



HYGIENE AND BEHAVIOUR CHANGE COALITION (HBCC) BASELINE PROJECT

IN

**MANICALAND PROVINCE (MUTARE & BUHERA),
MASVINGO PROVINCE (ZAKA & CHIVI), MIDLANDS
PROVINCE (MBERENGWA & ZVISHAVANE) AND
MASHONALAND WEST PROVINCE (NORTON)**

ZIMBABWE

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ABBREVIATIONS AND ACRONYMS

COVID 19	Coronavirus Disease 2019
DSTv	Digital Satellite Television
FCDO	Foreign, commonwealth and development office
FGD	Focus Group Discussion
FM	Frequency Modulation
GBV	Gender Based Violence
HBCC	Hygiene and Behavior Change Coalition
KII	Key Informant Interview
PPE	Personal Protective Equipment
SMS	Short Message Service
SI	Statutory Instrument
TV	Television
UK AID	United Kingdom Aid
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation

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SECTION 1: EXECUTIVE SUMMARY

CARE International in Zimbabwe is one of five countries under the CARE International's participation in the Hygiene and Behavior Change Coalition (HBCC) project, funded jointly by the FCDO (UK Aid) and Unilever. The HBCC project in Zimbabwe covers four provinces of Manicaland (Buhera & Mutare districts), Masvingo (Zaka & Chivi districts), Midlands (Zvishavane & Mberengwa districts) and Mashonaland West (Norton district). The project intends to minimize the transmission of and harmful impact of COVID-19 by delivering inclusive and interactive gender responsive mass media and digital communications, supported by product availability and community interventions that improve personal and environmental hygiene practices, and reduce stigma and discrimination.

This baseline study was carried out to understand current hygiene practices and their determinants, and to prioritize key hygiene behaviors and messages for inclusion in the CARE Zimbabwe HBCC program. Furthermore, the study will inform the design of the hygiene promotion package and behavior change strategy. The baseline was carried out to answer the following key questions;

- What is the prevalent level of understanding & hygiene practices observed among parents/caregiver on key hygiene practices linked to COVID 19 in the selected locations?
- What behavior change products are available in the household to practice routine behaviors?
- What are the current barriers for community members to perform key hygiene practices?
- Are there any hygiene promotion activities being delivered through routine immunization, social mobilization/ mass media or other avenues?
- What are the hygiene behaviors and messages that should be prioritized by CARE Zimbabwe's HBCC program?
- What would be appropriate means of communication for hygiene promotion in the targeted locations?

Methodology

A mixed method approach using quantitative¹ and qualitative research methods, was used in this baseline study. The main approach that was used is WASH'Em². WASH'Em is a process for rapidly designing evidence based and context-adapted hand washing behaviour change programmes in emergencies. The approach was chosen in this project because Zimbabwe like any other country in the world is in COVID 19 pandemic emergency situation. Other benefits of using WASH'Em are in listed.³ The approach involves using 5 rapid assessment tools to understand behaviour. In this baseline survey three rapid assessment tools (hand washing demonstration, touch points and disease perceptions) were used. These were supported by

¹ Appendix : Individual Questionnaire

² About WASH'Em <https://washem.info/about>

³ Why use WASH'Em <https://washem.info/about>

hygiene baseline questionnaire that was administered to 452 study participants from a sample of four baseline districts, Mashonaland West (Norton), Manicaland (Mutare), Masvingo (Chivi) and Midlands (Zvishavane)⁴. The majority 60% of them were women. Key Informant Interviews were held with at least 1 school and 1 clinic in each district and 1 radio station.

Sampling frame, sample size and procedure

Participants of the Baseline were drawn from the four out of the eight targeted districts. The sample frame was designed to represent both urban and rural beneficiaries- Norton and Mutare represented urban districts, Chivi and Zvishavane represented rural districts. A combination of convenient, and purposeful sampling was used in this study. Districts were conveniently sampled. A purposive sampling (non-probability) procedure was employed in picking respondents for questionnaires and, touch points, disease perceptions FGDs and hand washing demonstration. The purpose was to select respondents that represented the cross section of different kinds of people (men, women and youths) in all the targeted rural and urban districts. To this end, 4 schools, 4 clinics, 1 radio station, and participants for 32 focus groups discussions were selected on the basis of gender, age, availability and willingness to discuss hygiene issues.

Data Collection

Quantitative Data collection

A structured household questionnaire was administered to a total of 452 people spread in all the four districts. More than 63% of the participants/ parents/ caregivers were women (Table1). Youths were the least represented age group with less than 7% of the participants. To minimise exposure to COVID 19 of data collectors and members of the community, questionnaires were administered using telephone calls.

Distribution by gender

Sex	Chivi	Mutare	Norton	Zvishavane
Male	37%	33%	37%	32%
Female	63%	67%	63%	68%

Distribution by age

Age	Chivi	Mutare	Norton	Zvishavane
18-24	4%	4%	7%	4%
25-34	5%	22%	29%	19%
35-60	60%	56%	59%	68%
>60	31%	19%	6%	9%

Qualitative Data Collection

WASH'Em⁵ data collection tools for disease perceptions, hand washing demonstrations and touch points were used in collecting qualitative data in all the four districts. In addition, key informants including, one radio station, 4 School heads, 4 clinics (Doctors/ or Sister in charges) were interviewed. Among the key informants 58% were women.

⁴ Mutare and Norton are Urban Districts; Chivi and Zvishavane are the rural districts

⁵ WASH'Em data collection tools: <https://app.washem.info/rapid-assessments>

Hand washing Demonstrations

A sample of 28 hand washing demonstrations videos were taken, 14 in urban and the other 14 in rural districts⁶. Hand washing demonstrations were taken to generate quick insights with the guide of WASH'Em tools⁷. Majority of the hand washing demonstration participants in all districts (>70%) were women.

Sex	Norton	Mutare	Chivi	Zvishavane
Men	28%	14%	28%	14%
Women	72%	86%	72%	86%

Key Informant Interviews

The key informants include, Provincial radio stations, 3 digital message service providers 4 School heads/Health Coordinators (40-50% of them women), 4 clinics (Doctors/ or Sister In charges). Among the key informants 58% were women.

