



Regis Sicheuunga's grandchildren eating dinner, Hambale, Chipenbele, Zambia. ID: 12503. Photo credit: Anna Kari.

INTEGRATED APPROACH TO HIV AND WATER, SANITATION AND HYGIENE IN SOUTHERN AFRICA A GAP AND NEEDS ASSESSMENT



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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARM	Águas da Região de Maputo (Waters of the Maputo Region)
ARV	Antiretroviral
CBC	Community-Based Organisation
CBV	Community-Based Volunteer
CHIMSHACC	Chiefdom Multi-Sectoral HIV and AIDS Co-ordinating Committee
CNCS	Conselho Nacional de Combate ao HIV/SIDA (National Council to Combat HIV/AIDS)
CSO	Civil Society Organisation
DACA	District HIV/AIDS Co-ordination Advisors
DAPP	Development Aid from People to People
DHS	Demographic Health Survey
DNA	National Directorate of Water
DPCF	Development Partners' Consultative Forum
EU	European Union
FGD	Focus Group Discussion
FIPAG	Fundo de Investimento e Património de Abastecimento de Água
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
JMP	WHO/UNICEF Joint Monitoring Programme
LWSC	Lusaka Water and Sewerage Company for Lusaka Province
MDG	Millennium Development Goal
MNRE	Ministry of Natural Resources and Energy
MoE	Ministry Of Education
MoH	Ministry of Health
NAC	National AIDS Council
NERCHA	National Emergency Response Council on HIV and AIDS
NGO	Non-Governmental Organisation
NRWSS	National Rural Water Supply and Sanitation Programme
OVC	Orphans and Vulnerable Children
PLHIV	Person/People Living with HIV
RHM	Rural Health Motivators
RSAP	Regional Strategic Action Plan on Integrated Water
RWSS	Rural Water Supply and Sanitation
SADC	Southern African Development Community
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID PEPFAR	United States Agency for International Development President's Emergency Plan for AIDS Relief
WASCO	Water and Sewerage Company
WASH	Water, Sanitation and Hygiene
WESA	Water and Sewage Authority
WHO	World Health Organization
WSS	Water Supply and Sanitation
ZNAC	Zambia National HIV/AIDS Council

Executive Summary

This report documents findings of a rapid assessment on existing implementation linkages between HIV responses on one hand, and water, sanitation and hygiene (WASH) on the other, in four southern African countries: Lesotho, Mozambique, Swaziland and Zambia. The review was conducted in July 2014 by consultants commissioned by SAfAIDS and WaterAid. This rapid assessment is a forerunner of a number of pilot activities to be conducted in Lesotho, Mozambique, Swaziland and Zambia to explore how HIV and WASH can be better integrated.

Ensuring that HIV and WASH services are carefully integrated can lead to positive health outcomes. Water, sanitation and good hygiene are the basic drivers of public health: access to safe water, adequate sanitation, and proper hygiene education can reduce illness and death from many diseases, and thus aid poverty reduction and socio-economic development.

The **purpose** of this assessment was to determine how well services for HIV and WASH were being integrated in Lesotho, Mozambique, Swaziland, and Zambia. The results would inform WaterAid and other interested organisations on policy provisions for integration, current practices, and existing gaps. The specific objectives of the assessment in the four countries were to:

- Determine the extent to which HIV and WASH policies provided for the integration of both.
- Identify specific WASH needs of people living with HIV (PLHIV).
- Assess the extent to which HIV and WASH issues are integrated in intervention projects by government, civil society and other actors.
- Identify bottlenecks that affect HIV and WASH integration.
- Recommend how WaterAid and SAfAIDS' planned project activities can be rolled out.

A cross-sectional study design was adopted for the assessment, and this allowed for the use of a multidisciplinary approach to data collection, using qualitative techniques. The approach also allowed for the triangulation of data collected at different levels to assess the need to integrate HIV and WASH in surveyed countries. A total of 80 key informants were interviewed and 11 FGDs conducted during the assessment.

The findings show that southern Africa remains heavily burdened by HIV. The Joint United Nations Programme on HIV/AIDS (UNAIDS) reports that 70% of PLHIV in the world come from sub-Saharan Africa; in 2013 there were 24.7 million PLHIV in southern Africa. According to WaterAid, 748 million people in the world still lack access to improved drinking water sources and 2.5 billion are without access to basic sanitation. A significant population in targeted countries do not have adequate WASH services. Comparison by country showed that Mozambique is worst affected, as only 21% of its population had access to improved sanitation, followed by Lesotho (30%). Swaziland is the only country among the four that had more than half of its population with access to improved sanitation (WHO/UNICEF, 2014).

Access to improved water supply is relatively high in Lesotho. As of 2012, the World Health Organization (WHO)/United Nations Children's Emergency Fund (UNICEF) Joint Monitoring Programme (JMP) for Water Supply and Sanitation report showed that 81.3% of people in the country had access to an improved water supply. A recent survey in three provinces of Mozambique showed that 85% of rural households did not use any improved water source for drinking, while

about 55% of households practiced open defecation (UNICEF, 2009). The sanitation situation in Swaziland has improved in the past 12 years, although a significant proportion of households in the rural areas still use unimproved sanitation facilities (44%). Some 17.3% still practiced open defecation. Statistics put out by JMP show that only 42.6% of the rural population in Zambia had access to improved water supplies; this figure was not very different from the national coverage of 56.2% of the population (WHO/UNICEF, 2014).

The Southern African Development Community (SADC) has a number of policies and strategic frameworks that have an influence on the policies of member states. Two main policies were reviewed: the SADC Regional Water Policy and the SADC HIV and AIDS Strategic Framework 2010 – 2015. The latter document is silent on integrating WASH and HIV. The SADC Regional Water Policy, however, makes a number of provisions for the integration of HIV. Foremost, the Policy Principles for Water Resources Management take into consideration the importance of gender mainstreaming and addressing HIV in water resources management at all levels. At country level, Swaziland, Lesotho and Zambia have incorporated some WASH and HIV integration provisions in prevailing policies, but this is not the case in Mozambique.

There are a number of platforms that are available in each country where different WASH or HIV stakeholders meet. Most of these platforms are specific either for WASH or HIV initiatives. The assessment did not find a single platform in any of the four countries that is formally meant to bring together WASH and HIV partners. At community levels in all four countries, WASH issues are addressed at clinics and hospitals and through the work of community-based volunteers (CBVs). The assessment showed that in all four countries, representatives of government, UN agencies, NGOs and health staff were not aware of specific guidelines or standard operating procedures for integration of WASH and HIV. There, however, existed several other guidelines, e.g., guidelines for integration of HIV and TB, HIV and nutrition, etc. Results from the literature review showed that lack of planned integration starting at policy level, and further reflected in both WASH and HIV programming, was sometimes a result of lack of country-specific research on linkages between WASH and HIV. Regardless, in each country, some activities do integrate WASH and HIV. Focused HIV or WASH only funding was mentioned as a serious barrier for integration.

CONCLUSIONS

The main stumbling block to WASH and HIV integration is inadequate national integration policies, guidelines and frameworks. At implementation level, WASH and HIV linkages exist, but in an ad-hoc manner. Lesotho has clearer policies in terms of provisions for HIV and WASH integration compared to other countries. More work, particularly on the HIV side, needs to be done in Zambia, Swaziland and Mozambique in that order. The availability of SADC regional frameworks and guidelines can be used to guide development of national and local HIV and WASH integration frameworks.

There is limited co-ordination between WASH and HIV sectors and unavailability of funding for both WASH and HIV activities makes these linkages difficult. Disparities between the two sectors in terms of co-ordination, funding and policy commitment also affects any efforts at synchronisation of activities. Although there are several in-country platforms where different HIV or WASH stakeholders meet, the platforms are more aligned to either sectors, with limited integration between each other. Stronger linkages exist between WASH and health, although through the Department of Environmental Health under the Ministry of Health and platforms exist at all levels. With regards to WASH and HIV, the critical question is who will lead the integration of HIV and WASH?

RECOMMENDATIONS

In the context of the assessment findings, the following recommendations are made:

- Consider strengthening capacities and broadening mandates of existing platforms to include WASH and HIV integration, rather than creating new structures or platforms.
- The WASH and HIV integration process should be owned by all stakeholders at all levels, from local to national levels, with national governments leading through their responsible ministries and departments.
- Efforts to initiate WASH and HIV integration should take note of existing guidelines, best practices and lessons learnt from integration initiatives, processes and practices in other sectors, such as those between HIV and TB, SRH, and nutrition.
- WASH and HIV integration initiatives should adequately assess existing implementation barriers in the respective sectors and provide adequate mitigation efforts to address policies.
- 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/HIV integration initiatives.
- 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.
- Funding of WASH/HIV integration processes should be additional and not shared from the current funding towards the two respective sectors.
- Ensure that existing inhibiting cultural beliefs and practices are addressed through appropriate strategies such as culturally sensitive but strong and effective advocacy programme at all levels.
- 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.
- The integration process should incorporate gender and other crosscutting issues. Balanced roles for women are critical as 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.
- Development of WASH and HIV integration mechanisms need to consider how guidelines can be used in both rural and urban settings.

Introduction

BACKGROUND TO THE ASSESSMENT

This report documents findings of a rapid assessment on existing implementation linkages between HIV responses on one hand and WASH on the other, in four southern African countries: Lesotho, Mozambique, Swaziland and Zambia. The review was conducted in July 2014 by consultants commissioned by SAfAIDS and WaterAid southern Africa.

SAfAIDS is a leading organisation in the documentation of HIV issues, and is recognised in southern Africa for its capacity to bring national lessons and experiences to guide advocacy and knowledge. WaterAid is an international charity that transforms lives by improving access to safe water, hygiene and sanitation. WaterAid seeks to promote better integration of WASH and HIV globally and locally. The organisation has a global framework on equity and inclusion that emphasises the necessity of reaching the neediest with adequate WASH services. People living with HIV and other marginalised groups, among them people with disabilities, receive special attention.

The rapid assessment is a prelude to a number of pilot activities to be conducted in Lesotho, Mozambique, Swaziland and Zambia to explore how HIV and WASH can be better integrated. The planned approaches will be piloted in WaterAid's programmes to further deepen the confidence and competence of country programme staff, local NGO partners and other actors to holistically address HIV in WASH programmes. The planned actions, when adequately internalised and applied, should lead to integrated HIV and WASH services for PLHIV, primary and secondary caregivers, and communities by:

- Better addressing WASH barriers for people living with HIV.
- Ensuring practitioners and communities have practical guidelines on HIV mainstreaming in WASH and vice versa.
- Providing knowledge on and instituting HIV/WASH collaboration among programme implementers from government, civil society and other sectors.

THE BASIS FOR INTEGRATING HIV AND WASH

According to WHO (2010) the term 'WASH' is used to refer to:

- *Water* – access to water, and consideration of issues of quantity and quality.
- *Sanitation* – safe handling and disposal of human excreta (faeces, urine, menstrual blood, sputum and sweat), management of wastes (including trash, wastewater, storm water, sewage and hazardous wastes) and control of disease vectors (such as mosquitoes and flies).
- *Hygiene practices* – in particular, effective hand washing.

Ensuring that HIV and WASH services are carefully integrated can lead to positive health outcomes ((Hillbrunner, 2007; USAID, 2007). According to the Online Business Dictionary (September 2014)¹ integration means a process of attaining close and seamless co-ordination between several departments, groups, organisations, systems or interventions, etc. Thus, ensuring close co-ordination between HIV and WASH interventions has enormous benefits, particularly for PLHIV. Water, sanitation and good hygiene are the basic drivers of public health: access to safe water, adequate sanitation, and proper hygiene education can reduce illness and death from many diseases, and thus aid poverty reduction and socio-economic development efforts.

¹ More often that note in development programming integration and mainstreaming are used interchangeably.

People living with HIV have an increased requirement for WASH services, yet limited efforts have been made to link service provision for health, HIV and WASH. Studies have shown that improved hygiene practices can reduce the risk of diarrhoea by up to 30% or more, thereby improving health and protecting livelihoods (UNAIDS, 2014). At national level, the economic benefits of a healthy population are evident in reduced health service demands and a more productive labour force.

