A FIELD GUIDE FOR INTEGRATING WASH AND HIV PROGRAMMES IN SOUTHERN AFRICA

AngloAmerican WaterAid SAfAIDS

Knowledge for action: The power to make a difference!

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Table of Contents

Abbreviations 6
About this guide 7
Who should use this guide? 7
How should you use this guide? 8
Section 1: Why integrate HIV and WASH? 9
Section 2: Four WASH and HIV Solution Areas 17
1. Identify barriers to WASH: inclusive and accessible solutions 21
2. Prioritise personal hygiene 26
3. Promote improved sanitation 34
4. Support better water access 38
Section 3: Planning for Change 47
Planning for WASH and HIV integration within your organisation 48
Establishing partnerships for integrating WASH and HIV 50
Relevant platforms for WASH and HIV advocacy and co-ordination 52
Working with structures at the community level 54
Gender, Culture And Social Inclusion – Tackling Stigma Head-On 56
The 4 A's approach 58
Section 4: Examples of WASH and HIV integration – quick look case studies 61
LESOTHO 62
MOZAMBIQUE 63
SWAZILAND 64
ZAMBIA 65
References and Resources 64

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVs	Antiretroviral Medicines
BCFs	Behaviour Change Facilitators
CBVs	Community-Based Volunteers
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
NCM	Nazerene Compassionate Ministries
MHM	Menstrual Hygiene Management
ODF	Open Defecation-Free
OI	Opportunistic Infection
OVC	Orphaned and Vulnerable Children
PLHIV	Person/People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
VHWs	Village Health Workers
WASH	Water, Sanitation and Hygiene

A note on terminology:

Within this text, the terms 'integration' and 'mainstreaming' are used interchangeably to mean the inclusion of WASH issues in HIV programme and HIV issues in WASH programmes

About this guide

This guide is evidence-informed and extends the work of the WaterAid 2014 'Gap and Needs Assessment' across four target countries[7].

In all these countries, the findings indicated that a simple, yet comprehensive, guide to give practical support to the bi-directional integration of WASH and HIV programmes (including prevention, treatment and care), that talks to local needs and priorities did not exist and was needed.

So we wrote one. The term 'bi-directional' means the guide can be used by organisations working in both the WASH and HIV sectors.

Who should use this guide?

This is useful for everyone working in and around the fields of water, sanitation and hygiene (WASH) and in HIV; both WASH and HIV prevention, treatment and care are fundamental to ensuring development in high HIV-burden countries.

This guide is a simple one-stop resource to raise understanding around the need for bi-directional integration of the WASH and HIV sectors and facilitate better programming around both WASH and HIV that responds to national needs and priorities. Integration of HIV prevention, treatment and care into WASH programmes can also have an impact on reducing stigma and discrimination against people living with HIV (PLHIV).

Remember:

- HIV prevalence in southern Africa is among the highest in the world, remaining in double-digits in all countries, with the exceptions of Mauritius and Madagascar, (UNAIDS, 2013).
- With the exceptions of South Africa and Botswana, half of all people in the region do not have access to improved sanitation facilities and around one third remain without access to improved sources of drinking water (UNICEF Joint Monitoring Project (JMP), 2015)

7 Lesotho, Mozambique, Swaziland and Zambia

- Improved WASH is essential for PLHIV to: prevent diarrhoea and other opportunistic infections; support prevention of mother-to-child transmission (PMTCT); and for effective HIV treatment and adherence[2].
- Stigma and discrimination remain significant for those living with HIV and impacts negatively on their uptake of services and participation in community initiatives, such as WASH programmes[8].

If you are concerned about any of these issues, this guide is for you!

How should you use this guide?

It is an everyday support to programming and community action in both the WASH and HIV sectors. It is simple and easy to read and encourages action through information sharing and reflection. There are four sections.

- The first section makes the case for integrated HIV and WASH – so you know WHY it is important.
- Section two looks at the issues, so you know WHAT is required. This is in the form of handy job aid cards.
- The third section shares information on HOW you can put this into action by looking at organisational planning tools, partnership strategies with communities, as well as working with existing co-ordination mechanisms at national and regional level.
- The fourth and final section provides examples of integration in action to add to the growing portfolio of learning around WASH and HIV across southern Africa. Will your programme be there?

Limitations

This guide's primary focus is on WASH in rural areas. This was based on the assumption that rural communities are more marginalised and usually poorer, based on data in the WHO/UNICEF JMP report published in 2015. This guideline is premised on lessons and evidence from four countries, namely Lesotho, Swaziland, Mozambique and Zambia. As a result, the guidelines may not fully address contexts in other African countries and may need to be adapted for suitability.

8 Integrated Approach To HIV And Water, Sanitation And Hygiene In Southern Africa: A Gap and Needs Assessment, Anglo American, WaterAid, SAfAIDS, 2014

Section 1:

Why Integrate HIV and WASH?

HIV and AIDS in southern Africa

Since 2001, new HIV infections across 21 highly affected countries in Africa have fallen by 38%, overall and by 58% in children. This is a significant milestone in the journey towards ending the AIDS pandemic as a public health threat by 2030; the next five years are critical (UNAIDS, 2015).

TARGETS

By 2020	By 2030
90–90–90 HIV treatment	**95–95–95** HIV treatment
500 000 New adult HIV infections	**200 000** New adult HIV infections
ZERO Discrimination	**ZERO** Discrimination

Source: Fast Track: Ending The Aids Epidemic By 2030 (UNAIDS, 2014)

90:90:90 by 2020

- 90% of people living with HIV know their HIV status
- 90% of people living with HIV who know their status are on antiretroviral treatment
- 90% of people on treatment have suppressed viral loads

Source: 90-90-90: An ambitious treatment target to help end the AIDS epidemic (UNAIDS 2014).

The new fast-track targets and ambitious prevention and stigma reduction targets require the broader environment to also stand up and support this accelerated effort. Everyone must work to close the gap to ensure that no one is left behind.

Situational overview of WASH

Water, sanitation and hygiene (WASH) interventions aim to improve hygiene practices and increase access to sanitation facilities and safe water. Access to safe water and sanitation are basic human rights, yet 663 million people across the planet still do not have access to an improved supply of clean water and 2.4 billion people lack improved sanitation facilities. Of these, 48% and 28% respectively live in sub-Saharan Africa (UNICEF JMP, 2015).

Where there is nowhere safe and clean to go to the toilet, people are exposed to disease, lack of privacy and indignity. When communities defecate in the open, disease spreads fast and unprotected water sources are polluted. Diarrhoea caused by poor WASH remains a leading cause of death across southern Africa – particularly for children under five years old and for PLHIV, whose risk of serious illness and death through faecal to oral disease, such as diarrhoea, cholera, typhoid, dysentery and hepatitis A and E is very high. Improved access to sanitation and safe water, combined with improved personal hygiene ,can dramatically improve the health of communities.

While improving the health of communities in general, improved WASH can also make a significant positive impact on neonatal survival. There are clear links between dirty hands, dirty water and infant mortality and these have even more serious consequences for babies born with HIV, or who acquire it during delivery or breastfeeding. As part of its campaign to reduce neonatal mortality, WaterAid is appealing to national governments to: make water, sanitation and hygiene services part of all plans to reduce infant mortality and improve nutrition; ensure that every healthcare facility has clean running water, safe, separate and accessible toilets for men and women, and functional sinks with soap in all treatment and birthing rooms. Healthcare workers should also commit to practising and promoting good hygiene.

Making the most of diminishing resources through WASH and HIV bi-directional integration

International funding has been key to the massive scale-up of the HIV response, but the global economic recession and 'donor fatigue' have seen support to single intervention projects flat-line in recent years. Now more than ever there is a greater need for strategies to maximise available resources by working to combine WASH and HIV platforms to the mutual benefit of both.

Poverty and poor access to education and health care, water and sanitation are key factors driving vulnerability to HIV infection. Integrating HIV into WASH programmes improves community health and reduces stigma and discrimination. Supporting PLHIV with improved WASH helps save money – medicines work better, burden of care costs reduce, with less vulnerability to opportunistic infections; time saved fetching water allows for more productive activities (like school attendance and income generation) in infected and affected homes.

Why is improved WASH and HIV integration important for PLHIV?

WASH is essential for ensuring that people living with HIV continue to live healthy and productive lives and work in harmony with the new life-saving and -extending HIV treatment access. There are **five** critical areas:

Prevention of opportunistic infections and diarrhoea: PLHIV are more susceptible to faecal to oral diseases such as typhoid, dysentery, hepatitis A and E and cholera, as well as skin diseases. PLHIV are six times more likely to acquire a diarrhoeal disease than non-infected persons. Diarrhoea leads to dehydration and malnutrition, depleted energy and movement and subsequent loss of earnings and may reduce the effectiveness of ARVs. Nine out of every ten people living with HIV experience diarrhoea at least once. Babies born to mothers living with HIV are also three times more likely to have diarrhoea (WaterAid 2011).

Personal, food and environmental hygiene also have important impacts on the health of families affected by HIV. Distances to sanitation and waste disposal facilities, as well as to clean water sources, pose a significant challenge and add a burden to household labour. This impacts on members' susceptibility to WASH-related diseases. Securing WASH is securing the future of communities. Households affected by HIV have altered needs for structural access to sanitation, water and waste disposal, due to physical limitations. Poor waste disposal practices and waste water drainage increase the risk of disease in PLHIV. The burden of fetching water is a strain for PLHIV when they experience reduced energy levels, side effects from medication or symptoms of opportunistic infections.

> PLHIV need 2 ½ times the amount of water compared with someone not living with the virus, and also need improved hygiene and sanitation to help prevent opportunistic infections by keeping the environment of the house and toilet clean **(WaterAid 2012).**

Prevention of mother-to-child transmission (PMTCT): Newborns are more at risk from preventable infections, such as sepsis, meningitis or tetanus, all of which are strongly linked to unhygienic conditions, especially lack of clean water. For PMTCT to be effective, the 'six cleans' must be practiced: clean hands, a clean delivery surface, a clean perineum, nothing unclean inserted into the vagina, a clean umbilical cord cutting tool and a clean cord tie. There is also a risk to those who assist HIV positive mothers while giving birth, if they are required to handle soiled linen and wash both mother and baby without adequate clean water, sopa and gloves.