Focus Group Discussions

A total of 30 focus group discussions (FGDs) were held with members of the community in the respected districts using Touch points and Disease Perception WASH'Em tools. Fifteen FGDs were on disease perceptions and the other fifteen were on touch points. In urban districts, participants were grouped into men, women and youths while as in rural districts the team was able to assemble participants into men, women, girls and boys groups. Participants ranged between 7-16 people per each group.

Tool used	Sex	Norton	Mutare	Chivi	Zvishavane
Disease Perception (FGDs)	Men	26%	21%	23%	28%
	Women	31%	31%	34%	30%
	Girls	22%	29%	25%	27%
	Boys	20%	19%	17%	15%
Touch points (FGDs)	Women	32%	35%	34%	32%
	Men	25%	24%	25%	28%
	Girls	23%	24%	19%	22%
	Boys	19%	17%	21%	17%

Data analysis

Qualitative data collected using hand washing demonstration, diseases perception and touch point tools was entered and analysed in the WASH'Em software. Questionnaire data was

⁶ Norton and Mutare are urban districts; Chivi and Zvishavane are the rural districts

⁷ WASH'Em tools: <https://app.washem.info/rapid-assessments>

captured and analysed in excel. Expert judgement was used to analyse and integrate key informant interviews with the results and recommendations of WASH'Em software outputs.

RESULTS AND DISCUSSION

Knowledge of COVID 19 and other hygiene related diseases

- More than 90% of both men and women in all the districts are aware of COVID 19. Knowledge of COVID 19 was enhanced by national lockdowns that were pronounced by the government from the beginning of March 2020 and massive awareness raising programs by government through radio and national television.
- The literacy level to understand COVID 19 awareness programs or promotions is above 50% in all respective districts. 89% of men and 88% of women are literate.
- More than 50% in all the districts do not know how COVID 19 spreads except approximately 57% in Norton and 55% in Mutare who know that COVID 19 can be spread by contact with infected persons and contact with infected droplets respectively.
- On average men in the study have slightly more knowledge of the symptoms of COVID 19; 50.5% in favour of men. 50% of women are aware of other symptoms such as breathing difficulties and shortness of breathiness
- Majority of respondents (94% in Chivi, 88% in Mutare, 82% in Norton and 87% in Zvishavane) know the importance of hand washing practices to prevent the spread of COVID 19
- Other commonly cited measures in the range of 40-60% across all districts include covering of mouths, avoid large gathering and avoiding handshakes.
- However there is limited knowledge on preventive measures such as staying at home when one is sick (28% in Chivi, 11% in Mutare, 6% in Norton and 30% in Zvishavane), cleaning and disinfecting surfaces (28% in Chivi, 26% in Mutare, 30% in Norton and 30% in Zvishavane)

Hand washing

- Approximately 33% of people in rural areas have hand washing places/ facilities near the toilet or kitchen
- 69% in urban area (67% Norton and 53% in Mutare) had hand washing places. however, 54% of the hand washing places/ facilities are multifunctional hence chances are high that people may not use them after using the toilet
- Among the rural districts, Zvishavane was the worst with, 71% of people have no hand washing facilities near the toilet or kitchen.
- Hand washing facilities that were desirable and attractive are less than 30% in all the districts. It was also observed during hand washing demonstration that some hand washing facilities especially handmade ones were difficult to operate. Some had signs that they had not been used for days. Participants reported that if hand washing facilities are unattractive and unpleasant, people will only wash their hands briefly and many may not bother at all.

- Majority over 70% in all districts are aware that hands should be washed when they are dirty, after using the toilet or defecating and before eating. However, since there was no water near most toilets the chances are high that majority do not wash their hands after using the toilets in rural areas
- Just above average (50%) are aware that they should regularly wash their hands when caring for the sick. This puts over 40% of people who care for the sick at risk of contracting COVID 19.
- In addition, less than 40% in urban districts and less than 20% of people in rural districts are aware that they should wash hands before feeding babies or after changing child nappies. The level of ignorance put minors at high risk of COVID 19 infection and other hygiene related diseases such as diarrhoea.
- Approximately less than 40% of people in urban districts and less than 25% in rural districts were aware that they should wash their hands after coughing or sneezing as recommended by WHO. Discussions with some participants revealed that most of them especially in urban areas are aware of covering mouth and nose with fixed elbow or tissue when coughing but not washing hands whenever one coughs.
- During hand washing demonstrations some participants were hesitant, for example one participant was not sure whether to wash her hands using a 10 liter empty bucket or empty dish that was available. It can be concluded that such kind of people may not be washing their hands after using toilets, when caring for the sick, after feeding babes after coughing or sneezing or before preparing food in the kitchen. Rural districts are the most affected because they have limited access to information compared to their urban counterparts.

Water Availability

- Approximately 75% of people in rural areas and 54 % in urban area had no water at the hand washing facilities/ places
- 54% (Norton 50% and Mutare 58 %) had readily available water near/ or in the hand washing facility in urban areas
- 48% of household demonstration in urban area, people had to go and fetch water for hand washing somewhere. Norton is the most affected among the urban districts and most people depend on public water points (boreholes).
- During hand washing demonstrations, majority of participants were observed fetching water from somewhere for washing hands because their tapes were dry.
- Water challenges can be attributing to reduced hand washing frequency at key times e.g. after coughing or sneezing, after feeding babies and when taking care of the sick
- The public water points can be a key touch point that HBCC project should consider

Availability of Soap

- A significant, 69% of people in rural districts had no access to soap and did not use ash for hand washing
- 31% of them who used soap for hand washing but they had to take it from somewhere. This showed that hand washing using soap is not a regular activity in the rural area.

- 73% of people in the urban district used soap for hand washing, however only 23% of them had soap near toilet or kitchen. Those that do use soap, do not use it regularly or have it positioned near to HW facilities due to the threat of the soap being taken.