Diarrhoea is a very common illness in southern Africa, affecting 90% of people living with HIV, resulting in significant morbidity and mortality (Katabira 1999; Monkemuller and Wilcox 2000). More than 88% of diarrhoeal cases are caused by use of unsafe drinking water, inadequate sanitation and poor hygiene (Pruss Ustun et al., 2008). Curtis and Cairncross (2003) indicated that more than half of PLHIV suffer from chronic diseases. Diarrhoea reduces the body's ability to absorb nutrients in food, causing malnutrition and limiting the efficacy of lifesaving medicines, which further exacerbates the effects of HIV. Antiretroviral (ARV) drugs are more effective when they are taken in conjunction with adequate food and at least 1.5 litres of safe drinking water a day (USAID, 2007). Literature shows that a person living with HIV needs approximately 100 litres of water per day to meet different requirements as indicated in Table 1.

Table 1: Basic water needs of people living with HIV and AIDS

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)	20–80 litres per day
Total	Approximately 100 litres per day

Source: Ngwenya & Kgathi, 2006; Molose, Potter & Mvula Trust, 2007; WSP, 2007

Other literature from Chaisson et al. (1998), Seage et al. (2002) and Hillbrunner (2007) show that:

- Without clean water it is not possible to maintain hygiene standards.
- HIV patients need clean water to take their medication, without which they risk further infection.
- Primary caregivers need clean water to bath patients and wash their materials, including clothes, blankets and many others.
- A person affected by HIV or AIDS can be easily attacked by opportunistic infections, since the virus weakens their immune systems. There is, therefore, need to teach such individuals good health and hygiene practices that reduce the risk of infection from other diseases, such as cholera, diarrhoea and dysentery.
- The safe disposal of materials used in the care of HIV patients, such as gloves, napkins, contaminated water and other items, requires proper sanitation facilities at household level to reduce chances of infection of primary caregivers and other household members.

- A person living with HIV needs good nutrition and this can be addressed in HIV programming through providing support for home and community gardens. The establishment and maintenance of nutrition gardens required reliable supplies of water.
- HIV positive mothers who decide not to exclusively breastfeed use formulas as a replacement. The preparation of formula milk requires access to sufficient quantities of potable water and good hygienic preparation in order to prevent water-related diarrhoeal diseases.

PURPOSE AND OBJECTIVES OF THE ASSESSMENT

This **purpose** of this assessment was to determine how well services for HIV and WASH were being integrated in Lesotho, Mozambique, Swaziland, and Zambia. The results will inform WaterAid, SAFAIDS and other interested organisations on policy provisions for integration, current practices and existing gaps. The specific objectives of the assessment in the four countries were to:

- Determine the extent to which HIV and WASH policies provided for the integration of HIV and WASH.
- Identify specific WASH needs of PLHIV.
- Assess the extent to which HIV and WASH issues are integrated in intervention projects by government, civil society and other actors.
- Identify bottlenecks that affect HIV and WASH integration.
- Recommend how WaterAid and SAFAIDS' planned project activities can be rolled out.

Methodology

STUDY DESIGN AND DATA COLLECTION METHODS

A cross-sectional study design was adopted for the assessment, which allowed for the use of a multidisciplinary approach to data collection, using qualitative techniques. The approach also allowed for the triangulation of data collected at different levels to assess the need to integrate HIV and WASH in surveyed countries.

The assessment was conducted in four WaterAid southern Africa project countries: Lesotho, Mozambique, Swaziland and Zambia. Data was collected at four levels of informants:

- Policy makers, donors and major stakeholders.
- Implementers (private and public institutions).
- Community.
- Household member.

The assessment at community level was conducted in selected WaterAid southern Africa project areas. Selection and mobilisation of communities and project stakeholders in each country was done in collaboration with WaterAid country teams. Data collection methods included literature review, in-depth key informant interviews, focus group discussions (FGDs), household case studies and direct observations. The number of communities and households visited was small, and served to ground findings from the literature review and secondary data.

Table 2: Communities Visited In Each Country

Country	Province/ Region	District
Lesotho	Maseru	Maseru Rural
Mozambique	Maputo	Luis Cabral
Swaziland	Lubombo	Mpolonjeni
Zambia	Lusaka	Lusaka

LITERATURE REVIEW

Literature review helped to set the context and background of HIV and WASH integration in southern Africa, and in identifying major WASH and HIV players to be targeted in the assessment in each country. Reviewed literature included HIV and WASH-related policy documents, strategic frameworks, country programme reports and evaluations, and other HIV and WASH studies in project countries and beyond. Most review documents were obtained during country assessment visits to key WASH and HIV players and relevant government ministries in each country. Other reviewed documents included those downloaded from trusted websites, such as those of UN agencies and international NGOs working on WASH and HIV.

KEY INFORMANT INTERVIEWS

Purposive sampling was used to identify key informants at national, provincial, district and community levels. Snowballing was also used to identify other key informants in the field. Semi-structured interviews were conducted with key informants who included representatives of relevant ministries responsible for health, water and sanitation, UN agencies (UNAIDS, UNICEF and WHO), donors, HIV and WASH co-ordinating bodies, and other organisations and institutions providing HIV and WASH services. Community leaders and representative of WASH committees at community level were interviewed in the areas visited. A total of 80 key informants were interviewed during the assessment (Table 3). The list of key informants per country is provided under Annex 6.2. The numbers of people reached is presented in the table below.

Table 3: Number of People Reached Per Group of Assessment Participants

<i>Study participants</i>	<i>Specific group</i>	<i>Lesotho</i>	<i>Swaziland</i>	<i>Mozambique</i>	<i>Zambia</i>	<i>Total</i>
Government and other policy makers	Policy makers, (government, UN Agencies etc.)	2	3	6	1	12
	Donors	2	2	4		8
Implementers	NGOs and CBOs	7	6	8	5	26
	Health personnel	3	3	5	2	13
Community	FGDs – CBVs	3	3	2	3	11
	Community leaders	3	1	5	2	11
	Household	4	3	3	2	12

FOCUS GROUP DISCUSSIONS (FGDS)

A total of 11 FGDs were held with community-based volunteers, a group that includes secondary home-based caregivers and village health workers or rural health motivators. The purpose of these FGDs was to gather new evidence on WASH needs for PLHIV, and check needs already identified in literature. These FGDs were held in all four countries as indicated in Table 3 above. Each FGD contained between eight and fifteen people. A snowballing technique was used to identify all community members who participated in the FGDs. The technique involved the selection of a group of individuals and asking those individuals to recruit people 'like' them or 'different' from them on particular attributes, behaviours, or opinions.

As part of the assessment, a plan was put in place to conduct separate FGDs with households with persons living with HIV. At implementation, however, practitioners pointed out the possibility of further fostering stigma and discrimination, FGDs were thus mixed, including households with and without people living with HIV.

HOUSEHOLD CASE STUDIES

Working with community structures, the assessment profiled case studies of different types of households in relation to water and sanitation issues. Four different types of households were identified and profiled. These included households:

- At least one PLHIV.
- With at least one disabled person living with HIV.
- Headed by a child.
- Headed by grandparents.

Profiling of these households was meant to provide the assessment with detailed information about the WASH needs in such households, including challenges in accessing water and sanitation services. The data collected was used to verify some assertions in literature.

DIRECT OBSERVATION

Direct observations were also made during the assessment. Among others, observations of water sources and sanitary facilities, such as water storage amenities and toilets were made

DATA ANALYSIS

Data was transcribed and analysed using a thematic approach. Qualitative indicators were assessed through cross comparative techniques where information was categorised, with content and emerging themes analysed. Validation of findings was done at a later stage through sharing of the preliminary findings with key persons and stakeholders in each country for their reflections and comments.

ETHICAL CONSIDERATIONS

The assessment was conducted following ethical guidelines in line with the 'UN Evaluation Group Ethical Guidelines for Evaluation'. Participation was voluntary and confidential. Study participants at household level voluntarily signed participation consent forms.

CHALLENGES

A few challenges were encountered in conducting the assessment. These included financial restrictions that did not allow sampling at household and community level to be truly representative of the countries assessed. To avoid promoting stigma, FGDs planned with households of PLHIV alone were not conducted.

Findings from the Assessment

CONTEXT

HIV AND AIDS SITUATION IN ASSESSMENT COUNTRIES

The burden of the HIV epidemic in the world is huge: around 33 million people are living with HIV globally. Sub-Saharan Africa is home to 25 million people living with HIV. The HIV epidemic has produced a huge number of orphans and vulnerable children in southern Africa, and as much as 20% of the population in countries such as Zambia and Zimbabwe. Many orphaned and vulnerable children have learnt to look after themselves at early ages or are being cared for by elderly grandparents. Their WASH service needs are specific.

UNAIDS statistics for 2012 show that 70% of PLHIV in the world were in sub-Saharan Africa. In the same year, reports showed that sub-Saharan Africa recorded 1.6 million new HIV infections and 1.2 million AIDS-related deaths in the region. The situation is worse in southern Africa, which is regarded as the epicentre of the HIV epidemic. The region has some of the countries with the highest HIV prevalence in the world, including Swaziland (26.5%) and Lesotho (23.1%). Countries such as Mozambique (11.1%) and Zambia (12.7%) still have significantly higher HIV prevalence rates among 15–49 year olds compared to other countries in the world. In southern Africa, HIV is viewed as a key challenge affecting development in the region, hence the need for a multi-sectoral response. The HIV response in the four assessed countries has received support from central governments and external donors such as the Global Fund and the United States Agency for International Development President's Emergency Plan for AIDS Relief (USAID PEPFAR), among others.

WASH SITUATION IN ASSESSMENT COUNTRIES

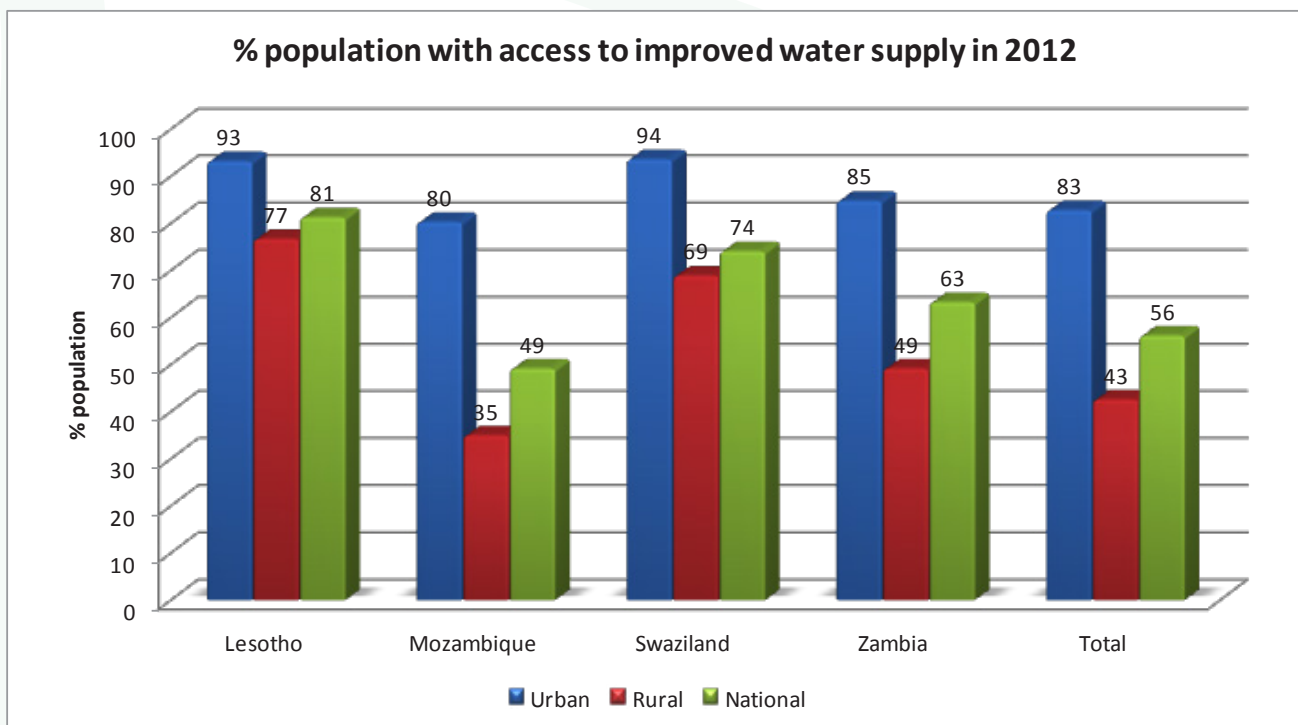
According to WaterAid, 748 million people in the world still lack access to improved drinking water sources and 2.5 billion are without access to basic sanitation. Poor water, sanitation and hygiene practices exert a particularly heavy toll on people living with HIV because of their vulnerability to opportunistic infections. In addition to facing the physical effects of HIV-related illnesses, PLHIV often find it difficult to support themselves economically and require care from family and community members. In many cases they are stigmatised and discriminated against, marginalising them further.

