

UNICEF MOZAMBIQUE

Hand hygiene for all

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KEY MESSAGES

1. Communicable diseases are diseases that spread from person to person, accounting for nearly three quarters of all deaths (73 per cent) in Mozambique. Pneumonia (9.8 per cent) and diarrhoea (8 per cent) are in the top five leading causes of death of children under five years in Mozambique.
2. Hand hygiene is one of the most cost-efficient measures to prevent communicable diseases. For example, 50 per cent of diarrhoea related deaths could be prevented by handwashing with soap, while investing in a hygiene campaign could yield a 92-fold return on investment.
3. Access to and compliance of hand hygiene are key to preventing Covid-19 transmission, therefore it is now to focus on hygiene promotion and improve access to water, sanitation and hygiene (WASH) services, for now and for the future.
4. Equitable access to WASH services in general and specifically in schools and health facilities is alarmingly low. Only 15 per cent of schools have a functional handwashing station with soap and just over half (56 per cent) of health facilities have access to basic water supply.
5. Achieving equitable access to water, sanitation and hygiene (WASH) services requires; (a) developing contextualized national norms and standard for WASH services in schools, health facilities and other public spaces, (b) including WASH indicators in routine monitoring mechanisms and (c) investing in schools, health centres and other public spaces to meet these national norms and standards.
6. Launching a national handwashing campaign now would complement the school reopening process, reinforce compliance with hand hygiene for COVID-19 prevention and contribute to sustaining handwashing behaviours, preventing communicable diseases now and in the future.

EXPLANATION OF TERMS

WASH Services: water, sanitation and hygiene services being provided as a result of a system of infrastructure, operation and maintenance regime, supported by sustained financing resulting in functional handwashing stations with soap.

Norms: agreed minimum services levels, defined by a legal document, for instance one toilet per fifty students in schools.

Standards: related to designs of infrastructure in order to reach a level of standardization. For example, a toilet should be gender sensitive and inclusive, have a lockable door and separating walls between female and male toilets.

INTRODUCTION

Communicable diseases account for a large proportion of deaths at global level. It is estimated that there are around 1.1 billion diarrhoea cases globally.ⁱ Diarrhoea death is the eighth leading cause of global deaths of all age groups, and the fifth cause of deaths of under five-year old children globally.ⁱⁱ In Mozambique, communicable diseases account for nearly three quarters of all deaths (73 per cent), while pneumonia (9.8 per cent) and diarrhoea (8 per cent) are number two and four top causes of death in Mozambique.ⁱⁱⁱ The prevalence of diarrhoea (having had a diarrhoea in the last two weeks) is 11.1 per cent for all age groups and 18.5 per cent for the 1 to 2 years of age group.^{iv} These cases can be prevented to a great extent with the practice of handwashing with soap.

The impact of hygiene services is most strongly reflected in neonatal period (the first 28 days of life) as this is the most vulnerable time for a child's survival.

Globally, 2.4 million children died in their first month of life in 2019 – approximately 6,700 neonatal deaths every day – with about a third of all neonatal deaths occurring the first day after birth, and close to three-quarters occurring within the first week of life. One of the most common killer of newborns is neonatal infection, meaning that these deaths could be prevented through childbirth care and hygiene. Mozambique has a very high neonatal mortality rate of 28.5/1,000 live births. This figure is much higher than the average global rate of 17 and it is also high compared to its neighboring countries: South Africa (11.5), Zambia (23.3) Tanzania (20.3), Eswatini (18.4), Malawi (19.8) and Zimbabwe (25.9).^v

Substantial global evidence shows that handwashing with soap at critical times stops disease transmission:

- Washing hands with soap and water could reduce diarrhoeal disease-associated deaths by up to 50 per cent.^{vi}
- Handwashing can reduce the risk of respiratory infections by 16 per cent.^{vii}
- Handwashing with soap by birth attendants and mothers increases newborn survival rates by up to 44 per cent.^{viii}
- Handwashing with soap has been found to help reduce school absenteeism that is caused by diarrhoea, influenza and conjunctivitis by up to 50 per cent.^{ix}

Handwashing promotion campaigns are the most cost effective compared to any other hygiene intervention;

- The rate of return on investment in handwashing programs is significant. For example return on investment in a national handwashing program was estimated to yield a 92-fold return in India and a 35-fold return in China.^{ix}
- An investment of \$3.35 in handwashing promotion is estimated to deliver the same amount of health benefits as a \$200 investment in household water supply.^{ix}
- Building a self-made handwashing station, “tippy tap”, can cost as little as \$5 and it only requires an empty water container and locally available materials.