Disease perceptions

- Majority > 80% are aware that COVID 19 illness is of great concern
- 79% felt that in their families and their neighbours could get COVID 19
- 69% felt that if a member of their families gets infected, they might get seriously ill
- 58% in rural areas, and 68% in urban areas are worried of the health impacts of COVID 19
- 70% of people in the urban and 53% in rural districts are worried of socio-economic impacts of COVID 19
- 60% in urban areas and 58% in rural areas think hand washing practices have improved as a result of COVID 19
- During FGDs it was established that soon after announcement of the shutdown over 80% of people in both urban and rural districts were periodically washing their hands and in the case of urban areas hand sanitizing. However more than 60% of people had returned to their daily practices including ignoring hand washing. In some districts like Norton it was reported that access to water for hand washing is a challenge, making it hard to maintain high frequency of hand washing per day. Some reported that during the period when locked down were announced, everyone was very afraid, but now because of wrong perceptions and myths that there is no COVID in their communities, some people are now relaxed.

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Touch points and preferred channel of communication

- Over 65% of people across all districts in the 25-34 years and 35-60 age groups can be reached on radio, mobile phones, social media, hairdressers/saloons and religious places.
- The most important touch points for the elderly across all districts are 82% radio, 48% religious, 45% community leaders.
- **Urban Districts-** Most popular touch points in both Mutare and Norton are radio, mobile phones, religious institutions, hairdressers and public transport (buses)
- Majority of women 82% in Norton and 79% in Mutare prefer communication through mass media (radio) and community health promoters. A significant 30-40% of women also prefer use of social media as a means of communication and mobile
- Men in the urban areas, 70-80%, prefer mass communication (radio), as a main source of communication. A significant 50% in Norton prefer use of social media and 38% in Mutare prefer social media.
- The youths (18-24) years of age in urban districts prefer the use of mobile phones (75%) radio (65%), and above approximately 48% of them can be reached through public transport and religious places.

- **Rural Districts-** >80 women prefer communication through radios and community health promoters. Less than 30 % prefer social media and use of mobile communication as means of COVID 19 and hygiene related communication.
- Approximately 70% of men prefer mass media (radio) and community health promoters. Approximately 40% also prefer social media and communication through members of community.
- Majority of youths in rural area >70% prefer mass communication (radio) and approximately 48% have access to social media. However, the major challenge cited in terms of use of social media was high costs of mobile data.
- It was revealed during focus group discussions that majority of young people do not watch the national television, but prefer certain sessions that appeal to young people on radio stations and DSTv.
- Men and women also have preferred programs on radio. Men reported that they only watch TV during prime news time.
- All the groups > 80% reported that they use mobile phones and youths are more on social media than adults. Youths reported that they are limited from using social media by high costs of data.

Hygiene barriers

- No hand washing facilities/places close to toilets and kitchen in majority of rural homes (67%). This discourages people from hand washing after using toilets
- Use of multifunctional hand washing places (54%) in urban areas may discourage hand washing behaviour in most people. It might not be convenient to go and wash hands after toilet use at the same place used by those using the kitchen.
- Poor condition of the available hand washing facilities can be a barrier to hand washing practice by people in all the districts, as approximately 70% of the assessed facilities are unattractive and undesirable
- Water is a serious challenge in Norton as an urban district and rural districts like Chivi. This discourages people to wash hands after toilet use and before eating
- This might also be the reason why majority of parents do not wash hands before feeding babies and changing nappies
- Women are the most affected by water shortage because more than 70% of people responsible for collecting water and looking after children are women. Women are mostly responsible for fetching water from public water points, prepare food and look after kids and clean the household. The elderly and people living with disabilities are also affected most when there is water shortage because they will not be able to travel long distance to the nearest water points or move to hand washing or toilet facilities that are far from their dwelling places. Messages should be developed that encourage men to get involved and assist their old aged neighbours or persons living with disabilities
- Therefore water shortage puts more women at risk of contracting COVID 19 than men

- There was no soap/ash close to the toilet and kitchen in majority of households especially in the rural areas.
- Limited resources- shortage of transport in urban areas, high costs of hand sanitizer leading to congestion in ZUPCO⁸ buses, no sanitization
- Shortage of resources at homes and public places (no adequate hand washing facilities in schools, bus stations, clinics and market places, shortage of desks and chairs in schools to ensure social distance, inadequate PPE in clinics and soap/ hand sanitizer)
-

Awareness barriers

- Ignorance of the effectiveness of ash for hand washing because it is rarely used.
- Beliefs that are acting as barriers towards COVID 19 preventative measures
 - o COVID 19 die in high temperatures so in our country we are safe
 - o COVID 19 is just like flue it does not kill
 - o Many people have recovered from COVID 19 so many people feel relaxed and less afraid of the diseases
 - o High sense of feeling safe when with family members, friends or workmates and hence relaxing hygiene practices such as avoiding handshaking and wearing of masks
 - o School children do not observe social distance and they do not like to wear face masks unless they are forced to do so

Emerging issues

- Water points is an unexpected touch point that can be utilised to reach out to most women and young people in both rural and urban districts. Most people in the rural areas and urban districts like Norton fetch water from community water points
- Hairdressers is another touch point with huge potential especially in the urban districts. Over 70% of urban women regularly visits hairdressers in public places
- Majority of people (>78%) in all the sampled districts use public transport. ZUPCO⁹ is the main bus company that provides transport to the members of the public and can be a useful touch point
- National lockdown as a result of COVID 19 caused high level of pregnancies of school children. For example 40 girls in one school in Norton District fell pregnant during National COVID 19 lockdown period (April 2019- August) when all schools were closed. There is need to capacitate children and respective caregivers to protect the girl child from early pregnancy or contracting sexually transmitted diseases during and after full/ partial lockdown

⁸ Mandatory use of Zimbabwe United Passenger Company buses for public transport

⁹ ZUPCO- Zimbabwe United Passenger Company – Government Bus Company only authorized to be commuter transport in cities and towns.

CONCLUSION

It can be concluded based on the findings from the four sampled districts that members of the community are facing hygiene related challenges. Majority people are aware of COVID 19, and reported that the pandemic caused socioeconomic impacts to their lives. The main challenge that majority of people face in the targeted communities is lack of capacity, limited knowledge and perceptions of COVID 19 infections. Lack of capacity is caused by lack of resources (face masks and hand sanitizers are expensive to majority, there is shortage of hand washing facilities and water). Majority of people still use crowded public transport system and crowd at water points because of water shortage. Perception of the seriousness of COVID 19 pandemic has diminished over the course of the year. Many people used to be so afraid and were using wide range of sanitation and hygiene methods of preventing against the disease such as washing of hands with soap, social distancing and wearing of masks. This study established that even though the participants still think COVID 19 is a serious pandemic and can affect anyone, their hygienic behaviour has changed, and it is now business as usual for the majority. Some are no longer washing their hands, sanitize their hands or wear face masks in public. Certain myths/ beliefs acted as barriers to behaviour change. These include the thinking that people in high temperature area do not get affected by the virus and also that majority of people recovered from the virus.

