NATIONAL HAND HYGIENE STRATEGY

AND COSTED IMPLEMENTATION PLAN FOR LESOTHO (2022-2026)

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CONTENTS

ACRONYMS

AMR	Antimicrobial drug-resistance
ANC	Antenatal Care
ART	Anti-Retroviral Treatment
CLTS	Community Led Total Sanitation
DHMT	District Health Management Team
DHS	Demographic Health Survey
ECCD	Early Childhood Care and Development
GoL	Government of Lesotho
HH	Household
HHTWG	Hand Hygiene Technical Working Group
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HWF	Handwashing Facility
HWWS	Handwashing with Soap
IPC	Infection, Protection, Control
KPAs	Key Priority Areas
LNFOD	Lesotho National Federation of Organizations of the Disabled
MEL	Monitoring, Evaluation and Learning
MICS	Multiple Indicator Cluster Survey
MOE	Ministry of Education
MOH	Ministry of Health
MOLG	Ministry of Local Government
MOW	Ministry of Water
MRSA	Methicillin-resistant Staphylococcus aureus
NGO	Non-Governmental Organization
NHSP	National Health Strategic Plan
NSDPII	National Strategic Development Plan II
NST1	National Strategy for Transformation
PHAST	Participatory Hygiene and Sanitation Transformation
PLHA	Person Living with HIV/AIDS
PPP	Public Private Partnership
PWD	People with Disabilities
SADC	Southern African Development Community
SDGs	Sustainable Development Goals
TB	Tuberculosis
TED	Technologies for Economic Development
VHW	Village Health Worker

WASH	Water, Sanitation, Hygiene
WG	Working Group
WHO	World Health Organization

PREFACE

The unprecedented impact of the COVID-19 pandemic over the last two years provides a unique impetus to institutionalize hand hygiene as a fundamental component of health, safety and well-being. This pandemic has helped the world to recognize that creating universal hand hygiene habits takes multi-sectoral collaboration, learnings and investment. As we enter a new normal, beyond COVID-19, the Kingdom of Lesotho is taking the opportunity to transform the nation into one in which all people wash their hands with soap at critical times in all settings. Prioritizing this behaviour in the home, schools, health facilities, and throughout all public and private institutions, will not only prevent the spread of COVID-19, but also decrease school dropout rates, promote the nutrition of children, result in better medical outcomes in health care facilities and, ultimately, improve the economic life and well-being of people and communities.

To foster a strong culture of handwashing with soap for all people in Lesotho, as well as to contribute to building a road map for improved health and well-being, the Ministry of Health developed the National Hand Hygiene Strategy, with support from UNICEF. This strategy was developed through a consultative process, that not only included government, civil society stakeholders and implementing WASH (Water, Sanitation and Hygiene) partners, but also community members in Lesotho.

The Ministry of Health and UNICEF in Lesotho are committed to galvanizing government and partner-led programmes, and to working across sectors to prioritize the delivery of hand hygiene for all. The strategy highlights four main areas of action: 1) **LEADERSHIP** from the national level to the local level to create the political, societal and behavioural changes to inspire a national culture of hand hygiene; 2) Building an **ENVIRONMENT** that **ENABLES** hand hygiene interventions and practices for all; 3) Creation of sustained **DEMAND** by employing evidence-based behaviour change activities that will build, enable and sustain practice; and 4) Ensuring accessible **SUPPLY** to enable people to create a nation where people can access the facilities and products necessary to sustain their practice of handwashing with soap. With dedicated and collaborative effort, the National Hand Hygiene Strategy goal can be achieved, creating a country where all people – men, women, boys, girls, people with disabilities and vulnerable populations – shall wash their hands with soap at all critical moments.

Hon. Semano Sekatle
Minister of Health
Lesotho

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ACKNOWLEDGEMENTS

Special appreciation is extended to UNICEF Lesotho Country Office for envisioning and financing this National Hand Hygiene Strategy, with the aim of leading Lesotho towards being a nation in which hand hygiene is the culture.

This strategy is the result of a consultative process with critical input from key stakeholders, including ministries concerned with the social determinants of health and well-being, development partners, civil society and health professionals. Before drafting the strategy, an extensive series of consultations was undertaken to create a picture of current hand hygiene practices, resources and needs, and to begin to define a common vision, clear strategic objectives and realistic but aspirational targets.

The draft was circulated amongst stakeholders for final input, before undergoing validation by a select technical team from the WASH Technical Working Group. The final strategy document was then submitted to the Hon. Minister of Health for consideration.

The Ministry of Health and UNICEF would like to recognize the following institutions for their time and shared wisdom that informed the development of this strategy: the Ministry of Water; the Ministry of Education and Training (MoET); World Vision Lesotho, Technologies for Economic Development (TED), Lesotho National Federation of Organisations of the Disabled (LNFOD), the Lesotho Red Cross Society (LRCS), and Catholic Relief Services (CRS).

Special thanks to the following people for significantly contributing their time and knowledge in supporting the development of this Strategy: Tebello Kolobe and Pheello Phera, WASH Unit, Ministry of Health; Nthabiseng Mokhabuli and Khotso Mosoeu, Office of the Water Commission, Ministry of Water; Lepoqo Moshoeshoe, Department of Rural Water Supply, Ministry of Water; Thuto Ntsekhe, MoET; Heather Moran, Consultant; Bernard Keraita, Relebohile Bohloko and Khotso Likhomo, UNICEF Lesotho Country Office; Kabelo J. Tseetsana, World Vision, Lesotho; Mantopi M.Lebofa, TED; Nkhasi Sefuthi, LNFOD; and Peter Clark, CRS.

KEY DEFINITIONS AND TERMS

Critical points of health care. The place where three elements come together: the patient, the health care worker, and care or treatment involving contact with the patient or his/her surroundings.[1]

Critical times. The key moments that all people should wash their hands with soap to have the greatest impact on child health, specifically:

- After contact with faeces, including after using a toilet/defecation or after cleaning someone who has defecated;
- Before contact with food, including before preparing food, before eating, before feeding a child.

The Centers for Disease Control and Prevention (CDC) also recommends washing hands at the following times for public health benefit:

- After blowing your nose, coughing or sneezing;
- After contact with an animal/pet, animal feed or animal waste;
- After touching garbage.

Cues. Sights, sounds and places that trigger an automatic behavioural response.

Desired behaviour. The targeted behaviour of this strategy is the practice of handwashing with soap. In the case of infection, protection, control (IPC) in health care settings, the behaviour should follow Lesotho guidelines – and may be referred to as 'hand hygiene'.[2]

Determinants. Factors that influence the performance or non-performance of a targeted behaviour.

Habit. Frequent, learned behavioural responses that are cued automatically by context cues, such as physical settings and preceding actions in a sequence (e.g., morning bathing sequence, food preparation habits, daily travel). Handwashing habit formation means converting handwashing from a behaviour that a person must think about to

1 A Guide to the Implementation of the WHO Multimodal Hand Hygiene Improvement Strategy, WHO, 2009.
2 Safe Environment for Staff and Patient Policies and Procedures, ES3-04 Hand Hygiene, Republic of Rwanda Ministry of Health, http://www.moh.gov.rw/index.php?id=566

undertake, into a procedure that is automatically taken in response to cues.

Hand hygiene. Any action of hygienic hand antisepsis to reduce transient microbial flora – generally performed either by hand rubbing with an alcohol-based formulation or handwashing with plain or antimicrobial soap and water. Health service related hand hygiene applies antiseptic techniques to eliminate transient flora and reduce resident skin flora.

Handwashing Facility (HWF). Any inclusive facility that allows handwashing with soap practice by all people, including sinks with tap water, buckets with taps, tippy taps and portable basins.[3]

Handwashing (HW). The act of cleansing the hands with water or other liquid with soap or another detergent to removing soil or microorganisms.

Health care critical times. The key moments that health care professionals should practice handwashing[4], specifically:

- Before touching a patient;
- Before clean/aseptic procedure;
- After body fluid exposure risk;
- After touching a patient;
- After touching a patient's surroundings.

Inclusive handwashing facilities. Facilities that are designed and implemented to empower and enable all people to use them, considering the unique needs of young children, people with disabilities and the elderly.

Nudges. Environmental cues that signal a desired response from the end user or channel their decision-making (e.g., placing fruit at eye level to encourage consumption).

Social and behaviour change. An approach that aims to affect key behaviours and social norms by addressing their individual, social and structural determinants.[5]

Social norms. The accepted behaviour that an individual is expected to practice and expects others to also conform to in a particular group, community or culture. These norms often serve a useful purpose and create the foundation of correct behaviours.

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3 JMP Methodology: 2017 Update & SDG Baselines, WHO/UNICEF, March 2019. file:///Users/heathermoran/Downloads/JMP-2017-update-methodology.pdf

4 See the Rwandan Ministry of Health Safe Environment for Staff and Patient Policies and Procedures, ES3-04 Hand Hygiene.

5 USAID. Social and Behavior Change for Water Security, Sanitation, and Hygiene. USAID Water and Development Technical Brief 10.

INTRODUCTION

The appropriate practice of hygiene behaviours can prevent exposure to countless diseases. Every year, millions of people die from diseases caused by inadequate and unsafe use of water supply, sanitation and hygiene services.

Approximately 58 per cent of diarrhoeal disease associated deaths[6], which is the second leading cause of death in children under five in the world, is attributed to unhygienic water supply and sanitation, and insufficient hygiene.

Hand hygiene or handwashing with soap is the single most effective way to prevent diarrhoea and other hygiene related diseases. Handwashing with soap is a behaviour that can be practiced at home, in school, at restaurants, in the workplace, in health care settings and in communities, reducing rates of diarrhoeal disease by up to 30 per cent and respiratory infections by up to 20 per cent[7][8]. In addition, handwashing with soap at critical moments and the use of basic sanitation can prevent infection in neonates and children under five (reducing both neonatal and under five mortality), help prevent stunting caused by chronic infections, cut absenteeism in schools, and is a key control and prevention measure in the case of epidemics like cholera.

The current COVID-19 pandemic has further highlighted the critical role hand hygiene plays in disease prevention and control. There is a need to take immediate action on hand hygiene across all public and private settings to respond and control the pandemic. Even more importantly, there is a need to build on the current momentum to make hand hygiene an essential tool in public health interventions beyond the pandemic and create a culture of hand hygiene at all levels of society.

Despite the life-saving properties of hand hygiene, 82 per cent of all households in Lesotho are reported to have no handwashing facility of any type and 48 per cent do

6 Pruss-Ustun A., Bartram, J., Clasen, T. & Colford, J.M. Burden of disease from inadequate water, sanitation and hygiene in low- and middle-income settings: a retrospective analysis of data from 145 countries. Tropical Medicine and International Health, 2014; 19(8): 894-905.

7 Aiello AE, Coulborn RM, Perez V, Larson EL. Effect of hand hygiene on infectious disease risk in the community setting: a meta-analysis. American Journal of Public Health. 2008;98(8):1372-81.

8 Ejemot-Nwadiaro, R.I., Ehiri, J.E., Arikpo, D., Maremikwu, M.M., & Critchley, J.A. Hand-washing promotion for preventing diarrhoea. Cochrane Database Syst Rev. 2021; 12(1):CD004265.

not have access to improved sanitation available in their own homes[9]. Investment in hygiene in Lesotho is critical to ensure that all people are enabled and motivated to practice hand hygiene to save lives and foster well-being for all.

The evidence shows a striking need for a National Hand Hygiene Strategy that will transform Lesotho into having a national norm around hand hygiene at critical times. Fostering social norms is complex and requires a multi-faceted approach that requires leadership and enabling systems, addresses supply needs, changes and sustains behaviours, and breaks down barriers that prevent practice.

PURPOSE OF THE STRATEGY

This five-year National Hand Hygiene Strategy has been developed to serve as a roadmap that will guide Lesotho into a nation in which all people – urban and rural communities, men, women, children, elderly, people with disabilities and marginalized groups – are practicing life-saving hand hygiene behaviours in appropriate settings at all critical times. This strategy is intended to serve all stakeholders engaged in regulating, funding, planning, implementing and/or monitoring hand hygiene actions in Lesotho. Key partners include, but are not limited to, national, district and local government and leaders, development and implementing partners, civil society, the private sector and community stakeholders.

9 Lesotho Bureau of Statistics. (2019). Lesotho Multiple Indicator Cluster Survey (MICS) 2018, Survey Findings Report. Maseru, Lesotho: Bureau of Statistics.

Below and previous: © UNICEF/Karin Schermbrucker

METHODOLOGY AND SOURCE OF STRATEGY

This strategy was developed in a participatory manner, engaging key government agencies and civil society stakeholders invested in improving hygiene in Lesotho. The first step of the strategy development included a comprehensive desk review of the hand hygiene situation globally and specifically in Lesotho. The desk review was conducted prior to the stakeholder consultation phase and involved a review of hygiene reports from national Demographic and Health Surveys (DHS) and the Multiple Indicator Cluster Survey (MICS), as well as examination of various government strategy documents relevant to hygiene, and local and global reports by key hygiene stakeholders. A comprehensive list of reviewed documents can be found in Annex 1.

The desk review was followed by consultations conducted via Zoom, with key stakeholders including senior staff (directors and managers) at key government ministries, development agencies, donors and non-governmental organizations (NGOs). See Annex 2 for a comprehensive list of stakeholders engaged in the landscape consultations.

Both the desk review and stakeholder consultations were aimed at exploring the following areas:

- Key behaviours, settings and target groups;
- Actions being taken to improve hygiene in Lesotho;
- Existing and required policies and systems to enable and sustain hygiene practice;
- Hygiene coordination and capacity building systems;
- Public and private resourcing for hygiene at the household, community and institutions levels.

POLICY CONTEXT FOR HYGIENE IN LESOTHO

The National Hand Hygiene Strategy has been developed in accordance with the aspirations of the Lesotho government, working in parallel with the Sustainable Development Goals (SDGs), the Constitution of Lesotho and the National Strategic Development Plan II (NSDP II), with its commitment to strengthening human capital through investment in health, nutrition, skills development, social protection and

migration, and the national and international frameworks. Fostering a national culture of hand hygiene is grounded in the Constitution of Lesotho's commitment to "adopt policies (strategies) aimed at ensuring the highest attainable standard of physical and mental health for its citizens".

While hand hygiene is a simple behaviour, and one that can be practiced by both young and old, it is intrinsic to good health and subsequently the strengthening of employment and inclusive growth for Lesotho. The NSDP II articulates four key priority areas (KPAs) to guide political and budgeting decision-making to improve employment and inclusive growth. While the NSDP KPAs and subsequent actions do not directly refer to hand hygiene, all are relevant to enabling and empowering the sustained practice of key hand hygiene behaviours for all people living in Lesotho. They inform the core of the National Hand Hygiene Strategy.

