the external environment with the internal weaknesses and strengths, and to analyse the influence of external factors on the hygiene sector in the region. On the basis of the extensive

consultations with stakeholders from Member States and development partners working in the WASH sector, the following have been identified as the major strengths, weaknesses, opportunities and threats in the hygiene sector: Results of extensive consultations with MS stakeholders show that most MS governments have no budget lines allocated to hygiene. The SWOT analysis is shown in Table 7.

Table 7: SWOT analysis of the hygiene sector in the SADC region	
STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • Availability of Multiple Indicator Cluster Survey (MICS) data on hygiene coverage that could be used to measure progress as well as highlight the disparities • Availability of local private sector providers of hygiene services and products • Existence of relevant sector policy and legislative instruments that support hygiene practices • Existence of capacity of the Ministries responsible for hygiene to stimulate and promote quality hygiene practices 	<ul style="list-style-type: none"> • Implies facilities close to home that can be easily reached and used when needed
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • Introduction of Community-Led Total Sanitation (CLTS) and School-Led Total Sanitation (SLTS) approach which is an innovative methodology for mobilising communities and schools to completely eliminate open defecation (OD) in Member States and promoting hygiene in schools • Availability of evidence based proven approaches into the sector such as 'Behaviour Centred Design Approach (Aunger and Curtis, 2013) and RANAS Approach etc • Covid-19 has brought hygiene into the spotlight which include personal, hand and home hygiene as well as hygiene in public place, businesses and all other facilities • The work of community-based organizations, international/national Non-Governmental Organizations (NGOs) and United Nations Agencies in WASH • Global, continental and regional initiatives, international agreements and agenda relating to WASH such as the International Decade for Sanitation (2008), resolutions of AfricaSan+5 and the resultant eThekweni Declaration (2008), Ngor Declaration (2015), the Abuja (2009) and Cairo (2008) Declarations on sanitation in Africa, Global Handwashing Day (2008), and Hand Hygiene for All initiative (2020) • Availability various funding sources that could be tapped to realize the implementation of the Strategy 	<ul style="list-style-type: none"> • Rapid urbanization due to massive rural-urban migrations which in turn gives rise to crowded conditions, poor sanitation, and inadequate water supplies, poor facilities for preparing and storing food, and inadequate hygiene all of which contribute to biological pathogen-induced ill health. • Natural disasters such as floods, earth quakes and droughts often overrun hygiene services and infrastructure which resultant people being unable to access safe hygiene services. • Civil conflicts in the resulting to the influx of refugees

3 The Strategy



An young girl is cleaning their water point in Miangaly village, Antanimbaribe Fokontany, Ankazobe II commune, Analamanga region. Madagascar.

WaterAid/ Ernest Randriarimalala

3.1 The goal of the strategy

The goal of the Strategy is for SADC Member States to significantly increase hygiene coverage and practices across all settings for improving the quality of life of people in the SADC region.

3.2 Strategic priority areas

Following the consultative process described in the introduction and the literature review on Ngor Commitments, a number of strategic priority areas, strategic objectives and strategic responses were defined for the Strategy. The structure of the implementation framework for the Strategy is thus organized around the following three identified strategic priority areas:

Strategic Priority Area 1:

Political Leadership, Commitment and Accountability;

Strategic Priority Area 2:

Strengthening the Enabling Environment for Hygiene Practices;

Strategic Priority Area 3:

Increasing Supply and Demand for Hygiene Services and focus on behaviour change.

3.3 Strategic objectives

The strategic objectives which address the three strategic priority areas are:

- (i) To secure strong leadership, commitment and accountability in creating a culture of

hygienic behaviour and practices across all levels of government and society;

- (ii) To create an enabling policy environment for hygiene services and practices;
- (iii) To promote hygiene and basic sanitation services and focus on hygiene practices / behaviour change; and
- (iv) To develop and implement monitoring and evaluation systems for hygiene,

Strategic Objective 1 calls for the high-level leadership at policy level to promote hygiene behaviour change and embed the culture of hygiene practices across all levels of government and society. Strategic Objective 2 calls for action to implement the four building blocks promoted by Sanitation and Water for All (SWA), which are:

- Integration of hygiene in all sectoral policies, strategies and programmes;

- Institutional arrangements for the hygiene sector;
- Financing hygiene; and
- Capacity development for the hygiene sector.

Strategic Objective 3 calls for action to enhance hygiene products and services and promote hygiene behaviours focusing on behaviour change/practices in all hygiene settings. Strategic Objective 4 calls for actions to monitor and evaluate/review all hygiene interventions.

3.4 Operational plan

The operational plan is presented in Table 8. It tabulates the strategic objectives, associated goals, actions, performance indicators, time lines, minimum required budget where necessary and responsibility.



Synodia Mtutile, 32, hygiene behaviour change volunteer, demonstrating how to properly use a tippy tap, Mkolimbo village, TA Chikweo, Machinga, Malawi.

WaterAid/ Dennis Lupenga



Table 8: Strategy implementation plan									
Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility
				2021	2022	2023	2024	2025	
STRATEGIC OBJECTIVE 1: To secure strong leadership, commitment and accountability in creating a culture of hygienic behaviour and practices across all levels of government and society									
GOAL 1: To champion hygiene as key part of national development plan									
1.1.1 Prioritise hygiene in all national development plans	Develop a comprehensive operational plan / road map for implementing this strategy	National reports	2021-25	–	–	–	–	–	Member state
	MS to incorporate into all national policies and strategies relevant activities that promote good hygiene	National reports	2021-25						Member state
1.1.2 Establish hygiene as key public intervention for a healthy nation	MS to allocate resources (financial and human) for establishment of HSAP Sub-Committee at SADC to ensure that MS leaders prioritise hygiene in national plans	National reports	2021-25	30.00	31.00	33.10	34.70	36.50	Member state
1.1.3 Establish handwashing with soap as a key part of public health and preparedness	MS to support the nationwide provision of handwashing with soap facilities in all hygiene settings	National reports	2021-25	50.00	52.00	55.10	57.90	60.80	Member state
GOAL 2: To demonstrate strong government leadership that integrates hygiene behaviour change with nation building									
1.2.1 Integrate hygiene behaviour change in nation building	Government to centralise hygiene behaviour change as a necessary condition of wider social, political and institutional transformations, such as nation-building	National reports	2021-25	–	–	–	–	–	Member state
1.2.2 Allocate long-term resources (financial and human) to hygiene behaviour change interventions	Establish and operationalise hygiene behaviour change budget line in all government sectoral budgets	National reports	2021-25	40.00	42.00	44.10	46.30	48.60	Member state



Table 8:
Strategy implementation plan continued

Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility	
				2021	2022	2023	2024	2025	Total	
STRATEGIC OBJECTIVE 2: To create an enabling policy environment for hygiene services and practices										
GOAL 1: To strengthen policy and regulatory instruments										
2.1.1 Harmonisation of policy and regulatory instruments	To assist MS with the process of alignment and harmonisation of policy and regulatory instruments	Published policy alignment and harmonisation protocol	2021-25	–	–	–	–	–		SADC
2.1.2 Review policy instruments	Study to review and assess relevant sector policies and regulatory instruments	National policy review and assessment report	2021						10.00	Member state
	Mainstream hygiene in harmonised sector policies and legislation	Policy documents	2021-25	–	–	–	–	–		Member state
2.1.3 Review regulations	Identify areas that require formulation of new regulations	Study report	2021	15.00					15.00	Member state
	Engage a legislative drafter to prepare applicable regulations	Developed regulations	2021	20.00					20.00	Member state
2.1.4 Develop standards	Identify areas that require standards	Report	2021-25	–	–	–	–	–		Member state
	Draft standards for hygiene services	Standards developed for defined areas	2021	10.00					10.00	Member state
2.1.5 Strengthen implementation of child's diets framework	Update national water, sanitation and hygiene sector policy and strategies to include actions to promote safe complementary feeding at facilities, communities and at household level	Sector report	2021-25	–	–	–	–	–		Member state



Table 8: Strategy implementation plan <i>continued</i>										
Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility	
				2021	2022	2023	2024	2025		Total
GOAL 2: To strengthen Hygiene division in the SADC Secretariat										
2.2.1 Strengthen the hygiene coordination under the health and nutrition unit in the SADC Secretariat	Mobilize sufficient financial resources to enhance the coordination of Hygiene programmes.	Hygiene Division Budget allocation records/report	2021-25	100.00	105.0	110.20	115.8	121.60	552.60	SADC
	Recruit two hygiene professionals (Policy and Technical Experts) to strengthen the Regional Hygiene Agenda	2 Hygiene Specialist recruited to support Coordination of Hygiene programmes in the region	2021-25	145.00	152.25	160.00	168.00	176.40	801.65	SADC
2.2.2 Policy development and harmonization	Conduct a study on quality of hygiene services and infrastructure in the region	Study report and recommendations published	2021	25.00					25.00	SADC
	Produce regional guidelines and standards for hygiene services and infrastructure	Regional Hygiene guidelines domesticated in all MSS	2022		10.00				10.00	SADC
2.2.3 Coordination of Regional Hygiene Programmes	Enhance and strengthen coordination mechanisms at SADC Secretariat	Annual SADC Hygiene report	2021-25	50.00	50.00	50.00	50.00	50.00	250.00	SADC
	Create/strengthen platforms at the regional level to share best practices on WASH & nutrition (e.g., knowledge portal)	Annual SADC Hygiene report	2021-25	–	–	–	–	–		SADC
GOAL 3: To strengthen institutional framework in Member states										
2.3.1 Strengthen hygiene line Ministries	Establish and strengthen hygiene division in hygiene line Ministry	MS report on line Ministry structure	2021-22	–	–					Member state
	Recruit two hygiene professionals to strengthen capacity of the Ministry	Hygiene Division Staff complement records/report	2021-25	80.00	84.00	88.20	92.60	97.20	446.00	Member state
	Adopt and enforce guidelines and standards for hygiene services and infrastructure	Published guidelines and standards	2021	15.00					15.00	Member state