Of major concerns is that majority of households have no hand washing facilities close to the toilets and kitchens. Rural districts are the most affected. Where the hand washing facilities are available, some of them especially the handmade are not user friendly and fragile. Majority of people in the urban districts use multifunctional hand washing facilities. Urban districts like Norton have no access to reliable water supply. Even though they are connected to city council water supply system, they can go for months without any supply. In the rural communities like Chivi, water access is a challenge as well. Lack of water is a barrier to hand washing.

Another observed barrier during hand washing demonstration is lack of soap close to the hand washing facilities in majority of cases. In most cases where water was used during hand washing demonstrations, soap was taken somewhere in the house showing that people are not usually using soap during hand washing. People are also not using ash as an alternative. Failing to see the link between hand COVID 19 and hand washing by some communities.

Various forms of media (radio, TV, social media and mobile telecommunication companies) played a pivotal role in raising awareness of COVID 19. It can be concluded that there are

various touch points and communication channels can be used to enhance effectiveness of HBCC project.

Communication channels that can be used include provincial radio stations, community broadcasting van, WhatsApp hotline, running promotional programs in public place such as public transport, hair salons, water points and market places.

Recommendations

Hand washing

- Design and construct hand washing facilities for use at household level and for use at public places (water points, bus terminuses, schools and market places among others). They should be located at convenient places accessible by all (men, women, children and people living with disabilities)
- Design hand washing facilities that are attractive, durable and user friendly. The household hand washing facilities should be affordable to ensure high adoption and sustainability
- Improve water access by developing more water points (drilling more protected wells or boreholes)
- Design and secure hand washing soap storage place at hand washing facilities.

Hygiene Behaviour change

- Use the most preferred touch points to raise awareness and reverse the diminishing perception on the COVID 19 pandemic. Help people to view COVID19 as something that is affecting many people and there are things, they can do to reduce their risk. These include mass media (radio) for all age groups, mobile and social media for the young people and community health workers.
- In terms of targeting women should be the main target because there are more women (above 60%) than men in the project area. Furthermore because most family set ups in Zimbabwe, women have much capacity to influence men especially their husbands and children if they are capacitated. The second target group is people living with disabilities and the elderly because they are often neglected. Urban districts are more at risk because people are highly mobile and congested, however they have better capacity to respond than the rural districts.

- Develop and circulate on social media hand washing demonstrations including demonstrating use of soap/ and or ashes in effective hand washing
- Consider use of provincial radio stations that use local language to deliver COVID 19 awareness and hand washing intervention. This could be through short radio advertisements or interviews with people who recovered from COVID. Can try to create short radio dramas that tells guiding story, talk show for the elderly targeting man and women, music and entertainment program using musicians popular to the youths or radio competitions. Talk show with the people living with disabilities.
- Engage with respected and influential people and institutions to promote hygiene behaviour change (encourage hand washing, social distance and use of face masks). For example, church leaders, hairdressers and celebrities. HBCC can run promotion with hairdressers that encourage hand washing with soap, run some competitions and awarding winners. Religious leaders are often trusted people within the community, so doing activities through a religious institution can help build acceptance.
- Consider use of mobile phones to deliver hand washing intervention. Can reach many people especially young people through targeted SMS messaging or WhatsApp hot lines.
- Consider use of face masks promotional competitions. For example competition in designing of affordable, comfortable but effective face masks
- Consider use of other communication channels to educate the people in public places (bus stations, market places) for example COVID 19 awareness and prevention bill boards and social distance markings at public transport queues
- People are not only worried about the health impacts of COVID 19. Heightening the economic impact of COVID 19 could be an effective way to motivate hand washing
- Consider ways of capacitate children and respective caregivers to on health and hygiene behaviour change that help protect the girl child during from early risks associated with early sex such as early pregnancy and contracting sexually transmitted diseases such as AIDs

SECTION 2: BACKGROUND OF THE STUDY

CARE International in Zimbabwe secured funding from Unilever to implement a Hygiene and Behavior Change Coalition (HBCC) project. In response to COVID 19, a global pandemic, CARE realized the importance of up scaling its hygiene promotion work to complement WASH infrastructure. To be effective, the organization chose to primarily focus on promoting key hygiene behaviors such as hand washing with soap at critical times, maintaining physical/social distancing, respiratory hygiene and surface hygiene. The HBCC project targets four provinces of Manicaland (Buhera & Mutare districts), Masvingo (Zaka & Chivi districts), Midlands (Zvishavane & Mberengwa districts) and Mashonaland West (Norton district).

The project is aimed at minimizing the transmission of and harmful impact of COVID-19 by delivering inclusive and interactive gender responsive mass media and digital communications, supported by product availability and community interventions that improve personal and environmental hygiene practices, and reduce stigma and discrimination.

2.2 Baseline Objectives

The main purpose of this baseline assessment study is to understand current hygiene practices and their determinants, and to prioritize key hygiene behaviors and messages for inclusion in the CARE Zimbabwe Hygiene Behavior Change Communication (HBCC) program. Furthermore, the study will inform the design of the hygiene promotion package and behavior change strategy. The baseline survey will address the following key questions;

- What is the prevalent level of understanding & hygiene practices observed among parents/caregiver on key hygiene practices linked to COVID 19 in the selected locations?
- What behavior change products are available in the household to practice routine behaviors?
- What are the current barriers for community members to perform key hygiene practices?
- Are there any hygiene promotion activities being delivered through routine immunization, social mobilization/ mass media or other avenues?
- What are the hygiene behaviors and messages that should be prioritized by Care Zimbabwe's HBCC program?
- What would be appropriate means of communication for hygiene promotion in the targeted locations?

