

An integrated approach to HIV and water, sanitation and hygiene in Southern Africa



Regis Sicheunga's grandchildren eating dinner, Hambale, Chipenbele, Zambia. Regis Sicheunga has lived with HIV for many years. Use of safe water has decreased the frequency of diarrhoea for her.

An estimated 12.7 million people in the Southern Africa sub-region are living with HIV¹ – 36.4% of the global total.² 174 million people in Southern Africa, almost two thirds of the population, do not have access to basic sanitation, and more than 100 million do not have safe water.³

Why does WASH matter for people living with HIV?

Many life-threatening opportunistic infections are caused by inadequate access to safe drinking water, sanitation and hygiene (WASH).⁷ Diarrhoea affects 90% of people living with HIV, causing significant morbidity and mortality.^{8,9} 88% of cases of diarrhoea are caused by poor WASH.¹⁰

With increasing availability of antiretroviral therapy (ART), more people with HIV live longer and need comprehensive care, treatment and preventive services to help boost their resilience to infections and illnesses and help them to live longer and healthier lives. Antiretroviral drugs are more effective when taken with adequate food and clean water. People living with HIV need about 100l of water per day.

Water needs	Amount of water needed per day
Drinking, food preparation, laundering, personal hygiene	20l (recommended minimum)
Taking antiretroviral medications	1.5l
Replacement feeding of infants < six months	Minimum 1l (excluding for cleaning)
Replacement feeding of infants > six months	2l (excluding water for cleaning)
Cleaning people; laundering clothes and bedding (daily during diarrhoea)	20–80 l
Total	Approximately 100l

Source: Ngwenya and Kgathi;⁴ Molose and Potter;⁵ WSP.⁶

The scale of the challenge

Southern Africa includes countries with some of the highest HIV prevalences in the world. Access to improved water and sanitation is considerably better in urban areas than in rural areas where most people live.

Countries	HIV prevalence
Swaziland	26.5%
Lesotho	23.1%
Mozambique	11.1%
Zambia	12.7%

Source: UNAIDS

Countries	Proportion of population with access to improved water supply (2012)			Proportion of population with access to improved sanitation (2012)			Proportion of population practising open defecation (2012)		
	Urban	Rural	National	Urban	Rural	National	Urban	Rural	National
Swaziland	94%	69%	74%	63%	56%	58%	1%	17%	14%
Lesotho	93%	77%	81%	37%	27%	30%	5%	45%	34%
Mozambique	80%	35%	49%	44%	11%	21%	13%	52%	40%
Zambia	85%	49%	63%	56%	34%	43%	2%	26%	16%

Source: WHO/UNICEF

The assessment had the following objectives:

- To establish the extent of and identify bottlenecks in integration of HIV and WASH in policies, projects by government, civil society and other actors
- To identify specific WASH needs of people living with HIV
- To establish recommendations for steps going forward

The study showed that people living with HIV have specific WASH needs, and WASH is not adequately integrated in national policies, guidelines and frameworks. At implementation level, WASH and HIV are linked in an ad hoc manner because coordination between the two sectors is limited. Disparities between the two sectors in coordination, funding and policy commitment also affect efforts to synchronise activities.

Research methodology

SAfAIDS led the study using a cross-sectional study design at regional, national and local levels. Data collection methods included literature review, key informant interviews, focus group discussions, household case studies and direct observations. Findings were validated by sharing them with stakeholders from the WASH and HIV sectors in each of the four countries, who also discussed how to take them forward.

WASH and HIV integration in policies and framework

Integration was reviewed in the policies and framework at regional and national levels in each of the four countries. The findings from the review are summarised in the table:

	Integration recognised in	Integration not adequately recognised in
Regional policies	<p>Southern African Development Community (SADC) regional water policy:</p> <ul style="list-style-type: none"> • Recognises that HIV and AIDS affects all sectors including water • Makes provision for integration, collaboration and cooperation of water and health sectors • Provision of hygiene education integration into water and sanitation programmes • Takes into consideration importance of gender mainstreaming and addressing HIV and AIDS in water-resource management 	<p>SADC Regional HIV Policy:</p> <ul style="list-style-type: none"> • Specifically does not reference WASH issues for people living with HIV, or integration • Does not mention the water and sanitation sector and it can only be assumed that HIV is deemed an important issue by member states • Mentions water, exclusive of sanitation and hygiene, in the context of sustaining agricultural production <p>Regional strategic action plan recognises:</p> <ul style="list-style-type: none"> • Effect of water quality on human health, but is silent on HIV and AIDS
National policies	<p>Lesotho</p> <ul style="list-style-type: none"> • National Water and Sanitation Policy highlights importance of creating links between WASH and HIV and AIDS • National HIV and AIDS Strategic Plan details WASH as an impact-mitigation approach <p>Zambia</p> <ul style="list-style-type: none"> • Water and Sanitation department programme builds a strong case for their integration <p>Mozambique</p> <ul style="list-style-type: none"> • Rural Water Supply and Sanitation Programme recognises the role of WASH in mitigating HIV 	<p>Swaziland</p> <ul style="list-style-type: none"> • National Water Policy does not consciously establish links but states that everyone should have access to safe water and sanitation to guarantee dignity and health • National Multi-Sectoral Strategic Framework for HIV and AIDS recognises water and sanitation as key challenges but has no clear guidelines on HIV responses <p>Zambia</p> <ul style="list-style-type: none"> • National HIV and AIDS Policy lacks the provisions of WASH in HIV and AIDS interventions <p>Mozambique</p> <ul style="list-style-type: none"> • 1995 Water Policy has no provision for HIV integration • The Strategic HIV and AIDS Response Plan has no specific provision for addressing WASH issues when responding to HIV.