Table 8: Strategy implementation plan continued									
Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility
				2021	2022	2023	2024	2025	
2.3.2 Strengthen coordination mechanisms of hygiene in Member States	Establish and strengthen hygiene sector Institutions in MS	MS gazette of the establishment of the National Hygiene Coordination Group	2021-22	–	–				Member state
	Allocate financial and human resources for running the National Hygiene Coordinating Group	Budget records and staff appointment records/reports	2021-25	30.00	31.50	33.10	34.70	36.50	Member state
GOAL 4: To develop sustainable financing mechanisms for hygiene									
2.4.1 Improve financing for hygiene with internal sources	Conduct budget and expenditure review to facilitate monitoring of funding from various sources and enable longer-term reliable budget allocations to hygiene	Review report	2021	–					Member state
	Establish and track budget lines for hygiene in all MS Ministries in charge of hygiene	Budget allocation records	2021-25	–	–	–	–	–	Member state
	Establish a semi-autonomous Hygiene Fund to which NGOs, government, private sector, local government authorities (LGAs) and other development partners shall be encouraged to contribute	Hygiene Fund Report	2021	–					Member state
	Develop systems to ensure progressive cost recovery towards set targets for financial sustainability	Progress report	2021	–					Member state
2.4.2 Improve financing for hygiene with external sources	Develop and implement a resource mobilization plan including public-private sector partnerships	Funding mobilization plan	2021-22	–	–				Member state
	Develop fully costed hygiene plan for the country	National hygiene plans	2021-25	–					Member state
	Write proposal to fund specific priority areas in the hygiene sector	Project proposal	2021	15.00					Member state
								15.00	



Table 8:
Strategy implementation plan continued

Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility	
				2021	2022	2023	2024	2025		Total
GOAL 5: To develop sustainable financing mechanisms for hygiene										
2.5.1 Human development in hygiene sector	Carry out comprehensive study on human resources in the hygiene sector	Study report	2021	15.00					15.00	Member state
	Build capacity to better design, implement and evaluate hygiene programmes	Human development plans	2021-25	–	–	–	–	–		Member state
	Lobby for and allocate budget necessary to fill the capacity gaps in hygiene professionals	Budget report	2021-25	–	–	–	–	–		Member state
2.5.2 Recruitment and training of hygiene experts	Put in place and implement policy framework for recruiting and retaining 2 hygiene professionals	Staff complement report	2021-25	50.00	52.50	55.10	57.90	60.80	276.30	Member state
	Put in place and implement a training programme for hygiene professionals	Number of professionals trained	2021-25	10.00	10.50	11.0	11.60	12.20	55.30	Member state
2.5.3 Generate new knowledge and innovations	Support action-oriented research on hygiene behaviour change, practices and services	Report of evidence of research activities and results	2021-25	55.00	57.75	60.64	63.67	66.85	303.91	Member state



Table 8: Strategy implementation plan continued										
Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility	
				2021	2022	2023	2024	2025		Total
STRATEGIC OBJECTIVE 3: To promote hygiene and basic sanitation services and focus on hygiene practices / behaviour change										
GOAL 1: To improve household hygiene										
3.1.1 Drinking water	Implement a campaign for safe extraction, transportation and storage of drinking water in households	Campaign flier	2021-25	20.00	21.00	22.05	23.15	24.31	110.51	Member state
	Initiate a project which support application of appropriate drinking water treatment technologies in households	Project report	2021-25	20.00	21.00	22.05	23.15	24.31	110.51	Member state
	Commission a project which promotes faecal sludge management and waste management in households on the 3R principle	Project report	2021-25	40.00	42.00	44.10	46.30	48.60	221.00	Member state
3.1.3 Improve interventions for BabyWASH	Develop and implement project for preparing households for WASH safe births and clean environments	Project report	2021-25		–	–	–	–		Member state
	Develop and implement project for preparing labour and delivery facilities for WASH safe births and hygienic postnatal care	Project report	2021-25		–	–	–	–		Member state
3.1.4 Improve food hygiene	Develop and implement project for maintaining clean environment in households and communities and promoting breast feeding and increasing nutrient intake for the protection of newly-born, infants and those in early childhood.	Project report	2021-25		–	–	–	–		Member state
	Integrate and promote the WHO “golden rules” of food hygiene in all stages of the production chain in the food industry	Food hygiene promotion report	2021-25	–	–	–	–	–		Member state



Table 8:
Strategy implementation plan continued

Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility	
				2021	2022	2023	2024	2025	Total	
GOAL 2: To improve household hygiene										
3.2.1 Improve hygiene practices in schools	Conduct formative research / bottleneck analysis for hygiene in schools	Study report	2021	15.00					15.00	Member state
	Designing attractive, engaging and surprising hygiene behaviour change intervention package to promote key behaviours for school population through a creative process.	A behaviour change intervention package for school	2021	30.00					30.00	Member state
	Develop and implement project for installing hygiene facilities with visual cues and nudges (handwashing with soap, toilets, waste disposal) that cater for the special needs of female learners and staff as well as people with disabilities in all schools	Project report	2021-25	50.00	52.50	55.13	57.88	60.78	276.29	Member state
	Support and strengthen School-Led Total Sanitation approach (SLTS) in all schools	SLTS report	2021-25	–	–	–	–	–		Member state
3.2.2 Improve hygiene practices in health care facilities	Mainstream hygiene practices (handwashing with soap, menstrual hygiene, waste disposal) in school curricula	School curricula documents	2021	30.00					30.00	Member state
	Conduct formative research / bottleneck analyses for hygiene in health care facilities and other critical public settings	Study report	2021	30.00					30.00	Member state
	Designing attractive, engaging and surprising hygiene behaviour change intervention package to promote key behaviours in healthcare settings through a creative process.	Intervention package	2021	30.00					30.00	Member state
	Develop and implement projects that improve hygiene services and behaviours in health care facilities and other public settings	Project report	2021-25	40.00	42.00	44.10	46.30	48.60	221.00	Member state



Table 8:
Strategy implementation plan continued

Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility	
				2021	2022	2023	2024	2025		Total
3.2.3 Improve hygiene practices in communities	Conduct formative research targeting to households/ community setting to understand the behavioural determinants, motives, barriers and touch points	FR report	2021	30.00					30.00	Member state
	Design attractive, engaging and surprising hygiene behaviour change intervention package to promote key behaviours for communities through creative process.	Hygiene intervention package	2021	30.00					30.00	Member state
	Implement hygiene intervention either through mainstreaming into WASH programme or in campaign approach or through integrating into health, education programme, nutrition programme with high level of frequency and reach. And also promote building context specific handwashing facilities.	Hygiene intervention with higher reach and exposure. Context specific handwashing facilities built.	2021-25	-	-	-	-	-		Member state
	Integrate hygiene into ongoing Community-Led Total Sanitation approach (CLTS) in communities	CLTS report	2021-25	-	-	-	-	-		Member state
3.2.4 Improve hygiene services for people with disabilities (PWDs)	Facilitate alignment and inclusion of messages on complementary feeding practices within the hygiene practice package	Hygiene intervention package	2021-25	-	-	-	-	-		Member state
	Develop and implement project for installing specifically-designed WASH facilities (drinking water, toilets, handwashing, waste disposal) that meet the needs of PWDs in all hygiene settings	Progress Report	2021-25	40.00	42.00	44.10	46.30	48.60	221.00	Member state
	Involve people with disabilities in design processes to ensure that programme approaches will meet their needs and preferences	Progress Report	2021-25							Member state
	Advocate to households, community leaders, companies and/or government to take action on improving WASH for children and adults with disabilities in all environments (including the workplace) and support children with disability.	Progress Report	2021-25							Member state



Table 8: Strategy implementation plan continued									
Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility
				2021	2022	2023	2024	2025	Total
3.2.5 Improve hygiene services during emergencies	Develop and implement project for provision of WASH facilities during periods of emergency. The facilities include chemical toilets, temporary pit latrines, bucket latrines or elevated toilets or ecological sanitation (Eco-San) latrines, narrow trench latrines with temporary privacy structure, water source, hand washing facilities with soap and water	Emergency Preparedness Report	2021-25	10.00	10.50	11.0	11.60	12.20	55.30
	Provide emergency kits which include handwashing supplies (soap and/or alcohol-based hand-rub, a hygiene kit also needs to include an 'a bucket with a tap and lid' so that people can also store water and treat), appropriate sanitary materials and underwear for all women and girls including hygiene promotion	Emergency Preparedness Report	2021-25						
	Implement emergency operation and maintenance regimes which should include emergency operator training and community education	Emergency Preparedness Report	2021						
GOAL 3: To strengthen hygiene behaviour change information									
3.3.1 Hygiene behaviour change information	Establish and integrate the data related to hygiene sector in all its forms, into the Sanitation and Hygiene Management Information System (SHMIS)	Information management system	2021-25	10.00	10.50	11.0	11.60	12.20	55.30
	Develop and implement e-knowledge on hygiene among all stakeholders	Progress report	2021	10.00					10.00
	Produce and promote use of hygiene intervention package, manuals on hygiene to provide a compendium of guidelines, indicators of national hygiene standards and various hygiene options'	Manuals and package	2021	30.00					30.00
	Create a SADC knowledge hub on hygiene	Knowledge hub created	2021	–					
	Establish "hygiene centres of excellence" to create more pull of resources and offer coordinated support and skills	Hygiene centre of excellence	2021	–					
									SADC
									SADC