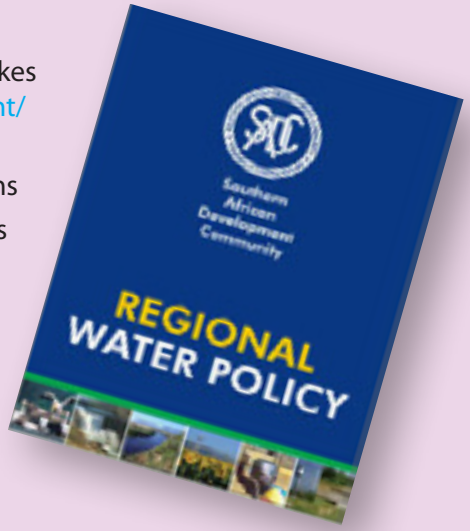
Effective HIV treatment: Antiretroviral medicines (ARVs) are essential to enable PLHIV to lead healthy and productive lives. To take ARVs approximately 1.5 litres of safe water is needed daily (WaterAid). Good WASH practices are essential, as diarrhoea may reduce the effectiveness of ARVs.

Overcoming stigma and discrimination: It is well documented that PLHIV face high levels of stigma and discrimination. Lack of knowledge and education, as well as myths and misconceptions regarding the routes of transmission of HIV, result in PLHIV being excluded from accessing basic services, including safe water and sanitation. Integrated WASH programmes promote inclusivity and ensure all are able to participate fully, irrespective of differences that may include HIV status, gender and disability. They offer an opportunity to include PLHIV in community WASH decisions, improving community knowledge about HIV and reducing stigma and discrimination. People living with HIV should be included in the WASH governance matrix at community level. Their meaningful participation ensures that programmes reflect and address access barriers to WASH services.

Integrated WASH and HIV programmes can help correct mistaken beliefs in communities that lead to discrimination against PLHIV, such as the idea that HIV can be transmitted via poor waste disposal practices of used sanitary wear and condoms, or that people can become infected with HIV through groundwater pollution near burial sites or latrines.

The legal and policy framework for integrating WASH and HIV at regional level

The SADC HIV and AIDS Strategic Framework 2010 – 2015 does not mention integrating WASH and HIV; however, the SADC Regional Water Policy does makes provision for the integration of HIV in some of its sections (http://www.sadc.int/files/1913/5292/8376/Regional_Water_Policy.pdf).



This water policy recognises the impact of HIV at workplace level, in terms of illness and death, which eventually affects productivity and can lead to loss of skills.

The policy also recognises the importance of educating people about HIV in places where HIV prevalence is high, and how good hygiene practices can improve their health.

In addition, the Water Policy encourages the inclusion of all stakeholders in decision-making around programmes, with a priority on PLHIV or those affected by HIV, as well as people living with disability and women and girls, who bear the brunt of home-based care and domestic water collection.

What are the barriers to WASH in communities?

It is important to identify what specific needs or barriers to WASH people in communities have, and why. There may be a technological problem (poor water source) or an exclusion problem (people being discriminated against). These barriers will be different in urban versus rural areas.

A social exclusion model can help identify the kinds of barriers in a community. Social exclusion is the way individuals or entire communities are blocked from or denied full access to resources that are normally available to members with the consequence of affecting social integration within the community (e.g. housing, healthcare, civic engagement, democratic participation, etc.).

PLHIV – and people living with disability – may be unable to access existing sanitation and hygiene facilities and so need either support (increasing the family workload), or to continue with open defecation. Ideally, everyone should be able to access facilities independently, or communities will never be truly open-defecation free (ODF). Therefore, achieving an ODF community must be inclusive of PLHIV and those in the community who are living with disability; a single open defecator can threaten the whole community.

See section 2 of this guide for more information on analysing barriers in the community

Gender, HIV and WASH

Gender is also an important issue to look out for in WASH and HIV integration and in setting up new WASH technologies.

- **More work for women?** Women already carry the greater burden of water related issues – fetching household water, cooking and washing, as well as caring for the sick, older people and people with disabilities. Long hours spent fetching water mean less time available for other more productive work, including attending school or studying.

> *"Having no proper sanitation means that there is a vicious cycle of poverty, disease and bad hygiene…"*
>
> **Nkululeko Nxesi, Director South African National Association of People Living with AIDS (NAPWA)**

In communities with high HIV prevalence, girls are often required to take on additional domestic and agricultural responsibilities leading to them dropping out of school. Access to sanitation, hygiene technologies and to adequate, accessible water supplies saves labour and energy, contributes to diversification of income, leads to improved nutritional status and reduces expenditure on healthcare for women and girls, improving sustainability for families and communities. Always consider gender issues and take into account the different needs of women, men, girls and boys.

- **Maintain safety and dignity!** The hygiene issues involved in caring for a bedridden PLHIV or disabled person also often fall primarily on the women of a household. This includes washing soiled bed linen, and disposing of faeces from bed pans and used sanitary wear. Lack of privacy in carrying out some of these tasks can lead to women and girls being stigmatised and discriminated against, especially if the sick person is HIV positive, or has some other infectious disease.
- **Avoid double stigma!** Communities can be reluctant to share water points or sanitation facilities due to misinformation as to how HIV is spread. Women and girls may also be exposed to faecal-oral disease if they are not aware of proper hygiene practices in their caring duties. In such cases, women face double stigma and may be excluded from community WASH activities, or be excluded from equitable access to WASH resources.
- **Find the hot spots!** Early-warning systems and initial assessments need to include analysis of the impact of HIV at community and household level and take into account new areas of vulnerability due to HIV, e.g. groups such as widows, older people and orphans.
- **Use inclusive approaches!** Be aware that targeting PLHIV may cause or increase stigma. For example providing reduced water tariffs to 'HIV-affected households' may inadvertently stigmatise. It is important to implement WASH interventions across communities to reduce the likelihood of stigmatising households affected by HIV by having an inclusive approach to all people living with disability, as well as older people. Always consider the ways in which your work could negatively impact on those affected by HIV in a community.
- **Know the vulnerability factors!** Consider in what ways staff or community members could be inadvertently placed at direct or indirect risk of HIV, for example, young girls walking long distances to fetch water are at risk of rape and sexual abuse.

For more information on gender and WASH see http://violence-wash.lboro.ac.uk

Progressio/Macpherson Photography

Section 2:

Four WASH and HIV Solution Areas

This section looks at WHAT can be done through a set of simple visual guides that can double up as job aids. Addressing these critical areas is a first step in integrating HIV and WASH efforts. Remember that the issues – and the solutions to them – may be very different in urban and rural areas. Solutions that work in rural areas (such as pit latrines) are much less suitable in urban areas where space is limited and latrines may leak into groundwater sources. Urban areas may have better access to running water or to wells, which can be used in pour-flush toilets or for washing, but it may not be clean enough to drink, or may not be affordable. But in any location, the main priority should be ensuring a clean and healthy environment.

1. Identify barriers to WASH: Inclusive and accessible solutions

Common to any combined WASH and HIV programme is the need to understand the barriers to WASH that exist for PLHIV. Following this, the community as a whole must be supported to improve their understanding of the needs of vulnerable people in their community and those people must be included in the design of solutions to ensure that they will be accessible and suit to their needs.

2. Prioritise personal hygiene

For PLHIV, hygiene is critical for preventing the spread of disease, including pneumonia, TB, diarrhoeal diseases and other faecal-oral diseases, which pose serious health risks to PLHIV and their families. Handwashing with soap is estimated to reduce the risk of developing diarrhoea by 23%.[7] Furthermore, having soap in the home was shown to reduce children's episodes of diarrhoea, acute respiratory infections, eye infections, helminth infections, and school absences.[8] Food hygiene is also essential for all, and especially for those with reduced immunity. Good menstrual hygiene management (MHM) is important for all women and girls, but carers of PLHIV may specifically require training on this to support those they are working with and avoid risk of infection.

3. Promote improved sanitation

Whilst personal hygiene is key to preventing diarrhoeal disease, putting an end to open defecation must be part of an integrated approach. Only about 30% of the population in Lesotho, Mozambique, Swaziland and Zambia has access to improved sanitation facilities, even in urban areas[9]. The promotion of household latrines from the demand and supply sides, with a focus on adapting or designing for specific needs, will reduce the increased risk of diarrhoea for PLHIV and help to break down social barriers and stigma. It is important to remember to consider the entire sanitation chain from containment, to the removal and safe disposal or re-use of waste, particularly in urban areas.

7 Freeman MC, Stocks ME, Cumming O, Jeandron A, Higgins JP, Wold J, Pruss-Ustun A, Bonjour S, Hunter PR, Fewtrell L, Curtis V. 2014. Hygiene and health: Systematic review of handwashing practices worldwide and update.

8 Multiple sources. See https://sanitationupdates.wordpress.com/2015/01/16/washplus-weekly-handwashing-research-in-2014/

9 WHO/UNICEF JMP, 2015

4. Support better water access.

Increasing access to safe water can be life-changing where a programme has the capacity and resources to do this. Where it is not possible, then household treatment of water is an effective immediate solution to unsafe water sources. Affordable, safe drinking water that is close enough not to be a burden[10] is in short supply, especially for families with higher water needs, including those affected by HIV or disability of any kind. Overall, the sub-Saharan Africa region failed to meet the MDG target for safe drinking water, with only 68% of the population having access to drinking water, as opposed to the target of 74%. In Mozambique, 51% of the population has access to improved water sources, although there are high levels of contamination in water supplies; in Zambia, poorer families may not be able to afford to pay for safe water and must walk long distances to access unsafe water[6]. Increasing access to safe water not only reduces transmission of waterborne disease, but also cuts down on valuable time that is used in the collection and treatment of water.