Table 1: National Strategic Development Plan II key priority areas and relevance to hand hygiene

	Key priority area	Relevance to hygiene
1	Promoting inclusive and sustainable economic growth and private sector-led job creation	Sustainable economic growth is only feasible if Basotho citizens are healthy and free from diseases preventable by good hygiene behaviours.
2	Strengthening human capital (health, nutrition, education and skills development	Human capacity around hygiene is essential for health service providers, school teachers, national and district leaders, and programme implementers in order to make target behaviours a norm for all. Furthermore, hygiene is critical for improved HIV/AIDS and nutrition outcomes, which are currently a significant burden on the health and well-being of Lesotho.
3	Building enabling infrastructure	Access to basic water, sanitation, and hygiene (WASH) services is essential for the practice of key hygiene behaviours. Infrastructure must be accessible to all people in Lesotho for critical hygiene behaviours to become social norms.
4	Strengthening government and accountability systems	Systems to support the delivery and monitoring of key hygiene behaviours need to be institutionalized in order to accelerate the adoption and practice of hygiene in Lesotho.

Box 1: Hand hygiene contributions to achieving the Sustainable Development Goals

SDG1 Poverty Reduction
Ensuring services for all, with focus on vulnerable groups.

SDG2 Nutrition
Preventing infections that compromise nutrition.

SDG4 Education
Improving hygiene practices in schools for better education outcomes.

SDG5 Gender Equality
Reducing gender barriers that may prevent access and practice of hand hygiene.

SDG 6 WASH
Contributing towards universal access to safe WASH services.

SDG 8 Economic Growth
Promoting hand hygiene for a healthy and productive workforce.

SDG 10 Tackling Inequities
Addressing physical, social, gender and economic barriers to enable hand hygiene practice.

SDG 17 Partnership for Health
Collaborating with health sector to optimize outcomes.

At the global level, the National Hand Hygiene Strategy will support the achievement of the SDGs that the United Nations adopted in 2015. Lesotho recognizes the transformative goal of the SDGs and has operationalized its commitment to the SDGs through the NSDP II. The National Hand Hygiene Strategy contributes towards this commitment, as seen directly in eight of 17 SDGs highlighted in Box 1.

To directly contribute to the achievement of health and well-being development commitments at national and regional levels, the National Hygiene Strategy contributes to and aligns with the following key policy frameworks.

1. At the **national level**, the **National Health Policy (2016)** and **National Health Strategic Plan (NHSP) 2017-2022** guide the health sector towards having "a healthy nation, living a quality and productive life" that will drive Lesotho towards a stronger inclusive economy that improves the quality of lives of all Basotho. The National Health Policy will support the health sector's work in establishing universal

access to quality health services by ensuring that all Basotho – men, women, boys and girls, the elderly and people with disabilities – are enabled, motivated and empowered to practice key hand hygiene behaviours.

In line with the NHSP's first objective – "to ensure equity in access to health services, infrastructure, equipment and technologies for quality primary and secondary health services for all Basotho" – the National Hand Hygiene Strategy will prioritize reducing the burden of communicable diseases and malnutrition through improved hygiene behaviours at key settings, including households, communities, public spaces, schools and health facilities.

2. Strategic Aim III.3 of the **Long-Term Water and Sanitation Strategy (2016)** aims to improve hygiene in rural and urban communities. The strategy places the responsibility for overseeing hygiene education and promotion with the environmental health staff of local councils, with technical assistance from the Ministry of Health, as well as the Department of Rural Water Services and the Ministry of Education as appropriate. The strategy acknowledges the need for the establishment of guidelines, standards and systems for monitoring progress on hygiene in schools and households.

3. The **Lesotho Food and Nutrition Policy (2016)** and **Strategy and Action Plan (2019)** highlight poor access to improved water sources, sanitation facilities and hygiene practices as one of the six major factors contributing to food and nutrition insecurity in Lesotho. The National Hand Hygiene Strategy directly contributes to Strategy 10.6 - WASH in the Lesotho Food and Nutrition Strategy that targets increasing the proportion of households with the ideal handwashing practices by 70 per cent in 2023.

4. The **Education Sector Plan's (2016)** mission to enhance the system that will deliver relevant and inclusive quality education to all Basotho effectively, efficiently and equitably is directly supported by the National Hand Hygiene Strategy in its aim to ensure that all institutions in Lesotho have access to inclusive hand hygiene facilities.

5. The **National Environmental Health Policy (2014)** and the **National Environmental Health Strategic Plan (2021-Draft)**, which is currently awaiting approval, both identify the strengthening of water, sanitation and hygiene services which are conducive to good health for every person as one of the nine key areas critical to promoting environmental health. The legal document highlights the use of behaviour change approaches like Community Led Total Sanitation (CLTS), Participatory Hygiene and Sanitation Transformation (PHAST) and communications to trigger the uptake of hygiene behaviours. It also highlights the importance of

using hygiene practices as a tool to prevent and control the HIV/AIDS epidemic in Lesotho.

The development of the National Hand Hygiene Strategy shall be guided by the policies and strategies detailed above, but has also been informed by other associated documents, as referenced in Table 2.

At the **regional level**, the National Hand Hygiene Strategy aspires towards the commitments made by the **N'gor Declaration on Sanitation and Hygiene (2015)**, for adequate and sustainable sanitation and hygiene services by 2030.

The **South African Development Community (SADC) Hygiene Strategy 2021-2025** provides both a guide and leverage to strengthen Lesotho's policy environment to enable sustained hand hygiene behaviour change, providing a framework that prioritizes: 1) political leadership; 2) a strong enabling environment; and 3) supply and demand for hygiene services.

Table 2: Comprehensive list of policy documents informing strategy development

Ministry	Relevant policies, strategies and guidelines
Ministry of Water	National Water and Sanitation Policy (2007) National Long-Term Water and Sanitation Strategy (2016)
Ministry of Health	National Environmental Health Strategic Plan (2019) Draft- National Environmental Health Policy (2014) National Health Strategic Plan (2017) Lesotho Food and Nutrition Policy (2016) Lesotho Food and Nutrition Strategy and Action Plan (2019) Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition Strategy (2017) HIV and AIDS Policy (2006) Village Health Workers Policy 2019 and Training Manual
Ministry of Social Development	Lesotho National Social Protection Policy and Strategy (2014) Lesotho National Disability Mainstreaming Plan (2021)
Ministry of Education	Education Sector Plan (2016) Child Friendly Schools Manual School Health and Nutrition Policy (2019)
Ministry of Local Government	Decentralization Policy (2014)

Hand hygiene is a pre-condition for health and development. Hand hygiene is not only critical to human health and well-being, but also contributes to nutrition, economy, livelihoods, education and dignity. Hand hygiene is an essential ingredient in creating resilient individuals living in healthy communities.

Box 2: Proper handwashing sequence

HANDWASHING SEQUENCE

1. Wet hands with running water
2. Lather with bar or liquid soap
3. Scrub for 20 seconds – fronts and backs of hands, between fingers and under nails
4. Rinse with clean running water
5. Dry – air or clean towel

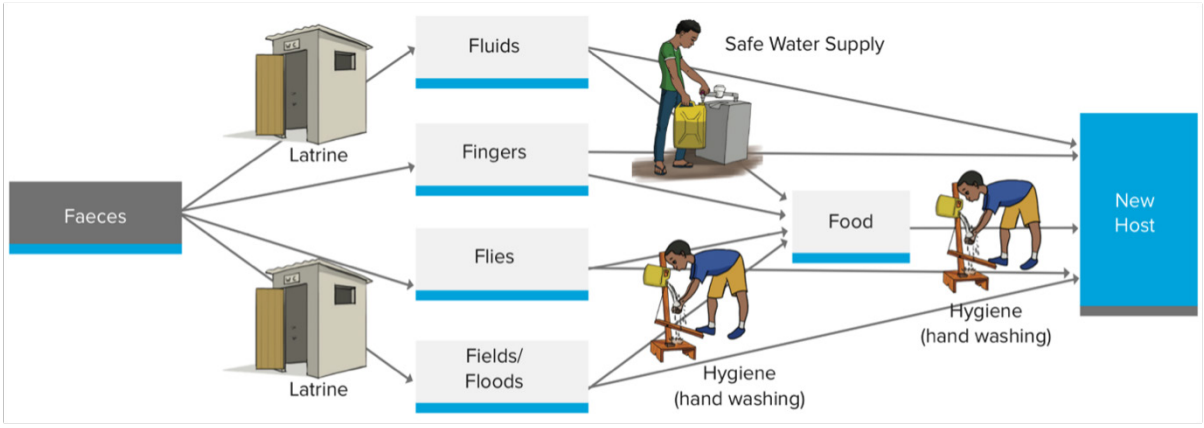
Individual, household and community setting

Unhygienic management of household drinking water, inadequate availability of services for hygiene and a lack of access to sanitation together contribute to around 58 per cent of deaths from diarrhoeal disease[10]. Environmental enteropathy[11], caused by chronic childhood exposure to faecal microbes due to poor sanitation and hygiene practices, affects the small intestine's ability to absorb nutrients, which has an effect on nutrition, child growth and development, and contributes to stunting. Globally, 22.2 per cent of children are stunted, which may be attributable to environmental enteropathy. The impact of inadequate WASH results in millions of child deaths and prevents health, education and livelihood improvements.

10 Pruss-Ustun A., Bartram, J., Clasen, T. & Colford, J.M. Burden of disease from inadequate water, sanitation and hygiene in low- and middle-income settings: a retrospective analysis of data from 145 countries. Tropical Medicine and International Health, 2014; 19(8): 894-905.

11 The Global Nutrition Report, 2018.

Figure 1: The F-diagram and effective hand hygiene barriers



Yet simple hand hygiene practice could potentially prevent an estimated 165,000 deaths from diarrhoeal disease each year[12]. Handwashing with soap is one of the most protective barriers available to reduce the spread of infections. The use of soap effectively traps and removes germs, harmful chemicals and dirt in lather pockets called micelles. Rinsing hands with water eliminates the micelles with all of the pathogens from hands, leaving them clean and germ free. As illustrated in Figure 1, handwashing can effectively break the route of faecal-oral transmission almost completely. Many diseases and infections, most of which impact children, are the result of a lack of hand washing with soap at critical moments.

Handwashing with soap can reduce the risk of diarrhoeal disease by more than 40 per cent,[13] while the use of improved sanitation reduces the incidence of diarrhoea in children by 36 per cent.[14] In addition, handwashing with soap at critical moments and the hygienic use of basic sanitation can prevent infections that will subsequently reduce neonatal and under five mortality, help prevent stunting, reduce the prevalence of other infectious diseases, cut absenteeism in schools and is a key intervention in cutting the transmission of COVID-19.

Despite the life-saving and improving impact of hand hygiene, target behaviours are still not globally prioritized. Unfortunately, hygiene practices remain alarmingly poor across the world. Three billion people, or 40 per cent of the global population, do not have a place at home to wash their hands with soap and water.[15] In the least developed countries, this number grows higher, with three out of four people lacking basic

12 Pruss-Ustun, Annette, et al. Burden of disease from inadequate water, sanitation and hygiene for selected adverse health outcomes: An updated analysis with a focus on low- and middle-income countries." International Journal of Hygiene and Environmental Health; 222.5 (2019): 765-777.
13 Aiello, AE, Coulborn RM, Perez V, Larson EL. Effect of Hand Hygiene on Infectious Disease Risk in the Community Setting: A Meta-Analysis. Am J Pub Health, 2008; 98(8): 1372-81.
14 Waddington, H., Snilstveit, B., White, H., Fewtrell, L. Water, sanitation and hygiene interventions to combat childhood diarrhoea in developing countries. The International Initiative for Impact Evaluation (3ie), 2009.
15 UNICEF. The Hand Hygiene For All, Retrieved from https://www.unicef.org/media/71776/file/Hand-hygiene-for-all-2020.pdf on 6 May 2021.

hygiene facilities.[16] The gap in infrastructure for handwashing also lies outside of the home, where transport hubs, markets, workplaces and other gathering places also lack facilities to enable handwashing with soap at critical moments. Only 19 per cent of people across the world wash their hands with soap after defecation.[17] And amongst the existing handwashing facilities in the world, consideration of accessibility and usability by people with specific physical needs has been limited.

Health care settings

Within health care settings, Infection, Prevention and Control (IPC) is critical to decrease hospital-acquired infections.[18] Hand hygiene is the simplest and most important intervention that has been consistently proven to prevent up to 50 per cent of avoidable infections acquired during health care delivery. Improved hand hygiene can also combat the global crisis of antimicrobial drug-resistant (AMR) bacteria, which presently contributes to 700,000 deaths each year in health care settings.[19] One model estimated that each increase of 1 per cent in hand hygiene compliance could save nearly US$40,000 in MRSA (methicillin-resistant Staphylococcus aureus) related health care costs per year in a hospital setting.[20] The WHO recently released a Hand Hygiene campaign with tools to guide the establishment of procedures and standards for hygiene within health care settings (see Figure 2).

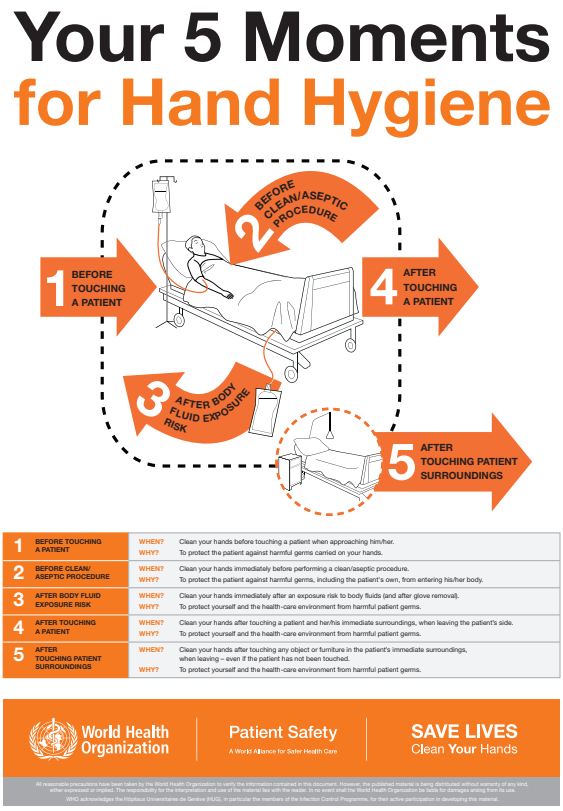


Figure 2: The WHO's 5 Moments for Hand Hygiene in Health Care Settings

Hygiene is also critical for caring for the estimated 38 million people living with HIV/

16 Retrieved from https://washdata.org/monitoring/hygiene on the 10th of May 2021.
17 Freeman M, Stocks M, Cumming O, Jeandron A, Higgins J, Wolf J, et al. Hygiene and health: A systematic review of handwashing practices worldwide and update of health effects. Tropical Medicine and International Health. 2014; 19(9): 906-16.
18 Jarvis, W. Handwashing – the Semmelweis lesson forgotten? Lancet. 1994;344(8922):1311-2.
19 Allegranzi B, et al. Burden of endemic health-care-associated infection in developing countries: systematic review and meta-analysis. Lancet. 2011;377(9761).
20 Collins, A. Preventing Health Care-Associated Infections. Hughs, R.G. (ed) 2008. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. https://www.ncbi.nlm.nih.gov/books/NBK2683/

AIDS (PLHA)[21], who, being more susceptible to opportunistic infections, have rates of diarrhoeal diseases up to six times higher than those who are not infected and require good nutrition for antiretroviral treatment (ART) to work.[22]

Educational settings

Globally, nearly half of all schools do not have facilities with water and soap, resulting in 900 million school-age children and their teachers being unable to wash their hands with soap or manage basic menstrual hygiene needs. The inability to wash hands with soap at home and at school negatively impacts a child's education and their ability to stay in school due to WASH related diseases. Because children spend such a significant amount of time in schools, the ability to access these facilities to practice hand hygiene behaviours is essential to positively impact children's health, academic growth and overall well-being. Considering the inherent role that the school environment plays in a child's education, schools are the best place to learn, practice and inculcate hygiene behaviours. Children also have the opportunity to act as change agents, positively influencing the hygiene behaviour of their family and community members.