Table 8: Strategy implementation plan continued										
Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility	
				2021	2022	2023	2024	2025		Total
GOAL 4: To enhance awareness raising, changing behaviour and advocacy										
3.4.1 Advocacy and awareness raising	Conduct advocacy campaigns on hand hygiene and benefits of good hygiene for better financing and institutional mechanism	Campaign materials	2021-25	30.00	31.50	33.08	34.73	36.47	165.78	Member state
	Promote hygiene to change behaviours and sustain over time through a right delivery mechanism	Promotional materials and campaign to expose people multiple times.	2021-25	30.00	31.50	33.08	34.73	36.47	165.78	Member state



Table 8: Strategy implementation plan <i>continued</i>										
Priority intervention areas	Strategic actions	Key performance indicators	Time	Indicative budget (US\$'000)					Responsibility	
				2021	2022	2023	2024	2025		Total
STRATEGIC OBJECTIVE 4: To develop and implement monitoring and evaluation systems										
GOAL 1: To conduct monitoring and reporting on the implementation of the HSAP										
4.1.1 HSAP monitoring and evaluation	Replacing the paper-based Monitoring Information System with a Web Based Real Time Monitoring (RTM) system that interfaces with District Health Information Software 2 (DHIS2), a free and open-source health management data platform used by multiple organizations and governments	Use of DHIS2 report	2021	40.00					40.00	Member state
	Review and agree on a regional standard set of indicators for monitoring hygiene interventions across countries on a routine basis	M&E report	2021	–						Member state
GOAL 2: To establish monitoring units										
4.2.1 Establish and strengthen hygiene monitoring units	Support the establishment of M&E Coordination Units at the level of the National Hygiene Agency in all Member States	Gazette records	2021-25	–						Member state
	Strengthen the capacity of the Community Hygiene Committees in participatory M&E to ensure the monitoring and evaluation of CLTS	Training records	2021-25	30.00	31.50	33.08	34.73	36.47	165.78	Member state
	Establish a mechanism to set-up a national baseline for hygiene and its follow-up evaluation over time.	Baseline and follow-up report	2021	–						Member state
	Develop Hygiene web portal for public dissemination of information collected through District Health Information Software 2 (DHIS2)-based Management Information System	Web portal manual	2021	10.00					10.00	

4 Initiatives to promote hygiene and basic sanitation practices

Trained community actors showing children how to wash their hands properly during the celebration of the Global Handwashing day in Manjakandriana. Manjakandriana commune, Analamanga region, Madagascar.

WaterAid/ Ernest Randriarimalala



One of the important steps in the planning of the implementation of the strategy was to identify existing initiatives across the globe, in the region and in Member States that are being implemented to promote hygiene and, hence, will help deliver the strategic goals. There are number of initiatives which are being implemented to promote hygiene. There are those international and national initiatives which have long been implement to support hygiene practices and services and have already made great impact on hygiene in the region. There are other initiatives which have just been introduced and have potential for making an impact in the hygiene sector in the region.

4.1 International initiatives

Global Handwashing Day

The Global Handwashing Partnership (GHP) established Global Handwashing Day (GHD) in 2008 as a way to promote a global and local vision of handwashing with soap.²⁶ The GHD is an international handwashing promotion campaign to motivate and mobilize people around the world to improve their handwashing habits. Washing hands at critical points during the day and washing with soap are both important. Global Handwashing Day occurs on 15 October of each year. The GHD is a global advocacy day dedicated to increasing

awareness and understanding about the importance of handwashing with soap as an effective and affordable way to prevent diseases and save lives.

The global initiative of GHD is an opportunity to design, test, and replicate creative ways to encourage people to wash their hands with soap at critical times. The COVID-19 pandemic provides a stark reminder that one of the most effective ways to stop the spread of a virus is also one of the simplest: hand hygiene, especially through handwashing with soap. In order to beat the virus today and ensure better health outcomes beyond the pandemic, handwashing with soap must be a priority now and in the future. The theme for GHD for 2020 is *Hand Hygiene for All*, which calls for the society to achieve universal hand hygiene.²⁷ The GHD is an important event which the Hygiene Strategy will use as part of public awareness campaign of the importance of hygiene practices such as handwashing.

Hand Hygiene for All

WHO and UNICEF launched Hand Hygiene for All (HH4A) Global Initiative on Friday, 26 June 2020, which aims to implement WHO's global recommendations on hand hygiene to prevent and control the COVID-19 pandemic and work to ensure lasting infrastructure and behaviour.²⁸ The Global Initiative is designed around three stages: Responding to the immediate pandemic, Rebuilding infrastructure and services, and Reimagining hand hygiene in society. Each stage has three core dimensions: creating an institutional and policy environment that enables progress, ensuring the availability of hand hygiene stations, alcohol-based hand rubs, soap and water, and drawing on evidence-based behaviour change approaches to encourage sustained hand hygiene practices. The Global Initiative is working with a number of partners to further progress in specific settings, including health care facilities, schools and child-care centres, workplaces, transport hubs, households, institutions and places of worship. The initiative calls countries to review financing and investment opportunities, put in place national hand hygiene policies and plans, strengthen legal and regulatory frameworks, and assess gaps in hand hygiene policies, capacities and monitoring. The initiative will help to drive the

main purpose of the Hygiene Strategy, which is to instil the behaviour of handwashing with soap in the SADC society for lasting health impact

World Toilet Day (WTD)

World Toilet Day (WTD) is an official United Nations international observance day on 19 November to inspire action to tackle the global sanitation crisis.²⁹ World Toilet Day celebrates toilets and raises awareness of the 4.2 billion people living without access to safely managed sanitation. It is about taking action to tackle the global sanitation crisis and achieve Sustainable Development Goal 6: water and sanitation for all by 2030.³⁰ The 2020 World Toilet Day focused on sustainable sanitation and climate change. Climate change is getting worse with flood, drought and rising sea levels threatening sanitation systems – from toilets to septic tanks to treatment plants. Everyone must have sustainable sanitation, alongside clean water and handwashing facilities, to help protect and maintain our health security and stop the spread of deadly infectious diseases such as COVID-19, cholera and typhoid. Sustainable sanitation systems also reuse waste to safely boost



Elise, 14, and Flyness, 11, cleaning toilets at Kasungu LEA Primary School, Kasungu, Malawi.

WaterAid/ Dennis Lupenga

agriculture, and reduce and capture emissions for greener energy. The WTD is an important event which the Hygiene Strategy will use as part of public awareness campaign of the importance of sanitation and hygiene practices.

International Menstrual Hygiene Day

Menstrual Hygiene Day (MH Day) which falls on 28 May is International Menstrual Hygiene Day. Every year members come together to hold community events to raise awareness of good menstrual hygiene management and the impact it can have on girls' lives. Poor menstrual hygiene caused by a lack of education on the issue, persisting taboos and stigma, limited access to hygienic menstrual products and poor sanitation infrastructure undermines the educational opportunities, health and overall social status of women and girls around the world. As a result, millions of women and girls are kept from reaching their full potential.

Menstrual Hygiene Day (MH Day) is a global advocacy platform that brings together the voices and actions of non-profits, government agencies, individuals, the private sector and the media to promote good menstrual hygiene management (MHM) for all women and girls.³¹ More specifically, MH Day:

- breaks the silence, raises awareness and changes negative social norms around MHM; and
- engages decision-makers to increase the political priority and catalyse action for MHM, at global, national and local levels.

The MH Day is an important event which the Hygiene Strategy will use as part of public awareness campaign of the importance of good menstrual hygiene management (MHM).

Ngor commitment on sanitation and hygiene

The Ngor Declaration vision focuses on universal access to adequate and equitable sanitation and hygiene services and an end to open defecation (OD) by 2030, and as such reflects the paradigm shift of the Sustainable Development Goals (SDGs) (AMCOW, 2020). The Ngor Declaration on Sanitation and Hygiene sets out the Ngor Commitments which recognise the areas of the enabling environment

that need to be addressed in order to achieve its Vision. The Ngor Commitments are the building blocks of an effective sanitation and hygiene sector. It is only when progress is achieved across all the Ngor Commitments that the enabling environment will support accelerated access. In order to realise this vision, the governments of SADC committed to:

- 1) Focus on the poorest, most marginalised and unserved aimed at progressively eliminating inequalities in access and use and implement national and local strategies with an emphasis on equity and sustainability;
- 2) Mobilise support and resources at the highest political level for sanitation and hygiene to disproportionately prioritise sanitation and hygiene in national development plans.
- 3) Establish and track sanitation and hygiene budget lines that consistently increase annually to reach a minimum of 0.5% GDP by 2020; AfricaSan 4, May 2015, Dakar, Senegal – Draft Ministerial Statement;
- 4) Ensure strong leadership and coordination at all levels to build and sustain governance for sanitation and hygiene across sectors especially water, health, nutrition, education, gender and the environment;
- 5) Develop and fund strategies to bridge the sanitation and hygiene human resource capacity gap at all levels;
- 6) Ensure inclusive, safely-managed sanitation services and functional hand-washing facilities in public institutions and spaces;
- 7) Progressively eliminate untreated waste, encouraging its productive use;
- 8) Enable and engage the private sector in developing innovative sanitation and hygiene products and services especially for the marginalised and unserved;
- 9) Establish government-led monitoring, reporting, evaluation, learning and review systems; and
- 10) Enable continued active engagement with AMCOW's AfricaSan process.

The 10 Ngor Commitments on Sanitation and Hygiene address the areas of the enabling environment that as a whole, need to be in place to drive sanitation and hygiene progress.