A 2014 WHO and UNICEF JMP report contains water supply and sanitation estimates from 2000 to 2012 for countries including Lesotho, Mozambique, Swaziland and Zambia. Data from the JMP report show that there has generally been an improvement in water supply and sanitation since 2012 in all four countries. Marked improvements had been realised in urban areas, compared to rural areas, due to improved urban water and sewerage systems. Rural areas, where an average 66% of the population in the four countries reside, still face challenges in accessing clean water and sanitation facilities such as toilets. The specific country findings below show that a number of factors, including socioeconomic, culture and natural phenomena such as drought affect improvement of water and sanitation services in rural areas.

The four assessment countries were at different levels in terms of access to improved water supply and sanitation services. Findings in Figure 1 show that Lesotho (81%), followed by Swaziland (74%), has a large majority of the population with access to improved water supply. Mozambique has lower access figures compared to the other three countries. Approximately half of Mozambique's total population still uses unimproved water supply services. A similar trend can also be observed with regard to access to improved water supply in rural areas.

The four (4) assessment countries were at different levels in terms of access to improved water supply and sanitation services. Findings in Figure 1 show that Lesotho (81%) followed by Swaziland (74%) had the large majority of their population with access to improved water supply. Mozambique had lower access figures compared to the other three countries. The country has approximately half of its total population that still uses unimproved water supply services. A similar trend can also be observed as regards access to improved water supply in rural areas.

Figure 1: Proportion of Population with Access to Improved Water Supply In 2012



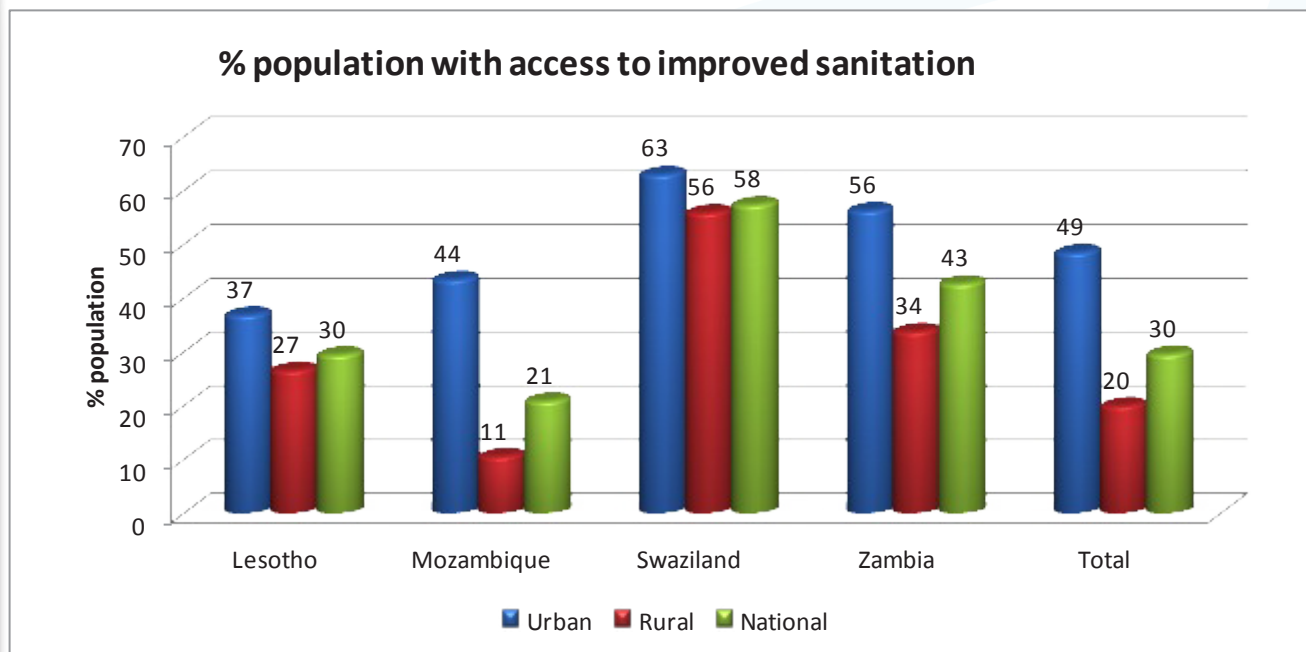
Source: WHO/UNICEF, JMP, 2014

Access to improved sanitation was still very low in all four countries, with an average of only 30% of their populations having access to improved sanitation. This showed the need for more work to be done in view of the MDG target, which is to half the population without access to improved water and sanitation by 2015.

Comparison by country showed that Mozambique is worst affected as only 21% of its population had access to improved sanitation, followed by Lesotho (30%). Swaziland is the only country among the four that had more than half of its population with access to improved sanitation.

Figure 2 on next page concurs with the above statements that the situation is worse off in the rural compared to urban areas.

Figure 2: Proportion of Population with Access to Improved Sanitation in 2012



Source: WHO/UNICEF, JMP, 2014

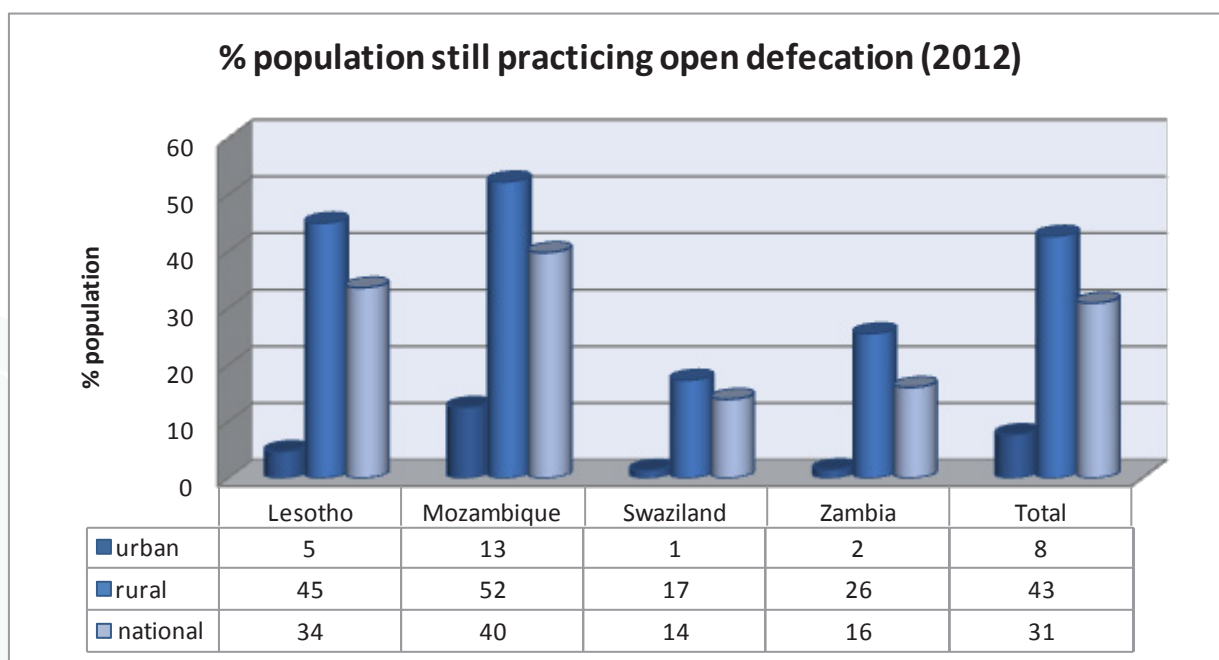
Figure 3 below reflects a disturbing reality that still exists in the assessment countries. A significant proportion of their population were still practicing open defecation. On average, within the 70% population that use unimproved sanitation facilities, 31% are practicing open defecation, i.e., they defecate in the bushes or open spaces. This practice is common in all four countries, with Mozambique and Lesotho having a significantly high proportion of their population still practising open defecation.

Findings from the assessment of communities visited show that there still exist households that do not have toilets at their homesteads, whilst in some cases several households share a single toilet, a practice that has its own challenges. In general, poverty was cited as the main reason why poor households could not afford to build toilets. The assessment revealed that in Swaziland, even for households that have been assisted through WASH programmes with materials for constructing the toilets, some had failed to build the toilets at least one year later.

This brought out the second reason that was cited by several stakeholders from the different countries, i.e. culture. It was indicated that some people in rural communities, including traditional leadership, see anything wrong with open defecation, as it is a practice that has existed in their way of life for a long time. Hence they do not value the importance of having an improved sanitation facility. This lack of commitment was cited as the main barrier to improvements in safe sanitation coverage, particularly in rural communities.

Additionally, the sprouting of some improperly planned urban communities without proper water and sewage services is a reason why access to improved sanitation in some urban areas remains low.

Figure 3: Proportion of Population Still Practicing Open Defecation in 2012



Source: WHO/UNICEF, JMP, 2014

LESOTHO

Access to improved water supply is relatively high in Lesotho. As of 2012, the JMP 2014 report showed that 81.3% of the people in the country have access to an improved water supply. In the same vein, the proportion of people with piped water on their premises has also increased from 10.2% to 21.5% in 2000 and 2012 respectively.

The major sources of water in Lesotho are surface and underground water. Underground water sources include natural springs, wells and boreholes. Surface water includes rivers and natural and artificial water bodies. Where springs and surface water bodies are on slopes above the villages, water is harnessed into water tanks and distributed to community water points using gravity.

Protected springs, boreholes and pumps were provided by several partners, including the Government of Lesotho, through the Millennium Challenge Account, World Vision, and LRCS. Community boreholes and pumps are other major sources of water in the rural areas. Water from these sources was safe as samples were analysed at WASCO Central Laboratory before sources were protected.

Despite the positive picture above, water used by households is not always safe. Not all households have access to protected water sources and in the winter season cold temperatures often cause the water to freeze, resulting in water challenges.

MOZAMBIQUE

Figures on WASH access were disputed in Mozambique. WASH coverage statistics and figures were from UNICEF/WHO, based on the results from the Joint Monitoring Programme for Water Supply and Sanitation and on demographic health survey (DHS) data differed from those from

³See http://en.wikipedia.org/wiki/Water_supply_and_sanitation_in_Mozambique

the Ministry of Public Works, which used the water access figures of 38% in urban areas and 40% in rural areas. This posed a challenge in checking which targets to set for the MDGs. In 2009, a baseline on WASH was conducted in 18 districts in Manica, Sofala and Tete by UNICEF under the One Million Initiative. The key findings were:

- 85% of rural households do not use an improved water source for drinking
- There were high levels of microbiological contamination of drinking water
- About 55% of households practiced open defecation
- There is a need to build proper hand washing facilities as only 1% of households washed hands with running water and soap.

SWAZILAND

Although the sanitation situation for Swaziland has improved in the past 12 years, Annex 2 shows that a significant proportion of households in the rural areas still use unimproved sanitation facilities (44%). Of these, 17.3% still practice open defecation. In the visited region of Lubombo, the MoH reported that diarrhoea and skins diseases were among the top 10 diseases in the region. The region still experiences diarrhoeal outbreaks.

ZAMBIA

JMP statistics show that only 42.6% of the rural population in Zambia have access to improved water supplies and that this was not very different from the national coverage of 56.2% of the population. Water is among the major problems faced by most people in communities visited during the assessment. Water is not available the whole day. In some communities, the water and sewerage company has put in boreholes. However, communal taps in these areas are only opened at 03:00hrs, 04:00hrs, 05:00hrs or, at the latest, at 06:00hrs and water is only available for an hour. In some communities, access to safe water is at a cost and those who cannot pay resort to using unsafe sources of water. PLHIV face a number of challenges when trying to access water due to long distances and long queues that sometimes occur in the different communities. ⁴

Access to improved sanitation facilities in Zambia's rural communities is only 20.1%, lower than the national coverage rate of 29.7%. Very few people own flushable toilets in most rural areas. Those who own pit latrines share them with not less than five other households. In some communities, as many as 10 housing units had no toilets and used neighbours' pit latrines or Shake-Shake/Chibuku packs for defecating, which are later disposed of at the nearest garbage dumping site. In very rare cases, plastics bags are used, especially at night, and disposed of early the following morning.