CONTEXT IN LESOTHO

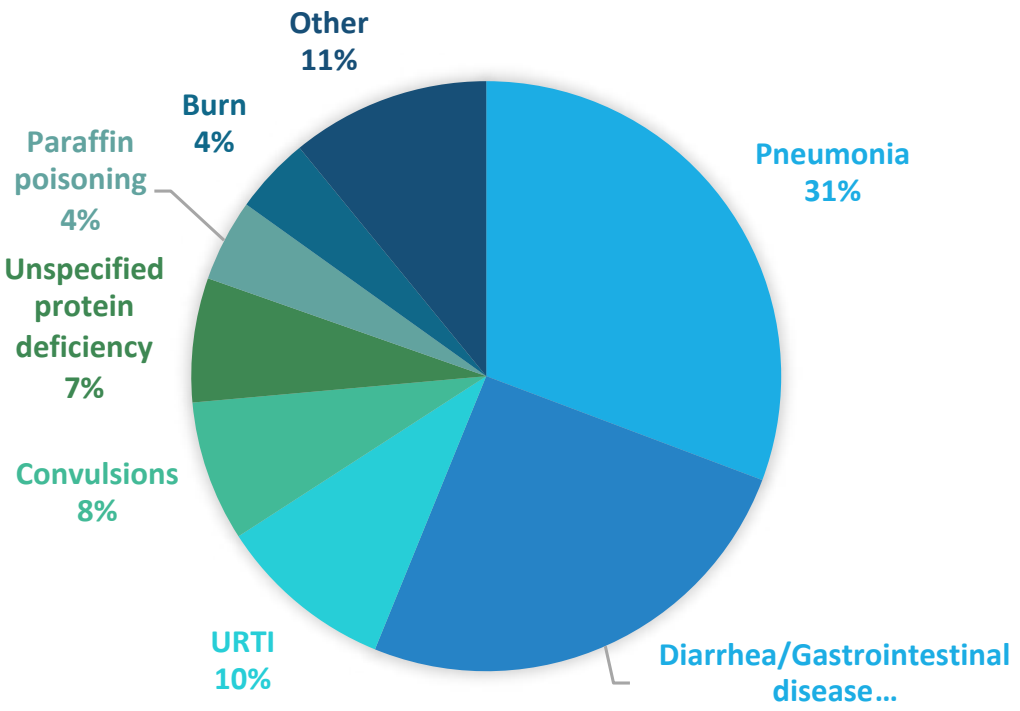
Health and well-being

Almost two thirds of under-five clinical admissions in Lesotho are associated with poor hand hygiene behaviour, presenting with pneumonia, diarrhoea/gastrointestinal disease and upper respiratory tract infections (see Figure 3)[23]. Lesotho has an under-five mortality rate of 76.2 deaths per 1,000 live births[24]. Thus, it can be extrapolated that these three conditions, preventable with improved hand hygiene practices, contribute to the high under-five mortality rate. The 2018 MICS report for Lesotho shows a substantial burden of preventable infectious disease, with 8.6 per cent of children reported as having diarrhoeal disease and 3.3 per cent having acute respiratory infection symptoms in the two weeks preceding the survey. Improved handwashing with soap practice is also critical from an outbreak control perspective. It is a key strategy for preventing and controlling the spread of COVID-19 and cholera, both of which threaten the health and well-being of Lesotho.

Opposite: © UNICEF

21 Retrieved from The Global Health Observatory at https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-number-of-people-(all-ages)-living-with-hiv#:~:text=Globally%2C%2038.0%20million%20%5B31.6%E2%80%93,considerably%20between%20countries%20and%20regions on the 12th of May 2021.
22 WaterAid. Water, sanitation and hygiene and HIV and AIDS: Opportunities for integration, WASH Matter.
23 Bureau of Statistics. 2017-2018 Health Statistics (Statistical Report No. 22). Maseru, Lesotho: Bureau of Statistics, 2018.
24 Bureau of Statistics, Ministry of Development Planning. Lesotho MICS – Multiple Indicator Cluster Survey, Survey Findings Report, 2019.

Figure 3: Causes of health facility admission for children under five



HIV and AIDS. HIV/AIDS carries the heaviest burden for the health care system. With a prevalence rate of 25.6 per cent, it is the lead cause of mortality in Lesotho, disproportionately affecting women with a prevalence rate of 30.4 per cent, compared with 20.8 per cent for men.[25] Good hygiene can play a key role in relieving this burden, with good handwashing practices reducing the incidence of opportunistic infections of which PLHA are at greater risk. The impact of antiretroviral drugs can also be optimized with good nutrition, making food hygiene and hand hygiene around food preparation and consumption also critical.

Nutrition. Stunting, caused by low protein and nutrient absorption in young children, is incredibly high at 35 per cent in Lesotho. This means that one in three children under five are too short for their age, which is associated with sub-optimal cognitive development. While food diversity and intake are important factors in preventing stunting, WASH also plays a key role in preventing chronic gut infection, called environmental enteropathy, which can compromise the gut's ability to absorb nutrients. Episodes of diarrhoeal disease, caused by poor WASH practices, also contributes to the 2 per cent of children under five who are wasted, and 11 per cent who are

25 Thin K, Frederix K, McCracken S, et al. Progress toward HIV epidemic control in Lesotho. AIDS. 2019; 33(15): 2393-2401. doi: 10.1097/QAD.0000000000002351.

underweight in Lesotho.[26] Improving hand hygiene practices, especially around food handling and consumption, is critical to reducing rates of malnutrition in Lesotho.

Disability. According to the 2018 MICS results, 8.2 per cent of children aged two to four have a functional difficulty, in the areas of seeing, hearing, walking, fine motor, communication, learning, playing or controlling behaviour. Lesotho's 2016 Population and Housing Census documented 2.5 per cent prevalence of disability, within the domains of seeing, hearing, communication, remembering, walking and self-care.[27] Because of different definitions for disability and inconsistency in enumerator categorization, this variance in prevalence rate is not unexpected. In 2011, the Lesotho National Federation of Organizations of the Disabled (LNFOD) conducted a household survey using the Washington Group Questions, which are globally considered the gold standard for assessing disability. This survey found that 10.1 per cent of households had at least one member with disability. Of these households, 5.7 per cent were reported to have a member with a severe disability.[28] Considering LNFOD's use of the Washington Group Questions, it can be assumed that actual prevalence of disability in Lesotho at present is higher than what is being reported in the MICS and the Census. To ensure that this strategy succeeds in transforming Lesotho into a country in which all people are practicing hand hygiene behaviours, it is crucial to consider and address the unique needs of people with disabilities.

Disease outbreaks. Because of Lesotho's positioning within South Africa, with porous borders and economic reliance on South Africa, the COVID-19 pandemic has created a major health risk. As a control measure for the pandemic, Lesotho has prioritized hygiene policies and actions to reduce the risk of spread, including physical distancing, proper hand hygiene, food hygiene, safe water practices and safe cooking practices.[29] As has been seen globally, the emphasis on hand hygiene as a control measure for COVID-19 has inevitably accelerated the uptake of hand hygiene practice in households, public spaces (churches, taxi ranks, restaurants), schools and health facilities in Lesotho. Insufficient hand hygiene monitoring systems mean that this progress has not been documented.

While Lesotho has fortunately not recently been impacted by outbreaks of cholera or Ebola Virus Disease, both diseases are causes of outbreaks in Sub-Saharan African and require rapid response to control spread and impact. Lesotho's recent experience with managing the COVID-19 pandemic has provided a foundation and systems for using hand hygiene as a key tool in breaking routes of transmission.

26 Bureau of Statistics, Ministry of Development and Planning. Lesotho MICS – Multiple Indicator Cluster Survey, Survey Findings Report, 2019.Maseru Lesotho.
27 Bureau of Statistics, Ministry of Development and Planning. 2016 Lesotho Population and Housing Census Analytical Report, Volume IIIA Population Dynamics, 2016. Maseru, Lesotho.
28 Ministry of Social Development, GoL. A Report of a National Disability Situation Analysis, 2019. Maseru, Lesotho.
29 Kingdom of Lesotho. COVID-19 Emergency Preparedness and Response Project, 2021. Maseru Lesotho.

Hand hygiene

As seen in Figure 4, the Joint Monitoring Programme's (JMP) most recent data from 2020 estimated that Lesotho is ranked third amongst least developed countries for lowest household access to hand washing facilities that have soap and water, reporting that only 5.5 per cent of households had a basic handwashing facility, categorized as a

Figure 4: Access to hygiene Services at household level amongst the least developed countries - JMP 2020

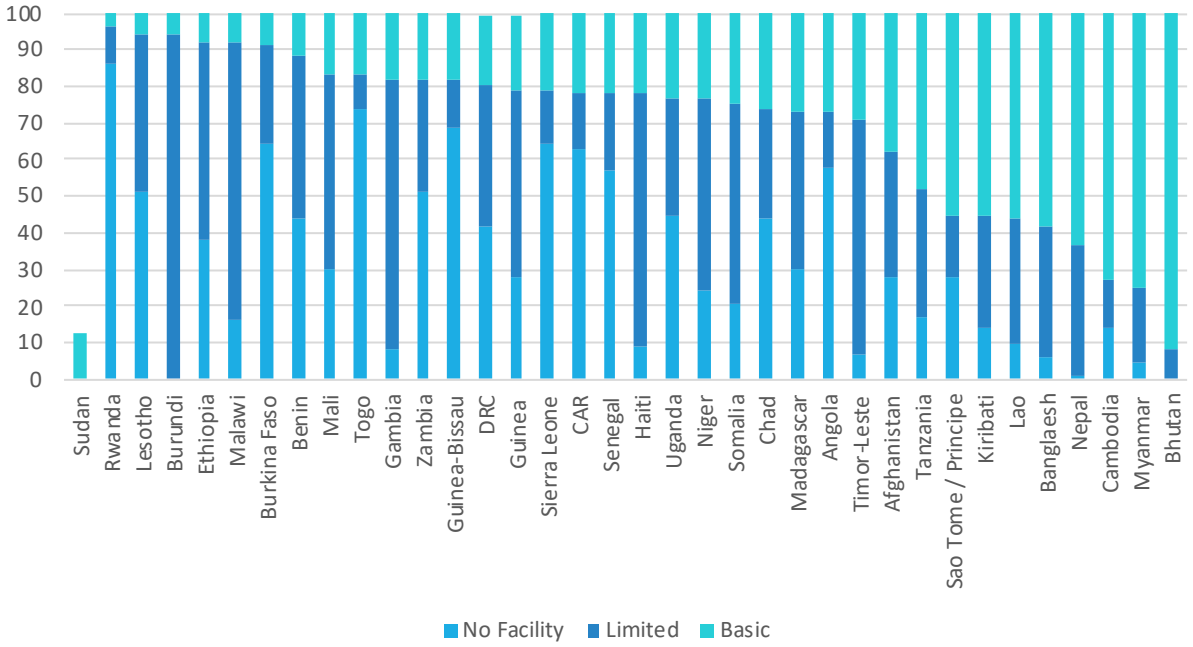
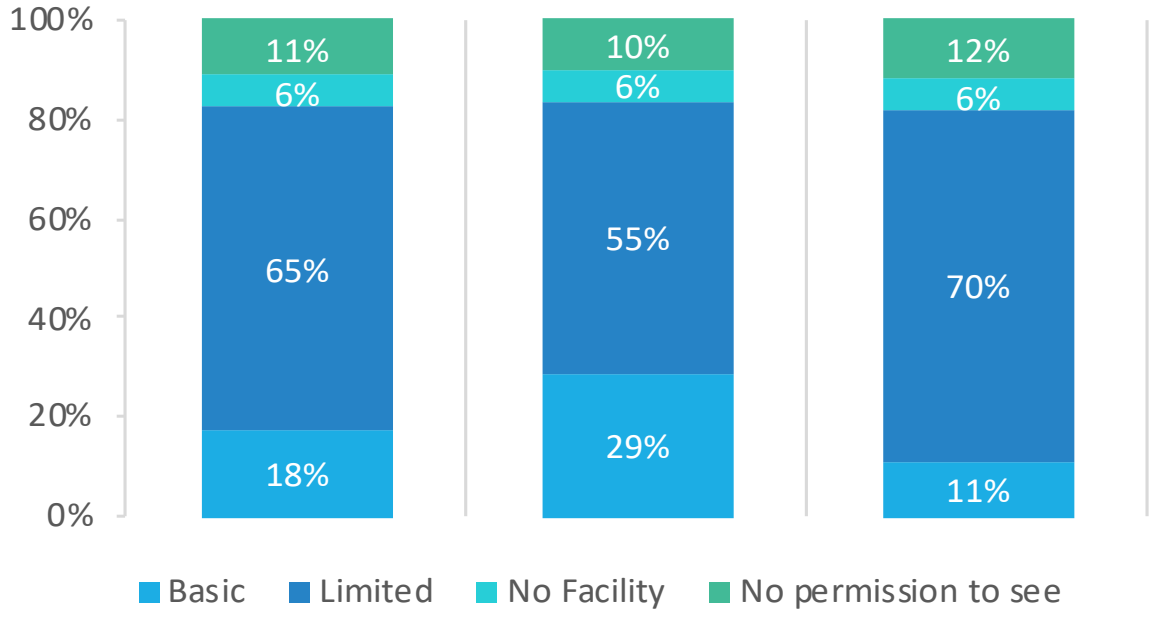


Figure 6: Per cent access to hygiene services in Lesotho (MICS 2018)



facility that has both soap and water. While this access has undoubtedly improved, this figure highlights the vast change that this strategy targets.

Compared to the 2016 JMP numbers, the 2018 MICS data shows a positive upward trend, with 18 per cent of households in Lesotho having access to facilities that enabled them to wash their hands with soap and water. Despite this positive trend, still only 1 in every 10 rural dwellers and one in every four urban dwellers had basic handwashing facilities that enabled appropriate handwashing practice with soap on their household's premises. There is a further discrepancy in access to basic handwashing facilities according to wealth, with almost half of the top wealth quintile owning a basic handwashing facility, versus less than 5 per cent of the poorest quintile, indicating a great need to consider the financial requirements of hygiene infrastructure and software when developing interventions to promote hygiene services.