The study highlighted a lack of planned integration at policy level. This was further evident in both WASH and HIV programming, which was sometimes a result of a lack of country-specific research on links between WASH and HIV. Nevertheless, in each country, some activities were shown to integrate WASH and HIV. One major barrier has been that funding sources for HIV and WASH are separate, which inhibits effective integration.

Opportunities for better integration of HIV and WASH

Opportunities and networks are available in each country where WASH and HIV stakeholders work. Most such networks and opportunities are specific either to WASH or HIV initiatives. Because of a lack of integration, discussions of HIV issues in WASH platforms and vice versa are weak and secondary. The weaknesses are more apparent nationally than at the provincial, regional and district levels.

WASH sector coordination challenges in some countries threaten integration efforts. Most key stakeholders interviewed in countries such as Swaziland and Mozambique believed that, although integration is weak, there are structures that offer opportunities for strengthening. Unlike WASH, HIV is a priority for all four countries, and has received much more funding than has WASH. Coordination is well structured from national to community level; it would not be difficult to strengthen the WASH component in HIV.

In all four countries, several community-level structures support people living with HIV by providing information on HIV and WASH and other services.

Research findings

Selected stakeholders' perspectives and initiatives for WASH and HIV integration

Water availability

- 1 In Lesotho, the water policy states that waterpoints should be located within 150m of the household. The assessment showed that most households were 1km from the nearest waterpoint.
- 2 In Mozambique, water was not always available where waterpoints were, causing people to revert to unprotected sources.
- 3 In Swaziland, access to water is difficult in the dry season when boreholes dry out because of the low water table. Piped systems for water delivery exist, but are not affordable for all.
- 4 In Zambia, water accessibility and availability is a problem. In the communities visited, households had water cards and fetched water from communal taps where each household is rationed 20l per day at a cost of US\$5 per month. In other communities, households collect more than 20l of water at a cost of US\$1 per 210l drum, and an additional fee is charged for the labour to roll the drums to the house. Long queues at collection points are normal and can be a problem for people living with HIV because they can miss their ART medication schedules.

Water quality

All the four countries faced water quality issues because of pollution and contamination of open water sources. It was highlighted that water shortages led to households using open water sources to collect water. Treating drinking water is not common because people cannot afford water purification equipment. Access to safe water still needs to be improved in the countries.

Sanitation conditions

- 1 In Swaziland, open defecation is still practised in the areas assessed. Cultural beliefs and practices can inhibit improvement of sanitation facilities. Swaziland's Ministry of Health has adopted a policy to construct double pit latrines in communities, which can be used for separate disposal of medical and human waste. However, health professionals reported that most households in which

people are living with HIV could not afford the construction and that the government is unable to provide funds.

- 2 In Zambia, the sanitation conditions in communities visited were poor. People either used neighbours' toilets or defecated in beer cans or plastic bags, disposing of them at the nearest garbage dump. Pit latrines were usually cleaned with water because soap is too expensive.
- 3 In Mozambique, menstrual hygiene management was found to be poor. Women reported challenges to accessing sanitary towels, especially patients who are bed-ridden. Men reported that, where toilet facilities were inadequate, used sanitary material is sometimes disposed of in the open.

Stakeholder interviews and literature review in Lesotho highlighted that there are few WASH and HIV integration interventions. UNICEF does not deliberately integrate WASH and HIV and supports the government to handle aspects of WASH in relation to HIV. Lesotho's Ministry of Health is running HIV and WASH programmes, and the services are given simultaneously. In Mozambique, organisations are implementing programmes that mainstream HIV in their community WASH interventions. In Zambia, programmes and interventions were oriented either exclusively to HIV or to WASH. This singularity was primarily attributed to there being little room to innovate with programmes during implementation. Practitioners reported that integration of interventions is difficult because the integration is missing at the national level. At the national level, no specific procedures or guidelines are in place for collecting and recording integrated data on WASH and HIV.