Cleaning of pit latrines is usually done using plain water and sometimes, soapy water, when soap can be afforded. Due to affordability challenges in accessing recommended detergents such as Harpic, households opted to use plain water, or to scrub the latrine floors with charcoal ash.

WASH AND HIV INTEGRATION IN REGIONAL POLICIES AND FRAMEWORKS

SADC has a number of policies and strategic frameworks that have an influence on the policies of member states. Two main policies were reviewed: the SADC Regional Water Policy and the SADC HIV and AIDS Strategic Framework 2010–2015. The integration of WASH issues into HIV policies on one hand, and of HIV into WASH issues could thus have a regional dimension.

³ See http://en.wikipedia.org/wiki/Water_supply_and_sanitation_in_Mozambique

⁴ Refer to page 30 on community and household perspectives for more details

Under the current Regional Strategic Action Plan on Integrated Water Resources Development and Management 2011–2015 (RSAP 3), programme 10 focuses on water and sanitation. The programme's objective is to improve access to water and sanitation services. The RSAP gives seven priority interventions (alternative financing strategies for WSS, WSS monitoring and reporting, institutional strengthening of WSS, knowledge management and information sharing on WSS, WSS infrastructure development support, WSS and water demand management and training on WSS). However, RSAP 3 is silent on HIV, although programme 14 outlines an intervention – i.e. training members of the sub-committee on water quality on the long-term impacts of water pollution on human health and the environment in the context of sustainable development. The strategy is being used by the four countries to enhance regional attainment of the Millennium Development Goal (MDG) on WASH.

The SADC HIV and AIDS Strategic Framework 2010–2015 is silent on integrating WASH and HIV. Clause 7.2.3 recognises that water development has an important role to play both in terms of sustaining agricultural production and food supplies, which are threatened by HIV and in improving the health status of the population. The framework mandates the Directorate for Infrastructure and Services (I&S) to co-ordinate development and maintenance of health and wellness programmes for transport, water and energy infrastructure, amongst other things.

The Strategic Framework is currently being used by all four countries in guiding their response to HIV, especially to move towards MDG 6 and its targets.

WATER POLICY

The SADC Regional Water Policy makes a number of provisions for the integration of HIV. Foremost, the Policy Principles for Water Resources Management take into consideration the importance of gender mainstreaming and addressing HIV in water resources management at all levels. The other issue taken into consideration is poverty and its linkage to HIV. Poverty in the region is further aggravated by the impact of HIV. The SADC Regional Water Policy appreciates the prevalence of HIV, with the associated challenges for the capacity, sensitivity and requirements posed in respect to water resources management in the region.

The policy also takes into account that HIV is a cross-cutting issue which impacts all sectors, including the water sector. In addition, HIV is also impacted on by the water sector. Therefore, the Regional Water Policy seeks to promote activities to *“mitigate the impact of HIV/AIDS, such as improving access to reliable water supply and sanitation, increasing food security”*. Furthermore, the policy makes provisions for collaboration between the water and health sectors to raise public awareness and carry out information campaigns to address this paramount health concern.

The Regional Water Policy also recognises the impact of HIV on capacity development and training i.e. *“The personnel and sector institutions in the water sector have not been spared the ravaging effects of HIV/AIDS (illness, deaths and the associated loss of skills and productivity within sector institutions)”*. The policy, therefore, makes provisions for collaboration and the co-operation of the water and health sectors with other sectors in supporting measures to combat the pandemic in the region.

Provision is made in the policy for the integration of hygiene education in water and sanitation programmes (section 4.2.7). The provision is to facilitate awareness creation about diseases and to promote positive hygiene practices, especially where HIV prevalence is high. This is in terms of use of water, and its relationship with health and poverty in the affected households and

communities. The policy (section 8.5.2) also encourages the participation of all stakeholders in *“decision-making processes for dam development and, where appropriate, with adequate facilitation and empowerment of vulnerable groups to ensure their effective involvement in decision-making”*. Vulnerable groups normally include people living with and affected by HIV.

HIV POLICY

Unlike the Regional Water Policy, the SADC HIV Policy does not specifically or directly make reference to WASH issues for people with HIV. According to the SADC Strategic Framework 2010–2015, a number of member states have made progress in mainstreaming HIV into key non-health sectors such as education, welfare, labour and criminal justice. There is no mention of the water and sanitation sector and it can merely be assumed that it is also regarded as a key sector by member states. It makes provision for integration of HIV issues into various sectors and this by implication includes the WASH sector. Mention of water is made under the sub-topic on the Directorate for Infrastructure and Services. The importance of water, exclusive of the sanitation and hygiene components, is mentioned in terms of sustaining agricultural production and food supplies that are threatened by HIV, and in improving the health status of the population⁵.

Section 5.6 of the framework talks about the importance of meaningful participation, particularly of people living with and affected by HIV, in policy development and programme delivery. Similarly, section 7.4 makes provision for the identification of “HIV and AIDS-related vulnerabilities and effective responses in other SADC sector programmes”. By inference, this implies that the input of marginalised groups and identification of HIV-related vulnerabilities in all sectors, including water and sanitation, are essential for ensuring an effective HIV response.

WASH AND HIV INTEGRATION IN NATIONAL POLICIES AND FRAMEWORKS

For each of the four countries assessed, both WASH and HIV policies were reviewed.

LESOTHO

The Lesotho Water and Sanitation Policy, 2007 was reviewed. The Policy identifies mainstreaming of HIV/AIDS as one of the principal challenges facing the water sector in Lesotho. Policy Statement 2 which deals with water and sanitation services under Objective 4 reiterates the need to promote equity in access to water supply and sanitation among vulnerable and marginalized groups including PLHIV. It outlines the need to develop and implement programmes aimed at creating public awareness on linkages between water supply, sanitation and hygiene. Policy Statement 3 provides for the integration of HIV/AIDS into water resource programmes through emphasis on environmental impact assessments of water projects to also address issues relating to the reduction in the spread of HIV/AIDS. The policy also provides for the participation of all in water and sanitation issues including vulnerable groups such as PLHIV, and goes on to provide for the preparation of guidelines that state how this could be done.

Lesotho’s National HIV and AIDS Policy, 2006 has provisions for the integration of HIV and WASH, particularly sanitation through safe handling and disposal of blood and its products. Under Section 3.11 the policy provides for the protection of health workers, HBC and other personnel likely to come into contact with infected blood through safe disposal of needles and other medical waste dealing with open wounds. However, it is clear that the primary focus for this provision is at secondary carers (health personnel, HBC, traditional healers, etc.), and not at household level. The policy is silent on primary carers in households that have PLHIV.

The country's National HIV and AIDS Strategic Plan (2011/12–2015/16) details WASH as an impact mitigation approach. The priority for impact mitigation is to strengthen the coping capacity and mechanisms of vulnerable households and communities, and help them move from dependency to self-reliance. While addressing the broader issues of vulnerability, stakeholders are encouraged to focus on implementing strategic interventions targeting OVC and vulnerable households. Some key prescribed interventions include ensuring equitable access to basic needs such as clean water, sanitation, and decent shelter, among others.

SWAZILAND

Swaziland's National Water Policy, Final Draft (2009) does not clearly provide for any linkages between WASH and HIV, although it does mention that the pronouncement of water use for primary purposes would make strides in fighting diseases such as HIV. Although the policy states on page 26 that all citizens should have access to safe water and adequate sanitation to guarantee human dignity and health, it falls short of indicating vulnerable and marginalised groups, such as PLHIV or their families, who might need more targeted WASH interventions. The HIV/AIDS and STD Prevention and Control Policy (1998) recognises that the response to HIV should be multi-sectoral for a positive response. However, it does not deliberately establish linkages between HIV and WASH. Section 3.7 recognises the need to reduce or completely eradicate the discrimination of PLHIV in all spheres, and provides for support of those who experience such discrimination. This can be taken to also include non-discrimination of PLHIV in accessing WASH services, although not explicitly.

The National Multi Sectorial Strategic Framework for HIV and AIDS, 2009–2014, with extension 2014–2018 recognises water and sanitation as a key challenge identified during the review of the previous strategy (National Strategic Plan II), in particular its effects on access and adherence to HIV treatment and care services. The strategy identifies community systems as having the potential to reduce poverty and improve vulnerable households' access to basic needs, including sanitation. It is clear within the framework that households with PLHIV in Swaziland should receive WASH-related support from development partners. Swaziland does not seem to have clear guidelines for the integration of WASH in the country's HIV responses. Under section 3.4.1, which deals with OVC education, the strategy only states that support to be provided for early childhood care and development should include water and environmental sanitation. The strategy also commits the Ministry of Natural Resources to mainstream HIV in the construction of water dams (Annex 2: page 91).

The Health Sector Response to HIV/AIDS Plan, 2009–2014, in Section 5.2.5, focuses on community-based care and support shows that the health sector response has made efforts to integrate some components of WASH, particularly on issues of waste disposal management. The MoH reports that through its Environmental Health Department it has successfully piloted a double pit latrine initiative where the pit latrine would also be used for medical waste disposal management. Hence, in its plans for 2009–2014, the MoH planned to conduct 356 trainings on proper waste management and to construct 250 double pit latrines for waste disposal per region, as part of efforts to strengthen the capacity of caregivers to apply universal precautions in providing care support (page 105).

MOZAMBIQUE

Mozambique's National Water Policy (1995) has no provision for HIV integration. The National Rural Water Supply and Sanitation Programme (NRWSSP) (2010–2014), however, recognises the role of WASH in mitigating the impacts of HIV. Government developed the rural WASH policy and strategy in 2007 for water supply and sanitation in rural areas, where 62% of the population lives. A barrier towards integration is that external donors finance about 85% of all public investments in the WASH sector, and rarely provide funds for mainstreaming.

Mozambique's National Strategic HIV and AIDS Response Plan, 2010–2014 was approved by the 10th Session of the Council of Ministers on 23rd March 2010 as the main government document for directing responses to HIV. There are no specific provisions for addressing WASH issues when responding to HIV. However, groups such as young adults and women are included among high-risk groups, and should be reached with interventions that address both their vulnerability to HIV and poverty, and cultural factors that make them vulnerable. Interventions that rely on adequate WASH facilities, such as home-based care (HBC), are well articulated in the policy, but they do not specifically include the need to address WASH. Nutrition is an integral component of all HIV responses.

ZAMBIA

In an appraisal of the programme, the Water and Sanitation Department in Zambia (2006) indicated a number of relationships that exist between WASH and HIV and built a case for the integration of the two. Some of the issues mentioned under section 2.5.8 and 3.2 include:

- Increased deaths and periods of sickness and incapacitation as a result of HIV can affect water supply delivery, e.g. if pump minders and water facility caretakers fall ill or die as a result of HIV.
- PLHIV, particularly women living with HIV, face several challenges in accessing water, e.g. inability to walk long distance, stand in a queue for long hours or carry a heavy load.
- The extent to which the NRWSSP programme in Zambia integrated HIV and that WASH improvement were likely to have a positive contribution on other sectors, such as HIV.

Subsequently, Zambia's Water Resources Management Act, 2011 (No. 21 of 2011) mandates that the Water Resources Management Authority s8.2 (v) address the impact of malaria, HIV and other diseases on, or in, the water sector. Additionally, the National Rural Water Supply and Sanitation Programme (NRWSSP), 2006–2010 spells out strategies for the delivery of rural water supply and sanitation. The programme integrates HIV and has clear strategies on how this will be done. In the programme log-frame, Activity 4 states one of the activities of the programme as including capacity building in HIV mitigation at all levels, and the provision of supervision of such through technical teams and NGOs. Activity nine of the programme log-frame includes mainstreaming of HIV, among other issues in Rural Water Supply and Sanitation (RWSS) through integration of HIV in RWSS training and capacity building activities.

Zambia's National HIV/AIDS Policy (2010) seems to be lagging; the policy does not make any provisions for the integration of WASH issues in HIV interventions.

COUNTRY LEVEL CO-ORDINATION MECHANISMS

HIV OVERVIEW

In all four assessment countries HIV falls under ministries responsible for health. Each country has a co-ordinating body that has the mandate to co-ordinate all HIV responses in the country. However, in **Lesotho** the MoH, with help from the Prime Minister's Office, is the interim co-ordinator of the national HIV response as the National AIDS Commission was dissolved in 2010. UNAIDS, through its development leadership role, is supporting and advocating for the establishment of a national co-ordination mechanism. UNAIDS, in collaboration with MSF, recently facilitated the organisation of civil society working on HIV to come up with a health advocacy forum for civil society organisation (CSOs) which has been useful in joint planning, identification of resources and sharing of information.