10 http://waterindustry.org

1. IDENTIFY BARRIERS TO WASH: INCLUSIVE AND ACCESSIBLE SOLUTIONS

Identify barriers to WASH for PLHIV:

The barriers to water, sanitation and hygiene access need to be understood and recognised before solutions are identified. These can include:

- **Individual barriers** due to a person's own limitations, for example people who are ill become easily tired.
- **Physical barriers** in the environment, like steep steps to a latrine or a long distance to walk for water.
- **Social barriers,** like negative attitudes of family or society, or the shame in being identified as having HIV.
- **Institutional barriers** such as lack of appropriate policies, insufficient information, or lack of knowledge and skills in an organisation. For example, where no hygiene messages are included in existing HIV programmes.

Progressio/Macpherson Photography

PLHIV are often most affected by the less obvious social and institutional barriers. This can mean that households led by PLHIV or orphans are not included in decision-making structures, thus denying their priority needs with regards to accessing WASH services. Lack of consultation and participation by those affected can lead to inappropriate design or location of facilities, overlooking their needs, and limiting or denying their access to sanitation. Identifying these barriers is crucial for ensuring integration of WASH and HIV.

This simple document contains more practical guidance to help identify barriers to WASH access
http://wedc.lboro.ac.uk/resources/learning/EI_AS2_Identifying_barriers_v2.pdf
And this checklist suggests ways to overcome common barriers
http://wedc.lboro.ac.uk/resources/learning/EI_Inclusive_WASH_what_it_looks_like_v2.pdf

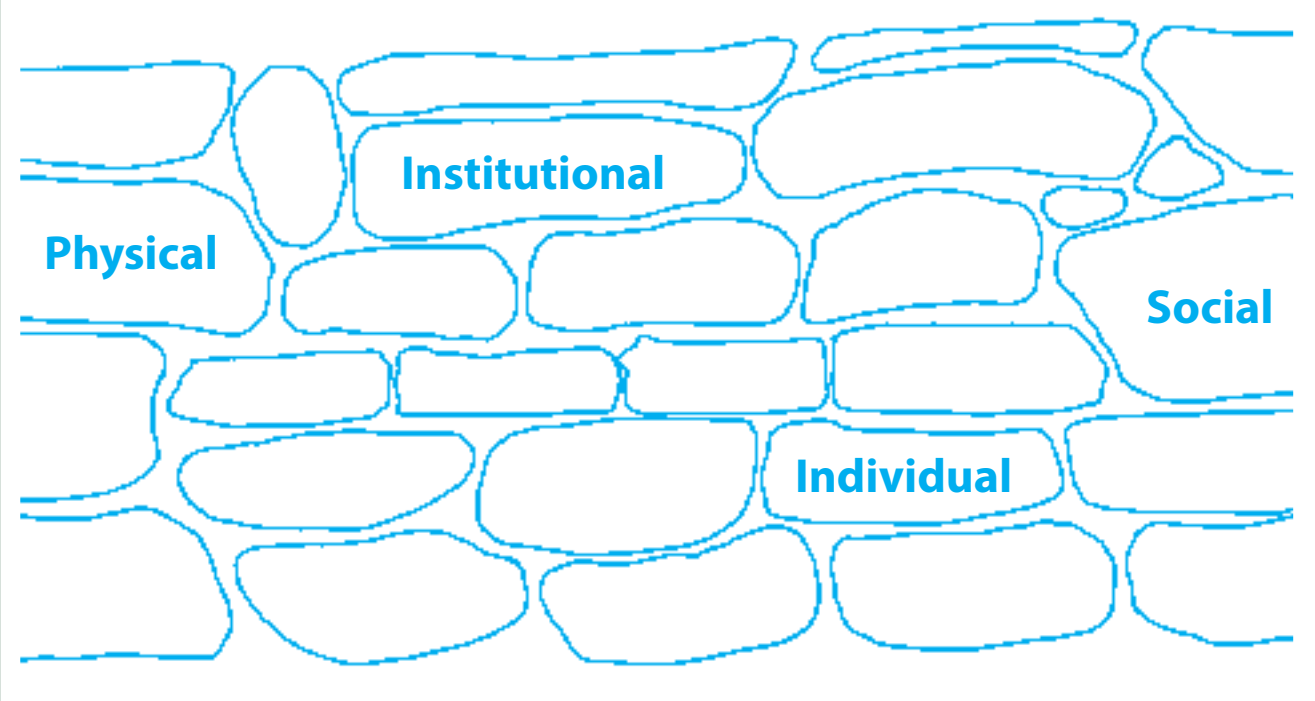


Illustration of the barriers communities may face

Make WASH accessible and inclusive: Once the barriers to WASH have been identified solutions can start to be designed. You should now have a better understanding of whether those solutions need to come in the form of increased access to technologies or by addressing institutional or social barriers. Not all barriers will be able to be addressed within the constraints of a WASH and HIV programme but, for example, although you can't strengthen a person's weak legs, you can make it easier for them to use a toilet by constructing low steps, a seat, or a handrail. As part of any inclusive WASH solution, knowledge and awareness on HIV prevention, treatment and support and on disability are vital.

The understanding and skills needed by WASH and HIV programme staff, including local government, can be improved by training in barrier analysis, and helping them find solutions to address barriers through programming approaches and technical designs.

Challenges faced by PLHIV

Adequate nutrition	• PLHIV need roughly 10% more energy in the form of food. At some stages of their illness, their bodies may be unable to absorb the necessary nutrition from food and they become malnourished and experience 'wasting'. • They may suffer from conditions such as thrush and sores in the mouth that reduce their ability or desire to eat. • When they have diarrhoea or another opportunistic infection, their need for nourishing food is increased. • Where access to water is reduced, PLHIV may be unable to grow sufficient healthy foods to stay strong
Prevention of HIV transmission	• PLHIV have a responsibility to ensure they do not spread the infection to others, or be re-infected with another strain of HIV. Correct adherence to ARVs is an important part of this (treatment as prevention – TasP). • Prevention of mother-to-child transmission: When an infant is infected with HIV during pregnancy, birth or breastfeeding, the child is at much greater risk of dying if the mother has poor access to sanitation and good hygiene.

Access to clean water	• PLHIV need access to clean water in order to take their antiretroviral medicines. • PLHIV need 2.5 times more water than uninfected people. • Without access to clean water, and because of their weakened immune systems, PLHIV are more likely to suffer from faecal-oral diseases and diarrhoea, which further worsens their health. • PLHIV may not be strong enough to fetch water from long distances, further increasing the risk to their health.
Need for good hygiene	• If water sources are far away, PLHIV may not have access to enough water to ensure their hygiene requirements are met, further risking their health.
Access to sanitation	• Having no proper sanitation means a vicious cycle of poverty, disease and bad hygiene for PLHIV. • PLHIV with disabilities as a result of HIV infection, or who have AIDS, may suffer from conditions that limit their ability to access toilets; they may have weak legs and be unable to squat, or they may lose their sight and be unable to find their way safely to the latrine. • AIDS patients, or PLHIV who have an opportunistic infection (OI) may need to use bedpans within their homes. Safe disposal of this waste is an additional problem and a health risk.
Stigma and discrimination	• Stigma and discrimination remain a significant problem for PLHIV and their families. Among other problems, this can prevent them from being included or participating in WASH activities.

For additional sources of information on HIV see the following links:
http://www.aidsmap.com/hiv-basics
http://www.avert.org/

Communities can conduct an accessibility and safety audit of existing WASH facilities to help understand potential solutions related to technical design
http://wedc.lboro.ac.uk/resources/learning/EI_FN2_Accessibility_Safety_Audit_v2.pdf

The WaterAid Compendium of Accessible WASH technologies
http://www.wateraid.org/accessibleWASHtechnologieshas plenty of concrete examples for adapting a range of technologies for specific needs.

Training materials with practical activities can be found here
http://www.inclusivewash.org.au/resource-library-inclusive-wash-training-materials.