Table 9:
Progress on stage 1 indicators which measure the enabling environment

Source: AMCOW, 2020

Ngor commitment on sanitation and hygiene		DRC	Eswatini	Lesotho	Madagascar	Malawi	Mozambique	Namibia	South Africa	Tanzania	Zambia	Zimbabwe
1	Progressively eliminating inequalities in access to and use of sanitation and hygiene services	●	●	●	●	●	●	●	●	●	●	●
2	Mobilise support and resource at high political level for sanitation and hygiene	●	●	●	●	●	●	●	●	●	●	●
3	Establish and track sanitation and hygiene budget lines	●	●	●	●	●	●	●	●	●	●	●
4	Ensure strong leadership and coordination at all levels	●	●	●	●	●	●	●	●	●	●	●
5	Bridge the sanitation and hygiene human resource capacity gap	●	●	●	●	●	●	●	●	●	●	●
6	Ensure functional handwashing facilities in public institutions and spaces	●	●	●	●	●	●	●	●	●	●	●
7	Progressively eliminate untreated waste and encouraging its productive use	●	●	●	●	●	●	●	●	●	●	●
8	Enable and engage the private sector in developing innovative products and services	●	●	●	●	●	●	●	●	●	●	●
9	Establish government-led monitoring, reporting, evaluation and review systems	●	●	●	●	●	●	●	●	●	●	●
10	Enable continued active engagement with AMCOW's AfricaSan Process	●	●	●	●	●	●	●	●	●	●	●

KEY

Poor progress Some progress Good progress

● ● ● ● ●

Monitoring of the Ngor Commitments was conducted in 2018 and the results for the countries that participated in the process are presented in Tables 9 and 10. Table 9 presents the progress on stage 1 indicators which measure the enabling environment. The results in Table 9 show that, across the region, there has been good progress against the commitment to establish leadership and coordination structures. This is a key area which drives progress in the sector.

The commitment to develop and fund strategies to bridge the human resources capacity gap, and to establish budget lines for sanitation and hygiene remain critical bottlenecks which threaten to undermine progress in the SADC region. This is critical for the region as financing and capacity have both been identified as constraints to SDG 6 globally (UN Water, 2018). The countries that have made significant

progress across the 10 commitments are Zambia, Malawi, Tanzania and South Africa, followed by Madagascar, Democratic Republic of Congo and Zimbabwe. There has been little progress on achieving most of the commitments in the Kingdom of Eswatini, Lesotho and Namibia.

There has been poor progress in establishing the enabling environment for institutional sanitation and hygiene, including ensuring inclusive, safely managed sanitation and hygiene services are available in urban and rural settings. Progress in eliminating untreated waste and encouraging its productive re-use is also limited in the SADC region. Except for Tanzania, the overall private sector engagement in sanitation and hygiene which benefits the poorest is limited in the region. There has been some progress in establishing government-led monitoring and review systems in the region. SADC countries



Table 10:
Progress on stage 2 indicators: progress against published country targets

Source: AMCOW, 2020

Ngor commitment on sanitation and hygiene		DRC	Eswatini	Lesotho	Madagascar	Malawi	Mozambique	Namibia	South Africa	Tanzania	Zambia	Zimbabwe
1	Progressively eliminating inequalities in access to and use of sanitation and hygiene services	●	●	●	●	●	●	●	●	●	●	●
2	Mobilise support and resource at high political level for sanitation & hygiene	●	●	●	●	●	●	●	●	●	●	●
3	Establish and track sanitation and hygiene budget lines	●	●	●	●	●	●	●	●	●	●	●
4	Ensure strong leadership and coordination at all levels	●	●	●	●	●	●	●	●	●	●	●
5	Bridge the sanitation and hygiene human resource capacity gap	●	●	●	●	●	●	●	●	●	●	●
6	Ensure functional handwashing facilities with soap and water in households, community buildings, public institutions, work places and key places	●	●	●	●	●	●	●	●	●	●	●
7	Progressively eliminate untreated waste and encouraging its productive use	●	●	●	●	●	●	●	●	●	●	●
8	Enable and engage the private sector in developing innovative products & services	●	●	●	●	●	●	●	●	●	●	●
9	Establish government-led monitoring, reporting, evaluation and review systems	●	●	●	●	●	●	●	●	●	●	●
10	Enable continued active engagement with AMCOW's AfricaSan Process	●	●	●	●	●	●	●	●	●	●	●

KEY

Poor progress Some progress Good progress

have a fairly consistent history of active engagement in the AfricaSan movement.

The progress on stage 2 indicators which measure progress against published country targets is presented in Table 10. The results on progress stage 2 indicators show that, across the region, four countries are able to report on implementation progress against country targets for Commitment 1. Of these, only Tanzania is on track against its own targets for reducing inequalities. Eight countries are able to report on implementation progress for Commitment 2. Of these, only Malawi has met its national sector policies sanitation and hygiene objectives. Four countries are able to report on implementation progress for Commitment 3. However, none of these has reports having a budget which is increasing and has reached at least 0.5% of GDP.

None of the countries were able to report on implementation progress for Commitment 4. Only two countries report on implementation progress for Commitment 5. However, neither of countries reported that human resource actions are funded, under implementation or are on track. Under Commitment 6, countries report on progress against their own targets and milestones for sanitation and hygiene in different institutional settings – schools, health facilities and other public institutions and spaces.

Seven countries had targets and milestones to report against, none are fully on track. None of the countries were able to report on implementation progress for Commitments 7, 8 and 10. Of seven countries reporting on progress on Commitment 9, three stated that the results of monitoring and review processes are used



to adjust plans and strategies and that adjusted activities are then funded and implemented.

The importance of the Ngor Commitments is that they call for African Governments to prioritize hygiene financing by ensuring that not less than 0.5% of national gross domestic product is allocated to this sector, and that African Governments must develop human capacities at the national and sub-national levels as knowledge, skills and innovation are indispensable for any meaningful progress towards hygiene targets. Some of the commitments are for high-level decision makers (MS Leaders) and the others are for some member states to take particular action that would enable them to make progress on each commitment. The Ngor Commitments help to guide decision makers at the regional and country levels to take strategic actions that will lead to the accelerated progress toward meeting the hygiene access targets of the SDG agenda. The Commitments emphasize that SADC as part of Africa must intensify its efforts to accelerate progress towards these commitments in order to achieve the SDG 6.2 target.

4.2 National initiatives and approaches

There are various initiatives and approaches which MSs are implementing to promote hygiene in their countries. The country initiatives serve as examples of actions for scaling up and out interventions for promoting hygiene in the region.

Community-Led Total Sanitation (CLTS)

Community-Led Total Sanitation (CLTS) is an innovative methodology for mobilising communities to completely eliminate open defecation (OD).³² Communities are facilitated to conduct their own appraisal and analysis of open defecation (OD) and take their own action to become ODF (open defecation free). At the heart of CLTS lies the recognition that merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene (Mwakitalima et al., 2018).

In its fullest sense, total sanitation includes a range of behaviours such as: stopping all open defecation; ensuring that everyone uses a hygienic toilet; washing hands with soap before

preparing food and eating, after using the toilet, and after contact with babies' faeces, or birds and animals; handling food and water in a hygienic manner; and safe disposal of animal and domestic waste to create a clean and safe environment (Kar and Chambers, 2008)). This is an important initiative which will need to be upscaled across the region to ensure that communities embrace hygiene behaviour as promoted by the Hygiene Strategy. It is identical that this approach includes the core hygiene behaviours and focus on behaviour change while promoting sanitation through this approach (Safari et al., 2019). Hygiene can be integrated into existing CLTS campaigns if address since its inception.

School-Led Total Sanitation (SLTS)

School-Led Total Sanitation (SLTS) is a process of facilitating school communities (learners, teachers, parents, School Management Committee members, village heads, etc.) to analyse the current sanitation and hygiene situation, their practices and consequences, and to improve their sanitation and hygiene status.

SLTS has been adapted for schools from Community-Led Total Sanitation (CLTS) approach. It is expected to lead to collective actions to achieve total sanitation in both schools and catchment communities. School-Led Total Sanitation (SLTS) is designed to promote sanitation and hygiene at both schools and communities through child-centred approach. Given the high vulnerability of children to diarrheal diseases, their greater receptivity of behaviour changes and their propensity for development of lifelong behaviours, targeting school children as primary recipient as well as leaders of sanitation and hygiene promotion would be most effective and efficient way of disseminating messages and transforming behaviours. The guiding principles of SLTS are to; facilitate, not dictate; let people design toilets, not rely on “engineers”; focus more on behaviour change and capacity building, rather than “hardware”; and let people monitor and follow progress toward total sanitation with indicators,

One of the important aspects of SLTS programme is that it recognizes the school as an entry point for promoting hygiene behaviour



and student as the change agents. Upscaling SLTS will be necessary to mobilize learners to promote hygiene behaviour in their schools and homes, and this will be critical component of the implementation of the Hygiene Strategy in school and household settings. It is identical that this approach includes the core hygiene behaviours and focus on behaviour change while promoting sanitation through this approach. Hygiene can be integrated into existing SLTS campaigns if address since its inception.

The National Program for Healthy Villages and Schools (VEA)

The National Program for Healthy Villages and Schools (VEA), or *Le programme national Village et Ecole Assaini* (PNVEA) in French, was first introduced by the government of the Democratic Republic of the Congo (DRC) in the 1990s as the main initiative to provide water supply in rural and peri-urban communities (String et al, 2017). String et al (2017) report that, in 2006, UNICEF partnered with the Ministry of Health to re-launch the program in all provinces of the country, with a program objective to ensure equitable access to safe and affordable water, ensure equitable access of all people to adequate sanitation and hygiene services to end open defecation, to ensure water resources are used more efficiently in all sectors, to ensure the sustainability of freshwater harvesting and supply to reduce the number of people impacted by water scarcity, and to support and strengthen local participation in improving water and sanitation management.