In **Mozambique**, a key institution in co-ordinating HIV responses is the *Conselho Nacional de Combate ao HIV/SIDA*, or the National Council to Combat HIV/AIDS (CNCS). This is the equivalent of National AIDS Councils in other countries of the region. CNCS is a state institution, created in the year 2000 to co-ordinate a multi-sectoral approach in combating HIV. CNCS is headed by an Executive Secretary, with internal units or departments and provincial centres for HIV/AIDS. CNCS's role is to co-ordinate planning, implementation, monitoring and evaluation of HIV programmes. At national and especially provincial level, CNCS maintains a directory of government, donors and non-government partners implementing HIV initiatives.

HIV responses in **Swaziland** are co-ordinated by the National Emergency Response Council on HIV and AIDS (NERCHA). NERCHA is a body formed in 2003 to co-ordinate the multi-sectoral responses in the country. NERCHA is represented at regional, *inkundhla* and community level. NERCHA also has offices at regional level. Co-ordination at all other levels is conducted through several multi-sectoral co-ordination structures such as the Regional Multi-Sectoral HIV and AIDS Co-ordination Committee (REMSHACC), *Tinkhundla* Multi-sectoral HIV and AIDS Co-ordinating Committee (TMSHACC) and the Chiefdom Multi-Sectoral HIV and AIDS Co-ordinating Committee (CHIMSHACC). These structures are constituted by different stakeholders, including co-ordination bodies, government ministries, civil society and private organisations.

In **Zambia**, the HIV response is co-ordinated through the National HIV/AIDS Council (ZNAC). ZNAC was constituted in 1999 through an Act of Parliament. Its mandate is to co-ordinate national responses to the HIV epidemic. ZNAC has structures at national, provincial and district levels. At national level, NAC is superintended by a Committee of Cabinet Ministers, chaired by the Minister of Health. The NAC secretariat has responsibility of implementing all ZNAC policies. At provincial and district levels, NAC is represented by Provincial AIDS Co-ordination Advisors (PACA) and the District HIV/AIDS Co-ordination Advisors (DACA). They co-ordinate HIV issues through the Provincial HIV/AIDS Task Forces (PATFs) and District HIV/AIDS Task Forces (DATFs)⁶. The membership of these structures consists of government line ministries, NGOs and private organisations. At community level there is supposed to be community HIV task forces to co-ordinate activities at that level.

WASH CO-ORDINATION MECHANISMS

In all four countries, water and sanitation services are centrally managed through government parastatals and/or departments under ministries responsible for water and health. According to key stakeholders, this is in recognition of the fact that WASH services are basic commodities that every government should strive to satisfactorily provide to its people. However, this limits the roles of municipalities in cities and towns in the providing these services, despite their legal obligations.

LESOTHO

Water is Lesotho's second most important natural resource after its people because it is the country's largest single source of foreign currency. Water resources in Lesotho are managed under the Water Act of 2008. The Department of Water Affairs within the Ministry of Natural Resources is responsible for the general administration of the Water Act. The commissioner of Water within the Ministry of Natural Resources is mandated to promote coordination of programs and activities within the water sectors. The commissioner is responsible for the Department of Water Affairs and Rural Water Supply (DRWS). He also oversees the Lesotho Highlands Water Development Authority and the Water and Sewage Authority WESA. WESA manages water supply to urban areas. DRWS is mandated to manage water supply in rural areas. In terms of service provision, water and sewage services are provided through a government parastatal known as the Water and Sewerage Company (WASCO) which serve over 300 000 people in the urban centres with potable water. The Authority provides safe drinking water to approximately 47, 559 post-paid connections, plus approximately 400 public standpipes. WASCO also serve domestic prepaid connections, communal pre-paid card holders and industries.

MOZAMBIQUE

The National Directorate of Water (DNA) in the Ministry of Public Works and Housing is in charge of water supply policy in Mozambique. The Water Supply Investment and Asset Fund – *the Fundo de Investimento e Património do Abastecimento de Água* (FIPAG), an asset holding company in Maputo and several other cities, operates under three-year performance contracts with the Ministry of Public Works and Housing to provide water and sanitation services in the large urban centres. The Ministry of Health sets and monitors drinking water standards. FIPAG owns water and sewerage assets in 13 main cities and sub-contracts operations in Maputo to Águas da Região de Maputo ((ARM), meaning Waters of the Maputo Region).

Conselho de Regulacao do Abastecimento de Agua (CRA) is the main regulatory body for urban WASH, and balances supply with demand by ensuring that tariffs charged can deliver an acceptable service quality. The agency also attends to complaints from users and municipalities. However, CRA does not have authority over urban sanitation or small-scale independent water providers.

SWAZILAND

The Ministry of Natural Resources and Energy (MNRE), through the Department of Water Affairs, is the custodian of all water issues in Swaziland. The water sector can be divided into two, i.e. urban water and rural water. Rural water is managed and co-ordinated through a unit in the MNRE known as the Rural Water Supply Branch, whilst urban water falls under the mandate of the Swaziland Water Services Corporation (SWSC). SWSC is a corporate body wholly owned by the Government of Swaziland and duly constituted under the Water Services Corporation Act, No. 12 of 1992.

⁶ Global HIV/AIDS Initiatives Network (2008), Global HIV/AIDS Initiatives in Zambia: Issues of Scale up and Health Systems Capacity, Interim District Report

The corporation provides water and sewage services to an estimated 26 cities and towns in the country. Furthermore, the Ministry of Health through the Environmental Health Department has the mandate to ensure a healthy and safe environment for all Swazis through implementation of WASH programmes, among other interventions that promote environmental health. As such, the Environmental Health Department is reflected at all levels, down to the community clinics.

ZAMBIA

Water and sanitation services in Zambia fall under the Ministry of Local Government and Housing (MLGH). The department that directly oversees such services is the Department of Housing and Infrastructure Development. There are government parastatals that provide services in towns, cities and rural areas. These are Provincial Commercial Utility Companies that exist in each and every province, e.g. the Lusaka Water and Sewerage Company (LWSC) for Lusaka Province, Southern Water and Sewerage Company (SWASC) for Southern Province, etc. The water and sewerage companies are quasi-government institutions formed out of the water and sewerage departments at district councils. These operate as commercial water utility companies providing water and sanitation services to all provinces. All the water and sewerage companies are regulated by the National Water Supply and Sanitation Council (NWASCO). NWASCO is the body charged with the responsibility of regulating water supply and sanitation service provision for efficiency and sustainability.

A water and sewerage company can delegate the responsibility of managing water and sanitation services in certain peri-urban areas to community-based organisations called 'Water Trusts'. For example, LWSC has developed partnerships with various community-level stakeholders such as Ward Development Committees (WDC), Water Committees, and Neighbourhood Health Committees. WASH actors are also organised under the Water and Sanitation Association of Zambia (WASAZA). WASH forum meetings are usually held at WASAZA offices.

PLATFORMS FOR INTEGRATING WASH AND HIV

There are a number of platforms available in each country where WASH or HIV stakeholders meet. Most of these platforms are specific either for WASH or HIV initiatives. Due to lack of integration, discussions on HIV issues in WASH platforms and vice versa are weak and only happen as secondary items. The weaknesses are more apparent at national level compared to the provincial/regional and district levels where local authorities in all four countries have provincial/regional or district development committees which bring all stakeholders together to discuss development issues specific to their areas. However, even in these platforms the discussions are generally broad and if WASH or HIV or the integration of the two is not taken as a key development issue for that province or district, it does not appear on the development agenda and hence is only discussed in passing.

In all countries, HIV stakeholders indicated that WASH fell under impact mitigation and hence it could be discussed under a technical working group that dealt with HIV impact mitigation. However, WASH is not a regular topic in these technical working groups because it is not prioritised.

Most key stakeholder sentiments from countries such as Swaziland and Mozambique showed that there is belief that even though integration is weak, structures that offer opportunities for strengthening the integration of WASH and HIV were available. This school of thought is inclined to the notion that there is no need to come up with a new structure for integration of WASH and HIV but that is more important to work within available platforms.

WASH sector co-ordination challenges in some countries threaten to affect integration efforts. Stakeholders reported that WASH Sector co-ordination challenges in some countries was the result of limited funding, lack of commitment in terms of national budgeting for WASH and limited data or information on WASH at all levels.

Unlike WASH, HIV is a priority area for all four countries. The sector has received much more funding, compared to WASH. Its co-ordination is well structured from the national to the community level and hence it would not be difficult to strengthen the WASH component in HIV. Table 4 below shows different WASH/HIV platforms in the four countries that offer opportunities for strengthening integration of WASH and HIV.

Table 4: Country Level HIV and WASH Platforms

	Lesotho	Swaziland	Mozambique	Zambia
National	<ul style="list-style-type: none"> National Sanitation Taskforce. Global Fund CCM. CSO Health Advocacy Forum. Development Partners. Consultative Forum (DPCF). WASH/ HIV Technical Working Groups. 	<ul style="list-style-type: none"> National WASH Forum. NERCHA Coordination Meetings. WASH/ HIV Technical Working Groups. 	<ul style="list-style-type: none"> Common Fund Partners Meetings. CNCS Coordination Meetings. Grupo de Água e Saneamento meetings - Chaired by DNA CNCS Technical Working Groups. UN WASH Cluster Meetings. FIPAG Meetings. Monaso. 	<ul style="list-style-type: none"> National WASH Forum ZNAC Coordination Meetings. ZNAC Technical Working Groups.
Provincial/ Towns		<ul style="list-style-type: none"> Regional Health Management Teams Regional Multi-Sectoral HIV and AIDS Coordination Committees Regional Development Teams Regional Environment Committees Municipality HIV and AIDS Teams 	<ul style="list-style-type: none"> Apoio Sectorial ao sector de Água e Saneamento (AIAS) 	<ul style="list-style-type: none"> Provincial HIV/ AIDS Taskforces. Provincial Health Management Team. Provincial Development Coordination Committee.
District	<ul style="list-style-type: none"> District Disaster Management Teams. Health Partners' Forum meetings. District Health Management Teams (DHMT) 	<ul style="list-style-type: none"> Tinkundhla Multi-Sectoral HIV and AIDS Coordination Committee. Inner Council. Secretary of Inkundhla . 	<ul style="list-style-type: none"> CNCS Coordination Meetings. FIPAG Meetings. Monaso. 	<ul style="list-style-type: none"> District WASH Committee. District HIV/AIDS Taskforce. District Health Management. District Development Coordination Committee.
Community and village level	<ul style="list-style-type: none"> Community Councils Community Meetings. Awareness Raising Campaigns. Community Based Volunteers. Water Point Committees. 	<ul style="list-style-type: none"> Community Development Committee. Community Based Volunteers. Water Point Committees. Chieftdom Multi-Sectoral HIV and AIDS Coordination Committee. Kagogo Centres. 	<ul style="list-style-type: none"> Water point committees. Community Based Volunteers. CBOs 	<ul style="list-style-type: none"> Community Development Committees. Water Point Committees. Community Based Volunteers. Community HIV/ AIDS Taskforces.

⁷This list might not be exhaustive

STRUCTURES WORKING AT THE COMMUNITY LEVEL

In all four countries, a number of community level structures that support PLHIV with information on HIV and WASH and other services exist. The names and structures of these institutions differs from one country to the other, but their key generic functions converge.

Local Clinics – 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. Nurses and other health centre staff use this platform for community health and hygiene education, including on WASH issues. Health centres play central roles in the provision of WASH and HIV services. It is thus ideal that these health institutions should also be used to co-ordinate the WASH and HIV integration interventions of institutions at local level.

Community-Based Volunteers – Community-based volunteers are either Village Health Workers (Rural Health Motivators in Swaziland) or Neighbourhood Health Committees in Zambia who operate at each health centre supporting the MoH with the dissemination of information, community education, and client follow-ups, among other issues. Results from FGDs with CBVs revealed that their community level work integrated WASH and HIV as they conducted community mobilisation and education activities on general cleanliness and hygiene, provided care and support to home-bound and critically ill patients and identified community health needs. They also provided counselling services to patients. In Lesotho and Swaziland, the assessment found that each community had set up health post or health care points where community health education activities are carried out. CBVs in general lacked resources such as gloves, soap, detergents, etc. needed for caring for and supporting bedridden patients. In some countries, these resources were sometimes available through the local clinic but not all the time.