Anecdotally, rural households are using tippy taps, which have been promoted throughout the years and further scaled up during the COVID-19 pandemic. Of households that were observed in the 2018 MICS to have had some sort of handwashing facility (not including water and soap), only 13.5 per cent had fixed facilities – the rest were reported as having a mobile object like a basin or a scoop. Urban household ownership of fixed handwashing facilities is greater at 28 per cent, as a result of greater access to household connections to piped water. Aiming for sustained coverage and use of hand hygiene facilities, the design of hand hygiene facilities should strive to be fixed in a way that will enable easy filling of water.

Sanitation facilities enabling hand hygiene practices

Slightly over half (52 per cent) of households in Lesotho have access to basic sanitation (see Figure 4).[30] However, one in every five households are still using improved sanitation facilities that are also shared with several other households. It should be noted that there is a dearth of information regarding actual use of sanitation facilities, and whether the facility is accessible to everyone in the household. Age, disability and even taboos[31] may result in inadequate sanitation services that force the practice of open defecation.

While basic sanitation service coverage is greater in rural areas, there is a significantly higher rate of open defecation in rural areas as well. Access to a sanitation facility is associated with greater rates of handwashing practice after defecation because it enables the establishment of a fixed place to wash hands with soap, and thus is a key enabler of hand hygiene behaviour at critical moments.

30 Bureau of Statistics. (2019). Lesotho Multiple Indicator Cluster Survey 2018,, Survey Findings Report. Maseru, Lesotho: Bureau of Statistics.

31 Stakeholders reported that men are not supposed to share a toilet with a daughter-in-law.

Water – A critical requirement for handwashing with soap

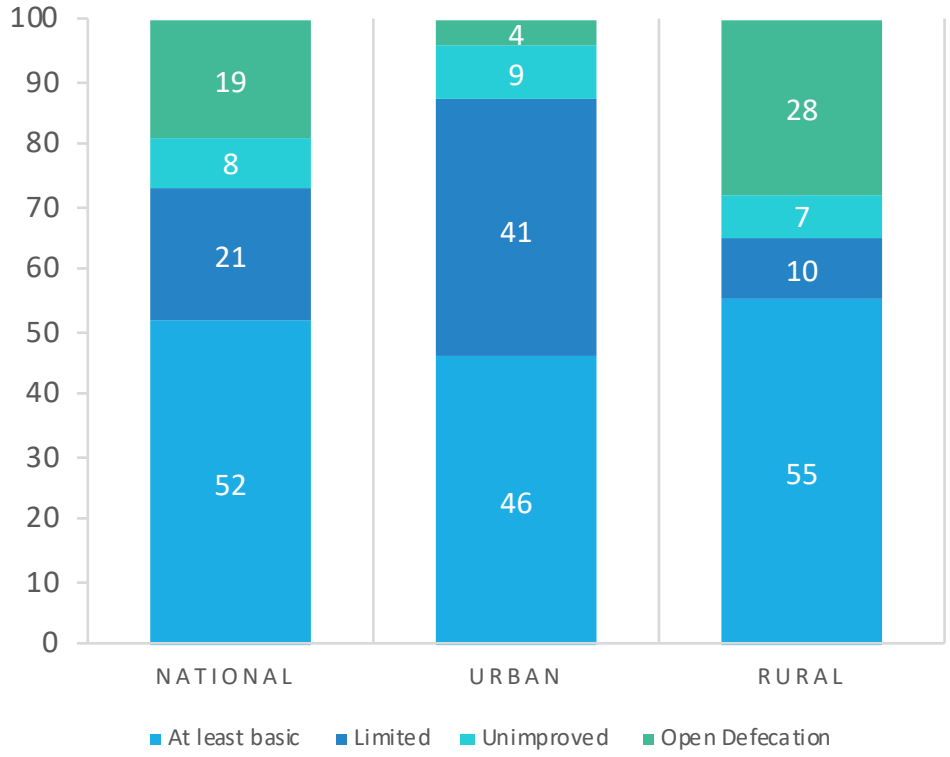
Inherently, poor access to safe water inhibits the practice of hand hygiene behaviours. However, almost 80 per cent of people living in Lesotho have adequate access to improved water within a 30-minute round trip, although this number drops to just over 70 per cent in rural areas. The surplus of water in Lesotho should mean that there is relatively good access to water to enable hygiene practices. The gaps that do exist are due to various challenges related to uneven distribution of water resources and supply, the dispersed settlement of rural communities in remote, mountainous areas of Lesotho, and WASH sector planning and management gaps.[32] Water in hard to access places will be susceptible to contamination and management challenging to ensure sufficient quantities can be collected for household hygiene needs.

The burden of water management lays heavily with women, with 71 per cent of households reporting that a woman over 15 years collected the household water. Since 36 per cent of households spend over 30 minutes every day collecting water, this burden presents a significant barrier to having sufficient water for handwashing practice, as well as to females pursuing jobs or education.

Opposite: © UNICEF

32 Bureau of Statistics, Ministry of Development Planning. Lesotho MICS – Multiple Indicator Cluster Survey, Survey Findings Report, 2019.

Figure 7: Per cent access to sanitation services in Lesotho

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STRATEGIC FRAMEWORK FOR CREATING A SUSTAINABLE CULTURE OF HAND HYGIENE

Vision	**National health sector vision:** A healthy nation, living a quality and productive life. **Strategy vision:** Hand hygiene is practiced by all at critical times, contributing to the prevention and reduction of disease prevalence, which in turn improves health, nutrition, livelihoods and well-being for all people living in Lesotho, especially the marginalized and children under five.			
Principles	**Valuing people** Values community input, basic needs and resources. Targets people in appropriate settings.	**Sustainability** Builds capacity, self-reliance and systems. Evidence-based. Stakeholder engagement	**Integration** Aligned with national and international goals and targets. Integration and harmonization. Strengthens decentralization, but remains coordinated	
Goal	Foster a culture in which 50 per cent of people living in Lesotho practice hand hygiene at all critical moments by 2023 and 100 per cent by 2026.			
Strategic objectives	Leadership	Enabling environment	Demand	Supply
Strategies	• Channel momentum of COVID-19 response into long-term sustainable change. • Bring together, harmonize and coordinate diverse collection of partners.	Develop capacity, systems and standards. Negotiate Private Sector Partnerships. Utilize continuous review and learning for evidence-based programming.	• Utilize evidence-based social and behaviour change. • Integrate into priority programmes. • Prioritize and enable demand creation actions for all.	Ensure availability of inclusive products and services. Enhance market access to appropriate supply. Promote functioning and adequate water and sanitation services.

VISION

Hand hygiene is practiced by all at critical times, contributing to prevention and reduction of disease prevalence, which in turn improves health, nutrition, livelihoods and well-being for all people in Lesotho, especially the marginalized and children under five.

GOAL

Foster a culture in which 50 per cent of people living in Lesotho practice hand hygiene at all critical times by 2023 and 100 per cent by 2026.

VALUES AND GUIDING PRINCIPLES

The fulfillment of this strategy is based on values and guiding principles that position and fortify actions proposed to enable all people in Lesotho to practice hand hygiene at critical times. The guiding principles are classified under three key values: 1) Valuing People; 2) Sustainability; and 3) Integration.

Valuing people

Values individual and community input, resources and basic needs

In order to optimize the impact of interventions and systems, individuals in Lesotho benefiting from hygiene services shall be actively involved in planning, decision-making and oversight of activities. Programmes and activities will consult with community members to understand capacity, preference and needs for hand hygiene infrastructure and promotion. However, within the household, the final decision and responsibility for hand hygiene remains an individual issue.

Targets people in appropriate settings

Settings for hand hygiene should be organized to enable practice. Availability of and easy access to water and soap simplifies an individual's decision to wash hands with soap at critical times – near a toilet or place of food consumption. Environmental cues or visuals, like posters and stickers, can remind individuals to wash their hands at critical moments. Signs or patterns that lead to handwashing facilities can trigger an individual to automatically move to thefacility to wash hands after using a toilet or before eating. See Box 4 for a comprehensive list of settings and the target groups

relevant per setting.

Prioritizes inclusion for all – women, men, children, elderly, people with disabilities and the marginalized

In order to ensure that all people in Lesotho are benefiting from and contributing to the strategy outcomes, the sector must strive to remove physical and communication barriers to hygiene infrastructure and information in order to promote social inclusion. The strategy acknowledges the crucial roles and interests of women and children in practicing and enabling hand hygiene. All sector actions will be designed and implemented in a way to ensure equal participation and representation, and to pay attention to the viewpoints, needs and priorities of all vulnerable populations.

Box 4: Settings for hand hygiene

1 HOUSEHOLDS
- Household members – adults, youth, children, elderly
- Caregivers
- People with disabilities
- People living with HIV/AIDS, tuberculosis and other chronic illnesses
- Herd boys

2 HEALTH CARE SETTINGS
- Health care workers and staff
- Visitors and patients
- Traditional healers

3 SCHOOLS AND EARLY CHILDHOOD CARE AND DEVELOPMENT CENTRES
- Administrators, teachers and support staff
- Learners and children

4 OTHER PUBLIC AND PRIVATE INSTITUTIONS
- Food handlers and patrons
- Government and other institutions' staff
- Market/taxi rank/store workers and patrons
- Religious leaders and members of places of worship
- Inmates, guards and service providers
- Staff and members of recreation and facilities
- Traditional leaders and initiates of initiation schools

Sustainability

Builds capacity and self-reliance of organizations and individuals

Achievement of the strategy goal – the creation of a sustainable national culture of hand hygiene – depends on both individuals and institutions having the capacity, confidence and systems to deliver strategic actions. Capacity will be strengthened to not only deliver but respond appropriately to emerging challenges and opportunities for optimal performance.

Evidence-based

Investment in infrastructure, interventions and systems shall be based on a body of evidence, demonstrating targeted results and value for money. Evidence shall inform decisions around investment and direction of interventions.

Stakeholder engagement and accountability

The hygiene sector recognizes the importance of a broad range of partner engagement to enhance the sustainability of outcomes, including government, development partners, civil society and the private sector. As government and implementing partners deliver interventions to enable and motivate the practice of hygiene behaviours, the private sector will be encouraged and facilitated to develop capacities for investment, marketing expertise and service delivery. Accountability of government and partners in delivering the strategy is essential for reaching and sustaining targeted hand hygiene outcomes.

Integration

Aligned and supports national and international goals

The strategy and strategic actions directly contributes to Lesotho and the global community's development agenda, targeting the inclusive growth and well-being of all in Lesotho.

Integration and harmonization

Acknowledging that handwashing with soap is a ubiquitous behaviour for all individuals, the hygiene sector will pursue opportunities to integrate hand hygiene promotion into existing services and interventions to optimize the reach and effectiveness of efforts. To maximize the spread and effectiveness of promotion, harmonization of approaches

and messaging will be prioritized amongst the constellation of partners that exists in Lesotho, from the national to the village level.

Strengthens decentralization but remains coordinated

The strategy prioritizes planning, implementation and monitoring at the district and local levels. As such, it shall strengthen decentralized planning, implementation, and management capacities, while optimizing coordination amongst partners and stakeholders in order to maintain a harmonized call to hand hygiene action across the nation.

STRATEGIES BY STRATEGIC OBJECTIVE

Guided by the situation assessment and the overarching National Health Policy and National Health Strategic Plan, the National Hand Hygiene Strategy presents four core strategic objectives to create a national culture of hand hygiene in Lesotho.

Strategic objective 1
To foster and facilitate **LEADERSHIP** at the national, district and local levels that will mobilize resources, coordinate and inspire a national culture of hand hygiene.

Strategic objective 2
To build an **ENVIRONMENT** that **ENABLES** hand hygiene interventions and practice for all.

Strategic objective 3
To create and sustain **DEMAND** for hand hygiene practice at critical times.

Strategic objective 4
To ensure accessible **SUPPLY**, including facilities, services and products for hand hygiene.

Each strategic objective will be achieved through the implementation of key strategies, as detailed in Table 3.

Table 3: Implementation of strategic objectives

Strategic objective	Strategies
1. To foster and facilitate **LEADERSHIP** at the national, district and local levels that will mobilize resources, coordinate and inspire a national culture of hand hygiene.	▪ Channel current momentum of COVID-19 response to inspire and lead long-term sustainable change at the national, district and local levels. ▪ Bring together the diverse collection of partners to function as effective and harmonized coordination bodies to facilitate the implementation of the National Hand Hygiene Strategy.
2. To build an **ENVIRONMENT** that **ENABLES** hand hygiene interventions and practice for all.	▪ Prioritize capacity development to build and strengthen government, implementing partners and community around hand hygiene. ▪ Build strategic partnerships in order to draw on the expertise of the private sector in influencing behaviours. ▪ Build evidence and learning to maximize the effectiveness, efficiency and sustainability of hand hygiene interventions/ programmes through monitoring and evaluation systems with harmonized guidelines, standards and tools.
3. To create and sustain **DEMAND** for hand hygiene practice at critical times.	▪ Use evidence-based social and behaviour change approaches that improve knowledge and awareness about handwashing and use key drivers, motivators and enablers to influence the practice of the desired behaviour. ▪ Integrate handwashing into priority health, nutrition, education, early childhood development and community programmes. ▪ Prioritize and enable demand creation actions for all people – women, men, girls, boys, elderly, people with disabilities, marginalized and vulnerable people.
4. To ensure accessible **SUPPLY**, including facilities, services and products for hand hygiene.	▪ Ensure the availability of inclusive handwashing facilities and hygiene supplies in homes and institutions to enable sustained practice of hand hygiene for all, including all men, women, boys, girls, people with disabilities, students, teachers and health care professionals. ▪ Strengthen local markets and supply chain to increase access to hand hygiene products that all people can afford and use, from the national to the community level. ▪ Strengthen hand hygiene related services (water services, public hygiene and sanitation facilities) to ensure that people can practice the desired behaviour in their homes, as well in institutions and in the public.

STRATEGIES BY STRATEGIC OBJECTIVE

STRATEGIES AND ACTIVITIES FOR OBJECTIVE 1: LEADERSHIP

Strategic objective 1
To foster and facilitate **LEADERSHIP** at the national, district and local levels that will mobilize resources, coordinate and inspire a national culture of hand hygiene.

Robust commitment at all leadership levels is paramount to garnering the engagement necessary to transform Lesotho into a nation in which all people practice hand hygiene at all critical times, in all settings. Coordinated advocacy efforts are needed to win support for actions (policies, laws, regulations, guidelines, programmes and capacity) intended to mobilize and sustain the practice of handwashing with soap and the use of hand hygiene services by the population of Lesotho. Leaders shall not only dedicate human, organizational and financial resources towards fostering environments in which individuals are enabled to practice hand hygiene, but leaders will serve as role models inspiring the practice of targeted behaviours.