The PNVEA is an eight-step process for water, sanitation, and household and environmental hygiene development. The steps of the process are: 0) community decision to engage in PNVEA; 1) signing of a Memorandum of Agreement between health zone and village; 2) the initial Knowledge, Attitudes, and Practices survey (KAP); 3) the community analyses its hygiene and sanitation; 4) election of a VA Committee; 5) the community develops a Community Action Plan; 6) implementation of improvements identified in the Action Plan; 7) final KAP survey; and, 8) certification by the Chief of Medicine of the health zone (DRC Ministry of Health, 2013). In order to become certified as a Healthy Village, the following standards must be met: the existence of a dynamic VA Committee; at least

80% of population has access to safe drinking water; at least 80% of households use hygienic latrines; at least 80% of households properly evacuate household waste; at least 60% of people wash their hands with soap or ash before eating and after using the toilet; at least 70% of the population knows the waterborne disease transmission routes and ways to prevent; the village is cleaned at least once a month.

This is a very important initiative which should be emulated in the other SADC countries as they implement this strategy.

Participatory Hygiene and Sanitation Transformation (PHAST)

PHAST stands for Participatory Hygiene and Sanitation Transformation. It is an innovative approach designed to promote hygiene behaviours, sanitation improvements and community management of water and sanitation facilities using specifically developed participatory techniques (WHO, 1997). It is an adaptation of the SARAR (Self-esteem, Associative strength, Resourcefulness, Action planning and Responsibility) methodology of participatory learning, which builds on people's innate ability to address and resolve their own problems.³³ It builds on people's innate ability to address and resolve their own problems. It aims to empower communities to manage their water and to control sanitation-related diseases, and it does so by promoting health awareness and understanding which, in turn, lead to environmental and behavioural improvements.

World Health Organisation (WHO, 1997) reported that the approach was first field-tested in Botswana and Zimbabwe in both rural and urban areas with good results. In 1998, UNDP and WSP (1998) reported that there was progress in the implementation of PHAST initiatives in Botswana, Mozambique, Tanzania, and Zimbabwe. In Eswatini, the combination of the Participatory Hygiene and Sanitation Transformation (PHAST) and Community Led Total Sanitation (CLTS) approaches to community and household hygiene has helped the health sector in reaching more communities with the goal of ending open defecation (OD) (Kingdom of Eswatini, 2019). There are opportunities of upscaling PHAST approach



across the region as part of implementation of the hygiene strategy. Through this approach, communities are empowered to improve their decision-making about the hygiene services they need and want to maintain. As communities gain awareness of their hygiene situation through participatory activities, they will be empowered to develop and carry out their own plans to improve this situation as part of the implementation of the hygiene strategy.

Provincial Hygiene Promotion Commission

One of the initiatives in Mozambique is the establishment of Provincial Hygiene Promotion Commission. In Mozambique (Comissão Provincial de Promoção de Higiene). Under this initiative, each Provincial Government is to establish a Provincial Hygiene Promotion Commission which is chaired by the Provincial Governor who is the deputy to the Provincial Director for Coordination of Environmental Action. In each municipal council, there is a Hygiene Promotion Committee the roles of which include coordinating and supervising hygiene assessment of public settings such as markets, restaurants, bakeries; promote proper construction and maintenance and use of hygiene facilities in public places, promote the hygiene of schools, health care facilities, offices and prisons. This hygiene strategy will upscale this initiative as it provides a good lesson for enhancing institutional framework for promoting hygiene in a country.

National Sanitation and Hygiene Coordination Group (NSHCT)

An important initiative in many counties is the establishment of hygiene coordination bodies which promote hygiene practices in each MS. For example, in Eswatini and South Africa, the governments have established the National Sanitation and Hygiene Coordination Group (NSHCT) which is responsible for coordination and implementation of hygiene related activities that include:

- Facilitating the evaluation and monitoring of the sector;
- Debating and refine priorities and action plans;
- Supporting the review and drafting of national documents: policy, strategy, regulation, standards, guidelines, manuals;

- Facilitating organisation of hygiene events;
- Informing about hygiene sector's progress.

This is another component of an institutional framework for implementing hygiene services and practices which the Strategy will upscale.

Children's Hygiene and Sanitation Training (CHAST)

One important initiative which has been introduced in SADC countries is Children's Hygiene and Sanitation Training (CHAST). CHAST is an approach for promoting personal hygiene among children and it is based on the well-established Participatory Hygiene and Sanitation Transformation (PHAST) approach and uses a range of exercises and educational games to teach children aged between five and twelve about the links between personal hygiene and health.³⁴ The approach is based upon the premise that hygiene practices are largely acquired during childhood and therefore it is much easier to change children's habits than those of adults. In Lesotho, it is reported that improvement of sustainable access to safe water, sanitation and hygiene by the poor and vulnerable in Mphahle's Hoek and Mokhotlong districts was achieved through use of combined interventions of Community-Led Total Sanitation (CLTS), Participatory Hygiene and Sanitation Transformation (PHAST) and Children's Hygiene and Sanitation Transformation (CHAST) approaches (Lesotho Red Cross Society, 2018). Inculcating hygiene behaviour among children is important for the implementation of the strategy to have lasting impact. Hence, this initiative will be upscaled to ensure that, children who are the foundations of the society, have adequate knowledge and skills to maintain hygiene behaviour in the region.

Behaviour-Centred Design (BCD)

Behaviour-Centred Design (BCD) is an approach which encompasses a theory of change, a suite of behavioural determinants and a programme design process. Changes in behaviour are viewed as the consequence of a reinforcement learning process involving the targeting of evolved motives and changes to behaviour settings, and are produced by three types of behavioural control mechanism (automatic, motivated and executive) (Aunger and Curtis,



2016). There is a sequence of five steps required to design, implement and evaluate an intervention to change specific behaviours: Assess, Build, Create, Deliver and Evaluate.

Five-step (ABCDE) approach to sustained behaviour change:

- **Assess:** Determines what is known and unknown about current and desired behaviours from secondary sources and discussing with relevant stakeholders.
- **Build:** Fill in the knowledge gaps by collecting data through formative research. Identify behavioural determinants, motives, barriers, touch points and social norms.
- **Create:** Based on insights from formative research and working with creative agencies design attractive, surprising and engaging behaviour packages for different settings.
- **Deliver:** Execute the intervention using novel approaches so the target population is sufficiently exposed (at least 4–6 times within a year). Implement hygiene together with water and sanitation programme, integrate hygiene into health, education, nutrition and also support district wide/region wide/nationwide campaigns.
- **Evaluate, monitor and adapt:** determine whether the predicted environmental, psychological and behavioural changes were achieved and aim to understand how actual behaviour has changed rather than knowledge at baseline and endline. Also document how and why the programme works through the process documentation. Measure programme sustainability over time.

The BCD approach, which has been implemented by various partners including WaterAid in a number of countries in SADC region such as in Ghana, Nigeria, Zambia, Malawi, Mozambique, Eswatini, Sierra-Leon, Burkina-Faso. Some of these campaigns including Zambia (Greenland et al., 2016), has been shown to change hygiene, nutrition and exercise-related behaviours and has the advantages of being applicable to product, service or institutional design, as well as being able to incorporate future developments in behaviour science. In Tanzania, the current BCD is managed by the Government of Tanzania.

Since BCD is a design approach and CLTS is a community engagement approach geared to eliminate OD (Mwakitalima et al., 2018; Safari et al., 2019), it is recommended that the two approaches be used in combination whereby BCD is used as programme design tool and CLTS is used as community engagement tool. Further, since CLTS engagement session is implemented only once in a community, then BCD can be used later (in communities where CLTS is implemented) for designing community-based hygiene programmes with involvement of community leaders.

Participatory Health and Hygiene Education (PHHE)

Participatory Health and Hygiene Education, (PHHE) is a facilitated community process that helps people develop the outlook, the competence, the self-confidence and the commitment to improve local hygiene practices and the management of local water and sanitation facilities (NAC, 2013). NAC (2013) reported that the use of PHHE approach in Zimbabwe has provided a strong impetus to positive behaviour change, such as improving hand washing and disposal of wastes. The other initiative which was introduced in Zimbabwe is the establishment of Community Health Clubs (CHC) which have a good track record in health and hygiene promotion and need institutional support to enable them to operate on a larger scale. Hygiene education and behaviour change will be part of hygiene awareness raising activities in the implementation of the Hygiene Strategy. Hence, this initiative will be upscaled to ensure that it is conducted across the region for successful implementation of the strategy.

4.3 Recommended case study initiatives for regional-wide application

Based on the basis on the analysis of the various national initiatives, it is recommended that the Behaviour Centred Design (BCD) approach be implemented across the region as a preferred tool for promoting hygiene behaviour change. It is also recommended that all Member States establish a National Hygiene Coordination Group as part of the institutional framework for the implementation of the Hygiene Strategy.



5 Strategy implementation mechanisms

Ana Sofia with her daughter, Nacapa community, Memba district, Nampula province, Mozambique.

WaterAid/ Helder Samo Gudo



The SADC Secretariat will drive the implementation of the Regional Hygiene Strategy in collaboration with the WASH structures in Member States, regional and international partners. The success of the implementation of the Strategy is therefore dependent on the various stakeholders playing their roles.