STAKEHOLDER PERSPECTIVES ON WASH AND HIV INTEGRATION

COMMUNITY AND HOUSEHOLDS' PERSPECTIVES ON WASH AVAILABILITY

LESOTHO

Although Lesotho's water policy stipulates that a household should not be more than 150 metres from the nearest community water point, the assessment revealed that most households were at least a kilometre away from the nearest water point. At the water points, water was not always available. In the assessed areas, safe water was available for just two hours each day. There were long queues and some household members missed the chance to fetch water. Thus, there are many households in the rural areas which use unprotected water sources such as dams and rivers. Water shortages were reportedly more pronounced for PLHIV and their households due to patients' physical weakness, among other issues. Another challenge reported was that open water sources were contaminated. The assessment revealed that people in Lesotho's rural areas do not usually treat their drinking water, mainly because they do not have adequate financial resources to purchase water purification components, or paraffin or firewood for boiling the water. Communities reported that on rare occasions, water was boiled for babies and disinfected with disinfectant for PLHIV. According to the MoH Division of Environmental Health, diarrhoea was on the top ten list of major communicable disease in the country, mainly due to limited access to clean water, contamination of water during transportation to homes, and poor hygiene in handling water in the home. There is thus still need to focus on improving access to safe water supply in the country.

MOZAMBIQUE

In Mozambique, the assessment team visited communities in a high density biro or suburb. In this community, WaterAid has done significant work to extend the water reticulation system to communities that were previously unserved. Nevertheless, the following problems were reported:

- Although communal pipes were now closer to the households, water was not always available. During the visit, three of the four communities visited did not currently have water flowing out of the taps.
- Local CBOs (Estamos and others) were implementing WASH activities in partnership with WaterAid. Communities commended their efforts, but reported that they often did not have adequate materials, and that some communities were still not well serviced. Estamos confirmed that their programme officers did not always have adequate knowledge on all questions asked by community members, and needed continuous training.
- In urban settings, single person households are plentiful, and when a person with HIV lives alone, special considerations for WASH should be made. In a case observed during the assessment, the HIV positive person was being cared for by the landlord, with minimal support. The landlord was also losing out on rentals, further worsening the plight of the person living with HIV as his condition placed him in a more precarious position. .
- Most women reported challenges with accessing sanitary napkins, especially for bed-ridden women. Men reported that where toilet facilities were inadequate, used sanitary materials were sometimes thrown out in the open.
- Men reported an emerging problem of WASH needs for elderly women suffering from effects of long-term use of contraceptives. These women reported experiencing weakness of the joints, and being unable to fetch adequate water for their families' needs as a result.

SWAZILAND

In Mpolonjeni, Swaziland, a few households still did not have toilets and used the bush for defecation. There were households that benefited from the World Vision WATSAN and Nazarene Compassionate Ministries-SD WASH programmes and thus received building materials for toilet construction. Some households kept the materials and did not build the toilets because they reported that the supplies were insufficient. Key informants revealed that cultural beliefs and practices affected improvement of sanitation facilities in some communities. It was, therefore, important to design community advocacy programmes that target community leaders as WASH change agents, to assist communities to appreciate WASH issues. Some WASH challenges were also cited in urban areas where there were construction activities. Key informants reported that some households start building houses before constructing toilets, resulting in environmental pollution around the construction site. Such activities resulted in water pollution in the rivers and dams, leading to health risks for households located downstream.

Headman Maziya in Mpolonjeni reported that most households in his area had access to clean water, although there were still a few communities without access to boreholes, which accessed drinking water from dams. Rural communities in Swaziland are different from most rural areas in southern Africa. Due to the small geographical size of the country, rural areas are not very far away from urban centres. This makes it possible to have different sources of clean and safe water, such as the piped water systems, connected to urban water supplies for rural populations, as well as to have water delivered by the Swaziland Water Corporation. However, information from key informant interviews and FGDs revealed that these supplies were affordable only to a few working class households. Water deliveries could last two to three months per 5,000 litres.

One case study of a household of PLHIV demonstrated incapacity to finance the initial infrastructure installation costs (pipes etc.) needed to access water 50 metres from the main system. This was irrespective of the fact that only a monthly fixed charge of ZARR50, plus usage, for piped water from urban water supplies was applicable. Information from community informants indicated that once connected, most households could afford this charge.

In the dry low veld of the country, boreholes and dams dry out due to the low water table. Respondents reported that householders travelled different distances to fetch water, depending on the proximity to the nearest water source. Two visited households with PLHIV travelled approximately one hour to and from the water source. Most used wheelbarrows to fetch water. Water collection is mostly done by women and girls. Households either boil or use Jik or Waterguard to treat the water prior to use and consumption. However, some reported that due to poverty, these chemicals were not always available. Communities reported that sometimes, Environmental Health Technicians assisted communities with testing the safety of their drinking water.

ZAMBIA

In the communities visited in Zambia, households obtain water from communal taps, with each household allowed to fetch 20 litres per day at a cost of an equivalent of US\$ 5 per month. Once they have paid, households with 'water cards' are allowed access to water from the communal taps.

In other communities, households collect more than 20 litres of water at a cost of ZMWK 5 (US\$ 1) per 210 litre drum and an additional fee charged for the labour to roll the drums to the house. Households that have challenges in paying, resort to using unsafe sources such as shallow wells and near-by streams. Water from the shallow wells and streams is usually contaminated. Respondents explained that during the dry season, communities experience erratic drinking water supplies. In one community, for example, seven boreholes cater for 25 zone areas, resulting in a number of households walking about a kilometre to find clean water sources. Due to the long distances to water sources, especially for PLHIV and people with disabilities, a number resort to fetching water from the nearest unprotected shallow wells.

At communal taps, long queues are the norm, causing further challenges for PLHIV who often defaulted on their ART adherence due to missing their medication schedules whilst waiting for their turn to fetch water. Furthermore, water availability was worsened by erratic electricity supplies that affect the pumping of water. Results from interviews revealed that people are knowledgeable about water treatment methods i.e. either boiling or chlorination. However, due to low disposable incomes, households cannot afford the costs of chlorine or charcoal for boiling.

In some communities visited, as many as 10 housing units have no toilets and use neighbours' pit latrines or beer containers (Shake-Shake/Chibuku packs) for defecating; these are then disposed of at the nearest garbage dumping sites. In some cases, plastics bags are used, especially at night, and disposed of early the following morning. Cleaning of pit latrines is usually done using plain water and sometimes with soap and water when soap can be afforded.

SELECTED STAKEHOLDERS INITIATIVES TO INTEGRATE WASH AND HIV

LESOTHO

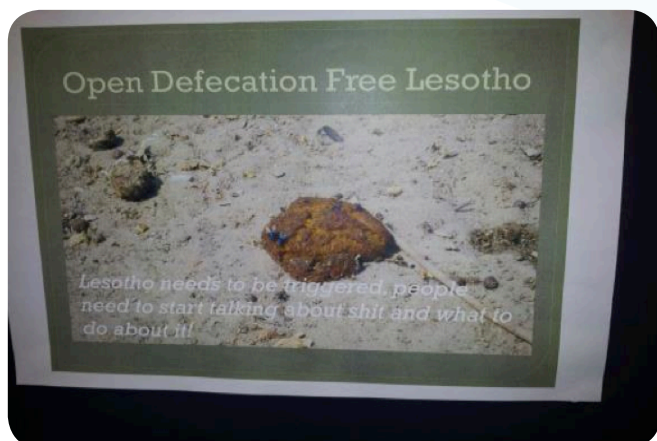
Results from interviews with stakeholders and literature review revealed that there are few WASH and HIV integration interventions in Lesotho. UNICEF, for example, has a number of WASH-related programmes although the body does not deliberately integrate the two. UNICEF, through the HIV and health programme, supports the government to deal with aspects of WASH in relation to HIV. The HIV programme covers PMTCT, paediatrics HIV care, adolescent HIV prevention programmes, child health and nutrition and water and sanitation. The water and sanitation component focuses on sanitation and hygiene activities because of the high incidence of diarrhoea-related deaths.

To improve infant feeding, UNICEF supported the Government of Lesotho to implement a behaviour change programme focusing on educating communities about hand washing with soap and the use of safe sanitation facilities. However, initiatives did not target HIV, but used nutrition as an entry point for water and sanitation. In March 2014 UNICEF, in partnership with line ministries, introduced a programme implemented following the community-led total sanitation approaches. The programme was at advocacy level, and was being implemented by the Government of Lesotho and national stakeholders at the time of the assessment. Through the programme, UNICEF planned to facilitate the formation of a national sanitation taskforce that would advocate for, plan and foster community-led total sanitation approaches. At the time of the assessment, taskforce membership included Rural Water Supply, MoH Environmental Health Division, MoE, Ministry of Local Government and the Red Cross. The membership, it was planned, would be widened to co-opt all relevant stakeholders as implementation gained momentum.

UNICEF also implemented a schools' WATSAN programme launched in 2012. Programme implementation focused on the construction of VIP latrines, as well as community sensitisation on water and sanitation.

The MoH provided both WASH and HIV programmes. Services for both were sometimes given simultaneously. WASH and HIV awareness rising was simultaneously covered during health talks given daily at secondary health care 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. Some care facilitators use their own resources to acquire disinfectants for the bedridden. The health centres distribute gloves for HBC which primary caregivers are encouraged to consistently use when bathing patients and changing their soiled diapers and sanitary ware.

Figure 4: Campaign Message against Open Defecation in Lesotho



The Lesotho Red Cross Society implemented a school-based WASH programme targeting teachers who were expected to cascade the information to schoolchildren. The organisation also provided communal taps for whole communities.

MOZAMBIQUE

There are organisations in Mozambique implementing programmes that mainstream HIV in their community WASH interventions. Examples include Water and Sanitation for the Urban Poor (WASUP). 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 those not who cannot exclusively breastfeed because of their positive HIV status.
- Specific hygiene practices for PLHV, including hygiene during menstruation.
- Economic empowerment options for households impacted by HIV so that they can improve their WASH infrastructures.

SWAZILAND

In recognition of the linkages between WASH and HIV, the Government of Swaziland, through the MoH, adopted a policy to construct double pit latrines in communities, which can be used for separate disposal of medical and human waste. A nurse at a local clinic in Mpolonjeni reported that households were encouraged to construct double-hole standard toilets i.e. one for disposal of used materials and the other for use as a toilet. Although the double-hole toilets are the national standard, reports from health professional revealed that most households, including those with PLHIV, could not afford the construction costs. Limited government resources mean the government cannot support construction of double pit latrine forll needy households.

Organisations such as NCM-SD utilised Rural Health Motivators (RHMs) as community entry points when designing their WASH programme. RHMs are a part of the MoH and work at community level to facilitate health and hygiene education and promotion. Reports from NCM-SD WASH programme informants were that the programme had been very effective and instrumental in community-based WASH planning. NCM-SD's strengths in facilitating community WASH programmes was attributed to its possession of all pertinent information on community WASH challenges and opportunities. In the same programme, RHMs reportedly to formed part of community water point committees.

Another organisation, Compassionate Swaziland, focuses on schools WASH interventions and focuses on constructing toilets that meet the needs of physically challenged and disabled school children.

Hospitals and clinics reportedly do not have records of WASH indicators for particular categories of patients, although health workers thought this was important to have. National data collection mechanisms such as the National Census and Demographic Health Surveys collected inadequate WASH and/or HIV data. The country does not have any routine and systematic national assessments that comprehensively focus on the collection and documentation of comprehensive WASH and HIV indicators.

ZAMBIA

At the time of the assessment, there were no strict and effective WASH and HIV linkages in Zambia. Programmes and interventions were either exclusively HIV or WASH-oriented. This was mainly attributed to the fact that at implementation level, there is little room to manipulate the types of programme to implement and how. As such, issues were allegedly dictated by programme funders.

At implementation level, practitioners reported finding it difficult to integrate interventions because integration at national level did not exist. It is therefore difficult to implement activities that would not have been well planned from the beginning. Few organisations, like DAPP, tried to integrate WASH and HIV in programmes. For example, DAPP child aid projects are integrated to some extent, mainly through 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 accessed drinking water from unprotected sources.

At national level there are no specific procedures or guidelines for the collection and recording of integrated data on WASH and HIV. National assessments such as the DHS collect both WASH and HIV information, but this is largely inadequate to assess integration. Furthermore, most organisations face adequate funding in their efforts to implement integrated interventions.