Strategy 1.1: Shift COVID-19 hand hygiene promotion gains towards long-term behavioural outcomes

The implementation of the National Hand Hygiene Strategy provides an opportunity to reimagine how hand hygiene is promoted, enabled and sustained in Lesotho. While the COVID-19 pandemic negatively impacted the world, it did raise the profile and prioritization given to handwashing with soap and hand hygiene practices, presenting an opportunity to mobilize and invest resources to transform how the government and partners enable social norms around handwashing behaviours. The Lesotho Government and partners can now look beyond actions that are currently focused on preventing COVID-19 transmission and enabling citizens to return to work and school safely. Future actions shall now focus on building systems, infrastructure, evidence and capacity that will transform Lesotho's hand hygiene social norms.

1.1.1 Develop advocacy tools to engage champions and raise the profile of hand hygiene. Different individuals will have different interests in engaging in hand hygiene promotion. It is important to

Box 5: Target leaders to enable practice

- **Policy-makers and government departments**
  - Ministry of Health
  - Ministry of Water
  - Ministry of Education and Training
  - Ministry of Local Government
  - Ministry of Finance and Development
  - Ministry of Planning
  - Ministry of Gender, Youth, Sports and Recreation
  - Ministry of Social Development
  - District Administrations
  - Prime Minister's Office
- **Social and cultural organizations (churches, sport clubs)**
- **Development partners, including donors and NGOs**
- **Local administrations and community leaders**
- **Private sector**
- **Organizations for people with disabilities**
- **Organizations for elderly people**

understand the perceived benefits of investing in hand hygiene for different stakeholders. Determine the value added by hand hygiene investments (resources, finance, time, reputation) and incorporate it into the advocacy tool and messages to engage champions.

1.1.2 Identify and engage national and district champions for hand hygiene. Utilizing prominent and respected figures to act as role models for hand hygiene can catalyze long-lasting handwashing behaviour among the target audience. Engaging champions within government can also ensure that hand hygiene is included in annual plans and budgets.

Together with champions, develop and implement an advocacy plan to increase the profile of hand hygiene in the national agenda and engage donors in funding national hand hygiene actions.

1.1.3 Conduct a national workshop to introduce the strategy and institutional framework to district administrators, private sector and key stakeholders. Use the workshop to develop district level action plans for the strategy, assigning responsibility for different aspects of the action plan. Progress on implementing the action plan should be updated at Hand Hygiene Technical Working Group meetings (see Activity 1.2.1) to hold districts and leaders accountable for progress in achieving hand hygiene outcomes.

Strategy 1.2: Coordination and harmonization

To effectively scale-up programmes to realize the strategic objectives, a clear institutional framework must be defined, establishing a set of formal organizational structures, rules and implementation norms. Fostering an effective coordination body, mandated to align government regulations, integrate programmes and plan, budget and coordinate implementation, will ensure that the strategy is implemented, progress is monitored and approaches are refined to optimize outcomes. Addressing hand hygiene practice in a holistic manner requires multiple stakeholders. Governments play an important role in prioritizing hand hygiene in national policies, while the private sector, implementing partners and civil society can provide insights on incorporating hand hygiene into specific activities and contexts. Table 4 presents key stakeholders who play critical roles in the implementation of this strategy.

1.2.1 Establish a Hand Hygiene Technical Working Group (HHTWG) to take responsibility for effective implementation of activities to

achieve the strategic objectives. While the Ministry of Water is currently responsible for coordinating the WASH Working Group, the National Long-Term Water and Sanitation Policy and Strategy both mandate that hygiene falls under the aegis of the Environmental Health Division in the Ministry of Health. Broad and diverse engagement and action are required of the hygiene sector, stakeholders from other sectors and the community to implement systems and programmes to protect and promote hand hygiene. The implementation and management of the National Hand Hygiene Strategy will evolve from a collaborative process, which will engage government, private sector and development partners.

1.2.1a. Draft and approve terms of reference to define the roles, responsibilities and ways of working for the HHTWG. The stakeholders proposed for the group should include those active in: 1) financing the implementation of the strategy; 2) designing and implementing the programmes and activities; 3) measuring progress in implementing the strategy and achieving outcomes; 4) representing the needs and interests of vulnerable groups, including women, children and people with disabilities; and 5) representing private sector contributions towards the strategy implementation.

1.2.1b. Convene quarterly HHTWG meetings to manage and report on the implementation of the strategy. In addition, the Coordination Group meetings should be used to share innovations in hand hygiene programming, explore mutual opportunities to address systemic barriers and initiate collaborations between government, implementing partners and the private sector.

1.2.2 Identify opportunities and advocate to integrate hand hygiene into national policies, strategies and programmes. Although handwashing is an easy, effective way to avert preventable deaths and ensure good health, handwashing practice in Lesotho remains low. To optimize the public health benefit of hand hygiene practices and successfully transform national social norms, hand hygiene must be prioritized and enabled in all settings for all people. It is therefore vital that health and development programmes and activities must include strategies to promote and enable hand hygiene. To facilitate this, the HHTWG will actively engage line ministries and the private sector in development planning that mainstreams hand hygiene, especially for health, HIV/AIDS, education, water, sanitation, trade and industry, and housing sectors.

Table 4: Institutional framework for hand hygiene in Lesotho

Institution	Proposed role/responsibility in the Hand Hygiene Coordination Group
Ministry of Health Environmental Health: WASH Programme	• Coordinates the hygiene sector, including stakeholders from nutrition, family health, disease control, HIV/AIDS, water and sanitation. • Leads the development of national strategies, guidelines and research around hygiene. • Implements programmes, systems and campaigns to promote household level hygiene and create demand for improved services. • Provides technical guidance and capacity building for district level oversight of hygiene interventions. • Strengthen the capacity of community health workers to achieve Strategic Objectives. • Ensures safely managed WASH and waste disposal in all health facilities.
Ministry of Health Disease Control	• Investigates and follows up on cases/trends of communicable and non-communicable diseases.
Ministry of Health Health Education	• Reviews, provides technical guidance and approves behaviour change communications tools used to promote handwashing. • Supports the training of district health and education staff in the use of Information, Education and Communication (IEC) materials.
Ministry of Health Family Health	• Ensures that handwashing with soap is integrated into the development, implementation and monitoring of Sexual, Reproductive, Adolescent, Maternal Child, Adolescent Health and Nutrition interventions.
Ministry of Health District Health Management Team: Environmental Health	• Oversees the planning, implementation and progress of government and partner programmes and activities addressing hand hygiene. • Builds capacity of staff and volunteers to deliver quality hygiene programmes. • Plans and allocates resources towards hand hygiene activities.
Ministry of Water	• Provides access to water supply and sanitation services, and improves handwashing outcomes by prioritizing, advocating and financing for the implementation of water supply programmes that deliver quality and sufficient quantity of water to communities and their institutions, including health facilities, schools and workplaces. - **Commission of Water**: Ensures that hygiene is adequately addressed during WASH Technical Groups, facilitating the coordination of programmes and activities addressing hand hygiene. - **Department of Rural Water Supply:** Provides technical guidance for district and local level planning, monitoring and reporting around hand hygiene.

Institution	Proposed role/responsibility in the Hand Hygiene Coordination Group
Ministry of Local Government District Councils	• Supports implementation and monitoring of hand hygiene interventions in communities through: • Ensuring allocation of budget and resourcing for strategy implementation at local councils; • Monitoring the progress of handwashing and its inclusiveness; • Developing the capacity of local councils to plan, finance and implement hand hygiene services.
Ministry of Education and Training	• Leads the design, implementation and monitoring of school health, hygiene and nutrition for Early Childhood Care and Development (ECCD) and primary and secondary schools, including hand hygiene infrastructure and supply, and hand hygiene inclusion in the curriculum and feeding programmes. • Advocates, finances and coordinates with relevant ministries and other key stakeholders (private and public) for adequate provision of inclusive sanitation, water and handwashing facilities and supplies in schools for both teachers and students.
Ministry of Social Development	• Supports the development, implementation and monitoring of interventions to ensure that all people in Lesotho have access to hand hygiene facilities, including households with extreme poverty or those that are marginalized and people with disabilities.
Food and Nutrition Coordination Office	• Coordinates and ensures accountability that hand hygiene is prioritized in the design, implementation and monitoring of food and nutrition programmes and activities.
Disaster Management Authority	• Coordinates the National Response Plan for emergencies and outbreaks, which is responsible for planning, financing, coordination and monitoring of hand hygiene measures needed to control disease transmission during outbreaks and emergencies.
Ministry of Planning	• Facilitates planning, financing and coordination of the inclusion of hand hygiene interventions and systems across ministries and districts. • Supports research and evaluations to build evidence for the design of effective hand hygiene interventions.
Ministry of Finance	• Facilitates the budgeting and allocation of funds for hand hygiene actions at the national and district level.
Development partners, NGOs and civil society	• Provides technical and financial support in the implementation of the National Hand Hygiene Strategy. • Strengthens community and social mobilization for handwashing promotion. • Strengthens the market to ensure access to all people in the community, including people with disabilities.

Implementation of the strategy shall also capitalize upon the relationship and trust that existing community organizations already have with individuals and communities by integrating activities into these existing forums. Churches, sport clubs and other social organizations shall be engaged as key entry points to reach different segments of the Lesotho population.

STRATEGIES AND ACTIVITIES FOR OBJECTIVE 2: ENABLING ENVIRONMENT

Strategic objective 2
To build an **ENVIRONMENT** that **ENABLES** hand hygiene interventions and practice for all.

In order to create a culture of hand hygiene for all people in Lesotho at all times, it is essential that strong leadership is backed by supporting systems, capacity and financing that enables government and partners to mobilize and sustain handwashing with soap behaviours in households, communities and institutions.

Strategy 2.1: Capacity development

Prioritize capacity development to build and strengthen government, implementing partners and community around hand hygiene. Developing capacity to enable and optimize sustainable hand hygiene outcomes requires: 1) the establishment of trained and accountable individuals to implement, oversee and monitor the delivery of hand hygiene programmes and interventions; 2) tools and resources; and 3) systems to support the implementation and management of programmes.

2.1.1 Collaborate with the Ministry of Education, the National Curriculum Development Centre and key learning institutions, such as the National Health Training College of Lesotho and the National University of Lesotho, to develop and facilitate training modules around hand hygiene for target groups in the training curriculum. While different target groups will require slightly different levels of understanding around hand hygiene, the curriculum should address: 1) the association between hand hygiene and health, nutrition, education and development; 2) proper techniques for hand hygiene and critical times for practice; 3) hand hygiene needs for specific vulnerable groups; 4) key behaviour change tools and messages to mobilize people to action; and 5) actions that can be taken to enable people in different settings to create a habit of washing their hands with soap at

critical times. See Box 6 for a comprehensive list of groups to target for capacity development.

2.1.1 Plan and implement workshops at the national and district levels to introduce the National Hand Hygiene Strategy and accompanying messages and sector specific tools, build defined capacity based on stakeholder roles and responsibilities, and agree upon district level strategy implementation plans.

2.1.2 Develop and implement a system for professional growth around hand hygiene over the span of the strategy for key national and district stakeholders.

Box 6: Target groups for capacity development

- National, district and community leaders
- Health professionals, including environmental health officers and village health workers
- Education sector, including teachers and ECCD carers
- Implementing partners and civil society organizations
- Food service providers and street vendors
- Faith-based and traditional leaders

Strategy 2.2: Private sector partnerships

Building strategic partnerships in order to draw on the expertise of the private sector in influencing behaviours and responding to consumer needs and preferences around hand hygiene will optimize outcomes achieved through the strategy. The private sector can benefit from scaling up hand hygiene efforts in Lesotho, leveraging national hand hygiene activities and messages to expand the visibility of their soap and hygiene brand. Collaboration with the private sector can manifest in multiple forms considering the expertise they have gained through their drive to sell products and services, including supply chain systems, marketing expertise to drive the uptake of handwashing with soap behaviour and innovations to respond to consumer preferences. The private sector also has the opportunity and promised benefit of reducing diseases transmission, thus avoiding absenteeism in their workforce and medical costs, as well as boosting overall productivity. Melding private sector interests with civil society and government development interests will drive better outcomes in collaboration rather than in isolation.

2.2.1 Identify opportunities to forge partnerships with the private sector to

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address hand hygiene issues for all. Explore opportunities that target consumers, schools and ECCD centres, health facilities, households and communities, pandemic control efforts and workplaces.

2.2.2 Conduct annual workshops to introduce and discuss experiences and future opportunities of partnerships with private sector. Use workshops to review and modify partnership agreements in order to best achieve strategic objectives.

2.2.3 Define appropriate roles and responsibilities and working arrangements for private sector partnerships to support government actions to motivate the population to practice hand hygiene. Review partnerships on an annual basis, modifying to meet new needs and opportunities.

Strategy 2.3: Monitoring, evaluation and learning

Evidence and regular learning are essential to maximize the effectiveness, efficiency and sustainability of hand hygiene interventions and to measure progress towards achieving strategic objectives. Currently there is a dearth of Lesotho-specific understanding around hand hygiene practices, access to water, preferred facilities and soap, and knowledge around current cultural norms and beliefs that influence hand hygiene practice. Having evidence around hand hygiene in Lesotho is critical in order to design effective social and behaviour change interventions that will create and sustain handwashing practices and allow for innovation. Building evidence and learning through standardized monitoring and evaluation systems, with harmonized guidelines, standards and tools that are integrated into both intervention delivery, as well as systematic national monitoring systems, will facilitate the development of more interventions that more effectively and efficiently achieve strategy targets.

2.3.1 Implement the National Hand Hygiene Monitoring, Evaluation, and Learning (MEL) Framework and management system to facilitate tracking progress in strategy implementation, achievements and challenges. See Annex 3 for the MEL Framework, which should be reviewed and revised on an annual basis to ensure relevance and feasibility.

2.3.1a. Develop and operationalize monitoring tools that provide clear definitions, standards, guidelines and indicators for hand hygiene to facilitate measuring household and institutional facility coverage and practice. National leaders must agree and approve clear definitions, standards and indicators for hand hygiene to ensure consistency,

comparability and confidence in reported achievements. Establishing standardized monitoring systems will facilitate the government in collating partner programme hand hygiene outcomes in order to measure true progress in the uptake and sustainability of hand hygiene in Lesotho. Regular dissemination and participatory review of hand hygiene facility coverage in households and institutions will hold partners and leaders accountable, as well as provide evidence around where investments are needed.

2.3.2 Prioritize shared learning amongst national and district hand hygiene stakeholders to promote innovation and collaboration to address common challenges to creating sustainable hand hygiene habits. Organize hand hygiene/WASH shared learning events on a semi-annual basis to provide opportunities to partners to present best practices, innovations and research. Conduct quarterly meetings to share, coordinate and determine learning needs that will promote and inform the hand hygiene agenda.

2.3.3 Plan and implement a midterm evaluation (2023) to measure progress against targets and assess effectiveness of strategies. Conduct a workshop to present the results to stakeholders to review the relevance of financing and pace of implementation, identify gaps and explore opportunities for improving the strategy.

2.3.4 Conduct an end of strategy review (2026) to assess the achievements of the strategy, identify future needs and propose direction for subsequent hygiene strategies.

STRATEGIES AND ACTIVITIES FOR OBJECTIVE 3: DEMAND FOR HAND HYGIENE

Strategic objective 3
To create and sustain DEMAND for hand hygiene practice at critical times.