SECTION 3: METHODOLOGY

A mixed method approach using quantitative and qualitative research methods, was used in this baseline study. The main approach that was used is WASH'Em¹⁰. WASH'Em is a process for rapidly designing evidence based and context-adapted hand washing behaviour change programmes in emergencies. The approach was chosen in this project because Zimbabwe like any other country in the world is in COVID 19 pandemic emergency situation. Other benefits of using WASH'Em are in listed in the toolkit. The approach involves using 5 rapid assessment tools to understand behaviour. In this baseline survey three rapid assessment tools (hand washing demonstration, touch points and disease perceptions) were used. These were supported by hygiene baseline questionnaire that was administered to 452 study participants from a sample of four baseline districts, Mashonaland West (Norton), Manicaland (Mutare), Masvingo (Chivi) and Midlands (Zvishavane)¹¹. The majority 60% of them were women. Key Informant Interviews were held with at least 1 school and 1 clinic in each district and 1 radio station.

3.1 Sampling frame

Participants of the Baseline were drawn from the four out of the eight targeted districts. The sample frame was designed to represent both urban and rural beneficiaries- Norton and Mutare represented urban districts, Chivi and Zvishavane represented rural districts. A combination of convenient, and purposeful sampling was used in this study. Districts were conveniently sampled. A purposive sampling (non-probability) procedure was employed in picking respondents for questionnaires and, touch points, disease perceptions FGDs and hand washing demonstration. The purpose was to select respondents that represented the cross section of different kinds of people (men, women and youths) in all the targeted rural and urban districts. To this end, 4 schools, 4 clinics, 1 radio station, and participants for 32 focus groups discussions were selected on the basis of gender, age, availability and willingness to discuss hygiene issues.

3.2 Quantitative Data- Household Questionnaire

¹⁰ Why use WASH'Em <https://washem.info/about>

¹¹ Mutare and Norton are Urban Districts; Chivi and Zvishavane are the rural districts

A structured household questionnaire was administered in the 4 sampled districts. The Rao soft sample size calculator (<http://www.raosoft.com/>) was used at 95% confidence level and 5% margin of error. The values calculated ensured that of all values to be reported the percentage findings were either a plus/minus 5% margin of error and there was 95% confidence certainty that these figures were correct. A total of 452 household participants were sampled using random lottery. Over 63% of the participants/ parents/ caregivers were women. Majority of respondents to the questionnaire survey (60% in Chivi, 58% in Mutare 59% in Norton and 68% in Zvishavane) fall within the age group of 35 and 60 years. Less than 10% of the participants were between 18-24years old. Participants older than 60 years of age were higher 31% in Chivi district than other districts. To minimise exposure to COVID 19 of data collectors and members of the community, questionnaires were administered using telephone calls.

Table 1: Distribution of household participants by a) sex and b) by age

Sex	Chivi	Mutare	Norton	Zvishavane	Age	Chivi	Mutare	Norton	Zvishavane
Male	37%	33%	37%	32 %	18-24	4%	4%	7%	4%
Female	63%	67%	63%	68%	25-34	5%	22%	29%	19%
					35-60	60%	56%	59%	68%
					>60	31%	19%	6%	9%

3.3 Qualitative Data

WASH'Em data collection tools for disease perceptions, hand washing demonstrations and touch points were used in collecting qualitative data in all the four districts. In addition, key informants including, one radio station, 4 School heads, 4 clinics (Doctors/ or Sister in charges) were interviewed. Among the key informants 58% were women.

3.3.1 Hand washing Demonstrations

A sample of 28 hand washing demonstrations videos were taken, 14 in urban and the other 14 in rural districts. Hand washing demonstrations were taken to generate quick insights into whether a person's home and community environment enable or prevent hand washing practices. The assessment involved going into people's homes and understand how they washed their hands in a real-world setting. Hand washing demonstrations videos were taken and analysed using WASH'Em guideline tools. During the demonstrations, assessments was

carried out on how people interact with objects (for example, soap and containers) and infrastructure (for example, hand washing facilities and water points) when hand washing. Majority of the hand washing demonstration participants in all districts (>70%) were women.

Table 2: Distribution of hand washing demonstration participants

Sex	Norton	Mutare	Chivi	Zvishavane
Men	28%	14%	28%	14%
Women	72%	86%	72%	86%

3.3.2 Key Informant Interviews

The key informant interview were held with 1 Provincial radio station, 4 School heads/Health Coordinators, 4 clinics (Doctors/ or Sister In charges). Schools and Clinics were considered to be part of the important touch centres. Interview with Provincial Radio Station was held to appreciate the current efforts by mass media as potential channel of communication in HBCC programming.

3.3.3 Focus Group Discussions

A total of 30 focus group discussions (FGDs) were held with members of the community in the respected districts using Touch points and Disease Perception WASH'Em tools. Fifteen FGDs were on disease perceptions and the other fifteen were on touch points (Table 4 and Plate 1-4). In urban districts, participants were grouped into men, women and youths while as in rural districts the team was able to group participants into men, women, girls and boys groups. Participants ranged between 7-16 people per each group.

Table 3: Distribution of focus group discussions

Tool used	Sex	Norton	Mutare	Chivi	Zvishavane
Disease Perception (FGDSs)	Men	26%	21%	23%	28%
	Women	31%	31%	34%	30%
	Girls	22%	29%	25%	27%
	Boys	20%	19%	17%	15%
Touch points (FGDs)	Women	32%	35%	34%	32%
	Men	25%	24%	25%	28%
	Girls	23%	24%	19%	22%
	Boys	19%	17%	21%	17%



Plate 1: Local man facilitating in men FDG on touch points



Plate 2: Local woman leading women FDG on disease perception



Plate 3: Men focus group discussion on diseases perception



Plate 4: Women FDG on touch points

3.4 Training, Pre-test and field work

A one-day training programme was held on the use of WASH'Em tools before the field work. The tools were pretested in Norton District. One day training of enumerators was held focusing on hands-on instructions on individual household questionnaire. The data collection team was introduced to their roles, data collection techniques (including verbal translation of questions into local language), and field preparations.

3.5 Data collection and quality control

Four field experts, comprising two females and two males, collected the data with assistance of enumerators. Enumerators administered questionnaires over the telephones and data entered using smart phones. The approach was meant to minimise the risk of exposing data collectors and members of community to COVID 19 infection. Smart phones and WASH'Em tools were also used to record house demonstration videos and capture FGDs data. Interview guided questions were used to solicit information from key informants.