FINDINGS ON WASH KNOWLEDGE AMONG HOUSEHOLDS WITH PLHIV

Households with PLHIV were generally knowledgeable on WASH issues, although this understanding was sometimes not reflected in their behaviours or practices. Rural communities were aware of the importance of good hygiene practices. They were conscious of the need to maintain the cleanliness of their homes, to bath regularly, use soap when washing hands and the critical times to wash their hands. They were very knowledgeable that the unavailability of water impacted on their hand washing methods and frequencies.

Communities were also very aware of the importance of latrines for safe disposal of human waste and other household waste and also expressed general positive interest in using latrines if they are available. Communities expected external help to construct toilets. In Lesotho and Swaziland, the major challenge was the need to translate positive and correct community health and hygiene knowledge into practice.

Interviews with MoH officials revealed that household members were generally reluctant to take up health and hygiene messages, allegedly due to high poverty levels and lack of commitment to address household sanitation issues. In situations where toilets were unavailable in the home, household members continued to defecate in the bush, especially at night. In child headed household visited during the assessment in Lesotho, garbage and wastewater was dumped hardly six metres away from the entrance into the house.

The need for concerted efforts in ensuring behaviour change focused health and hygiene education at community and household levels cannot be overemphasised.

Focus group discussions with CBVs also showed that more education on WASH issues is needed, particularly that targeting households with PLHIV to improve knowledge levels of primary caregivers on how to care for and support critically ill members. An HIV positive grandmother who heads a household in Swaziland explained that it is widely believed that due to lack of knowledge, she contracted HIV while nursing her son and his wife who were HIV positive but did not reveal their status to her.

STIGMA AND DISCRIMINATION IN ACCESSING WASH SERVICES

Due to increased awareness and education, stakeholders reported that stigma and discrimination against PLHIV had greatly reduced in all the four countries. One participant in Lesotho explained that, “... *why discriminate, they are us, we sleep with them, we share everything except for sharp utensils and tooth brushes*”. It was also stated that PLHIV do not face any discrimination in accessing community WASH services. The general key stakeholders’ perception was that in the context of reduced discrimination and stigma directed at PLHIV, it difficult to come up with a WASH programme specifically targeted at PLHIV. Doing so could potentially be viewed as some form of discrimination, which might increase community levels of stigmatising behaviours and attitudes towards PLHIV. Instead, proposals were in support of programmes which target all segments of a society, but take note of the special needs of the vulnerable groups, among them PLHIV.

Focus group discussions and household interviews from study sites in Zambia revealed that some discrimination still persisted, although at lower levels. It was reported that there were cases where if an HIV positive person approaches a water point, people often begin to whisper among themselves and pass statements that make people living with HIV uncomfortable. It was reported that in some cases, neighbours who had individual household taps refused access to PLHIV and the disabled to fetch water from these sources. The common excuse for refusal was the need to avoid increased water bills, not one’s HIV status. Such discriminatory behaviour was mainly attributed to poor knowledge of HIV transmission methods.

HYGIENE PRACTICES IN HOUSEHOLDS WITH PLHIV

WATER STORAGE

Most households were aware of recommended drinking water storage practices. A good number of households stored their drinking water in containers or buckets covered with lids at all times and used a cup to get water from their storage buckets. The containers differ in sizes but range from 20 litre buckets to 2,000 litre drums. Mostly, 20 litre drums are used for fetching water.

Cleanliness of the containers and items used to draw drinking water from the respective storage containers depended on general household hygiene standards, which depended on household member composition. Households with more children reportedly encounter greater challenges in maintaining household water cleanliness. There have been drives to encourage the use of buckets with taps but these types of bucket are not always readily available or affordable.

In most cases water is collected for immediate use and very little is stored; the longest storage is at most three days. However, in Lesotho in some villages water can be stored in the home for up to two weeks to cater for times when there is no water at all.

USE OF PROTECTIVE MATERIALS

In all the four countries, wearing gloves by primary and secondary caregivers was the common hygiene practice in the care and support of bedridden patients. In cases where gloves were not readily available, plastic bags were the most common alternative.

In extreme, cases especially involving care and support for close relatives, high risk practices such as the use of bare hands was reported. Using bare hands to clean patients who are close relatives is allegedly done because of lack of money to buy gloves and, more importantly, the fear of being labelled by family members as lacking love for the sick should one wear plastics or gloves.

In most of the countries assessed, gloves used to be available through the home-based care programme but at the time of the assessment such programmes were not as well supported as they used to be. In Swaziland clinics indicated that they sometimes provided gloves to primary caregivers through RHMs when available.

FAECES DISPOSAL

The problem of having bedridden persons has been greatly reduced in study countries partly attributable to the expansion and success of the ART programmes. However in cases where some PLHIV get to the stage of being bedridden, primary and secondary caregivers used buckets, basins, plastic sheets and disposable nappies.

Knowledge on recommended hygienic standards and practices was quite high among households with PLHIV. Findings showed that faeces or soiled nappies are disposed of in the latrines, buried in shallow holes or thrown away in the bush.

However in countries such as Swaziland the MoH did not encourage burying of used nappies or sanitary pads in shallow pits as these could be easily unearthed by dogs and end up polluting the environment including water sources. The basins, buckets or plastic sheets were washed with water, soap and detergents such as jik. However, soap and other detergents were not always available resulting in use of water only to wash the reusable items. The situation was similar across all countries.

MENSTRUATION

Assessment results revealed that the primary caregivers who are related to their patients are largely responsible for bathing and cleaning female patients during their menstrual periods. In cases where there were no female relatives, female patients are assisted by community-based volunteers (village health workers or RHMs) to wear proper sanitary wear, bath and change.



In Swaziland sanitary pads were reportedly not always available, resulting in clean sheets being commonly used instead. The findings of the assessment are that the sheets are washed and ironed before reuse as a sterilisation measure.

In Lesotho, care facilitators used their personal resources to ensure that the sick had proper sanitary ware. Some were supported with monthly hygiene packages from NGOs like the Red Cross Society, Swanep etc.

In Zambia, caregivers reported that patients used diapers during menstruation because patients can stay for more hours without messing themselves, compared to when pads are used.

This is because patients spend most of the time lying in bed, and diapers therefore, offer better protection for longer. Those who cannot afford diaper use either cotton wool or pieces of cloth, which are washed afterwards and left to dry before being re-used.

HAND WASHING

The practice of hand washing in all countries has reportedly improved, because of the recognition of the Global Hand Washing Day, celebrated on the 15th October every year, in study countries. This day was marked by extensive awareness creation campaigns on proper hand washing methods in different communities by governments and their partners. Findings showed that all households had adopted the run-to-waste method where running water is used to wash hands, either from the tap or from a container (jar or cup).

In Zambia, DAPP introduced 'tip-taps' an initiative where water is placed in a container and the vessel tied up a tree or a wooden pole, and a hole made at the top of the container. A rope is tied to the container at the very top and piece of wood attached in such a way that someone just has to step on the wood and the container automatically tilts and produces running water for hand washing. This invention is useful for ensuring that there is no direct contact between the hands and the container.

Caregivers explained that they knew that hands should be washed with soap, but that the challenge was that soap is not always available. There are a number of programmes in the communities assessed which provide soap and other disinfectants. The challenge, however, is that the packages usually ended at the point of project or programme implementation due to government failure to continue supporting initiatives.

Discussion

The assessment showed that in all four countries, key informants were unaware of any specific guidelines or standard operating procedures for integration of WASH and HIV. However, in each country there exists several other guidelines, e.g., guidelines for integration of HIV and TB, HIV and nutrition, etc. This means that it is possible to come up with guidelines for WASH and HIV integration.

The absence of country-specific WASH and HIV integration guidelines does not necessarily mean the absence of efforts to integrate WASH and HIV in study countries. Several efforts by NGOs and/or governments were identified, although these are predominantly implemented on ad-hoc bases and in an unco-ordinated manner. In many instances, these efforts are led by NGOs, particularly those in both HIV and WASH programming. Findings also revealed that for some organisations, unplanned and unintentional integration does exist.

Results from literature review showed that lack of planned integration starting at policy level and further reflected in both WASH and HIV programming was sometimes the result of lack of country-specific research on linkages between WASH and HIV. In recognition of this challenge, in 2006 WHO with support from USAID, commissioned country assessments in six countries on the *"Adequacy of Water, Sanitation and Hygiene in Relation to Home-based Care Strategies for People Living with HIV/AIDS"*. The assessments were conducted in China, Malawi, Nigeria, South Africa, Vietnam and Zambia as the first step to develop country-specific policies, strategies and programmes aimed at enhancing WASH and HIV integration⁸.

It could be concluded that the major WASH and HIV integration weakness at the time of the assessment was the absence of integration guidelines or operating procedures. However, the biggest opportunity for WASH and HIV integration is the pronounced integration practices of the two sectors with other sectors, from which best practices and lessons learnt can be drawn.

In HIV programming, stakeholders indicated that donors, particularly USAID PEPFAR and the Global Fund, were interested in funding proposals that addressed six "high impact areas" as spelt out in the UNAIDS Investment Framework. It was unfortunate that WASH was not among the six. This was irrespective of the majority of informants' perception that WASH is a basic requirement for one to achieve high impact in areas such as treatment, care and support for PLHIV and prevention of new infection in children was supposed to be one of the key high impact areas. A good example is the Swaziland's 2009–2014 Multi-Sectoral National Strategic Framework for HIV and AIDS which made provisions for the integration of WASH in HIV programming. The framework was revised in line with UNAIDS' Investment Framework guidelines into the new Extended National Multi-Sectoral HIV and AIDS Framework (2014–2018) which even then does not mention water and sanitation issues.

In all four countries assessed, both WASH and HIV were mostly externally funded, with UNICEF, the European Union, USAID, the Global Fund, and the United Kingdom Department of International Development (DFID), as the main external donors. It seems that meaningful inroads to integrated programming for HIV and WASH can be made if funding channels are also influenced to ensure benefits.

⁸ Chris Hillbrunner (2007) Background Paper, Workshop on Integration of Water, Sanitation and Hygiene into HIV/AIDS Home-Based Care Strategies, Lilongwe, Malawi : Oct 29 – Nov 1, 2007

Interviews with stakeholders seem to indicate that to some extent, external donors had specific funding procedures and conditions which did not necessarily incorporate issues of WASH and HIV integration. Funding conditions, however, tend to be flexible in most cases, but where inflexible, can affect efforts to strengthen integration of HIV and WASH. Some donor representatives interviewed, especially those from the EU, felt that there is some flexibility in funding procedures that can allow WASH and HIV integration. The general conclusion of the assessment is that limits start with the opinions of implementers, and not necessarily the donors. Broadening one's HIV proposal to include a major WASH component could be a high risk move with the threat of losing a funding opportunity, but including these issues in realistic terms could prove cutting edge and beneficial.

WHAT CAN WE DRAW FROM THE FINDINGS – AN ANALYSIS OF COMMON THREADS?

Whilst policy is the first entry point for driving the integration agenda, more is required at national and SADC level to support the plan. Whilst countries have policies and frameworks in place, these largely speak to WASH and HIV separately. This is the biggest stumbling block and there is need for dialogue in countries and regionally to ensure the adoption of effective policies and frameworks on WASH and HIV integration. The availability of SADC region frameworks and guidelines can be used to guide development of national and local HIV and WASH integration frameworks. At country level, the co-ordination of WASH and HIV integration agendas is not clearly defined, with the key question being who will lead this process? Once this is addressed, effective leadership can drive greater stakeholder participation and co-ordination. Evidence points towards greater need at community level for integrated programmes that promote access to sanitation services and remove socio-cultural barriers.

A key opportunity for driving WASH and HIV integration is the existence for diverse funding streams across the countries assessed. There is room to engage funding partners who either focus on WASH or HIV to promote greater integrative funding. Furthermore, all countries have functional structures for HIV and WASH, which can be used as effective entry points for greater co-ordination and collaboration. The existence of partners such as UNICEF and the Red Cross, which are implementing integrated WASH and HIV projects, is essential as important lessons can be documented and shared on what works and what does not work in integrated WASH and HIV programming. Wider documentation and dissemination through platforms for dialogue is required to provide effective evidence on what has worked in integrating WASH and HIV.