Progressio/Macpherson Photography

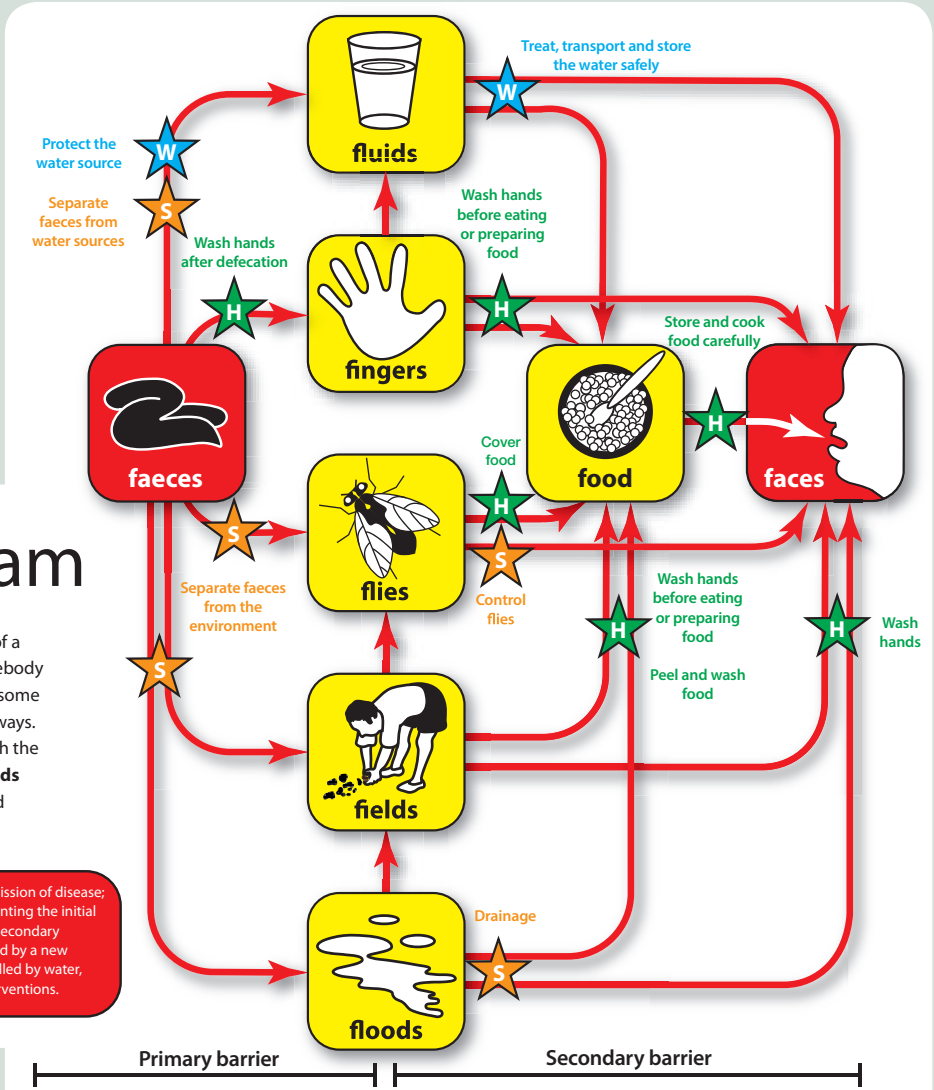
2. PRIORITISE PERSONAL HYGIENE

Stop the spread of germs: People living with HIV are more susceptible to WASH-related illnesses such as typhoid and skin diseases. They are also six times more likely to acquire a diarrhoeal disease, with nine out of every ten people living with HIV experiencing diarrhoea at least once. In addition, babies born to mothers living with HIV are three times more likely to have diarrhoea (WaterAid 2011). As more PLHIV live longer, practicing good personal hygiene becomes more important in ensuring they live long and healthy lives.

The 'f' diagram

The movement of pathogens from the **faeces** of a sick person to where they are ingested by somebody else can take many pathways, some direct and some indirect. This diagram illustrates the main pathways. They are easily memorised as they all begin with the letter **'f': fluids** (drinking water) **food, flies, fields** (crops and soil), **floors, fingers and floods** (and surface water generally).

W WATER S SANITATION H HYGIENE	Barriers can stop the transmission of disease; these can be primary (preventing the initial contact with the faeces) or secondary (preventing it being ingested by a new person). They can be controlled by water, sanitation and hygiene interventions.



Note: The diagram is a summary of pathways: other associated routes may be important. Drinking water may be contaminated by a dirty water container, for example, or food may be infected by dirty cooking utensils.

Adapted from Kawata, 1978

Tackling behaviour change: It can be difficult achieve sustained behaviour change. Generally, hygiene promotion approaches are divided into two groups: participatory, community-based 'total hygiene' approaches, and marketing methods. Most homes have an elderly or infant member so participatory health and hygiene education sessions are an excellent entry point for providing tailored support to PLHIV. Keep the learning community-wide to reduce stigma.

Suggested resources for designing hygiene behaviour change programmes:

CLTS: www.communityledtotalsanitation.org/

PHAST: http://www.who.int/water_sanitation_health/hygiene/envsan/phastep/en/

Components of a personal hygiene behaviour change programme

HOW TO STOP SPREADING GERMS

1 **Hands Washing:** Wash hands with water and soap (or ash) at critical times, especially after using the toilet, changing a baby's nappy, helping a patient into a bed, before preparing food, any contact with blood or other body fluids.

2 **Protect Hands:** Always wear gloves or plastic sheet material on hands to handle soiled items to prevent direct contact with blood or body fluids. Or use big, thick (liquid resistant) leaves (like banana leaves), a spring peg (clothe peg), or other utensil to pick up soiled items.

3 **Wound Care:** Cover hands with gloves or plastic sheet material when cleaning someone else's wounds. If it is not possible to protect your hands, be sure to cover any exposed wounds on your hands or your client with a waterproof bandage/covering.

4 **Clean up Harmful Spills:** Clean up spills of blood, faeces, or other body fluids with a mixture of one part household bleach (Jik) to nine parts water. Wear gloves or plastic sheet materials to protect hands. Protect feet when cleaning body fluids spilled on floors.

Adapted from USAID HIP

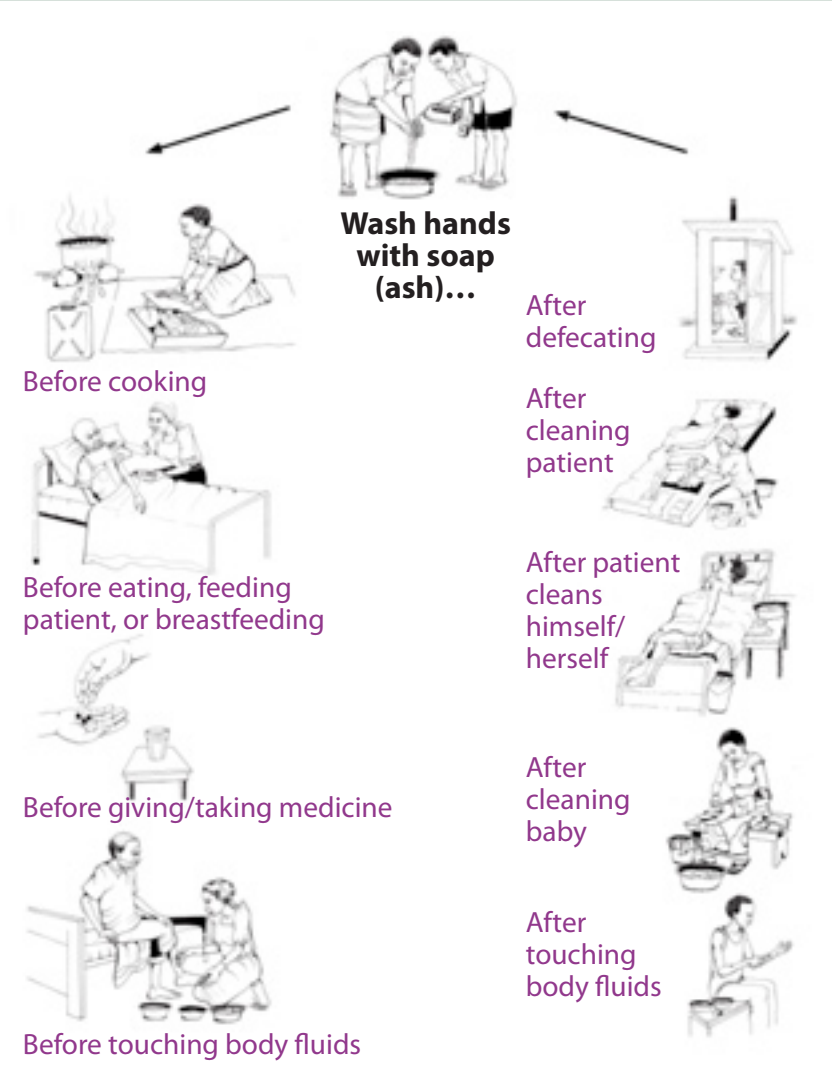
Promote handwashing as a first defence against disease: Encourage all family members to wash their hands the correct way. This is a community-wide activity that again, can have a follow-up with caregivers and community volunteers to ensure homes infected and affected by HIV and chronic illness are supported with behaviour change.

Making handwashing easier by bringing water closer to the home is a critical step in supporting PLHIV. There are many innovations, one very effective one being the 'tippy tap', which can be used by all and is a non-stigmatising approach to household water supply. It benefits everyone and is an excellent way to integrate WASH and HIV efforts.

There are many different ways to build a tippy tap but for a basic manual on tippy tap construction in several languages visit:

http://www.tippytap.org/build-a-tippy-tap-manual

CRITICAL TIMES TO WASH HANDS



Adapted from USAID HIP

http://en.howtopedia.org/wiki/How_to_Make_a_Tippy_Tap_for_Hand_Washing

Focus on food hygiene: Food hygiene is important for everyone, but especially so for community members with weak immune systems. This means the very young, the elderly and those living with chronic illnesses such as HIV. Focusing on good food hygiene practices is an excellent opportunity to integrate WASH and HIV needs. WHO recommends five important food hygiene practices. Share with all; ensure caregivers get a follow-up!

Five steps to safer food

Keep clean

- Wash your hands before handling food and often during food preparation
- Wash your hands after going to the toilet
- Wash and sanitize all surfaces and equipment used for food preparation
- Protect kitchen areas and food from insects, pests and other animals

Separate raw and cooked foods

- Separate raw meat, poultry and seafood from other foods
- Use separate equipment and utensils such as knives and cutting boards for handling raw foods
- Store food in containers to avoid contact between raw and prepared foods

Cook thoroughly

- Cook food thoroughly, especially meat, poultry, eggs and seafood
- Bring foods like soups and stews to the boil to make sure they have reached 70ºC. For meat and poultry, make sure that juices are clear, not pink. Ideally, use a thermometer
- Reheat cooked food thoroughly

Keep food at safe temperatures

- Do not leave cooked food at room temperature for more than two hours
- Refrigerate promptly all cooked and perishable food (preferably below 5ºC
- Keep cooked food piping hot (more than 60ºC) prior to serving
- Do not store food too long, even in the refrigerator
- Do not thaw frozen food at room temperature