3.6 Data processing and analysis

Qualitative data collected in the form of hand washing demonstrations, touch points and disease perception FGDs was uploaded and analysed in WASH'Em software. Quantitative data was transcribed and entered into Excel and SPSS to facilitate data analysis. Expert judgement was used to analyse key informant interview data. For ease of interpretation and value addition of results, graphical presentations were done. Data was collated, analysed and synthesized. Running themes or patterns identified, interpreted and explained accordingly.

3.7 Ethical considerations

Authority to conduct the research study was sought with the responsible authorities in each district. Informed consent was obtained from all the participants including radio stations, mobile service providers and parents/ caregivers among other participants for all data collection. Data confidentiality was exercised by ensure that data was collected by trained and contracted professionals. Collected data was not shared by any person except the baseline

assessment team and it was kept in secure server. Individual interviews were conducted in private settings which did not compromise the safety and security of the participants.

3.8 Baseline Survey Limitations

- Competing events such as seed and fertilizer distributions affected the survey as some households were deserted
- The baseline survey was carried 10 months after the announcement of COVID 19
- COVID 19 restrictions and protocols delayed the progress of data collection
- Intermittent network affected mobilization and administering of questionnaires using telephone calls.
- Rains disturbed the survey and forced the team to change the targeted areas due to inaccessibility of the initially chosen ones

SECTION 4: KEY FINDINGS

4.1 Socio-demographic Survey

4.1.1 Household Head Characteristics

Generally, more than 85% of the respondents who participated in the survey are parents as shown in Figure 1. Less than 10% of households' participants are care givers and child head households.

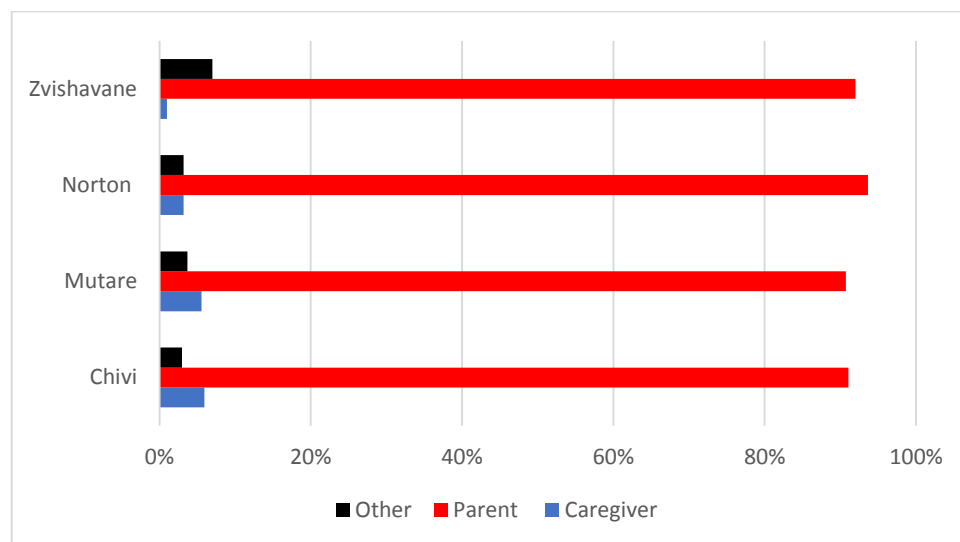


Figure 1: Status of household heads

4.1.2 Education Status

More than 50% of the people in all the districts attained secondary education. Those with tertiary ranged from 0-4%, while those with no schooling at all ranged between 2-8% as shown in Figure 2. The literacy level to understand COVID 19 awareness programs or promotions is therefore above 50% in all respective districts.