Conclusions and Recommendations

CONCLUSIONS

The main stumbling block to WASH and HIV integration is inadequate national integration policies, guidelines and frameworks. At implementation level, WASH and HIV linkages exist, in an un-coordinated and ad-hoc manner. Lesotho has clearer policies in terms of provisions for HIV and WASH integration compared to other countries. More work, particularly on the HIV side needs to be done in Zambia, Swaziland and Mozambique in that order. The availability of SADC regional frameworks and guidelines can be used to guide development of national and local HIV and WASH integration frameworks.

There is low co-ordination between the WASH and HIV sectors, and the limited funding available to organisations working on both WASH and HIV makes these linkages difficult to make. Disparities between the two sectors in terms of co-ordination, funding and policy commitment also affects any attempts at synchronisation.

Although there are several in-country platforms where different HIV and WASH sector stakeholders meet, these platforms are more aligned to either sectors, with limited integration between both. A critical question to be asked is who will lead the integration of HIV and WASH issues in initiatives? The process should be owned by all stakeholders at local and national level, with national governments taking the lead through their responsible ministries and departments.

Community and household hygiene knowledge seemed high, contrary to recorded statistics. This was because of education and support from village health workers in the communities visited. However, translation of the knowledge into practice could be the missing piece.

Access to improved sanitation remains very low in all four countries. Cultural and traditional values and beliefs emerged as key factors influencing access to and utilisation of improved sanitary facilities in Mozambique, Lesotho and Swaziland. Some communities believed that open defecation is not a risky health practices since it had been practiced for generations. In some communities there were designated areas for open defecation.

Issues of the inclusion of the WASH needs of vulnerable groups, including appropriate WASH technology options that address the physical needs of people with disabilities, cannot be overemphasised.

RECOMMENDATIONS

In the context of the assessment findings, the following recommendations are made:

- a) Consider strengthening capacities and broaden mandates of existing platforms to include WASH and HIV integration rather than creation of new structures or platforms.
- b) The WASH and HIV integration process should be owned by all stakeholders from local to national levels, with national government leading through their responsible ministries and departments.

- c) Efforts to initiate WASH and HIV Integration should take note of existing guidelines, best practices and lessons learnt from integration initiatives, processes and practices in other sectors such as those between HIV and TB, SRH, and nutrition.
- d) WASH and HIV integration initiatives should adequately assess existing implementation barriers in the respective sectors and provide adequate mitigation efforts to address policies.
- e) Ensure that a critical mass of stakeholders from all key Government Ministries (Health, Water, etc.) relevant UN agencies (UNICEF, UNDP etc.) local and international NGOs, community level representatives have adequate buy-in to the WASH/HIV integration initiatives.
- f) Ensure a community demand led process that guarantees effective representation and participation of the affected individuals, households and communities including the poor and other vulnerable groups.
- g) Funding of WASH/HIV integration processes should be additional and not shift from the current funding towards the two respective sectors.
- h) Ensure that existing inhibiting cultural beliefs and practices are addressed through appropriate strategies such as culturally sensitive but strong and effective advocacy programme at all levels.
- i) The WASH and HIV integration process and strategies should include interventions that address sustainability issues such as capacity building of beneficiary government institutions, communities, households and individuals to support project outcomes on a long-term basis.
- j) The integration process should incorporate gender and other cross cutting issues. Balanced roles for women are critical as women are disproportionately affected by WASH and HIV challenges compared to men and they are responsible for most WASH and HIV chores at household levels.
- k) Development of the WASH and HIV integration mechanism needs to consider how guidelines can be used in both rural and urban settings.

COUNTRY SPECIFIC CONCLUSIONS AND RECOMMENDATIONS

The following country specific recommendations are provided in addition to the general ones outlined above:

LESOTHO

- Although the country has in place policies that speak to the integration of WASH and HIV, there is need to develop and disseminate integration guidelines to all key stakeholders at national, district and community levels. It is also critical to align existing guidelines with international and regional standards. The country needs to consult communities in the development process to promote ownership and sustainability.
- Engagement of WASH and HIV funders by the government and civil society organisations advocating for integration of the two sectors should be initiated. It is also key to consider funding guidelines to enable effective integration of these sectors.
- Access to and utilisation of improved sanitation was a huge challenge in Lesotho. Interventions that promote demand and utilisation of improved sanitation services and facilities are important for the country to ensure meaningful impacts of WASH interventions. Improved resource mobilisation for HIV interventions needs to be spread to support WASH initiatives as a strategy to enhance integration of the two sectors.
- Integration of HIV and WASH should be formalised in HIV and WASH platforms at national, district and community level.

MOZAMBIQUE

In Mozambique, the major weakness of WASH and HIV integration efforts is the absence of strong and clear national integration policies and frameworks. In this context, the following recommendations are made:

- Policy frameworks need to be strengthened as they provide firm foundations for effective integration of WASH and HIV. The current policy environment is not conducive for integration. Policies should provide clear direction and guidelines on integration. It is also critical to disseminate these policies and guidelines to all key stakeholders at different levels. Community engagement in developing these guidelines should not be undermined.
- Engagement of donors who support WASH and HIV programmes by the government and civil society organisations advocating for integration of the two sectors should be initiated. It is also important to consider funding guidelines to enable effective integration of these sectors.
- Clear co-ordination roles between WASH and HIV government departments or ministries should be defined to reduce inefficiencies.
- The government, in partnership with its development partners, should scale-up interventions to improve access to safe water and sanitation services. Further investigations to understand factors contributing to such low coverage are important to enable evidence-based interventions.
- Integration of HIV and WASH should be formalised in HIV and WASH platforms at national, district, and community level.

SWAZILAND

In Swaziland, the key threats to effective WASH and HIV integration emanates from the absence of well-articulated policy positions on WASH and HIV integration, lack of clarity on co-ordination roles between government departments, especially MNRE and NERCHA, and the absence of effective WASH and HIV co-ordination platforms. In this context, the following recommendations are proffered:

- The country needs to strengthen its policies to articulate HIV and WASH integration issues. This should be accompanied by integration guidelines that are well known by all stakeholders at different levels. Various population groups, in rural, urban and other settlement types, must be consulted so that policies, frameworks and guidelines cater for all.
- To promote effective integration, co-ordination roles between MNRE and NERCHA must be defined.
- Engagement of funders of WASH and HIV programmes by the government and civil society organisations advocating for integration of the two sectors should be initiated. It is also important to consider funding guidelines to enable effective integration of these sectors.
- Consider strengthening existing platforms from both sides in terms of integration of WASH and HIV issues, rather than coming up with a new structure or platform that brings both WASH and HIV stakeholders together. This can be done by ensuring adequate representation of WASH and HIV issues, and creating effective feedback mechanisms.

ZAMBIA

- Similar to WASH-related policies and frameworks, HIV related policies and frameworks need to be strengthened to clearly articulate integration of WASH interventions. In addition, there is need to develop National HIV and WASH integration guidelines. Integration guidelines and the development of standards must be participatory, and the outputs disseminated to all relevant stakeholders at various levels.

- The government and CSOs advocating for the integration of HIV and WASH must engage donor agencies supporting HIV and WASH so that funding mechanisms are aligned and do not hinder integration efforts.
- The country has various national, district and community-level WASH and HIV structures which opportunities to integrate WASH and HIV interventions. The government, with support from its development partners, should strengthen these platforms so that deliberate integration takes place.

WHAT ROLES CAN STAKEHOLDERS PLAY?

NATIONAL GOVERNMENTS

- Create enabling environments which that allow players from the WASH and HIV sectors to meet, dialogue and plan together in efforts to strengthen coherence and co-ordination between the two sectors.
- In countries which are lagging behind in terms of regulations, national governments should ensure that existing health and water and sanitation policies and frameworks have provisions in place which allow for the integration of HIV and WASH.
- Support the development and contextualisation of HIV and WASH integration guidelines.
- Monitor implementation of the guidelines by relevant government departments and actors in the two sectors.

DONORS

- Avail funding to directly support the integration process.
- Donors from both sectors should provide funding opportunities that promote the integration of HIV into WASH, or vice versa. This can be done through the different calls under existing funding mechanisms for HIV or WASH.

ORGANIZATIONS IMPLEMENTING WASH AND HIV PROGRAMMES

- Advocate for an enabling environment that allows for and supports improved co-ordination between HIV and WASH sectors.
- Participate in the formulation and contextualisation of HIV and WASH integration guidelines.
- Mobilise resources for programmes that promote integration of the two sectors.
- Implement the guidelines at all levels as they implement their programmes.

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ZAMBIA

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WASH INDICATORS IN ASSESSMENT COUNTRIES

	Year	Population		Water				Sanitation		
		%	Rural %	Urban		Rural		Urban	Unimproved	
				%	%	%	%	Total	Total	Open Defecation (%)
L E S O T H O	2000	20.0	80.0	93.3	6.7	75.5	24.5	35.1	64.9	10.8
	2002	21.2	78.8	93.3	6.7	75.7	24.3	35.4	64.6	9.8
	2004	22.6	77.4	93.3	6.7	75.9	24.1	35.7	64.3	8.8
	2006	24.0	76.0	93.3	6.7	76.1	23.9	36.1	63.9	7.7
	2008	25.4	74.6	93.2	6.8	76.3	23.7	36.4	63.6	6.7
	2010	26.8	73.2	93.2	6.8	76.5	23.5	36.7	63.3	5.7
	2012	28.3	71.7	93.2	6.8	76.7	23.3	37.0	63.0	4.7
M O Z A M B I Q U E	2000	29.1	70.9	74.9	25.1	27.2	72.8	37.1	62.9	24.7
	2002	29.5	70.5	75.8	24.2	28.5	71.5	38.2	61.8	22.7
	2004	29.8	70.2	76.7	23.3	29.8	70.2	39.2	60.8	20.6
	2006	30.2	69.8	77.6	22.4	31.1	68.9	40.3	59.7	18.6
	2008	30.5	69.5	78.5	21.5	32.4	67.6	41.4	58.6	16.5
	2010	31.0	69.0	79.4	20.6	33.7	66.3	42.5	57.5	14.5
	2012	31.4	68.6	80.3	19.7	35.0	65.0	43.6	56.4	12.5
S W A Z I L A N D	2000	22.6	77.4	88.8	11.2	41.1	58.9	62.8	37.2	2.2
	2002	22.3	77.7	89.6	10.4	45.7	54.3	62.8	37.2	2.1
	2004	22.1	77.9	90.4	9.6	50.4	49.6	62.9	37.1	2.0
	2006	21.8	78.2	91.2	8.8	55.0	45.0	62.9	37.1	1.8
	2008	21.5	78.5	92.0	8.0	59.6	40.4	63.0	37.0	1.7
	2010	21.3	78.7	92.8	7.2	64.2	35.8	63.0	37.0	1.5
	2012	21.2	78.8	93.6	6.4	68.9	31.1	63.1	36.9	1.4
Z A M B I A	2000	34.8	65.2	87.1	12.9	35.0	65.0	58.8	41.2	2.0
	2002	35.4	64.6	86.7	13.3	37.4	62.6	58.4	41.6	1.9
	2004	36.2	63.8	86.3	13.7	39.7	60.3	58.0	42.0	1.8
	2006	37.0	63.0	85.9	14.1	42.1	57.9	57.6	42.4	1.7
	2008	37.9	62.1	85.6	14.4	44.5	55.5	57.2	42.8	1.6
	2010	38.7	61.3	85.2	14.8	46.9	53.1	56.8	43.2	1.5
	2012	39.6	60.4	84.8	15.2	49.2	50.8	56.4	43.6	1.5

	Rural		
	Unimproved		
	Total Improved (%)	Total	Open
	21.1	78.9	54.4
	22.1	77.9	52.9
	23.0	77.0	51.3
	23.9	76.1	49.7
	24.8	75.2	48.1
	25.8	74.2	46.6
	26.7	73.3	45.0
	4.7	95.3	67.8
	5.7	94.3	65.2
	6.7	93.3	62.6
	7.7	92.3	60.1
	8.7	91.3	57.5
	9.7	90.3	54.9
	10.7	89.3	52.3
	48.6	51.4	29.2
	49.8	50.2	27.2
	51.0	49.0	25.2
	52.3	47.7	23.2
	53.5	46.5	21.2
	54.7	45.3	19.2
	56.0	44.0	17.3
	31.0	69.0	33.2
	31.5	68.5	31.5
	32.0	68.0	29.8
	32.5	67.5	28.1
	33.0	67.0	26.4
	33.5	66.5	25.5
	33.9	66.1	25.5

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