Catalyzing hand hygiene behaviour is not a one-time activity, but rather an endeavor that requires support and reminders, and should be mainstreamed as a behaviour that every individual must practice multiple times every day at critical moments. To motivate individuals to adopt a behaviour, knowledge is not sufficient – it is essential to understand the determinants that drive their motivation, the barriers that prevent the practice and the enablers that can facilitate the creation of habits. Interventions should recognize the existence of various target groups and be designed around the

key determinants for the different target groups, focusing on relevant opinions, needs and preferences.

Ultimately, handwashing with soap should be an unconscious action, immediately initiated when a critical time is met. Handwashing habit formation requires transforming handwashing from a behaviour that people decide to undertake into an automatic response. Cues incorporated into a person's environment can automatically trigger and prompt a person to take the desired action.

Box 7: Behavioural determinants

Behavioural determinants are defined as factors that influence the performance or non-performance of a behaviour.

Strategy 3.1: Evidence-based social and behaviour change programming

Use evidence-based social and behaviour change interventions that improve knowledge and awareness about handwashing, and use key drivers and motivators for target groups in Lesotho to influence the creation of handwashing with water and soap habits, as well as implement actions to remove barriers and enable the practice of hand hygiene. Designing effective interventions to change hand hygiene behaviour requires evidence – understanding of the behavioural determinants that most influence the target audience members to perform the desired behaviour.

3.1.1 Conduct formative research to create an evidence-base for practice, drivers, enablers and barriers for hand hygiene. Taking time to understand and assess behavioural determinants that most influence the sustained practice of handwashing with soap is critical so that a handwashing programme or activity is relevant and inspires change for the target audience.

Conduct a HHTWG workshop to present formative research findings and identify and build stakeholder consensus around key motivators and drivers to develop social and behaviour change approaches that will influence the target groups to practice hand hygiene at key times.

3.1.2 Use the evidence around the key determinants for the target audience to design a social and behaviour change initiative concept, communications plan, activities and tools to promote a national culture of hand hygiene practice. Specific activities of handwashing improvement initiatives may include the use of communications and tools, including radio, drama, print materials, social media approaches, environmental cues and interpersonal communication, as well as engaging influential community leaders to role model social norms

Box 8: Nudging behaviours

NUDGING BEHAVIOURS

Environmental cues and visual reminders are effective tools to nudge hand hygiene practice at critical times in relevant settings. Nudges and cues that lead to, point or emphasize handwashing facilities help to remind users to wash their hands at critical times. For example, cues can be posted near toilets to remind people to wash hands with soap after defecating, and near kitchens and eating locations to trigger handwashing with soap practice before eating or preparing food. It is important to create an environment that triggers the desired practice of handwashing. Visual reminders can be as simple as having a handwashing facility with soap and water right next to a toilet, or they can be more elaborate like posters, stickers, paintings or mirrors. Cues can effectively reinforce and sustain unconscious decisions to practice handwashing at key settings, contributing to the creation of an individual's habit and a new social norm around hand hygiene.

regarding handwashing at critical times.

Launch the Hand Hygiene Social and Behaviour Change Initiative in high visibility, with national, district and local level leadership, to raise the profile of hand hygiene and create excitement at national, district and village levels.

Deliver the hand hygiene social and behaviour change initiative that includes advocacy, mass media and community promotion. This should include campaign events featuring high profile role models to influence the targeted behaviour as a national trend, house to house outreach activities, such as interpersonal communication, counselling, and promotion through existing programmes, such as the village health worker (VHW) programmes. To reinforce the importance of handwashing practice at critical times, regardless of setting, use diverse entry points to grab the audience's attention and show the practice across different settings, including homes, public spaces in communities, health care settings (antenatal care, vaccinations, under-five nutrition assessments and consultations for diarrhoea-related sicknesses), schools and ECCD centres, restaurants, taxi ranks, initiation schools and agricultural activities (mass vaccinations, agricultural shows, and wool and mohair shear centres).

Strategy 3.2: Integration into priority areas

Integrate hand hygiene into priority health, nutrition, education, early childhood care and development, and community programmes to maximize reach of intervention, as well as support the practice of hand hygiene wherever a critical time is met – within households and communities, schools, health facilities, workplaces, churches or restaurants. Not only is hand hygiene a behaviour that must be practiced throughout the day in different settings, but it is a behaviour that when practiced properly ensures better health, nutrition, education and economic outcomes.

Box 9: Ready for change

Hand hygiene activities should leverage the context of key moments where people are open to developing new habits, such as changes to the physical/action environment, like new motherhood or starting school. These moments can prompt a whole range of new habits, and handwashing should be effectively integrated at these change moments.

3.2.1 In addition to hand hygiene specific interventions, integrate hand hygiene into relevant district programmes and actions (including VHWs) to optimize the reach of promotion efforts, as well as to form hand hygiene habits in all settings. Conduct national, district and local level stakeholder meetings to raise the profile of hand hygiene, introduce the hand hygiene promotion tools and approaches, and garner interest and commitment in promoting hand hygiene across different programmes and interventions that represent different settings and sectors.

3.2.2 Capitalize upon the celebration of global days, such as Global Handwashing Day, World Toilet Day, World Food Day, World Water Day and Day of the African Child, to increase awareness about the importance of hand hygiene.

Strategy 3.3: Prioritizing and enabling demand for all people

Prioritize demand creation actions for all people, including women, men, girls, boys, the elderly, people with disabilities, and marginalized and vulnerable people. In order to foster a cultural norm of handwashing with soap at critical times, it is essential that handwashing facilities are accessible to everyone in all key settings. Any handwashing

Box 10: Priority programmes for integration

NATIONAL EARLY CHILDHOOD CARE AND DEVELOPMENT: Handwashing with soap promotion should be integrated into caregiver training and practiced by children and caregivers at ECCD centres. Young children are both particularly vulnerable to hygiene-related diseases and receptive to taking on new behaviours as habits, if the practice is learned and reinforced through play.

NUTRITION INTERVENTIONS: Handwashing with soap practice before preparing food, before eating, before feeding/breastfeeding a child should be prioritized and modelled throughout all nutrition interventions.

MATERNAL AND CHILD HEALTH INTERVENTIONS: Handwashing should be promoted before and during pregnancy and after delivery to reinforce the importance of the behaviour. Antenatal care (ANC) attendance and handwashing could be promoted through the distribution of Hygienic Mother Kits (reusable diapers, soap, handwashing promotion materials) and handwashing counselling at ANC and immunization appointments. New mothers are particularly receptive to adopting new behaviours that they believe will enable them to raise healthy children.

SERVICES FOR PLHA: Hand Hygiene is also critical for caring for people living with HIV/AIDS, who have rates of diarrhoeal diseases up to six times higher than those who are not infected and require good nutrition for ART to work.

WASH PROGRAMMES AND INTERVENTIONS: These can promote household handwashing practice through community meetings and interpersonal communication. Handwashing behaviour can be reinforced for sustainability through both programmatic monitoring activities and standardized government monitoring.

EDUCATION: Schools should integrate handwashing with soap into the curriculum, as well as ensure that sufficient inclusive facilities are available to demonstrate and allow the creation of handwashing habits at critical moments. When handwashing is taught and supported at schools in communities where handwashing is also being promoted through other channels, children often act as agents of change, reinforcing the practice at the home.

OUTBREAK PREVENTION AND CONTROL PROGRAMMES can include handwashing guidance and promotion as a key strategy in preventing disease transmission.

Programmes should engage religious and faith-based, traditional and community leaders in handwashing promotion, since they have established popular channels (services, initiation schools) that effectively gather large numbers of the population on a regular basis and the leaders delivering the messages are trusted information providers for the community.

facility design has its advantages and disadvantages, and local context must be considered to promote the right design and modifications that will enable all people to wash their hands with soap at critical times, regardless of physical, sensory or mental differences.

Different groups may also have different motivations and barriers to engaging in handwashing. The design of effective interventions that respond to the unique determinants of the different target audiences is complex and may require a phase of learning and intervention adaptation, in order to more effectively reach specific groups with actions that address their unique barriers and motivations.

Finally, different groups will have different access to and ability to afford services and products that will equip their households with adequate facilities to enable sustained hand hygiene practice. Systems must be in place to both empower households to invest in their own hand hygiene and provide social safety nets to ensure that even the most vulnerable can practice hand hygiene. Financing for sustainable hand hygiene improvements must focus on achieving and sustaining universal access to hygiene services for all people in Lesotho in all targeted settings. Financing needs to address the establishment of facilities, as well as the recurring cost of hand hygiene consumables and maintenance, which is essential for long-term sustainable outcomes. As such, a financing approach that maximizes investment of households, civil society and the private sector will achieve outcomes more quickly and more sustainably. It is critical that households recognize and play their role in the financing of household hand hygiene facilities and supplies, while public finance is leveraged to ensure services for public spaces and for those who are disadvantaged.

3.3.1 Engage design specialists to explore sustainable hand hygiene prototypes and communication approaches that meet the needs of different segments of Lesotho. Making handwashing facilities accessible to everyone is crucial to foster sustainable hand hygiene habits and ensure equality of access. Consideration for accessibility within handwashing facility design should consider age, disability, seasonality (e.g., rain and mud), location and size. Engaging community members who represent different segments of Lesotho and different accessibility needs in the design of hand hygiene facilities, as well as social and behaviour change tools, will optimize the appropriateness of designs, maximize the desirability of the facility to encourage people to use them and subsequently contribute to achieving the strategy's outcomes.

3.3.2 Develop hand hygiene facility options guidelines that provide myriad of technology options that can respond to different household needs, urban and rural differences, and are affordable. Providing households with affordable and accessible choices will maximize uptake of self-financed household hand hygiene facilities and encourage use, subsequently contributing to the creation of a national norm around hand hygiene. The guidelines can also provide inspiration and encourage adaptation both among implementing partners and among households and communities. The technologies shared in the guidelines can be considered a starting point and adapted based on individual context, user preference, cultural norms and practicalities.

Roll out distribution of guidelines through implementing partner and community meetings to introduce and facilitate the use of the guidelines. District and community leaders should facilitate and monitor self-financed and initiated construction and maintenance of household hand hygiene facilities.

3.3.3 Coordinate with the Ministry of Social Development to develop a system for supporting vulnerable households to establish sustainable household and community hand hygiene facilities. Subsidizing handwashing facilities and the recurring consumables like soap and water for all households cannot be sustainable for the Government of Lesotho or development partners. As such, the establishment, maintenance and operationalization of household hand hygiene facilities shall not be subsidized, except in specific situations where the households are disadvantaged and local government or community leaders identify:

- Extreme poverty;
- Severe disability;
- Disaster or conflict-afflicted households;
- Significantly adverse water access conditions.

Clear and objective national criteria for subsidy eligibility shall be set and introduced to communities and local governments. District and local governments shall budget sufficiently on an annual basis to ensure appropriate subsidy provision to all eligible households.

Roll out system for supporting vulnerable households in establishing sustainable hand hygiene facilities. Comprehensive communications and monitoring systems shall be established to avoid community disruption around provision of support and to hold district, local and community leaders accountable for determining eligibility and disbursing support.

STRATEGIES AND ACTIVITIES FOR OBJECTIVE 4: SUPPLY

Strategic objective 4
To ensure accessible **SUPPLY**, including facilities, services and products for hand hygiene.

Creating individual desire is essential for changing hand hygiene behaviours. However, handwashing behaviour is swayed by influences beyond individual demand. An environment that enables the practice of the desired behaviour is critical – access to products and services that are appropriate for the user is essential and can make or break the creation of a new hand hygiene habit, whether in the household, school, health facility, a public space in the community or the workplace. Ensuring that hand hygiene facilities are available in all settings creates cues to reinforce habit formation. Engagement with the private sector, which has connections with markets for innovation and supply, can act to reach urban and rural communities if there is demand. Government establishment of regulations around public and private institution requirements to have functional hand hygiene facilities that are usable by all people will also contribute to driving market development.

Strategy 4.1: Availability of hand hygiene facilities

Ensure the availability of inclusive handwashing facilities and hygiene supplies in homes and institutions in order to enable sustained practice

of hand hygiene for all, including all men, women, boys, girls, people with disabilities, students, teachers and health care professionals. To achieve the strategy's goal of hand hygiene practice by all people in Lesotho at all critical times, facilities with appropriate design must be accessible to all people in all needed settings.

4.1.1 Advocate at the national and district level that government ministries mandate and facilitate the equipping of functioning hand hygiene facilities and supply in public and private institutions at critical settings and entry points. Providing soap or another hand hygiene agent close to flowing water in a convenient and accessible situation increases the likelihood that the facility is used for proper handwashing. The Ministries of Education and Health, which are responsible for institutions including schools and health facilities, shall plan and budget for recurring consumables, such as soap and alcohol-based hand sanitizer. The Ministry of Water shall work with the Ministry of Local Government and Chieftainship Affairs and other line ministries, district administrations and partners to maximize community and institutional access to safe water supply.

4.1.2 District and local administrations lead and monitor households and communities to establish hand hygiene facilities. While implementing partners can and should play a strong role in providing technical and logistical support to improve hand hygiene at the community and household level, district and local administrations/ councils have the mandate, power and physical reach to effectively mobilize communities and households to improve their household hygiene. Accelerating the rate at which improvements are happening will have a significant impact on reducing infections that compromise health and nutrition. Monitoring systems shall be established and implemented by district and local administrations to track coverage and regulate the presence of functioning facilities.

Strategy 4.2: Enhance market access to appropriate supply

Strengthen local markets and supply chain to increase access to hand hygiene products that all people can use and desire from the national to the community level. Exploring and marketing different hand hygiene facility designs that respond to the different needs and preferences of people in Lesotho will increase household demand for hand hygiene products. The private sector can contribute to accelerating the rate at which household and institutional hand hygiene improvements are happening by marketing affordable and desirable hygiene products and by introducing measures that

facilitate community access to the products. With approximately 82 per cent of Lesotho's population still without handwashing facilities that have soap and water, the private sector stands to benefit greatly from a push to improve household hand hygiene. With improved household practice of handwashing with soap, the private sector stands to gain significant profit in increased recurring demand for soap.

4.2.1 Design and implement a handwashing market analysis to inform the development of market actions to respond to consumer preferences and needs, and improve demand, access and affordability. This work should include an exploration of the supply chain, innovation of technologies for facilities and affordability, as well as begin to identify private sector partners interested in collaborating to promote hand hygiene.

4.2.2 Conduct periodic inspections of outlet hand hygiene products and services to ensure quality.

Strategy 4.3: Strengthen relevant WASH services

Strengthen hand hygiene related services (water services, public hygiene and sanitation facilities) to ensure that people can practice the desired behaviour in their home, as well in institutions and in the public. To wash hands with soap and water, it is important that water is readily available at handwashing facilities, which is dependent upon a reliable and accessible water supply. Similarly, having a toilet with a handwashing facility nearby makes it more likely that people will wash their hands with soap after defecating.