Use safer water or treat it to make it safe

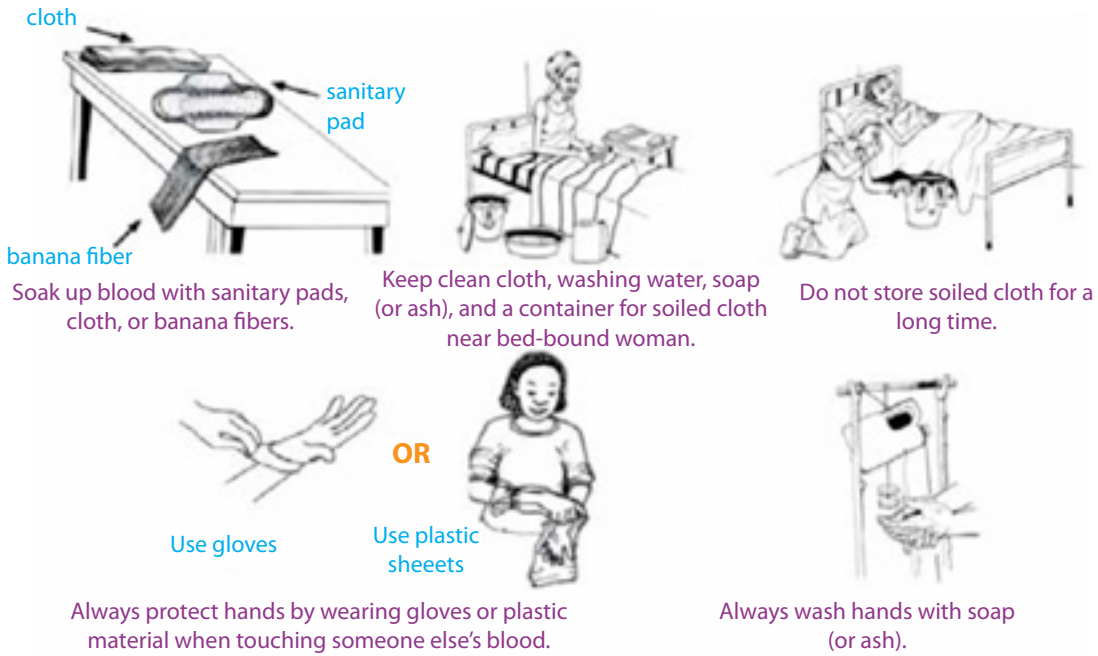
- Use safer water or treat it to make it safe
- Select fresh and wholesome foods
- Choose foods processed for safety, such as pasteurized milk
- Wash fruits and vegetables, especially if eaten raw
- Do not use food beyond its expiry date

Adapted from www.who.int

Menstrual hygiene management (MHM): With the increased availability of HIV treatment and adherence support, more women and girls living with HIV are now healthy and returning to having periods. HIV has a limited lifespan outside the body, but handling fresh blood does carry a risk, if someone has open cuts on their hands. Care should be taken when disposing of freshly used pads, or washing an AIDS patient who is having a period.

There is widespread misunderstanding about how HIV is transmitted. Many believe that used sanitary wear carries a risk of HIV infection. Whilst this is important for HIV programming, correct disposal is also a community-wide issue – incorrect disposal of used sanitary wear encourages pests, such as flies and rats. Tackling the need for safe, hygienic and convenient disposal of sanitary wear for all women and girls in the community is an integration entry point for supporting the more specific needs of PLHIV.

MENSTRUAL HYGIENE MANAGEMENT



Adapted from USAID HIP

For information on the theories around MHM and for examples of activities and teaching points see the *Menstrual Hygiene Matters* manual
http://www.wateraid.org/mhm

Training materials developed for carers of people with HIV in Uganda provide a range of practical advice on how to meet the menstrual hygiene needs of women and girls living with HIV or AIDS. Refer to Module 7.3 of the manual for visual aids from these training materials and Toolkit 7.3.1 for an overview of the training sessions.
http://www.washplus.org/sites/default/files/uganda-wash_hiv.pdf

Facilitating safe disposal

In schools and other public places, the following should be in place:

- A discreet washable container with a lid, in which used sanitary wear can be temporarily stored. This initial point of collection should offer privacy, preferably inside individual toilets and latrines.
- The safe and hygienic collection, transfer and emptying of the containers.
- The final destruction of the sanitary materials through burying, incineration or other method.

DISPOSAL OR CLEANING OF MENSTRUAL BLOOD-SOAKED MATERIAL

NOT RE-USED Soiled rags that **will not be used again** and sanitary pads and banana fibers and other natural materials should be disposed of by:

Burning (preferred method for urban and rural areas). While not ideal, burning used sanitary materials in urban areas is often the best alternative. In both rural and urban areas burning should be carried out as far as possible from living areas, and preferably inside a pit, to limit fine particles entering the air and reduce the risk of air pollution and respiratory diseases. Where houses are very close together and made of flammable materials, burning should be avoided.

Adapted from USAID HIP

NOT RE-USED

Put in latrine (rural areas only). Disposing of used sanitary materials in pit latrines is not good practice, as the materials may take a long time to decompose, as well as including plastics and other non-biodegradable materials. This causes the pit to fill more quickly and another latrine has to be dug.

Double bagged and put in trash (least preferred method for urban and rural areas)

RE-USED Soiled cloth that **will be re-used**:

Soak soiled cloth for at least 20 minutes in a mixture of nine parts water to one part bleach (if available)

Wash with soap and water

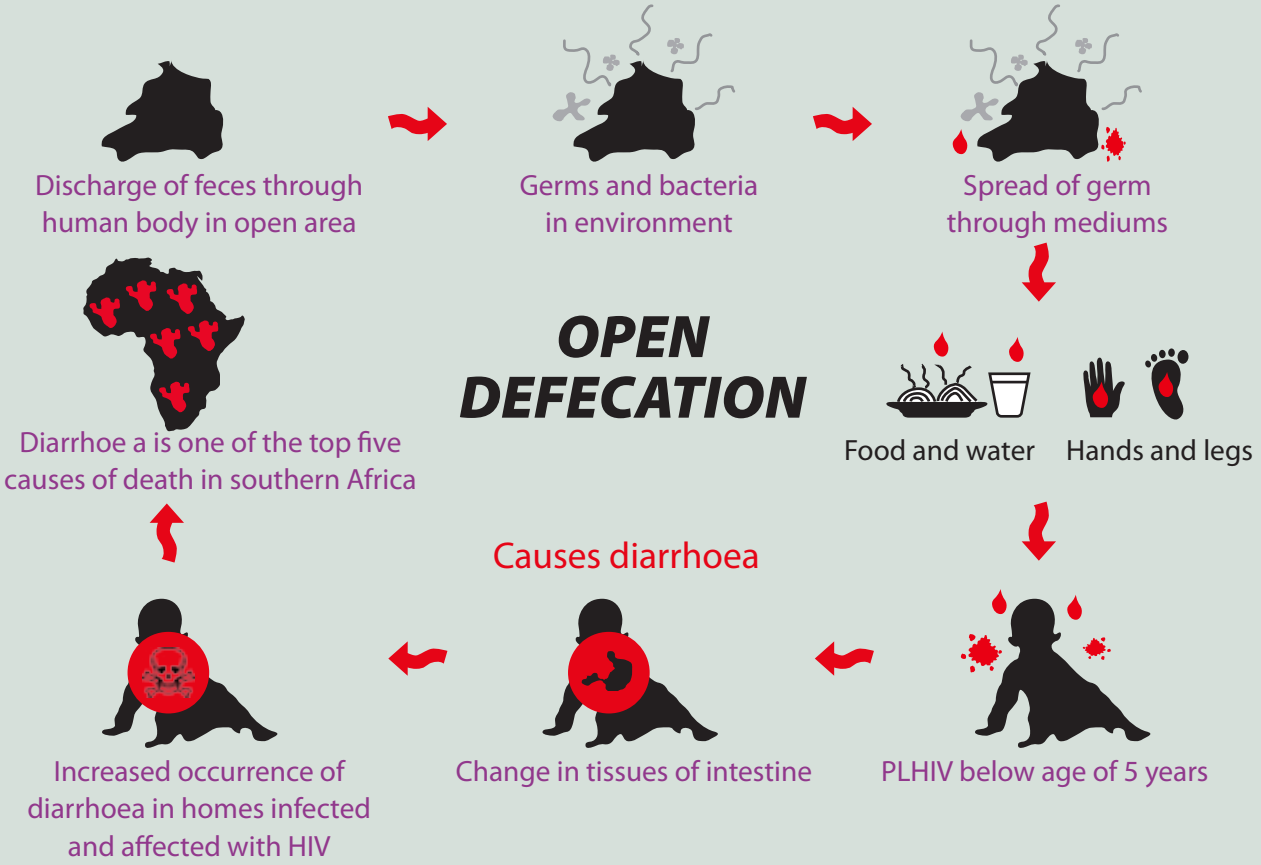
Dry in the sun

NOTE: Always wear gloves or plastic material when handling blood and wash hands afterward

Adapted from USAID HIP

Improved body hygiene (daily bathing) and regular laundering of clothing and bed linen reduce skin infections and skin parasites in the general population, and are even more important for people with compromised immune systems.

Open defecation-free homes and communities: In 2015, 229 million people in sub-Saharan Africa practiced open defecation (WHO/UNICEF Joint Monitoring Program for Water Supply and Sanitation progress report 2015). Twenty-three percent of people in sub-Saharan Africa still practice open defecation and another 27% use unimproved toilet facilities. Between 1990 and 2015, the number of people practising open defecation in sub-Saharan Africa actually increased, and the region now accounts for a greater share of the global total than it did in 1990 (JMP, 2015). Open defecation is one of the leading causes of diarrhoeal disease as germs and bacteria can be much more easily spread through the environment, especially where people are using surface and groundwater for hygiene purposes.



https://www.behance.net/gallery/15453005/OPEN-DEFECATION-National-Poster-competition-winner

Promote inclusive, patient-friendly latrines in the household: Household latrines can potentially reduce diarrhoeal disease by an average of 36%.[7] Even without adaptations for specific needs, there are several types of latrine that are commonly used throughout southern Africa and some may be more suitable for PLHIV than others. These range from very simple, low cost options, to sophisticated water-consuming ones. The input of WASH specialists is needed to ensure the correct siting and safe design of latrines.