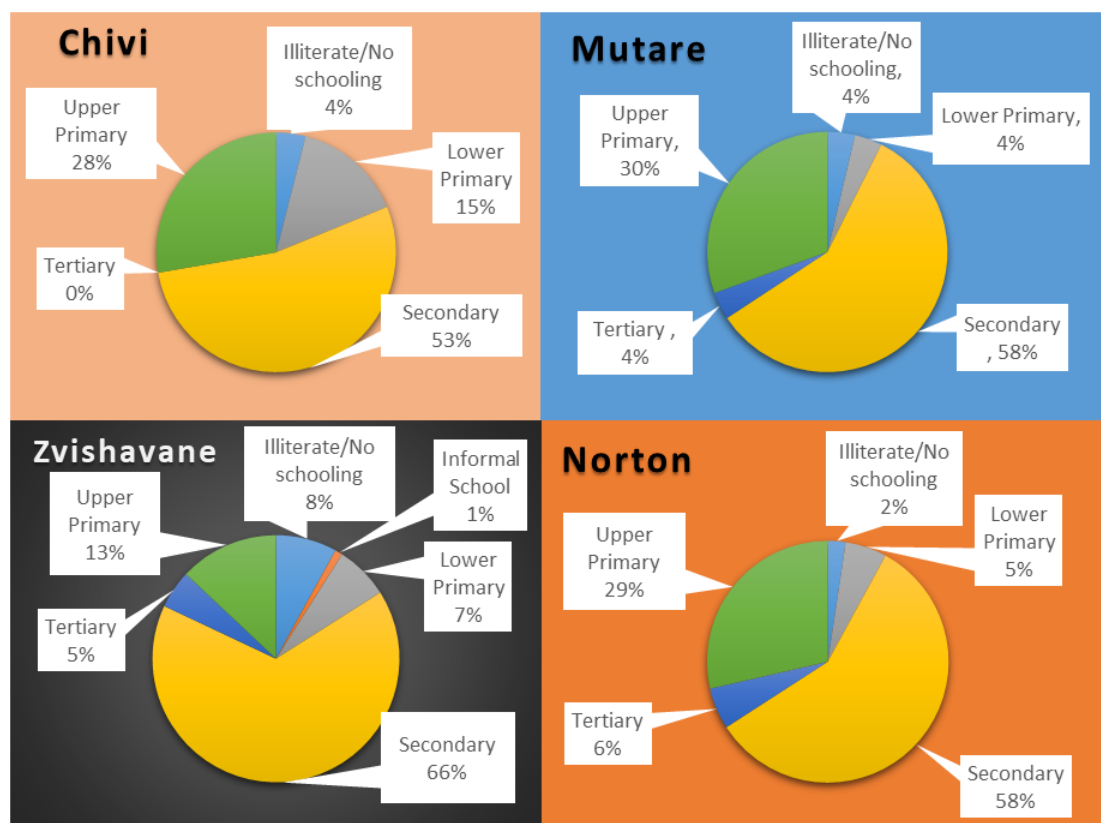


Figure 2: Education status in the four districts

4.2 Current hygiene behaviours and their determinants

4.2.1 Knowledge and Understanding of hygiene related diseases and the COVID19

Knowledge of how COVID 19 spreads is generally high amongst the communities in all the districts (Figure 3). More than 90% of both men and women in all the districts are aware of COVID 19. Knowledge of COVID 19 was enhanced by national lockdowns that were pronounced by the government from the beginning of March 2020 and massive awareness raising programs by government through radio and national television.

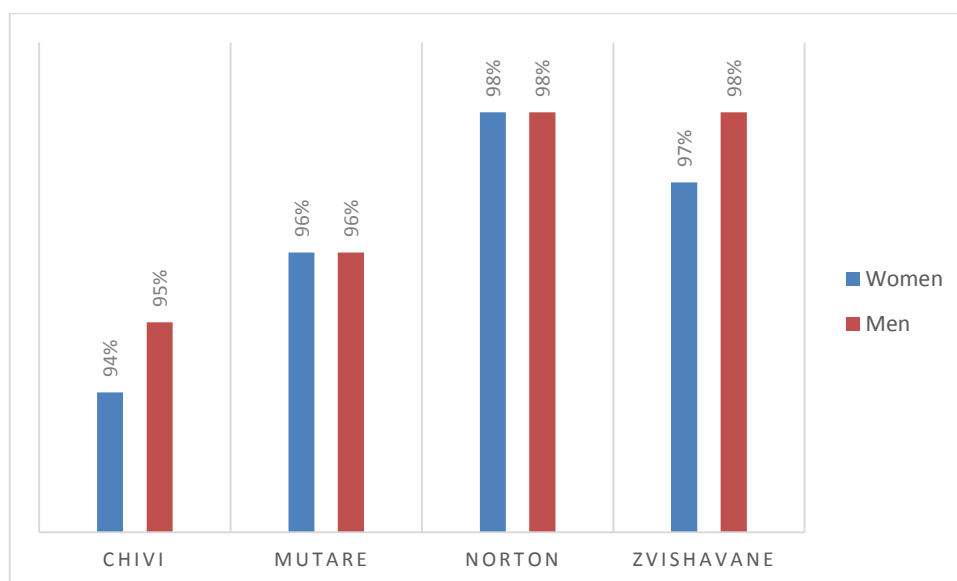


Figure 3: Knowledge of COVID 19 in all the districts

4.2.2 Knowledge of the different ways through which COVID 19 spreads

The communities also indicated different level of knowledge on the different ways through which COVID 19 spreads. According to Figure 4, most people, more than 50% in all the districts do not know how COVID 19 spreads except approximately 57% in Norton and 55% in Mutare who know that COVID 19 can be spread by contact with infected persons and contact with infected droplets respectively. Very few people, less than 20% are aware that COVID 19 can be spread by contacting contaminated object or surface.

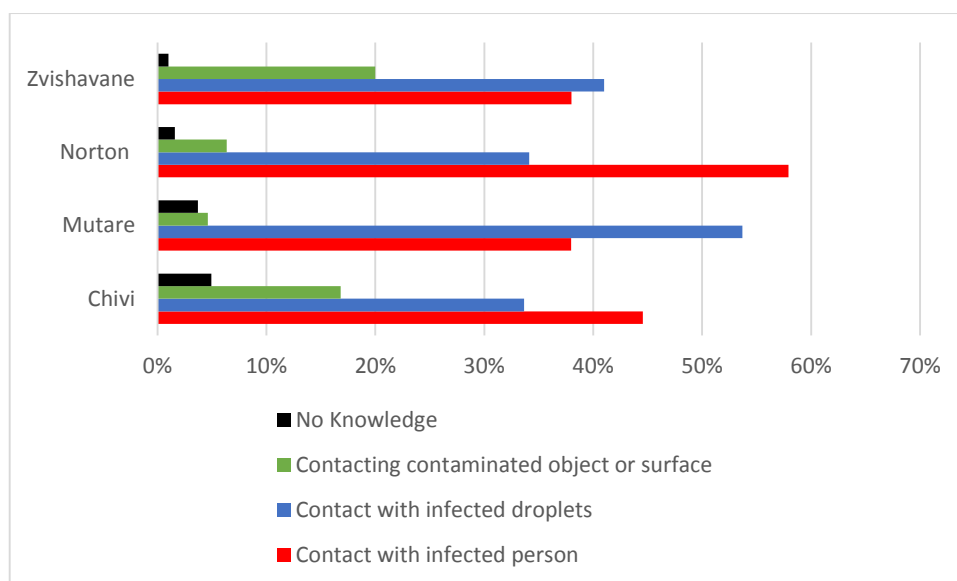


Figure 4: Knowledge of how the disease spreads in communities

4.2.3. Knowledge of symptoms of COVID 19 and measures to prevent the spread of the virus

Fever, Coughing and headaches are the most commonly known symptoms of COVID 19 amongst men and women in all the districts (Figure 5 and Figure 6). However, less than 50% of women are aware of other symptoms such as breathing difficulties and shortness of breathiness.