5.1 Principles for the implementation of the strategy

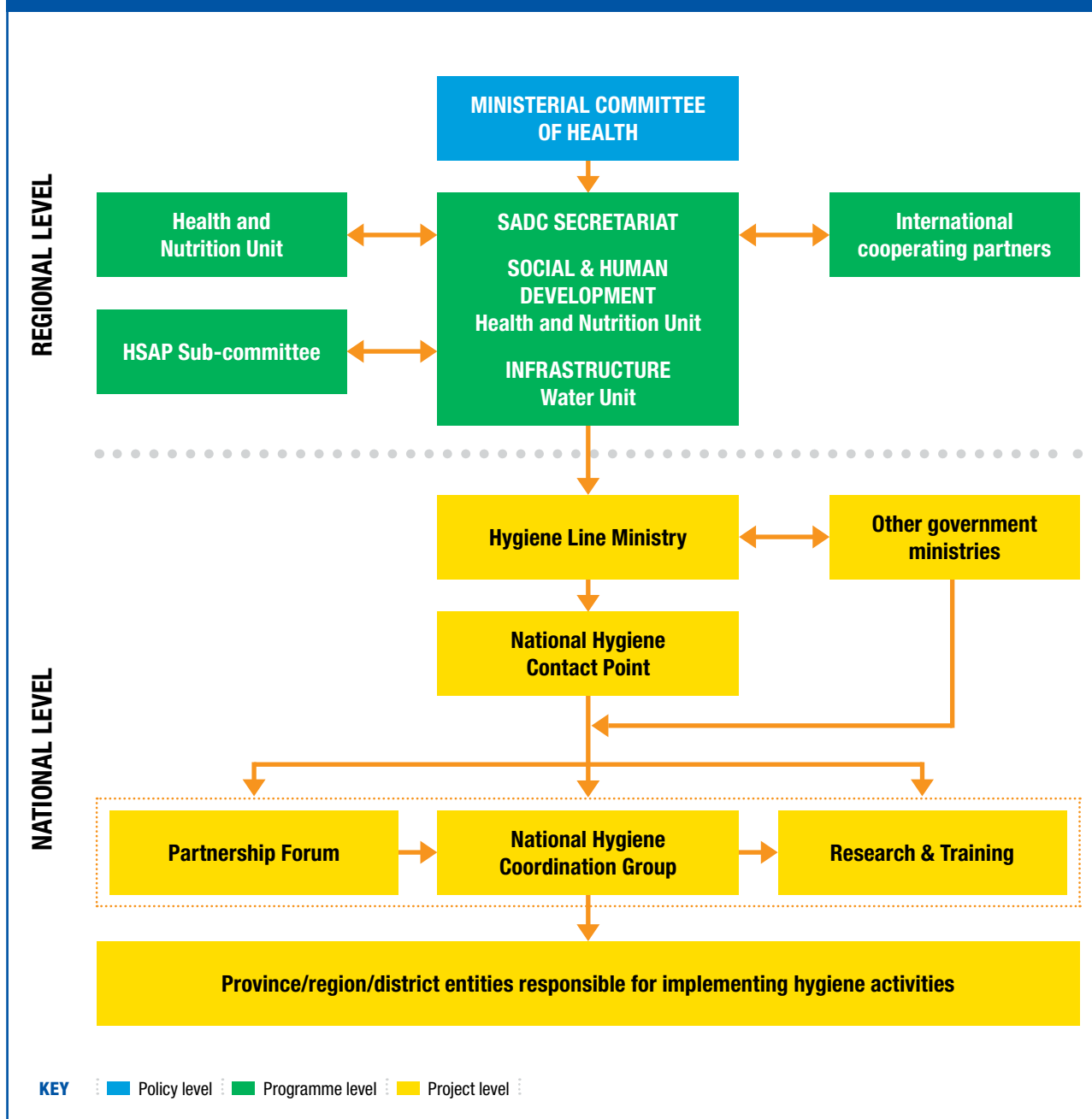
The institutional framework for the implementation of the Strategy is the one presented in Figure 15.

The implementation of the Strategy will be aligned to the general principles of the Regional Indicative Strategy Development Plan (RISDP), the SADC Protocol on Health, the SADC Health

Policy Framework and the SADC Nutrition Action Framework. Specifically, the following guiding principles will apply:

- Value addition – the interventions to be spear headed at the regional level will be limited to those that clearly add value or generate solutions to national initiatives;
- Broad Participation and Consultation – the implementation of the Strategy must be based on broad participation and consultation to ensure ownership and commitment.
- Subsidiarity (Suitability of implementation level) – the implementation of the Strategy will also recognize the need to ensure that programmes and activities are delivered at levels where they can be best handled. To this end, the Secretariat will promote partnership with other

Figure 15:
Institutional framework for implementing the SADC Hygiene Strategy



regional institutions outside SADC Structures to facilitate the implementation of the Strategy.

5.2 Key stakeholders and institutional arrangements

The key stakeholders in the implementation of the Strategy will include the following:

- SADC Ministers Responsible for Health, Ministers Responsible for Water among others;
- Appropriate agencies;

- Health Commissions/Councils, Professional Councils and Associations;
- Regional NGOs, Education and Research Institutions and Private Sector; and
- The International Cooperating Partners.

SADC Ministerial Committee of Health

The Ministerial Committee of Health will review, approve and oversee implementation of the Strategy. The Ministerial Committee will report to SADC Council annually / biannually.

SADC Secretariat

The SADC Secretariat will facilitate the execution, monitor and evaluate the implementation of the strategy. The Directorate of Social and Human Development (SHD) (Health and Nutrition) and Directorate of Infrastructure (Water) in the SADC Secretariat will be jointly responsible for the implementation of the Strategy.

International Cooperating Partners (ICPs)

The SADC Secretariat will work International Cooperating Partners who will provide financial and technical support in the implementation of HSAP projects.

Health and Nutrition Unit

The Health and Nutrition Unit will serve as the Contact Point within SADC Secretariat for the implementation of the strategy

SADC HSAP Sub-Committee

A SADC Hygiene Strategy Action Plan Sub-Committee will be established. This Sub-Committee will be responsible for coordinating and facilitating the implementation of the Strategy. The Sub-Committee will comprise coordinators of Health from all the Member States and key partners.



Ivy Michelo, 34, washing fresh tomatoes with clean water from the community borehole in Milimo village, Monze District, Zambia.

WaterAid/ Chileshe Chanda

Hygiene line Ministries of Member States

The obligation of the Member States (MSs) will be to demonstrate commitment, provide leadership, establish supportive administrative mechanisms, and formulate, monitor and evaluate the hygiene strategy. Full government commitment is necessary to ensure the development of satisfactory and comprehensive hygiene policies and strategies. Member States will work with relevant key partners including the private sector and civil societies and will oversee implementation of the hygiene strategy.

Other ministries of member states

Other Government Ministries (such as Education, Labour, Correctional Services) will integrate hygiene interventions in their sector-specific projects. The other Ministries will also serve as members of the National Hygiene Coordination Group.

National Hygiene Contact Point

The National Hygiene Contact Point will serve as the first national point of call on all hygiene matters in the MS. Its role will include facilitate communications among all stakeholders on the implementation of HSAP projects.

National Hygiene Coordination Group

The role of the National Hygiene Coordination Group is to provide strategic, technical and operational guidance to hygiene partners for effective planning and delivery of hygiene projects. The Group will be responsible for coordination and harmonization of hygiene interventions involving all relevant partners – and sharing outcomes widely, both within the hygiene sector and to the wider community.

Hygiene Partnership Forum

The Hygiene Partnership Forum will consist of the Private Sector and International and Local NGOs, Community-Based Organisations (CBOs) working on hygiene projects in the country.

The private sector will play crucial role in the implementation in various aspects. One role is that of manufacturing hygiene products of the strategy which is crucial. The private sector can, and does, contribute to universal access to hygiene through specific business



**Gloria Mkukawa working in a labour ward,
Ntosa health centre, Nkhotakota, Malawi.**

WaterAid/ Dennis Lupenga

models in hygiene-related value chains, in providing products and services. The private sector players of particular interest are those businesses that are able to reach the 'Base of the Pyramid' (BoP).

The private sector also plays vital roles in contributing to the enabling environment for universal access to hygiene through hygiene financing; technology development, capacity-building, trade, policy and institutional coherence, multi-stakeholder partnerships, and data, monitoring and accountability (Mason et al., 2015). There is scope for collaboration between larger companies and those smaller businesses working closer to the BoP which enhance the latter's capacity to deliver suitable hygiene products and related services. This can capitalise on what both types of provider offer best (e.g., larger companies have the capital to trigger economies of scale, whilst small-scale businesses have a better understanding of BoP needs). By working with small businesses on hygiene marketing, larger companies can increase market penetration for their brands and products.

The International NGOs will provide technical and financial support for the implementation of HSAP. The local NGOs and CBOs will provide technical support for the implementation of the strategy. The Hygiene Partnership Forum is also linked to the National Hygiene Coordination Group.

Research and training

The research and training component of the framework will consist of stakeholders from the research and academic education sectors. This group will coordinate the generation of hygiene technologies and innovation as well as training of hygiene professionals. As one of the main goals of the strategy is to inculcate lasting hygiene behaviour change, formative research will be essential to understand what behaviours are being practised and why. The Research and Training body is also connected to the National Hygiene Coordination Group.

Province/region/district entities

The province/region/district entities are the bottom of the structure. This is where the implementation of hygiene activities takes place.

6 Resource mobilisation



Left to right: Hlobile, 17, Nonduduzo Khoza, 19, and Pamela Mamba, 20, demonstrating how they keep a hand wash station provided by WaterAid clean at Mpolonjeni High School in Mpolonjeni, Lubombo Province, Eswatini.

WaterAid/ Nyani Quarmyne/ Panos

The minimum budget required for each Member State to implement the strategy is USD3.90 million. The minimum budget required for the SADC Secretariat to implement the Strategy is USD1.80 million.

The mobilisation of these financial resources is essential for the implementation of the Hygiene Strategy Action Plan (HSAP). The success of the implementation the HSAP will depend on availability of resources, particularly the financial resources. These will be required to domesticate the HSAP by MSs and also to implement actions at regional level. The development of National Action Plans (NAPs) by each MS will be a priority of HSAP. The SADC Secretariat will assist in mobilizing International Cooperation Partner (ICP) financial and

technical support for MS to develop their NAPs. Either International Cooperation Partners (ICPs) can support MS bilaterally or SADC Secretariat can have a coordinated funding strategy using ICPs support. Support can also be provided from MS to MS through bilateral exchanges of know-how and technologies. It is important that MSs demonstrate their commitment and ownership by making contribution to development of their NAPs.