Handwashing, and WASH knowledge among households with people living with HIV

People in households with people living with HIV were knowledgeable on WASH issues, but this was not reflected in their behaviours or practices. Communities were conscious of the need to maintain household cleanliness and aware of good sanitation practices. The major challenge in Lesotho and Swaziland was translation of community health and hygiene

knowledge into practice. Reluctance to adopt health and hygiene practices was caused by high poverty levels and lack of commitment to addressing household sanitation. People still defecate in the open where toilets are unavailable. Global Handwashing Day has improved handwashing knowledge and practice in all countries. However, caregivers reported that soap for handwashing is not always available.

Stigma and discrimination against people living with HIV

Increased awareness and education has reduced stigma and discrimination against people living with HIV in the four countries. Initiating a WASH programme targeted at people living with HIV could be viewed as a form of discrimination and might increase stigmatising behaviours and attitudes towards people living with HIV. It was therefore proposed that WASH programmes target everyone but incorporate special needs of



Regis Sicheunga washing her granddaughter's hands, Hambale, Chipenbele, Zambia.

vulnerable groups. Focus groups and interviews in Zambia showed that low levels of discrimination persist because of poor understanding of HIV transmission methods.

Water hygiene practices in households with people living with HIV

Most households were aware of recommended drinking water storage practices. In most cases, water is collected for immediate use and very little is stored. Cleanliness of containers and items used to draw drinking water from storage containers depended on general household hygiene standards, household size and member composition.

Use of protective materials

Primary and secondary caregivers use gloves for caring for and supporting bedridden patients. When gloves are not readily available, plastic bags are a common alternative. In extreme cases when caring for close relatives, bare hands are sometimes used, which is a high-risk practice. This is primarily done because of lack of money or the fear that family members might consider the carer to lack love for the sick. In most countries assessed, gloves were available through a home-based care programme. However, the programme was not well supported at the time of the assessment.

Faecal disposal and human waste management

The expansion and success of ART programmes has reduced the number of bedridden patients. However, in cases where people living with HIV become bedridden, caregivers used buckets, basins, plastic sheets and disposable nappies. The basins, buckets or plastic sheets were washed with water, soap and detergents. If soap was unavailable, water alone was used. Knowledge of hygiene standards and practices was high. Findings showed that faeces or soiled nappies were disposed of in latrines, buried in shallow holes or thrown away in the bush. However, the Ministry of Health in Swaziland discouraged burying used nappies or sanitary pads in shallow pits because these could easily be unearthed by dogs and pollute the environment and water sources.

Menstrual hygiene management

Swaziland

Sanitary pads were reportedly not always available, often resulting in clean sheets being used. The assessment found that sheets were washed and ironed before reuse as a sterilisation measure.

Lesotho

Care facilitators used their personal resources to ensure that the sick had proper sanitary ware. NGOs supported some with monthly hygiene packages.

Zambia

Caregivers reported that patients used diapers during menstruation because they could remain cleaner for longer than with using pads. For patients who spend most of their time lying down, diapers offered better protection. If diapers were unaffordable, people used cotton wool or pieces of cloth which were washed and re-used.

Conclusion

The main stumbling block to WASH and HIV integration is inadequate integration in national policies, guidelines and frameworks. Lesotho has clearer policies in terms of provisions for HIV and WASH integration than do the other countries. More work, particularly in HIV, needs to be done in Zambia, Swaziland and Mozambique. The