Despite these huge benefits, the current status of access to handwashing at home, schools and health centers is alarming:

- Only 26 per cent of the households in Mozambique have access to a dedicated handwashing station with soap and water. In rural areas the figure is even lower, with only 17 per cent households having access^{iv}. Persons with disabilities, particularly physical, have particularly limited access.
- The situation in schools is even more alarming, only 15 per cent of all schools have access to a handwashing station with water and soap.^x
- Only 40 per cent of the rural health facilities have basic access to handwashing stations, while it is crucial to ensure infection prevention control.^x

Access to WASH services at households, Joint Monitoring Program [JMP] 2019

- **Basic access to water:**
56% (urban: 84%, rural: 40%)
- **Basic access to sanitation:**
29% (urban: 52%, rural: 17%)
- **Basic access to hygiene:**
26% (urban: 47%, rural: 17%)*
DHS 2011 (No estimate on JMP)

Access to WASH services in schools, (JMP 2018)

- **Limited access to water:**
31% (urban: 46%, rural: 28%)
- **Basic access to sanitation:**
48% (urban: 50%, rural: 46%)
- **Basic access to hygiene:**
15% (urban: 15%, rural: 11%)

Access to WASH services in health facilities (JMP 2020)

- **Basic access to water:**
56% national
- **Basic access to sanitation:**
43% national
- **Basic access to hygiene:**
40% rural (No national level estimate)

Source: JMP <https://washdata.org/data/downloads#MOZ>





HANDWASHING IN COVID19 CONTEXT

Covid-19 pandemic has placed handwashing at the top of government priorities and the practice of handwashing has increased;

- A recent survey has shown a strong compliance by the general public, up to 80 per cent, with the practice of handwashing as a COVID-19 prevention measure^{xi}.
- The Ministry of Education and Human Development has established the access to water supply and handwashing as a minimum condition for the reopening of schools.
- The Ministry of Health has adopted handwashing as a key message and the COVID-19 isolation centers have been equipped with handwashing stations, as it is an essential requirement for the implementation of Infection Prevention Control (IPC) practices.
- Markets are being reorganized to reduce the risk of transmission which includes the availability of handwashing stations and supportive messages at the entries and exits.

BOTTLENECKS

This momentum could allow a further shift of paradigm and support addressing fundamental bottlenecks to move forward with the hand hygiene agenda. Some of the key bottlenecks identified by UNICEF and partners based on their work in the sector are:

- There are no national service norms and designed standards for WASH services at schools and health facilities. Capital investments made in health facilities and schools often exclude WASH infrastructure and services vary across facilities depending on the funding agency. The existence of national approved norms is important to guarantee that a minimum safe level of WASH service is implemented.
- Sectoral routine monitoring systems of the Ministries of Education (EMIS) and Health (HMIS) do not include access to WASH services in their list of indicators. There are therefore limited insights into current service levels at schools and health facilities and respective gaps. Data regarding these indicators would provide a regular overview on coverage of infrastructure, gaps and the needs to be addressed by line Ministries. It would also allow better targeting of interventions and investment prioritization.
- Regarding budgeting and expenditures, investments made into WASH services at schools and health facilities do not have a unique identification code in the national budget structure, therefore it is not possible to explicitly budget and track investments being made. Schools and health facilities do not have a dedicated budget to operate and maintain the infrastructure, undermining the sustainability of service delivery.

OPPORTUNITIES AND POLICY ACTIONS

To address these bottlenecks the following set of immediate (<6 months), medium term (6 months- 2 years) and long term action points (>2 years) are being proposed:

Immediate actions(<6 months)

- Launch a hand hygiene campaign in the context of Covid-19 and school reopening plans; promoting handwashing with soap and group handwashing as a daily routine activity across schools before commencing classes (MoH/MoE).
- Support and inform schools to implement low cost and accessible hygiene facilities to accelerate the reopening of schools; provide guidance on how to self-build handwashing stations with local materials, providing a budget to construct these handwashing stations and purchase soap on a routine basis, so that all schools have access to hand washing stations with soap and water (MoE).
- Develop gender sensitive and inclusive national norms and standards for WASH services at health facilities, schools and public institutions (MoE/ MoH).
- Engage with private sector on investments in markets, product innovations and supply chains that ensure the availability and accessibility of hand hygiene supplies when and where needed.

Medium term (6 months- 2 years)

- Develop an investment case to define what resources will be needed by when for all health facilities, schools and public institutions to meet the national norms and standards in an incremental way (MoE/ MoH/ MoPH).
- Use the program-based budget and the budget marker to meet the national WASH norms for schools, health facilities and public institutions. Sustain services by allocating budget for health facilities, schools and public institutions to maintain and operate the services (MoE/MoH/MoPH/MEF).
- Include gender sensitive and inclusive WASH services into sectoral routine monitoring systems for schools (EMIS) and health facilities (HMIS) (MoH/MoE).
- Develop and implement an operation and maintenance framework for WASH services at schools and health facilities, with clear definition of roles and responsibilities and capacity building to ensure sustainable service delivery (MoE/MoH).

Long term (>2 years)

- Review the investments made in WASH services and analyze the progress on increasing access of WASH services at health facilities and schools (MoE/MoH/MoPH), against international targets, including access to children with disabilities.
- Measure the effectiveness of the health promotion strategy and campaign for changing hygiene practices in schools and health facilities, as well as the impact on disease burden (MoH).
- Ensure that hygiene education, including menstrual hygiene management, is well positioned into a planned review and revision of curriculum (MoE).

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 | for every child

Av do Zimbabwe,1440
P.O. Box 4713
Maputo, Mozambique

maputo@unicef.org
www.unicef.org.mz

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Social Policy, Evaluation, and Research Unit