There is a mixture of financing instruments/ sources that can be used to fund the implementation of the HSAP; therefore, it will be important that MSs match funding sources and strategies with specific HSAP actions. Particularly, actions that entail developing enabling environment (policies, institutions,

capacity building, information systems and planning) are amenable to ICP grant funding. For projects type actions, both public and private sector funding can be deployed. Public funding will be a combination of government budgets, ICP grants and loans. Private sources will play an increasingly important role in financing hygiene products and services projects when the investment environment is more attractive, mature and secure.

There are also various sources of financing that can be obtained by project developers, with facilitation of both SADC and MS by providing the necessary support, such as guarantees and letters of support. The role of multilateral development banks is also central, particularly in project development, preparation and implementation. In addition to applying their own financing mechanisms, these institutions facilitate large-scale hygiene projects, by

catalysing public and private funds and mobilizing additional concessional and innovative finance. Another funding approach is where both MS and SADC can create special purpose investment funds particularly for small projects (currently without adequate access to financing, due to their inherent high transaction costs) involving both national and regional development banks.

The SADC Secretariat will have the responsibility to coordinate resource mobilization particularly for HSAP actions that will be implemented at regional level, but also assist MS in securing the resources they need to domesticate the HSAP in their countries. The actual amounts of financial resources required to implement HSAP at both regional and MS level will be determined on a case-by-case basis as the identified actions will need to be explored further and are expected to be different among MS.



Siphosenkhosi with the contents of a 'dignity pack' at Ndzangu High School. Recognising that there is a problem of older men taking advantage of school age girls who are in need of basics like sanitary pads, deodorant and so on in return, the school is part of an innovative pilot program that provides teenage girl students with a monthly package of essentials at no cost.

Unfortunately, according to a member of staff the current funder of the program has indicated that they are no longer able to keep supporting the program, and efforts to find an alternate sponsor are underway in Ndzangu, Lubombo Province, Eswatini.

WaterAid/ Nyani Quarmyne/ Panos

7 Monitoring, evaluation learning (MEL) mechanisms

“Having a nice latrine and safe water nearby make our life as girls easier.” Neny, 13 years old, cleaning their future water point with other women from Ambohibary village, Tsiroanomandidy district, Madagascar.

WaterAid/
Ernest Randriamalala



Information should be readily available on Member States’ performances in achieving their goals. Unreliable hygiene data affects negatively the capacity of governments and the SADC Secretariat to make informed decisions on the upscale of best hygiene practices and access to hygiene services.

7.1 Objectives of the Monitoring and Evaluation (M&E) system

The importance of establishing a robust M&E system to monitor the implementation of the strategy and action plan at national and regional levels cannot be overemphasized. The M&E system will aid the SADC Secretariat to track progress towards the achievement of SADC’s goals and objectives, and identify any deviation or bottlenecks. The M&E system will be based

on “sector performance indicators” to inform policy makers and constituencies on whether interventions in the hygiene sector are yielding the intended development results, and on “milestones” to advise implementers on the progress of the Action Plan execution.

7.2 Monitoring system

The monitoring and evaluation of the Strategy will be guided by the SADC Policy on Strategy Development, Planning, Monitoring and Evaluation (SPME) which was approved by Council in 2012. The SPME monitoring system is results based and for the Hygiene Strategy the following will be included:

- (i) **Impact indicators:** These will be reflected at the strategic goal and commitments and linked to post-SDG tracking;





Celina Hortence Razakaniaina, 20, at her home. Celina is an active Community Agent in Anivorano and Ambohibary villages, Tsiroanomandidy district, Madagascar.

WaterAid/ Ernest Randriarimalala

- (ii) **Outcome indicators:** these will reflect achievement and progress towards implementation of the strategic objectives;
- (iii) **Activities and process indicators:** reflected at regional and national levels and adequate coordination structures developed; and
- (iv) **Regional Steering Committee:** Drawing from technical officers identified from the SADC Member States.

7.3 Monitoring frequency

The Hygiene Strategy will be subjected to a mid-term review to ensure its suitability and adaptability in meeting the priorities and requirements of Member States. A data platform related to the SADC hygiene sector, which will be collecting data through standardized procedures, will be built to assist decision makers in evaluating the status of the sector and planning future interventions. It is proposed that institutional arrangements (such as needs for additional resources and specific capacity development) be developed to support

sustainable monitoring and evaluation processes of the hygiene sector. Such system would provide a framework for frequent review and update of HSAP implementation. It will contribute to establish trends over time, encourage policy dialogue within the MS and with cooperation partners, and aid the reporting of results concerning of the implementation of the hygiene targets set by each MS.

7.3.1 Regional performance measurement indicators

Indicators are identified in order to be able to monitor and evaluate. Indicators are how you measure whether you have achieved your objective and how this has been done.

The proposed indicators in relation to the targets, along with sources of data, means of verification and assumptions for each indicator are presented in the results framework. Baseline information is required from which progress will be measured. The proposed core indicators for monitoring the performance of the strategy are presented in Table 11.

Table 11:
Core indicators for monitoring the performance of the strategy

Hygiene setting	Core indicators
Households/ communities	<ul style="list-style-type: none"> • % of households with access to improved water sources; • % of households with adequate water handling practices to minimize contamination; • % of households that have sufficient quantities of water (≥ 20 litres per capita per day); • % of households with access to basic handwashing facilities with soap and water; • % of households with access to improved and hygienic toilet facility; • Toilets are used by the majority of men, women and children; • % of households that have child-friendly faeces disposal facility; • % of households that have hygienic solid waste disposal facility; • % of households participating in existing hygiene programmes. • % (proportion) of population practicing key hygiene behaviours (assess through survey)
Schools	<ul style="list-style-type: none"> • Proportion of schools with basic drinking water source; • Proportion of schools with single-sex basic sanitation which include menstrual hygiene management; • Proportion of schools with basic handwashing facilities with soap and water; • Proportion of schools with enabling hygiene promotion programmes such as School Total Sanitation, waste management awareness programmes; • Proportion of school participating in solid waste reduction programmes e.g., recycling, educational awareness programmes. • % (proportion) of school population practicing key hygiene behaviours (assess through survey)
Healthcare facilities	<ul style="list-style-type: none"> • % of healthcare facilities with access to improved water sources; • % of healthcare facilities with access to improved and hygienic toilet facilities which include menstrual hygiene management; • % of healthcare facilities with adequate medical waste disposal; • % of healthcare facilities with adequate handwashing facilities with water and soap at each point of care; • % of healthcare facilities with cleaning protocols available; • % of health facilities with enabling hand hygiene promotion programmes such as five moments of hand hygiene. • % (proportion) of healthcare staffs practicing key hygiene behaviours (assess through survey)
Hygiene behaviour change	<ul style="list-style-type: none"> • Existence of trained person or organisation responsible for carrying out hygiene behaviour change activities; • Availability of hygiene programmes in public settings such as communities, healthcare facilities and schools. • Hygiene survey demonstrating increases proportion of population practicing key hygiene behaviours when assessed
Disease burden	<ul style="list-style-type: none"> • % incidences of hygiene and sanitation related diseases in communities including outbreaks (through trend analysis); • % of children under 5 with faecal infectious diseases and malnutrition

Table 11: Core indicators for monitoring the performance of the strategy <i>continued</i>	
Hygiene setting	Core indicators
Financing	<ul style="list-style-type: none"> • Government has clearly defined budget line for financing hygiene practices.
Gender issues	<ul style="list-style-type: none"> • Women and girls are enabled to deal with menstrual hygiene issues in privacy and with dignity; • Women and men effectively participating in hygiene matters • Women participating in hygiene activities are empowered
Hygiene during emergencies	<ul style="list-style-type: none"> • Availability of adequate WASH infrastructure, supplies and services necessary to prevent outbreaks of WASH-related diseases and to maintain the dignity of communities during disasters and emergencies; • Availability of hygiene programmes during disasters and emergencies.
Hygiene for PWD	<ul style="list-style-type: none"> • Availability of adequate specifically-designed WASH facilities (drinking water, toilets, handwashing, waste disposal) that meet the needs of PWD in all hygiene settings; • All sectors of the community, including vulnerable groups, people with disabilities, are enabled to practise the target hygiene behaviours. • Availability of hygiene programmes for people with disabilities

Table 11 above provides a list of core indicators that may all require monitoring at some point during the implementation of the HSAP. However, it is appreciated that particular indicators chosen for monitoring in a MS at any given situation, and the frequency with which those indicators are measured, will reflect specific priorities identified

during assessment and planning and the practicalities of collecting and managing the data required to measure them. It is important that the National Action Plans (NAPs) of each MS clearly specifies the means of monitoring the indicators. Suggested ways of monitoring some of the core indicators are presented in Table 12.



Marie Angeline Raharisoa, 51, chief of Antsakambahiny Fokontany, while washing her hands at her home just two days before Madagascar declared its first Covid19 cases. Antsakambahiny village, Manjakandriana commune, Analamanga region, Madagascar.

WaterAid/ Ernest Randriarimalala

Table 12:
Suggested ways to monitor some of the core indicators

Indicator	Means of monitoring
Safe drinking water	<ul style="list-style-type: none"> • Water testing at source and household level; • Inspection of water containers at water points; • Household visits to look at water storage containers for signs of possible contamination (e.g., not covered, open necked, hands come in contact with water etc.)
Safe excreta disposal	<ul style="list-style-type: none"> • Exploratory walks to look for signs of open defecation; • Observation of maintenance and use of toilets/potties provided; • Reports from members of affected community expressing use and satisfaction with toilets provided.
Hygiene practices	<ul style="list-style-type: none"> • Observation of handwashing facilities with soap and water at household level; • Observation of hand washing at communal latrines; • Self-reported increase in hand washing by affected community. • Observed key hygiene practices by target population when assessed (in sub-set of the population through national survey/programme).
Menstrual hygiene	<ul style="list-style-type: none"> • Women in reproductive age reporting menstruation are no longer seen as a taboo issue in the communities • Reports of satisfaction with provision of menstrual materials from women.
Community participation	<ul style="list-style-type: none"> • Observation and discussion with community committees; • Observation and reports of response to vulnerable groups (e.g., latrine provision for people with disabilities); • Reports from men, women and children of satisfaction with facilities and improvements in hygiene.