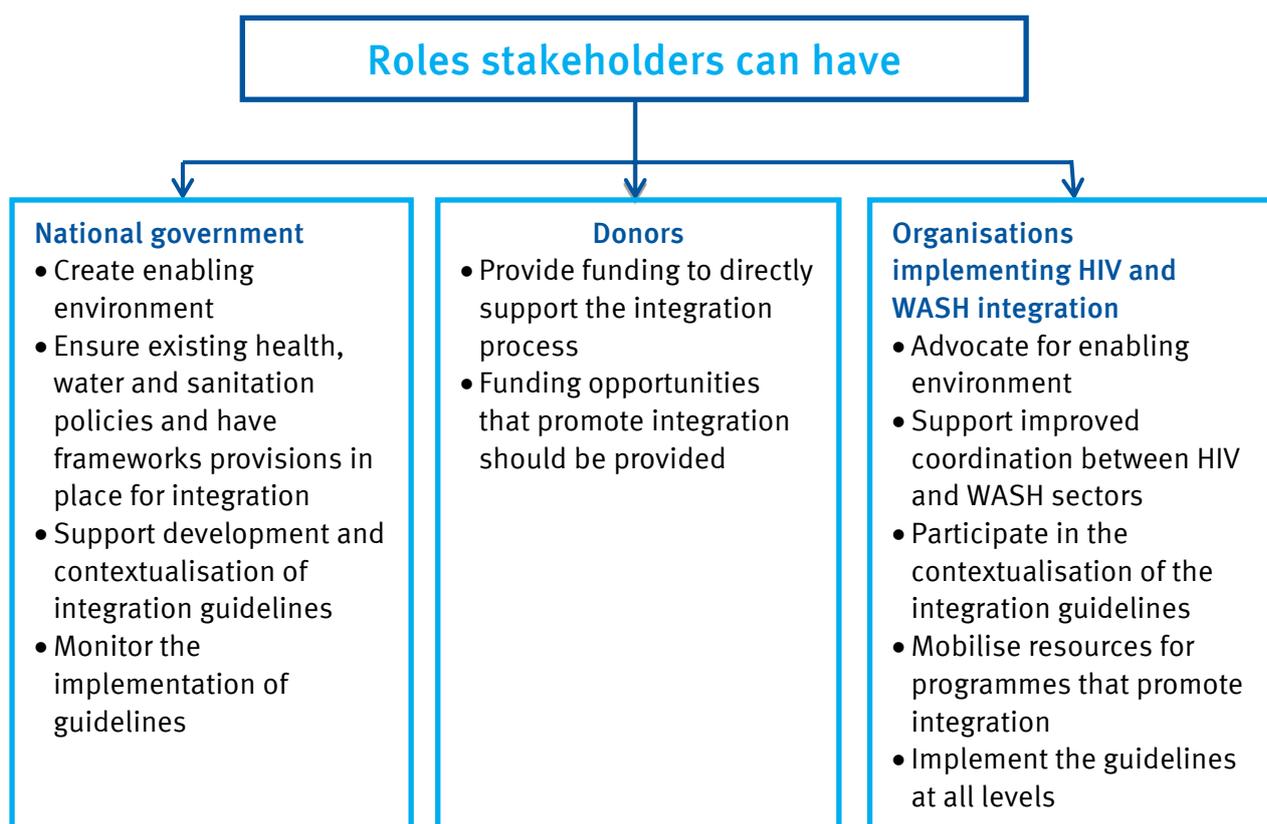
availability of SADC regional frameworks and guidelines can be used to guide development of national and local HIV and WASH integration frameworks.

Co-ordination between WASH and HIV sectors is limited, and unavailability of funding for both WASH and HIV activities makes links difficult. Disparities between the two sectors in co-ordination, funding and policy commitment also affect efforts at synchronisation of activities. Although several in-country platforms exist where different HIV or WASH stakeholders meet, the platforms are more aligned to one sector, with limited integration between. With regards to WASH and HIV, the crucial question is: who will lead the integration of HIV and WASH?

Recommendations

In the context of the assessment findings, we make the following recommendations:

- 1 Consider strengthening capacities and broadening mandates of existing platforms to include WASH and HIV integration, rather than creating new structures or platforms.
- 2 The WASH and HIV integration process should be owned by all stakeholders at all levels, with national governments leading through the appropriate ministries and departments.
- 3 Efforts to initiate WASH and HIV integration should take into account existing guidelines, best practices and lessons from integration initiatives, processes and practices in other sectors, such as those between HIV and TB, self-rated health and nutrition.
- 4 WASH and HIV integration initiatives should adequately assess existing implementation barriers in the respective sectors and provide adequate mitigation efforts to address policies.
- 5 Ensure that a critical mass of stakeholders from all key government ministries (health, water, etc.), relevant UN agencies, local and international NGOs, and community-level representatives have adequate buy-in to the WASH and HIV integration initiatives.
- 6 Ensure a community-led demand process that guarantees effective representation and participation of affected individuals, households and communities, including the poor and other vulnerable groups.
- 7 Funding of WASH and HIV integration processes should be additional and not shared from current funding for the two sectors.
- 8 Ensure that inhibiting cultural beliefs and practices are addressed through appropriate strategies such as culturally sensitive but strong and effective advocacy programmes at all levels.
- 9 The WASH and HIV integration process and strategies should include interventions that address sustainability issues, which include capacity building of beneficiary government institutions, communities, households and individuals to support project outcomes on a long-term basis.
- 10 Integration should incorporate gender and other crosscutting issues. Balanced roles for women are crucial because women are disproportionately affected by WASH and HIV challenges compared with men, and are responsible for most WASH and HIV household chores.
- 11 Development of WASH and HIV integration mechanisms should take into account how guidelines can be used in both rural and urban settings.



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