It is important that people are given a range of options and can decide which they would prefer. With guidance from WASH specialists and the right supply chains in place, families can build latrines for themselves. For people living with HIV or other chronic diseases and for people who are older, living with disability, or pregnant, there may be challenges to using a latrine. Yet, several simple solutions are available to make latrines more accessible. Rails or handles next to the toilet help people to stand up after using the toilet, while extra space inside the toilet and access corridors allows wheelchair access. The entry point for these improved accessibility options is not necessarily HIV, but care of the elderly and those living with disability at community level. This reduces stigma, while ensuring support where needed. Once a community-wide session has been conducted, caregivers should be followed up and their specific challenges discussed. Co-ordination with WASH professionals and health extension workers can facilitate latrine construction, including rallying of labour to help dig the pit and build the superstructure for vulnerable people. These approaches improve WASH efforts community-wide and at the same time, help reduce stigma against PLHIV and people who are elderly or living with disability.

7 http://www.lboro.ac.uk/well/resources/fact-sheets/fact-sheets-htm/Household%20Sanitation.htm

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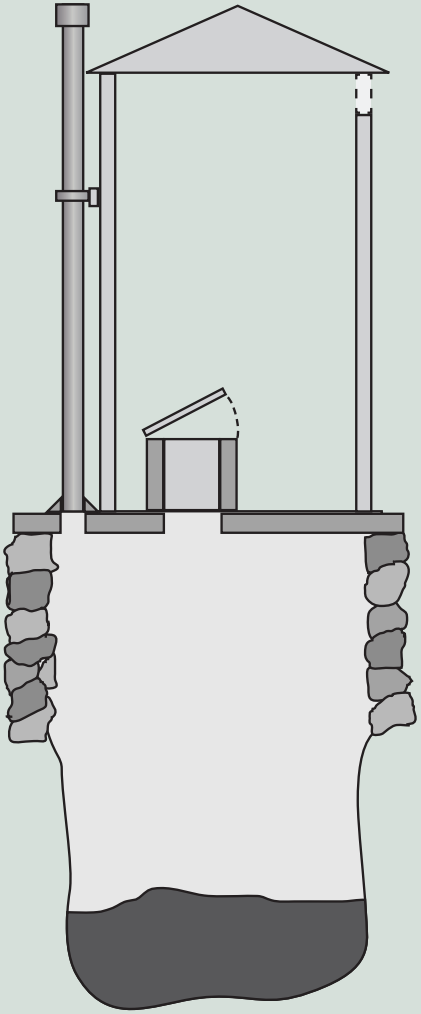
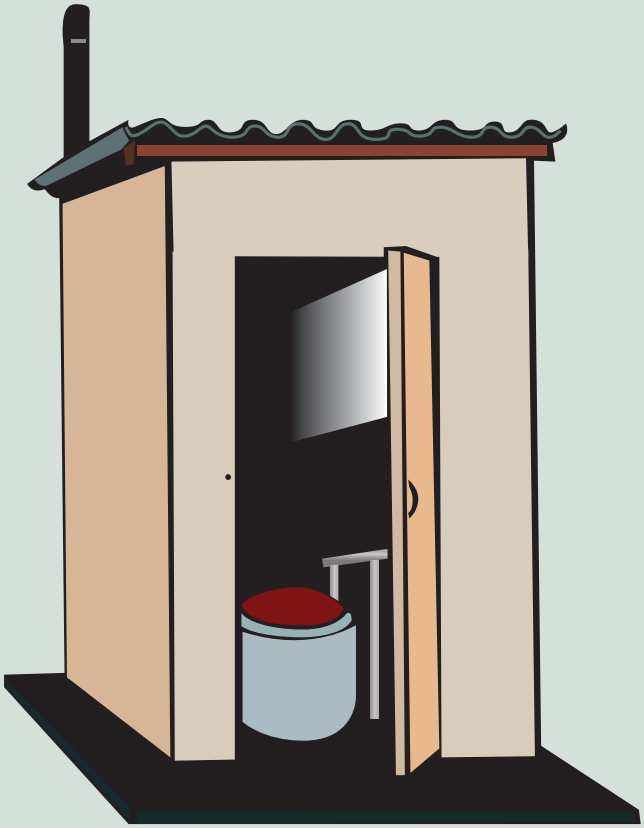




http://www.washplus.org/sites/default/files/latrines-access.pdf

Follow this link to get information on simple latrine design
http://www.toilettwinning.org/serious-stuff/latrine-technology/

For a range of latrine options in a simple format go to
http://www.wateraid.org/~/media/Files/Global/Publications-not-for-publications-library/Household-sanitation.pdf

See the compendium of accessible WASH technologies for examples of latrines that are suitable for a range of people living with disability
http://www.wateraid.org/accessibleWASHtechnologies

Consider all steps of the sanitation chain, including maintenance of the facilty: In rural areas the latrine can be the entire sanitation solution, but if it is not maintained, it will fall into disrepair. WASH expertise is required to site the latrine, advise on construction and ensure that it is not placed in an area where the contents can leach into groundwater that may feed wells. For community-managed latrines and in urban areas you also need to consider: how to collect and store excreta, removal and transport; treatment; and disposal or use. In a community, PLHIV may have less disposable income than others and may not be able to afford to have pits emptied so consider options which avoid this step, such as composting latrines, which can also be a source of income in the right areas.

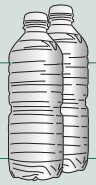
This eCompendium lets you check the strengths and weaknesses of each technology, and links to many detailed resources too
http://ecompendium.sswm.info/

For more information on each of the steps in the sanitation chain
http://www.wateraid.org/~/media/Publications/Wastewater-treatment.pdf

Akvopedia has a range of resources, mostly on appropriate technologies and approaches. Most pages then have links to more detailed guides if needed
http://akvopedia.org/wiki/Main_Page

What are the needs of PLHIV?

Water need	Amount of water required
Basic water for drinking, food preparation, laundering and personal hygiene	20 litres per day (recommended minimum)
Water for taking antiretroviral medications	Additional one and a half litres per day
Water for replacement feeding of infants under six months	Minimum one litre per day (excluding water needed for cleaning)
Water for replacement feeding of infants over six months	Two litres per day (without water needed for cleaning)
Cleaning PLHIV and laundering clothes and bedding (daily during bouts of diarrhoea), other water	20–80 litres per day
Total	**Approximately 100 litres per day**



Adapted from Nqwanya & Kqathi, 2006, Molosa, Potter and Mvula Trust, 2007, WSP,2007

Advocate for, or support, water source construction: Women in water-stressed regions walk on average five or six kilometres every day to get water to their homes (WHO 2004). The average weight of a container of water is nearly 20 kilograms (Environmental Health 2010, SA study). Households infected and affected by HIV are often poorer in energy and economy, as well as being labour constrained, so this distance and weight is an extra challenge. Looking at this through a gender and HIV lens, women in HIV-affected households generally bear the brunt of caring for PLHIV and children, as well as household chores. Distant water points make this harder, as they also need time to go to and from water points.

There are many different technologies available to provide a safe water supply, with a range of applications and associated costs. In rural areas with springs, simple piping systems can be used to bring water closer to households. Alternatively, hand-dug wells make affordable alternatives to boreholes and community-wide rainwater harvesting can be successful under certain conditions. WASH expertise is required to ensure wells are appropriately sited (not harming other's access to water) and secured, as well as to advise on the most appropriate pumping device to accompany the well. Sometimes, a carefully constructed headwork on a water source, and an adapted pump handle can make all the difference to a young caregiver, elderly guardian or PLHIV; something as simple as a well-maintained borehole supports HIV programming.

Remember to include the cost of on-going maintenance when you raising funds for water supply, to ensure maximum benfit for the longest period.

To select a technology, you can use the WaterCompass to guide you through the process http://www.watercompass.info/

Akvopedia lists various technologies http://akvopedia.org/wiki/Main_Page

Wikiwater has good summary pages on different options http://www.wikiwater.fr/home.html

The Compendium of accessible WASH technologies shows how water sources can be adapted for various needs.
http://www.wateraid.org/accessibleWASHtechnologies

This tool at :http://www.ircwash.org/projects/life-cycle-costing-tools takes you through the critical questions to estimate the on-going costs that will have to be covered.

Encourage self-supply: It is also possible for a community to improve their own supply. There are many examples of this. Areas with streams or rivers close by can investigate the possibility of creating a small dam to bring water closer to the community, taking care to ensure that there is no risk of flooding during times of heavy rain. WASH experts can help ensure that damming a water source will not reduce water supply downstream.

Where the water source is far from homes, simple ferro-cement water tanks can either harvest rainwater or be part of community schemes to fetch and store water, with the aim of helping the elderly and other vulnerable people, including those living with HIV. Instead of throwing wastewater away, communities can use it for watering vegetables or fruit trees around their homes. This reduces waste and the costs of buying fruit and vegetables, and improves household nutrition, something which is vital for PLHIV. Communities can also improve hand-dug wells by lining them or adding lids and locally made lifting devices. PLHIV should be represented at community meetings and at every stage of the self-supply process. Whatever system you choose, remember to build in maintenance costs.

Progressio/Macpherson Photography

For more information on self-supply see http://www.rural-water-supply.net/en/self-supply
This tool at :http://www.ircwash.org/projects/life-cycle-costing-tools takes you through the critical questions to estimate the on-going costs that will have to be covered.

Ensure continued supply: Involve women in the planning and supply of water, as they are the most affected group. A World Bank evaluation of 122 water projects found that the effectiveness of a project was six to seven times higher where women were involved than where they were not (quoted in http://www.unicef.org/esaro/7310_Gender_and_WASH.html). The same principle applies to PLHIV – nothing for them without them. Ensuring that PLHIV, the elderly and vulnerable are consulted and included on committees can help ensure that their needs are heard and met. This may mean that some meetings need to be closer to the homes of PLHIV or the elderly, or a little later so they can get their chores done, to ensure that they are able to attend.

Water point committees are a commonly used way of ensuring the sustainability of a water point. A committee can be trained to carry out simple maintenance and repairs and to collect fees from users when the need arises, but this should always be alongside a wider approach in co-ordination with local authorities to ensure the availability of spare parts and skilled technicians, for example. Where committees are formed, PLHIV should be represented on the committee and have the opportunity to have their needs heard by the community. Remember that committees can only do so much. External support, preferably from government, is essential to keep services running.