7.3.2 Milestones of the Action Plan

A list of milestones has been selected to assess the implementation status of the Action Plan of HSAP and these are presented in the results framework. It is envisaged that Member State (MS) and SADC Agencies will be monitoring and reporting on the implementation of the strategic Action Plans presented and there is assumption that reliable data for analysis and financial support shall be available to generate the information to produce the indicators.

7.4 Evaluation and reporting plans

The hygiene strategy will be subjected to annual evaluation and a mid-term review to ensure its suitability and adaptability in meeting the priorities and requirements of Member States. The annual evaluation process will review the progress made, assess the adequacy of the adopted strategy to meet the targets as planned and take any corrective action, if needed. The yearly progress will be presented in a performance assessment report showing clearly the baseline scenario and the progress made against the targets and milestones set.

Definition of terms/glossary

Base of the Pyramid (BoP): Base of the Pyramid (BOP) refers to the lowest socio-economic segment in the society. This refers to the masses at the bottom of the society ladder

Basic drinking water service: Drinking water from an improved source provided collection time is not more than 30 minutes for a roundtrip including queuing.

Child friendly schools (CFS): Child-friendly schools aim to develop a learning environment in which children are motivated and able to learn, and where staff members are friendly and welcoming to children and attend to all their health and safety needs.

Community-Led total sanitation (CLTS): An innovative methodology for mobilising communities to completely eliminate open defecation (OD). Communities are facilitated to conduct their own appraisal and analysis of open defecation (OD) and take their own action to become ODF (open defecation free).

Global Acute Malnutrition (GAM): It is a measure of acute malnutrition in children aged between 6 and 59 months. GAM provides information on the percentage of all children in this age range who are classified with low weight-for-height and/or oedema. It is obtained by combining the number of children in this age range who have moderate acute malnutrition and severe acute malnutrition.

Hand hygiene: This is a way of cleaning one's hands that substantially reduces potential pathogens (harmful microorganisms) on the hands. Hand hygiene is considered a primary measure for reducing the risk of transmitting infection among patients and health care personnel.

Health care facilities: These are places that provide health care. They include hospitals, clinics, outpatient care centres, and specialized care centres, such as birthing centres and psychiatric care centres.

Hygiene behaviour change (HBC):

The systematic approach to encourage the widespread adoption of safe hygiene practices, in order to keep people and their environments clean.

Impact: The long-term, cumulative effect of programs/interventions over time on what they ultimately aim to change, such as a change in hygiene behaviour, change in WASH-related morbidity and mortality.

Indicator: A quantitative or qualitative factor or variable that provides a simple and reliable means to measure achievement, to reflect the changes connected to an intervention, or to help assess the performance of a development actor.

Joint Monitoring Programme (JMP): This is a Water Supply and Sanitation monitoring programme established by WHO and UNICEF and it is the official United Nations mechanism tasked with monitoring progress towards the Sustainable Development Goal Number 6 (SDG 6) since 2016.

Limited drinking water service: Drinking water from an improved source where collection time exceeds over 30 minutes for a roundtrip to collect water, including queuing.

Menstrual health and hygiene (MHH): This encompasses both MHM and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment, and rights.

Menstrual hygiene management (MHM): Women and adolescent girls are using a clean menstrual management material to absorb or collect menstrual blood, that can be changed in privacy as often as necessary for the duration of a menstrual period, using soap and water for washing the body as required, and having access to safe and convenient facilities to dispose of used menstrual management materials.



Multiple Indicator Cluster Surveys (MICS):

These are household surveys implemented by countries under the programme developed by the United Nations Children's Fund to provide internationally comparable, statistically rigorous data on the situation of children and women.

No drinking water service: Drinking water collected directly from a river, dam, lake, pond, stream, canal or irrigation channel

Open defecation (OP): The practise of defecating in fields, forests, bushes, bodies of water or other open spaces rather than using a toilet.

Open defecation free (ODF): Condition where communities have shifted to using toilets instead of open defecation.

Outcomes: short-term and medium-term effects of an intervention's outputs, such as changes in knowledge, attitudes, beliefs, behaviours.

People with disabilities (PWD): Persons who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective.

Personal protective equipment (PPE):

Protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection.

Results: The outputs, outcomes, or impacts (intended or unintended, positive and/or negative) of an intervention.

Safely managed drinking water service:

Drinking water from an improved water source which is located on premises, available when needed and free of faecal and priority contamination

School-Led Total Sanitation (SLTS):

An approach designed to promote sanitation and hygiene at both schools and communities through child-centred approach. Given the high vulnerability of children to diarrheal diseases, their greater receptivity of behaviour changes and their propensity for development of lifelong behaviours, targeting school children as primary recipient as well as leaders of sanitation and hygiene promotion would be most effective and efficient way of disseminating messages and transforming behaviours.

Unimproved drinking water service:

Drinking water from an unprotected dug well or unprotected spring.



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Endnotes

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- 22 Personal communication from the Hygiene Promotion Service, Directorate of Sanitation and Hygiene, Ministry of Water, Sanitation and Hygiene
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Annexes

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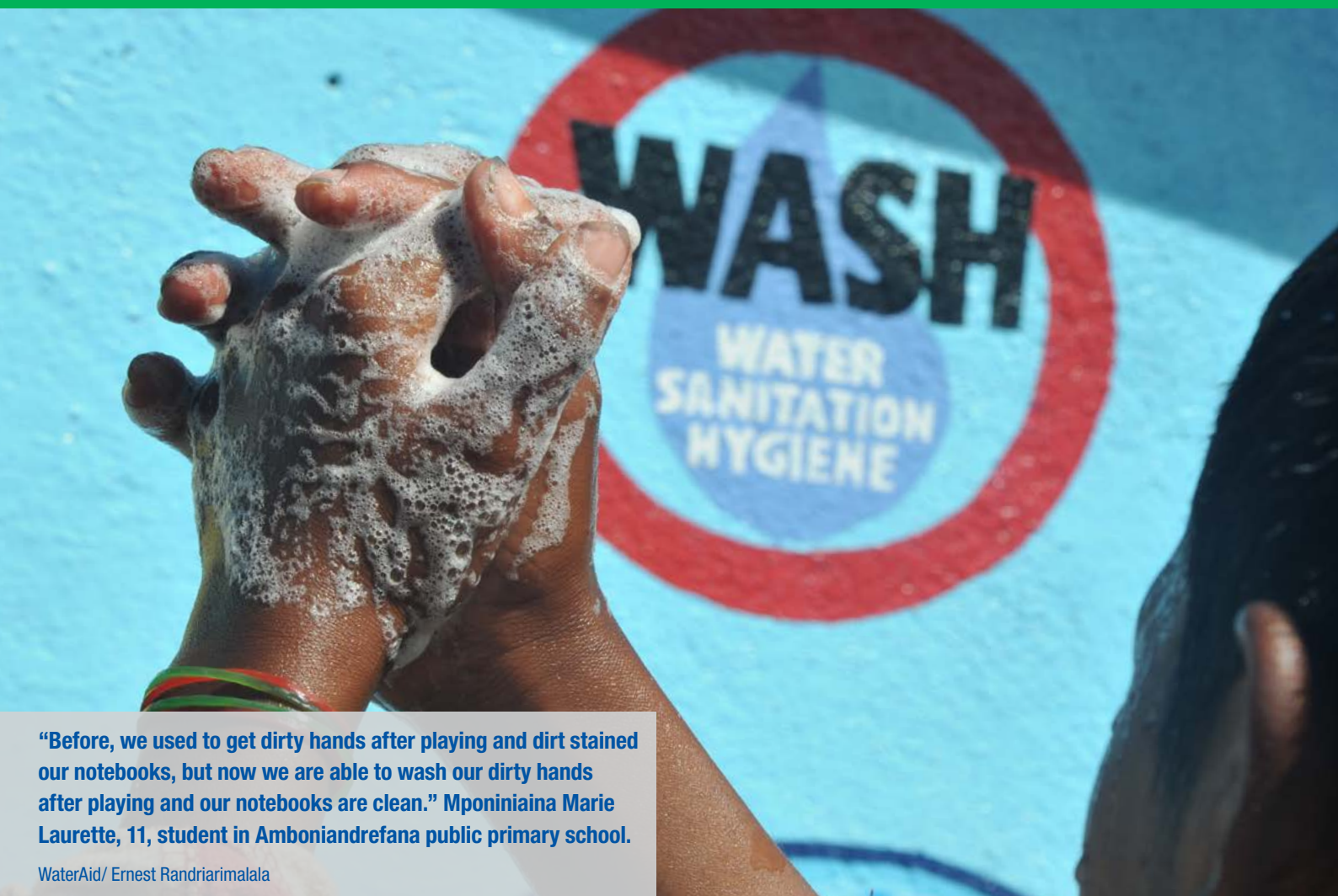
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“Before, we used to get dirty hands after playing and dirt stained our notebooks, but now we are able to wash our dirty hands after playing and our notebooks are clean.” Mponiniaina Marie Laurette, 11, student in Amboniandrefana public primary school.

WaterAid/ Ernest Randriarimalala

Front cover photo:
Angita, 10, and Safia, 12,
washing their hands at a kiosk in
Cabaceira Grande, Mozambique.

WaterAid/ Chileshe Chanda