4.3.1 Collaborate with the Ministry of Water to make a water system roadmap, targeted at establishing household and community water access that is sufficient in quantity to enable hand hygiene. Without access to an adequate supply of water, handwashing practice is not feasible. The more readily accessed water is, the more likely individuals are to wash their hands with soap and water. The Commission of Water, along with its Division of Rural Water Supply and water and sewage company WASCO, should be engaged as key partners with the Ministry of Health in implementing the National Hand Hygiene Strategy.

4.3.2 Relevant ministries (Ministry of Health, Ministry of Education and Training, and Ministry of Local Government) shall coordinate closely with the Ministry of Water to ensure that district service facilities (such

as health facilities, schools, taxi ranks, restaurants) in communities where water supply systems are built are connected to the water supply system. Relevant line ministries shall also serve to inform the Ministry of Water of service institutions and communities that do not yet have sufficient access to water supply.

4.3.3 Create regulation to ensure that public and private sanitation facilities (taxi ranks, restaurants, public spaces) are maintained adequately and that there is always water and soap available for handwashing at sanitation facilities.

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ANNEXES

ANNEX 1 – DESK REVIEW LITERATURE

Relevant global literature

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ANNEX 2 – STAKEHOLDERS CONSULTED FOR THE LANDSCAPE ASSESSMENT

Organization	Name	Role
Environmental Health Division, MoH	Tebello Kolobe	WASH Focal Point
Family Health Division, MoH	Lisemelo Seheri	Nutrition Manager
Maseru District Health Management Team	Pheello Phera	Environmental Health Officer
Water Commission, Ministry of Water	Nthabiseng Mokhabuli	Coordinator WASH Technical Working Group
Pre-Primary and Primary Education, Ministry of Education	Thuto Ntekhe	Chief Education Officer
World Vision International, Lesotho	Kabelo Tseetsana	WASH Technical Programme Manager
Lesotho Red Cross Society	Sechaba Mokhameleli	Programme Director
	Moluoane Ramakhula	Health and Social Services Coordinator
	Mookho Mafereka	
	Itumeleng Pampiri	WASH Volunteers
TED – Technologies for Economic Development	Mantopi Lebofa	Director
Lesotho National Federation of Organizations of the Disabled	Nkhasi Sefuthi	Executive Director
UNICEF	Lineo Mathule	Nutrition Specialist
Department of Rural Water Supply	Nthabeleng Moea	Principal Sociologist
	Mamokhele Setlaba	Community Liaison Officer

SECTION II: MONITORING AND EVALUATION FRAMEWORK

Outputs	Indicator	Baseline
Goal / End of Sub-Strategy Outcome: A culture where 80% of people in Lesotho practice handwashing at all critical times by 2026	% of individuals practicing hand hygiene at critical times in the 1) household, 2) schools, 3) health facilities, 4) restaurants	18% (MICS 2018)
Strategic Objective 1: To foster and facilitate LEADERSHIP at the national, district and local levels that will resource, coordinate and inspire a national culture of hand hygiene.		
Intermediate Outcome 1.1: Effective government and stakeholder leadership drives the focus from COVID-19 hand hygiene promotion towards the creation of a long-term culture of hand hygiene	# of ministries and districts committed to making hand hygiene a priority in their area of mandate	n/a
Output 1.1.1: Development of hand hygiene advocacy tools and plans	# of advocacy tools designed to effectively target different audiences	n/a
Output 1.1.2: Establishment of national and district champions for hand hygiene	# of hand hygiene champions at district and national level	n/a
Output 1.1.3: Development of district action and advocacy plans for strategy implementation	# district level action and advocacy plans developed	n/a
Intermediate Outcome 1.2: Functioning government-led Technical Working Group (TWG) to lead Hand Hygiene programming, including regulations, inter-sectoral integration, planning, budgeting and coordinating implementation		
Output 1.2.1: Creation and implementation of a national Hand Hygiene Technical Working Group(TWG)	National Hand Hygiene Technical Working Group with approved Terms of Reference	n/a
	# of meetings held	n/a
Output 1.2.2: Integration of hand hygiene into policies / strategies / guidelines	# of government policies and strategies in which hand hygiene is prioritized	n/a

	Target 2022-2026	Means of Verification	Responsible	Assumptions
	65% by 2024 80% by 2026	End of strategy evaluation or DHS / MICS	MoH	Current hand hygiene facilities estimates are underestimated because the MICS was conducted before the COVID-19 push for hand hygiene
	4 ministries 5 districts by 2023	Ministerial and District commitments	MoH	National and district leader commitments translate to commitment of financial and human resources
	3 tools by end of 2022 targeting: -gov leaders -private sector -donors	Tools	MoH	Resources are available to design and produce tools
	1 national and 10 districts by 2024	Agreements with champions	MoH	Influential individuals can be provoked to lend their influence to hand hygiene
	10 action plans by 2022	Action Plans	MoH	Hand hygiene workshops are designed and held to garner district commitment and effectively assign responsibilities
	2021	Coordination Body ToR	MoH	Hand hygiene stakeholders value the function of the coordination body to allocate time to participate
	Quarterly – minimum	Meeting Records	MoH	
	4	Policies and Strategies	MoH	Hand hygiene is enough of a national priority to galvanize leaders to dedicate resources to ensuring handwashing is integrated

Outputs	Indicator	Baseline
Strategic Objective 2: To build an ENVIRONMENT that ENABLES handwashing interventions and practice for all.		
Intermediate Outcome 2.1: Government, implementor and community capacity to promote and enable hand hygiene behaviours	% progress in implementing each strategy within the National Hygiene Strategy	n/a
Output 2.1.1: Development and implementation of capacity development plan	Capacity development plan approved for implementation	n/a
Output 2.1.2: Consultation workshops held with stakeholders on roles in implementing the strategy	Number of district stakeholder meetings held and # of stakeholders (disaggregated by role and gender) consulted and engaged	n/a
Output 2.1.3: Capacity of key stakeholders improved through the implementation of handwashing capacity development plan. Groups include: 1) district and community leaders, NGO and community-based organizations including churches 2) teachers and ECCD care givers, 3) health professionals, including VHWs, 4) food handlers, 5) herd boys/men 6) people with disabilities and the elderly	Approved hand hygiene training modules for different target groups	n/a
	Number of module trainings held	n/a
	# of individuals trained, disaggregated by gender and stakeholder group and district	n/a
Intermediate Outcome 2.2: Partnerships formed with private sector to support the promotion of hand hygiene in Lesotho	# of agreements formalized to promote hand hygiene	
Output 2.2.1: Private sector expertise is used to enhance the development and delivery of effective hand hygiene interventions	# of hand hygiene promotion events / activities conducted in partnership with private sector	n/a
Intermediate Outcome 2.3: System to enable tracking of progress and continual learning for evidence-based programme improvement is used by key stakeholders		
Output 2.3.1: MELF that provides definitions, standards, indicators, and M&E guidance for stakeholders	Approved Monitoring, Evaluation and Learning Framework and accompanying tools and systems	n/a
Output 2.3.2: Hand hygiene presentations included at WASH, nutrition, health, education Shared Learning Events	Number of hand hygiene learning events held	n/a
Output 2.3.3: Rapid assessment on the state of access to HH	Mid-term and end-term rapid assessment reports	
Output 2.3.4: Midline and Endline Assessment Learning Review	Assessment reviews and recommendations reports	

	Target 2022-2026	Means of Verification	Responsible	Assumptions
	65% - 2024 80% - 2026	Tool to be developed	MoH EH	Partners are committed to implementing the National Hand Hygiene Strategy
	1	Capacity development plan	MoH	Resources and tools available for implementation of plan
	10	Consultation participant lists	MoH	The correct level of stakeholders is available to attend workshops
	6 modules	Training participant lists	MoH	Programmes prioritize HW sufficiently to allocate training time to their teams
	60	Training participant lists	MOH	Programmes prioritize hand hygiene sufficiently to allocate training time to their teams
	Targets # to be confirmed	Training participant lists	MOH – EH, Nutrition, Disease Control, MoET	Programmes prioritize hand hygiene sufficiently to allocate training time to their teams
	3	Agreements	MOH EH	Private sector is convinced to engage in partnerships for hand hygiene and GoL is amenable to agreements with the private sector
	3 per year	Hand hygiene activity monitoring	MoH	Private sector sees the value in investing resources to promote hand hygiene
	Tools and systems in place by 2022	Framework document and tools	MoH	Hand hygiene stakeholders agree on standards, indicators and monitoring across different ministries and programmes
	3 per year	Shared Learning Event Agendas and Meeting Minutes	MoH	Hand hygiene stakeholders are engaged to share learnings with the larger community
	Midline-2024	Assessment results	MoH	Resources are available to conduct large scale assessments
	Midline-2024 Endline - 2026	Approved Reports	MoH	Resources are available to conduct large scale assessments

Outputs	Indicator	Baseline
Strategic Objective 3: To create and sustain DEMAND for handwashing practice at critical times.		
Intermediate Outcome 3.1: Demand creation for hand hygiene practice	% of HH with HWFs that have soap and water	18% (MICS 2018)
Output 3.1.1: Evidence around hand hygiene practices, drivers, barriers and enablers in Lesotho	Approved formative research report with consensus around key determinants	n/a
Output 3.1.2: Evidence based behaviour change strategy is used to create demand for hand hygiene	Approved hand hygiene social and behaviour change strategy, with implementation methodology and plan	n/a
Output 3.1.3: Delivery of a phased hand hygiene behaviour change initiative with national and district Advocacy, Community Mobilization, above the line promotion - mass media, and below-the-line promotion - Interpersonal communication and community events	# of radio modules developed and broadcast	n/a
	# of TV modules developed and broadcast	n/a
	# of districts promoting hand hygiene through community events / meetings / activities	n/a
	# of people reached with hand hygiene campaign messages	n/a
Output 3.1.4: Increased knowledge and awareness on the importance of handwashing	% of population correctly identifying the critical times for handwashing	n/a
Intermediate Outcome 3.2: Handwashing promotion and enabling integrated into priority programmes and settings	# of additional people (disaggregated by sex and age) reached with hand hygiene promotion messages through: 1) ECCD programmes, 2) ANC visits, 3) nutrition promotion activities, 4) community meetings, 5) primary schools, 6) disease control activities, 7) HIV/AIDS counselling	n/a
Output 3.2.1: Government programmes prioritizing and integrating hand hygiene promotion into interventions	# of districts with integrated inter-sectoral Hand Hygiene programmes	n/a
Intermediate Outcome 3.3: Enabling demand for all people – women, men, girls, boys, elderly, people with disabilities and vulnerable populations	% of households reporting that they used their own resources to establish their hand hygiene facility	n/a
	% of persons with a disability who report that they can access and use hand hygiene facilities without difficulty	n/a

	Target 2022-2026	Means of Verification	Responsible	Assumptions
	65% - 2024 80% - 2026	DHS/MICS	MoH	HH HWFs are a good proxy indicator to capture practice in HH settings
	Finalized report by 2022	Report and Validation meeting approval	MoH / UNICEF	There is expertise and resources available to conduct formative research and facilitate a workshop to identify key determinants
	Finalized SBC strategy by 2022	Strategy document	MoH / UNICEF	Formative research provides sufficient evidence to develop a strong SBC strategy
	1 module, 10 times per year	Bimonthly Coordination Body Reports	MoH	Radio stations broadcast according to agreed-upon schedules
	1 module, 5 times per year	Bimonthly Coordination Body Reports	MoH	TV stations broadcast according to agreed-upon schedules
	10	District reports	MoH/District Authorities	Leadership prioritizes hand hygiene. District reports capture hand hygiene
	750,000 per year	Handwashing activity monitoring	MoH/MoLG / Partners	Partners support implementation of the campaign and report on # of people reached. The BCC strategy is sufficient to reach to effectively increase community knowledge
	65% by 2024 80% by 2026	Strategy midline and evaluation	MoH	
	1,000,000 disaggregated	Hand hygiene activity monitoring	MoH – EH, Nutrition, Disease Control, MoET	Data collection systems have the capacity to capture all people exposed to hand hygiene messages
	4 by 2024	Annual reporting	MoH MoET, MoLG, MoW, MAFS	Annual reporting sufficiently describes inclusion of hand hygiene promotion
	40% - 2024 75% - 2026	Strategy midline and evaluation	MoH	Systems are put in place to provide social support to vulnerable households
	40% - 2024 80% - 2026			

Outputs	Indicator	Baseline
Output 3.3.1: Guidance is provided to households on low cost, accessible hand hygiene facility models	Guidelines for low cost, accessible, inclusive hand hygiene models are developed	n/a
Output 3.3.2: Support is provided to households that are vulnerable	% of HHs identified as vulnerable are supported to establish and maintain a sustainable hand hygiene facility	
Strategic Objective 4: To ensure accessible SUPPLY, including facilities, services and products for hand hygiene		
Intermediate Outcome 4.1: Hand hygiene facilities, available in households, schools, health facilities and other public and private institutions	% of households with a hand washing facility (HWF) that has soap and water	18% (MICS 2018)
	% of restaurants with hand hygiene facilities that have soap and water available for food handlers and available for patrons	
	% of schools with hand hygiene facilities with soap and water available for teachers and students	
	% of HCFs that have functional hand hygiene facilities (with water and soap and/or alcohol-based hand rub) at all points of care and within five metres of toilets (WHO definition)	
	% of community gathering spots with hand hygiene facilities with soap and water available for pastors and fellows	
Output 4.1.1: Government prioritization and investment in ensuring hand hygiene facilities are available	# of districts that include hand hygiene in annual plans and budgets	5-2024 10 - 2026
	# of government institutions that deliver official mandates to ensure that their institutions have functioning hand hygiene facilities with soap, water and environmental cues	5 – 2023-2024 10 - 2026
Intermediate Outcome 4.2: Hand hygiene products accessible in local markets/suppliers from the national to the village level	% of villages that have traders that sell soap and buckets/jerry cans/bottles	
Output 4.2.2: Comprehensive understanding of the hand hygiene market and needs for development	Completed market analysis and validated results	

	Target 2022-2026	Means of Verification	Responsible	Assumptions
	1 – 2022	Guidelines document	MoH MoW	Expertise is available to develop guidelines that are culturally acceptable
	25% - 2023 to 2024 100% - 2026	Budgets	MoH MoSP	Government and partners have standardized system for identifying and supporting vulnerable households
	100% - 2026	MICS / DHS	MoH	Water in sufficient quantity for hand hygiene is available for all households
	100% - 2026		MoH	Water in sufficient quantity for hand hygiene is available. Restaurants prioritize hand hygiene
	100% - 2026	MoET reporting	MoET	Water in sufficient quantity for hand hygiene and soap is available for schools
	100% - 2026	HCF monitoring	MoH	Water in sufficient quantity for Hand Hygiene is available for all health facilities
				HCFs have available resources to ensure that there is always sufficient supply for hand hygiene
	100% - 2026	Markets monitoring	MoH/MoW/ MoLG	Community gathering spots are defined and agreed by the Hand Hygiene TWG, and may include churches, taxi ranks, ports of entry, government buildings.
	Annual plans / budges	MoLG District Authorities		Advocacy sufficiently mobilize district leaders to make hand hygiene a priority
	Mandates	MoH, MoET, MoLG MoW, Prime Minister's office		Advocacy efforts sufficiently mobilize government entities to make hand hygiene facilities a mandatory for their institutions
	70% - 2024 90% - 2026	Rapid Assessment	MoH, MoLG, partners	Private sector is interested in supporting the implementation of the hand hygiene strategy
	2022	Market analysis report	MoH, MoLG, partners	Market expertise is available to conduct market analysis