Progressio/Macpherson Photography

Beyond the home: Clean and adequate water supply at local health facilities is an important way to support the needs of PLHIV and the community, especially with the expansion of PMTCT programmes, as well as the decentralisation of programmes for HIV treatment and care.

Poor environmental conditions in health care facilities contribute to maternal and neonatal mortality by increasing the risk of infection during and shortly after delivery. Infections account for 1.2 million neonatal deaths each year and for 15% of maternal deaths.

Installation of low-cost, portable handwashing and simple drinking water stations at health facilities, along with treatment of drinking water and health care provider training, encourages communities to adopt safe water storage and improved handwashing.

In urban areas, work with local authorities

In urban areas, increasing water quantity generally means working with local authorities to bring yard taps or household connections to priority households, such as those affected by HIV, or families with members living with disability or chronic illness. This can be very effective. Alternatively, you can negotiate for the installation of water kiosks or standpipes at regular intervals within communities.

A significant issue regarding water access in urban areas can be affordability, which can have a significant impact on how far a household has to go to find affordable water and the time spent in long queues to access it. In addition, water supplies may be restricted to only a few hours a day, such as in Zambia.

It is important to note that HIV is much more than a public health issue, as it also affects household productivity. Households with PLHIV face increased poverty owing to reduced productivity and are thus unable to meet the commercial costs of accessing quality water. This should be a key consideration, especially when designing programmes to improve access to quality water within HIV-affected households. In this case, exploring the possibility of special reduced tariffs for households with special needs can make a significant difference, again targeting all vulnerable households and communities, rather than just those affected by HIV, to avoid encouraging stigma.

Keep water safe: Even when a community has a safe water supply it has been shown that most contamination happens after the point of collection. Sometimes the simplest intervention can make the biggest difference. Community knowledge sessions on good water storage in the home, as well as schemes to replace old and worn water containers, are ideal ways to integrate the needs of PLHIV into community-wide WASH support.

HOW TO TAKE CARE OF DRINKING AND COOKING WATER

Back to basics: Sometimes the simplest intervention can make the biggest difference. Community knowledge sessions on good water storage in the home as well as schemes to replace old and worn water containers are ideal ways to integrate the needs of PLHIV into community-wide WASH support.

TRANSPORT

Carry your water home in a container with a lid

Do NOT transport it in a container without a lid

SERVING

Serve the water without letting anything dirty (such as your hands or a cup) touch it

Do NOT scoop the water out with a cup or a bowl

STORAGE

Store water in a container with a tight fitting lid

Do NOT store in a container without a lid or with a lid that does not fit tightly

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Water treatment: Where there is no safe water source, unprotected water sources can become contaminated with bacteria from faeces, causing diarrhoea. When the quality of water is seasonal, in need of a larger scale intervention, or has been subjected to contamination, then water treatment options are a priority for homes with PLHIV. Supporting household water treatment supports PLHIV.

Adapted from CAWST

Adapted from CAWST

CAWST have many useful training materials, posters and activity suggestions for household water treatment http://resources.cawst.org/topic/household-water-treatment-and-safe-storage

Progressio/Macpherson Photography

Section 3:

Planning for Change

Planning for WASH and HIV integration within your organisation

Respond to the barriers: Research has already been done that you can build from. Within your organisation you may need to set up teams to work together to overcome them. The first step is to know what the integration issues are in the communities you support.

This checklist can help.
Investigate what issues are facing you and your work in communities. All the **yes** answers should form the basis of internal planning that includes looking for additional capacity or partnerships in the areas you are not strong in. Use Section 2 to build a technical programme of action.

Type of WASH/HIV Integration Barrier	Yes	No
Barriers to improved water supply		
There are high water tariffs in urban areas		
There are long distances between homes and water points in rural areas		
There are seasonal changes in water availability and quality		
Stigma prevents PLHIV from using community water points		
Poor water quality, including high salinity and iron content, is a big issue		
There is limited treatment and disinfection of water at household level, despite questionable water quality		
There is poor maintenance of water points		

There is a limited number of water sources leading to long lines		
Barriers to improved sanitation		
The poor, generally including PLHIV, cannot afford to construct improved latrines without subsidies		
Most existing latrines are simple pit toilets which are often unsanitary		
Unlined pit latrines frequently collapse due to the sandy soil, particularly during the rainy season		
Stigma prevents PLHIV from using community facilities		
Barriers to good hygiene		
Low levels of good handwashing behaviour		
Significant proportion of latrines are contaminated with fecal matter		
Limited hygiene education		
Barriers to home-based care provision		
Coverage of home-based care is very low		
Home-based care volunteers are poorly trained, generally		
Home-based care volunteers are poorly trained with regard to hygiene		
Other issues		

Establishing partnerships for integrating WASH and HIV

Tackle the policy environment: The main stumbling block to WASH and HIV integration is inadequate national integration of policies, guidelines and frameworks. This has resulted in ad hoc implementation.

This checklist can help.
Investigate the policy issues you are facing. All the **no** answers should form the rationale to improve the co-ordination structures for integrating WASH and HIV.

Analysis of WASH/HIV Policy Environment	**Yes**	**No**
Policy relevance		
Do current national policies for HIV adequately reflect the linkages between water, sanitation and hygiene and home-based care where you work?		
Existing platforms for HIV and WASH		
Is there a national WASH forum or technical working group that meets regularly?		
Is there a national HIV forum or technical working group that meets regularly?		
Is there scope to broaden the mandates of existing platforms to include WASH and HIV integration? *(rather than creating new structures or platforms)*		

Do the existing platforms have a critical mass of stakeholders who attend from all key government ministries (health, water, etc.), relevant UN agencies, local and international NGOs, and community level representatives		
Do key stakeholders have adequate buy-in to the WASH/HIV integration initiatives?		
Are women adequately represented in these platforms (women are disproportionately affected by WASH and HIV challenges compared to men, and they are responsible for most WASH and HIV chores at household level)		
Are people with disabilities and other marginalised groups, including PLHIV, adequately represented on these platforms *(integration outcomes cannot be fully achieved without the participation of all groups)*		
Is there an institutionalised *reporting system* on WASH and HIV integration?		
Capacity to integrate HIV and WASH		
Do national policies have clear implementation plans?		
Are there strong linkages at community level?		
Is there a community level forum where these issues can be discussed?		
Is there a dedicated budget for WASH and HIV integration?		
Are key groups, such as PLHIV, included on any water point committee?		
Are there community-based volunteers with the capacity to educate communities on health and hygiene, monitor the hygiene and sanitation issues as well as other duties?		

Relevant platforms for WASH and HIV advocacy and co-ordination

Country level HIV and WASH platforms

Maintain and update a list for where you live and operate. This table provides a good starting point and is drawn from the gap and needs assessment findings in the four countries.

	Lesotho	Swaziland	Mozambique	Zambia
National	• National Sanitation Taskforce • Global Fund Country Coordinating Mechanism • CSO Health Advocacy Forum, Development Partners Consultative Forum (DPCF) • WASH/HIV Technical Working Groups	• National WASH Forum • National Emergency Research Council on HIV and AIDS Co-ordination Meetings • WASH/HIV Technical Working Groups	• Common Fund Partners' Meetings • *Conselho Nacional de Combate ao HIV e SIDA* (CNCS) Coordination Meetings • Grupo de Agua a Saneamento meetings – chaired by DNA • CNCS Technical Working Groups • UN WASH Cluster Meetings • *Fundo de Investimento e Património de Abastecimento de Água* (FIPAG) Meetings • Monaso (Mozambican Network of AIDS Services Organisations)	• National WASH Forum • Zambia National AIDS Council (ZNAC) Coordination Meetings • ZNAC Technical Working Groups

	Lesotho	Swaziland	Mozambique	Zambia
Provincial/ Towns		• Regional Health management Teams • Regional Multi-Sectoral HIV and AIDS Coordination Committee • Regional Development Teams • Regional Environment Committees • Municipality HIV and AIDS Teams	• *Apoio Secretarial ao sector de Agua e Saneamento* (AIAS)	• Provincial HIV/ AIDS Taskforces • Provincial Health Management Team • Provincial Development Coordination Committee
District	• District Disaster Management Teams • Health Partners' Forum meetings • District Health Management Teams (DHMT)	• *Tinkundhla* Multi-Sectoral HIV and AIDS Coordination Committee • Inner Council • Secretary of *Inkundhla*	• CNCS Coordination Meetings • FIPAG Meetings • Monaso	• District WASH Committee • District HIV/AIDS Taskforce • District Health Management • District Development Coordination Committee
Community and village level	• Community Councils/ Community Meetings • Awareness-raising campaigns • Community-Based Volunteers • Water Point Committees	• Community Development Committee • Community-Based Volunteers • Water Point Committees • Chiefdom Multi-Sectoral HIV and AIDS Coordination Committee • *Kagogo* Centres	• Water Point Committees • Community-Based Volunteers • Community-based Organisations	• Community Development Committees • Water Point Committees • Community-Based Volunteers • Community HIV/ AIDS Taskforces

Working with structures at community level

1. Local clinics are an important part of a community. It is important that they demonstrate good WASH principles to set the right example for community members; they should have high quality facilities and good WASH standards. If their WASH facilities are inadequate, local clinics should be at the heart of campaigning for improved WASH within their communities. Every healthcare facility should have clean running water, safe, separate and accessible toilets for men and women, and functional sinks with soap in all treatment and birthing rooms.

The community in general, and PLHIV in particular, access most medical services and information regarding health and hygiene through local clinics. Clinics provide health talks whenever patients visit the clinic. Health centres play a central role in the provision of HIV services and because of their role in educating communities on the importance of good hygiene and WASH issues, they can also help with integration of WASH and HIV at the local level. They are an ideal co-ordinating point for WASH and HIV integration interventions in local institutions and in helping identify solutions to community hygiene issues, such as safe disposal of used sanitary wear and condoms.

2. Healthcare workers to commit to practising and promoting good hygiene. It is important that healthcare workers set a good example to communities regarding WASH and HIV issues. For example, they must demonstrate excellent standards of hygiene in everything they do; as well as taking action to correct any HIV-related stigma and discrimination in the community.

3. Working with local leaders. This is particularly important to correct mistaken beliefs that contribute to HIV-related stigma and discrimination e.g. *"People can become infected with HIV due to groundwater pollution near burial sites" and "people (playing children) can become HIV infected through poor waste disposal practices of condoms and sanitary pads".* Local leaders include traditional, religious and political leaders and others. They influence opinions and can play an effective role in addressing HIV-related stigma. Programme activities can include orienting leaders on HIV and its relationship to access to WASH services. In turn, local leaders can be supported to utilise community platforms for education purposes.

4. Support caregivers of the chronically ill, those with disability and those with AIDS**.** This can be an ever-changing group and with the shift from institutional to home-based care, long-established skills-building to help this group cope better is critical. Lack of knowledge and skills in multi-water use techniques can lead to excessive water usage during home-based care. For example, water used for bathing bedridden patients can be safely used to wash clothes or water vegetables (avoid watering the leaves), or to clean latrines. Limited knowledge of hygiene practices can result in opportunistic infections. This can create tension within communities.

5. Community-based volunteers operate at health centres, supporting health ministries by disseminating information, providing community education and client follow-ups, among other issues. Results from focus group discussions with CBVs revealed that their community level work integrates WASH and HIV, as they conduct community mobilisation and education activities on general cleanliness and hygiene, provide care and support to homebound and critically ill patients and identify community health needs. They also provide counselling services to patients. However, community-based volunteers in general, lack the resources they need – such as gloves, soap, detergents and others – to care for and support bedridden patients.
In some countries, these resources were at times available through the local clinic, but not always.

6. Water point committees and local authorities: WASH programmes now engage communities in the development and maintenance of water sources in both rural and urban areas as a matter of routine. This may involve engaging local authorities who are responsible for water supply. Such committees are an ideal place to build capacity on issues to do with PLHIV. If there is no active committee, work to establish one. By training and supporting this committee they should see the need to include PLHIV, the elderly and those community members living with disability in their decision-making.

Gender, culture and social inclusion – tackling stigma head-on

Introducing the SAfAIDS Community Dialogue Model

The SAfAIDS Community Mobilisation and Dialogue Model helps to overcome the challenge of unequal voice in the community by engaging key groups to discuss and agree on the issues separately first, before bringing everyone together to discuss (dialogue) and reach agreement on possible solutions.

Community dialogues provide opportunities to raise awareness among community members and leaders on the importance and benefits of integrated WASH and HIV, and to gain the support of these key groups, while encouraging people, including PLHIV, to discuss their concerns and identify solutions together. Everyone in the community – religious, traditional, community leaders and others, government authorities, healthcare and WASH providers – is able to share their opinions, including those who may be less willing to share their thoughts and concerns (women and girls especially, as well as PLHIV and those with disability).

In the case of WASH and HIV integration, key groups may include:

- Community leaders and custodians of culture
- Healthcare providers, caregivers of PLHIV, PLHIV themselves and those with disability
- Women and girls
- Men and boys.

Remember that with improved access to ARVs, many older people may also be living with HIV and may have special WASH needs. Make sure this group is included in your consultations.

After engaging separate groups and building consensus within them on their key issues, broader community dialogues bring together all stakeholders and provide an open and non-confrontational platform for discussion and planning. The model on the next page illustrates the various steps in the community dialogue model.

1. Find your entry point! Engage a local partner, someone who knows the community, if you don't.
2. Remember your protocol. Always approach local authorities first!
3. Find and convince the local leaders! You need their buy-in.
4. Women and girls dialogue – spend a day with women in the community to get their concerns and opinions
5. Men and boys dialogue – give men their space too – issues to do with children and young people are the responsibility of both parents
6. PLHIV, the elderly and people with disability. It is vital that they are included in discussions (you may want to separate girls and boys, so that both are free to raise their issues)
7. Find the custodians – who do community members turn to on issues of culture and tradition?
8. Community dialogue – everyone together and share what you have learned

The 4 A's approach

The Four A's (Assess, Agree, Assist, and Arrange) is an approach to help programmers identify the needs of those they are supporting – this could be the general community if you are a WASH practitioner, or families infected and affected by HIV if you are a PLHIV support agency. When used together with a WASH Assessment tool, it can be an ideal way to assess the integration points for WASH and HIV.

Below is a table that will guide the approach.

Step	Goal	Action to Take
Assess	Identify current WASH practices/support to PLHIV Congratulate on good practices/support observed Discuss practices/support that need to be improved	Use the WASH and PLHIV support assessment tools
Agree	Agree on one practice/support area to improve, from the need-to-improve list If the ideal behaviour is not possible, agree together on the small doable actions that can be done	Use the job aids in Section 2
Assist	Demonstrate the new practice, if appropriate Identify potential problems/barriers and discuss how to solve them Develop a plan of action together Provide support on where to get help or materials (your HIV and WASH platforms should make good contact points)	Use the job aids in Section 2 Use/update your co-ordination table in Section 3
Arrange (follow-up support)	Set a date and time for your next visit Make a record of the WASH/PLHIV support assessment and the practice/support area to improve	Use the notes section at the back of this guide or your field notebook

WASH and HIV integration assessment tool

Here is a checklist to help with the assessment and negotiation stage of the 4 A's approach. Establish where the household or community is on the scale. There may be more than one option, so **tick all that are appropriate**. If there is room to improve, discuss the improvements can be made, which option they can move to (and what assistance, if any, they will need to do so).

Assessment Area	Options for Negotiation Scale					
Disposal of feaces	Open defecation ☐	Open defecation-designated area, digging and covering with soil ☐	Pit latrine ☐	Pit latrine with water/ tippy tap ☐	VIP latrine with tippy tap ☐	PLHIV/disability friendly latrine ☐
Safely disposing of baby's faaces	Open defecation ☐	Scooping baby's faeces into pit latrine or other ☐	Using potty and removing to pit latrine ☐	Assisting baby in pit latrine ☐		
Washing hands with soap/ash after defecation	No hand washing after using the toilet ☐	Covered bucket outside toilet ☐	Tippy tap ☐	Tippy tap and soap ☐		
Keeping water sources clean	Livestock and people use unprotected water source ☐	Livestock separated from water source and water source covered ☐	Livestock separated and area around covered water source kept clean ☐			
Safe water handling	Open pot or bucket ☐	Covered pot or bucket ☐	Clean water scoop to dispense water from covered pot or bucket ☐	Clean container with a tap for dispensing water ☐		

Assessment Area	Options for Negotiation Scale				
Cleaning house and compound	Household and yard untidy ☐	Family engages in regular cleaning chores inside and out ☐	Household and yard well planned and tidy ☐		
Keeping latrine clean	Dirty latrine ☐	Latrine swept regularly ☐	Latrine cleaned with disinfectant regularly ☐	Latrine kept covered and swept/ washed after each use ☐	
Essential times for hand washing	Before cooking ☐	Before breastfeeding ☐	Before eating ☐	After baby defecates ☐	After defecation ☐
Good food hygiene practices	Keep food covered ☐	Cook food thoroughly ☐	Reheat food to a high temperature before eating ☐		
Menstrual hygiene management	Wash reusable pads with soap and dry in the sun ☐	Dispose of pads directly in latrine ☐	Place used materials in sealed container then dispose safely ☐	Burn used materials in pit or incinerator ☐	Use gloves/ bags when handling menstrual blood and products from a bed ridden person ☐

Section 4:

Examples of WASH and HIV Integration – Quick Look Case Studies

Lesotho

Doubling-up!

In Lesotho, the Ministry of Health (MoH) delivers both WASH and HIV programmes, often simultaneously. WASH and HIV awareness raising are both covered during health talks open to all community members and given daily at secondary healthcare facilities, as well as during outreach programmes.

Care facilitators monitor the hygiene status of homes of PLHIV and child-headed homes. They also educate primary caregivers on proper WASH practices when caring for the sick.

Local health centres distribute gloves for home-based care HBC, which primary caregivers are encouraged to use consistently when bathing patients and changing their soiled diapers and sanitary wear. Support does not stretch to disinfectants for the bedridden, which remains a challenge.

Mozambique

Mainstreaming!

Water & Sanitation for the Urban Poor (WSUP) works in the slums of Maputo and Matola to improve water and sanitation.

The organisation's on-going work in Maputo mainstreams HIV in community WASH interventions. The programme emphasises environmental health and hygiene, particularly the four aspects covering:

- The importance of maintaining clean environments by ensuring good drainage systems to prevent opportunistic infections, especially in people living with HIV.
- The importance of clean water for breastfeeding mothers, especially for those who choose to substitute breast milk with formula feeding.
- Specific hygiene practices for PLHIV, including hygiene during menstruation.
- Economic empowerment options for households impacted by HIV so that they can improve their WASH infrastructure.

Swaziland

Champions for change!

Nazerene Compassionate Ministries (NCM) utilises Rural Health Motivators as community entry points when designing their WASH programmes.

RHMs are a part of the Swaziland Ministry of Health and work at community level to facilitate health and hygiene education and promotion. They work with families infected and affected by HIV, as well as other vulnerable groups such as the physically challenged and vulnerable children.

Reports from NCM programme informants were that the programme had been very effective and instrumental in community-based WASH planning as the RHMs were part of the community water-point committees. This way the needs of PLHIV and the physically challenged were better met during implementation.

Zambia

Small Do-able Actions!

In Zambia, programmes are exclusively HIV or WASH-oriented, aggravated by poor linkages between national policy documents. Despite the restrictions of the policy environment, Development Aid from People to People (DAPP) has begun to develop integrated programmes for the children they support. This is mainly though targeting PLHIV and/or their support groups with:

- Training in sanitation and well construction.
- Construction of pit latrines.
- Provision of water filters to PLHIV who access drinking water from unprotected sources.

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Notes

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