Outputs	Indicator	Baseline
Output 4.2.3: Private sector is stimulated to market affordable hand hygiene products to communities	# of appropriate hand hygiene products introduced to the market	TBD – Market analysis
Output 4.2.4: Government regulates to ensure quality hand hygiene products in the market	# of market monitoring reports	
Intermediate Outcome 4.3: Hand hygiene related services (water services, public hygiene and sanitation facilities) ensure that people can practice the desired behaviour in homes as well in institutions.	% of population with access to a basic drinking source	79% (MICS)
	% of public places with sanitation facilities that have functioning hand hygiene facilities with soap and water	
Output 4.3.1: Relevant government ministries prioritize water supply and other hygiene to HH, schools, HFS and restaurants	Annual plan and budget prioritize water supply systems that provide communities and their support institutions (schools, HCFs, markets), with enough water for hand hygiene practices	
Output4.3.2: Relevant public and private institutions finance hand hygiene services	% of institutions with hand hygiene financing plan	

	Target 2022-2026	Means of Verification	Responsible	Assumptions
		Midline and endline evaluation results	MoH, MoLG, Partners	Demand for hand hygiene products stimulates the private sector to innovate and take actions to increase community access
	2 / year	Monitoring reports	MoH, MoLG, partners	Government market regulatory systems incorporate quality checks of hand hygiene products
	90% - 2024	MICS JMP	MoW	Access to water source provides sufficient water to enable hand hygiene
	75% - 2024 90% - 2026	Market monitoring reports	MoW/ partners/ private sector	Functioning and equipped hand hygiene facilities assumes that sanitation services are functioning
		Government budget	MoW, MoET, MoH, MoL,	Water supplies at a sufficient service level to address handwashing water needs
	65% - 2024 100% - 2026	institutional plans and budgets	MoH/MoF/ Planning/ MoLG/ partners	Districts authorities have market management plans and budgets

#	Activities	Cost Element	Unit Cost	Quantity	Frequency	2022	2023	2024	2025	2026	Overall Budge	Responsible	Source of Funds
1	**To foster and facilitate LEADERSHIP at the national, district, and local levels that will mobilise resources, coordinate, and inspire a national culture of hand hygiene**												
1.1	**Leadership**					**580,000**	**-**	**-**	**-**	**-**	**580,000**		
1.1.1	Develop advocacy tools to engage champions and raise the profile of hand	Consultant hire	5,000	1	10	50,000	-	-	-	-	50,000	MoH and key stakeholders	GoL and Partners
		Printing	20,000	1	1	20,000	-	-	-	-	20,000	MoH and key stakeholders	GoL and Partners
1.1.2	Identify and engage national and district champions, introduce the hand hygiene strategy and develop district action and advocacy plans	Workshops at national and district level	1,700	30	10	510,000	-	-	-	-	510,000	MoH and key stakeholders	GoL and Partners
1.2	**Coordination and Harmonization**					**20,000**	**21,000**	**22,050**	**23,153**	**24,310**	**110,513**		
1.2.1	Establish a Hand Hygiene Technical Working Group with clear TORs	Quartely TWG meetings	5,000.0	1	4	20,000	21,000	22,050	23,153	24,310	110,513	MoH	GoL and Partners
2	**To build an environment that enables hand hygiene interventions and practice for all**												
2.1	**Capacity Development**					**4,085,000**	**-**	**4,158,000**	**-**	**-**	**8,243,000**		
2.1.1	Develophand hygiene training modules for identified priority target groups	Consultant hire	5000	1	25	125,000	-	-	-	-	125,000	MoH	GoL and Partners
		Printing	200	1800	1	360,000	-	378,000	-	-	738,000	MoH and key stakeholders	GoL and Partners
2.1.2	Conduct training to introduce hand hygiene messages and sector-specific tools to key programme	Trainings at district level	1,000	1800	2	3,600,000	-	3,780,000	-	-	7,380,000	MoH and key stakeholders	GoL and Partners
2.2	**Private Sector Partnerships**					**60,000**	**63,000**	**66,150**	**69,458**	**72,930**	**331,538**		
2.2.1	Conduct private sector hand hygiene meetings to introduce and discuss partnership experiences and opportunities	Meeting cost	1000	30	2	60,000	63,000	66,150	69,458	72,930	331,538	MoH	GoL and Partners

#	Activities	Cost Element	Unit Cost	Quantity	Frequency	2022	2023	2024	2025	2026	Overall Budge	Responsible	Source of Funds
2.3	**Monitoring, Evaluation, and Learning**					**303,500**	**119,375**	**984,144**	**43,411**	**969,581**	**2,420,011**		
2.3.1	Develop the Hand Hygiene Monitoring, Evaluation, and Learning Framework, tools and management system	Consultant hire	5000	1	20	100,000	-	-	-	-	**100,000**	MoH	GoL and Partners
		Validation workshop	1000	30	1	30,000	-	-	-	-	**30,000**	MoH	GoL and Partners
	Conduct trainings for district stakeholders on M&E tools	Training cost	1700	40	2	136,000	-	142,800	-		**278,800**	MoH and key stakeholders	GoL and Partners
2.3.2	Conduct HH learning events	Meeting cost	250	50	3	37,500	39,375	41,344	43,411	45,581	**207,211**	MoH and key stakeholders	GoL and Partners
2.3.3	Conduct rapid assessment on the state of access to hygiene in the country	Consultant hire	10000	1	40	-	-	400,000		420,000	**820,000**	MoH	GoL and Partners
		Data collection and analysis	5000	2	40	-	-	400,000	-	420,000	**820,000**	MoH	GoL and Partners
2.3.4	Midterm and end term evaluations to assess effectiveness of strategies, the relevance of the costing and pace of implementation, identify gaps and explore opportunities	Evaluation workshops	1000	40	2	-	80,000	-	-	84,000	**164,000**	MoH and key stakeholders	GoL and Partners

#	Activities	Cost Element	Unit Cost	Quantity	Frequency	2022	2023	2024	2025	2026	Overall Budge	Responsible	Source of Funds
3	**To create and sustain DEMAND for hand hygiene practice at critical times**												
3.1	**Evidence Based Social and Behaviour Change Programming**					**2,507,400**	**65,520**	**1,185,396**	**72,236**	**75,848**	**3,906,399**		
3.1.1	Conduct formative research , design evidence-based social and behaviour change approach and launch	Consultant hire	9000	1	30	270,000	-	75,600	-	-	345,600	MoH	GoL and Partners
		Conduct validation meeting	1000	40	1	40,000	-	-	-	-	40,000	MoH	GoL and Partners
		Production of materials, including cues/nudges to remind practice	2E+06	1	1	1,500,000	-	600,000	-	-	2,100,000	MoH	GoL and Partners
		Launch the Hand Hygiene Behaviour Change Initiative	235000	1	1	235,000	-	-	-	-	235,000	MoH	GoL and Partners
3.1.2	Implement the hand hygiene behaviour change strategy	Broadcast TV media adverts and programmes	3000	1	4	12,000	12,600	13,230	13,892	14,586	66,308	MoH	GoL and Partners
		Broadcast Radio media adverts and programmes	1200	1	12	14,400	15,120	15,876	16,670	17,503	79,569	MoH	GoL and Partners
		Broadcast newspaper media adverts	12000	1	3	36,000	37,800	39,690	41,675	43,758	198,923	MoH	GoL and Partners
		Trainings at district level	1000	200	2	400,000		441,000			841,000	MoH	GoL and Partners

#	Activities	Cost Element	Unit Cost	Quantity	Frequency	2022	2023	2024	2025	2026	Overall Budge	Responsible	Source of Funds
3.2	**Integration into Priority Programmes**					**1,445,000**	**47,250**	**1,519,613**	**52,093**	**54,698**	**3,118,653**		
3.2.1	Implement intergrated district level programs and actions (including VHWs) to promote hand hygiene at the community level	Inter-sectoral intergrated programme	140000	10	1	1,400,000	-	1,470,000	-	-	2,870,000	MoH and key stakeholders	GoL and Partners
3.2.2	Raise the profile of hand hygiene through global day celelbrations (Global Handwashing Day, World Toilet Day, World Hand Hygiene Day, World Water Day, Wolrd Nutrition Day, World Children Day...)	Celebrations	15000	3	1	45,000	47,250	49,613	52,093	54,698	248,653		
3.3	**Enabling Demand for All**					**12,675,255**	**12,603,255**	**13,233,418**	**13,895,089**	**14,589,843**	**66,996,859**		
3.3.1	Conduct human centered research to identify hand hygiene facility designs that are accessible and desired by all segments of Lesotho population	Consultant hire	9000	8	1	72,000					72,000	MoH and key stakeholders	GoL and Partners - LNFOD
3.3.2	Collaborate with Ministry of Social Protection to design and deliver programme to support vulnerable housheols with hand hygiene services (refer to calculations page for estimate of need)	Voucher / Cash transfer / Support system	145	86919	1	12,603,255	12,603,255	13,233,418	13,895,089	14,589,843	66,924,859	MoH and key stakeholders	GoL and Partners

#	Activities	Cost Element	Unit Cost	Quantity	Frequency	2022	2023	2024	2025	2026	Overall Budge	Responsible	Source of Funds
4	**Supply**												
4.1	**Enhance Access and Availability of Hand Hygiene services**					**324,000**	**252,000**	**264,600**	**277,830**	**291,722**	**1,410,152**		
4.1.1	Develop, produce hand hygiene services options and guidelines for different settings (link to 3.3.1), and use to trigger HH establishment of hand hygiene facilities	Consultant hire	5,000	6	1	30,000	-	-	-	-	30,000	MoH	GoL and Partners
		Printing	200	200	1	40,000	42,000	44,100	46,305	48,620	221,025	MoH	GoL and Partners
		Awareness creation and monitoring of progress of HH coverage of hand hygiene facilities	1,000	200	1	200,000	210,000	220,500	231,525	243,101	1,105,126	MoH, District Administrations, and key stakeholders	GoL and Partners
4.1.2	Support relevant line ministries to budget for hand hygiene services for relevant institutions (schools, health facilities, offices...)	Consultant hire to support line ministries to include financing in annual budgets	9,000	6	1	54,000					54,000	MoH, Key Ministries	GoL and Partners
4.2	**Enhance Access to Appropriate and Affordable Supply**					**226,400**	**90,720**	**242,256**	**100,019**	**105,020**	**764,415**		
4.2.1	Design and implement a hand hygiene market analysis to inform the development of market actions to improve access and affordability	Consultant hire	5000	1	20	100,000	-	105,000	-	-	205,000	MoH	GoL and Partners
		Conduct validation meeting of results and to collaborate on actions to strengthen market	1000	40	1	40,000	-	42,000	-	-	82,000	MoH	GoL and Partners
4.2.3	Conduct periodic inspections of outlet hand hygiene products and services to ensure quality	Meals	180	40	12	86,400	90,720	95,256	100,019	105,020	477,415	MoH	GoL and Partners

#	Activities	Cost Element	Unit Cost	Quantity	Frequency	2022	2023	2024	2025	2026	Overall Budge	Responsible	Source of Funds
4.3	Strengthen Relevant WASH Services					**40,000**	**322,000**	**44,100**	**151,305**	**48,620**	**606,025**		
4.3.1	Collaborate with Ministry of Water to make a water system roadmap that is targeted at establishing household water access that is sufficient in quantity to enable hand hygiene	Workshops / meetings with WASCO and Department of Rural Water Supply to advocate around water needs for hand hygiene needs	1000	20	2	40,000	42,000	44,100	46,305	48,620	221,025	MoH, MoW	GoL and Partners
4.3.2	Collaborate with Ministry of Water and relevant ministries (MOH, MoET, ?) to ensure that district service facilities (health facilities, schools, markets, restaurants) have access to sufficient	District level workshops / meetings with district service delivery entities to advocate around water needs for hand hygiene needs	10000	10	1		100,000		105,000		205,000	MoH, MoW, District Adminstrations	GoL and Partners
4.3.3	Create regulation to ensure that public and private sanitation facilities are maintained adequately to ensure that there is always water and soap available for handwashing	Consultant hire	9000	20	1		180,000				180,000	MoH	GoL and Partners

Overall Costs	2022	2023	2024	2025	2026	Total	USD
National Hand Hygiene Strategy Budget	22,266,555	13,584,120	21,719,726	14,684,592	16,232,572	88,487,565	6,008,674
Additional Costs to realize the National Hand Hygiene Strategy Targets: Costs above don't include household investment, capital and recurring O&M costs of water needs							
Minimum Household Investment for Hand Hygiene based on MICS 2018 HWF household coverage of 18% and a poverty rate of 49.7%	43,464,356	43,464,356	21,681,678	21,681,678	0	130,292,068	8,797,360
Comprehensive National Hand Hygiene Investments	65,730,911	57,048,476	43,401,404	36,366,270	16,232,572	218,779,633	14,806,034

Budget Summary						
Priority Area	**Y1 (2022)**	**Y2 (2023)**	**Y4 (2024)**	**Y1 (2025)**	**Y1 (2026)**	**Total Budget (Maloti)**
Leadership	580,000					580,000
Coordination and Harmonization	20,000	21,000	22,050	23,153	24,310	110,513
Capacity Development	4,085,000	-	4,158,000	-	-	8,243,000
Private Sector Partnerships	60,000	63,000	66,150	69,458	72,930	331,538
Monitoring, Evaluation, and Learning	303,500	119,375	984,144	43,411	969,581	2,420,011
Evidence Based Behaviour Change Communication	2,507,400	65,520	1,185,396	72,236	75,848	3,906,400
Integration into Priority Programmes	1,445,000	47,250	1,519,613	52,093	54,698	3,118,654
Enabling Demand	12,675,255	12,603,255	13,233,418	13,895,089	14,589,843	66,996,860
Enhance Access and Availability of Hand Hygiene services	324,000	254,000	264,600	277,830	291,722	1,412,152
Enhance Access to Appropriate and Affordable Supply	226,400	90,720	242,256	100,019	105,020	764,415
Strengthen Relevant WASH Services	40,000	322,000	44,100	151,305	48,620	606,025
	22,266,555	13,586,120	21,719,727	14,684,594	16,232,572	**88,489,568**

The National Hand Hygiene Strategy was developed in the context of the Lesotho Government's aspirations, including those committed to through Sustainable Development Goal 6 for water, sanitation and hygiene, the Constitution of Lesotho and the National Strategic Development Plan. It also speaks to the National Health Policy (2016), the National Health Strategic Plan (2017), the Long Term Water and Sanitation Strategy, the National Health Policy (2014) and the National Environmental Health Strategic Plan (2021).

For further information regarding the National Hand Hygiene Strategy, please contact the Environmental Health Division of the Ministry of Health.