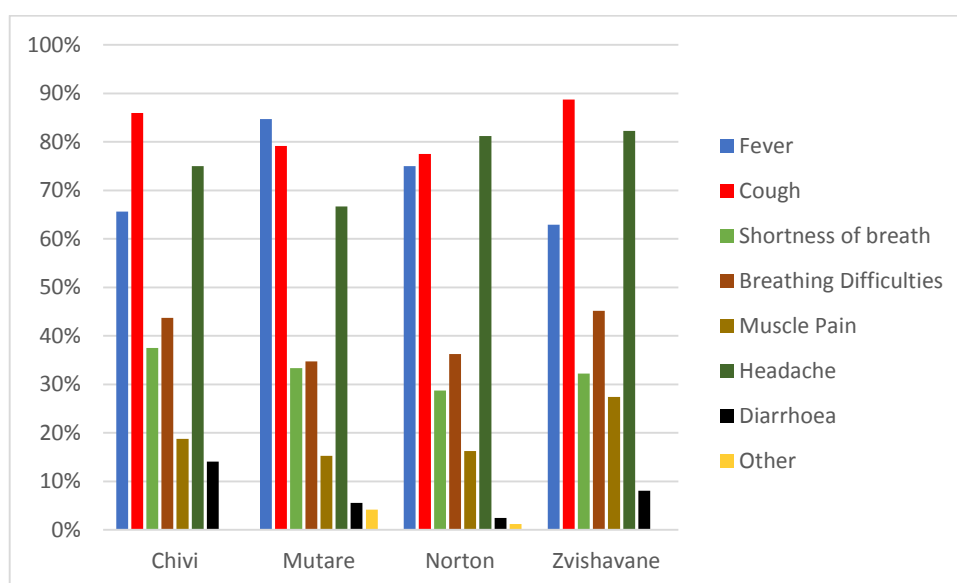


Figure 5: Knowledge of COVID 19 symptoms by women

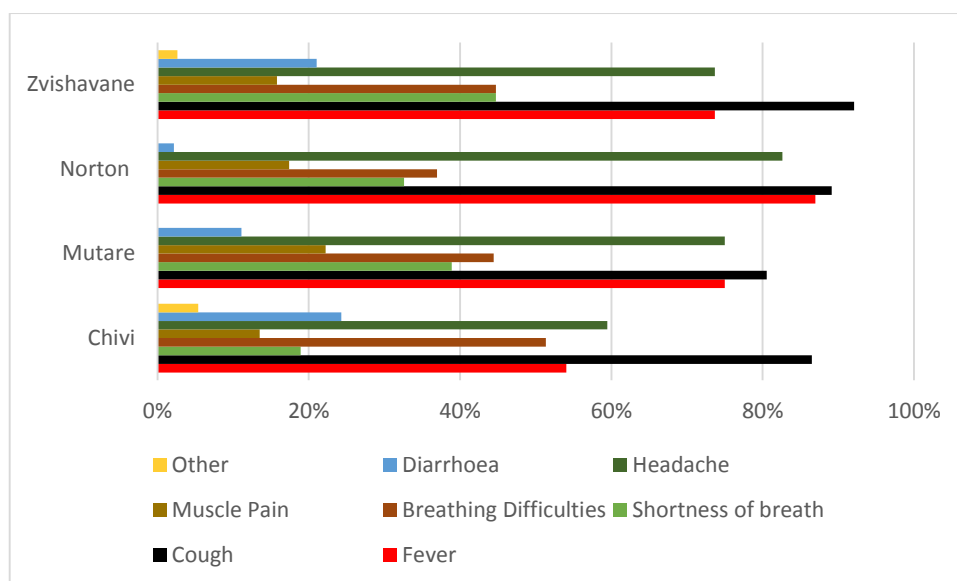


Figure 6: Knowledge of COVID 19 symptoms by men

According to Figure 7, men in the study have on average slightly more knowledge of the symptoms of COVID 19 than women.

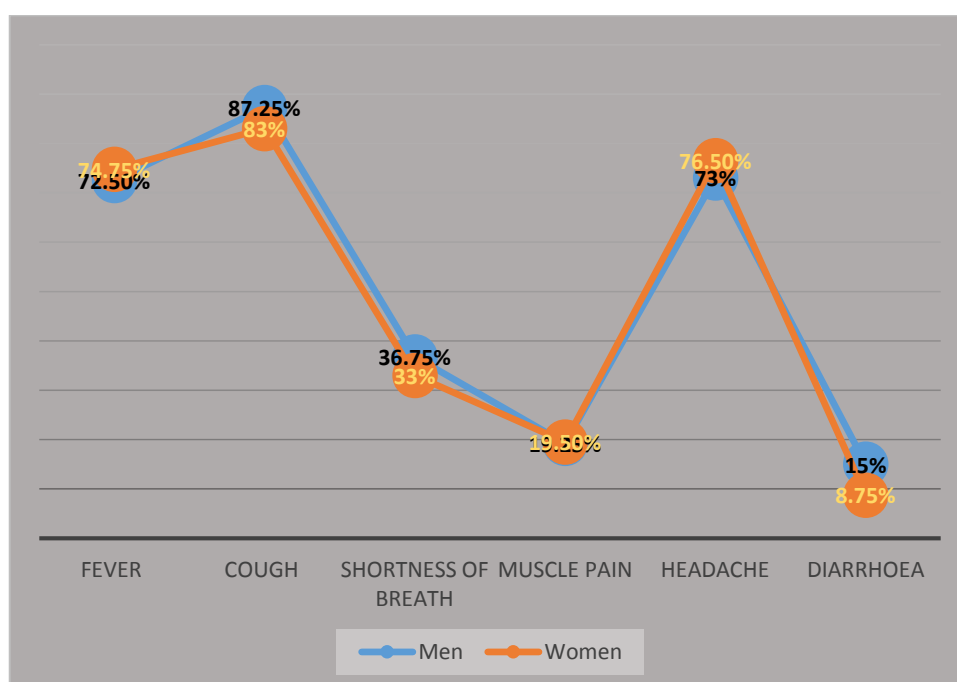


Figure 7: Knowledge of symptoms of COVID 19 by men versus women

Communities in all the districts are generally aware of the recommended measures needed to be taken to prevent the spread of COVID 19. Majority of respondents (94% in Chivi, 88% in Mutare, 82% in Norton and 87% in Zvishavane) are aware that hand washing help in preventing the spread of COVID 19 (Figure 10). Other commonly cited measures in the range of 40-60%

across all districts include covering of mouths, avoid large gathering and avoiding handshakes (Figure 8). Staying at home when one is sick (28% in Chivi, 11% in Mutare, 6% in Norton and 30% in Zvishavane), cleaning and disinfecting surfaces (28% in Chivi, 26% in Mutare, 30% in Norton and 30% in Zvishavane) are not common practices which the communities are aware of to prevent the spread of the disease.

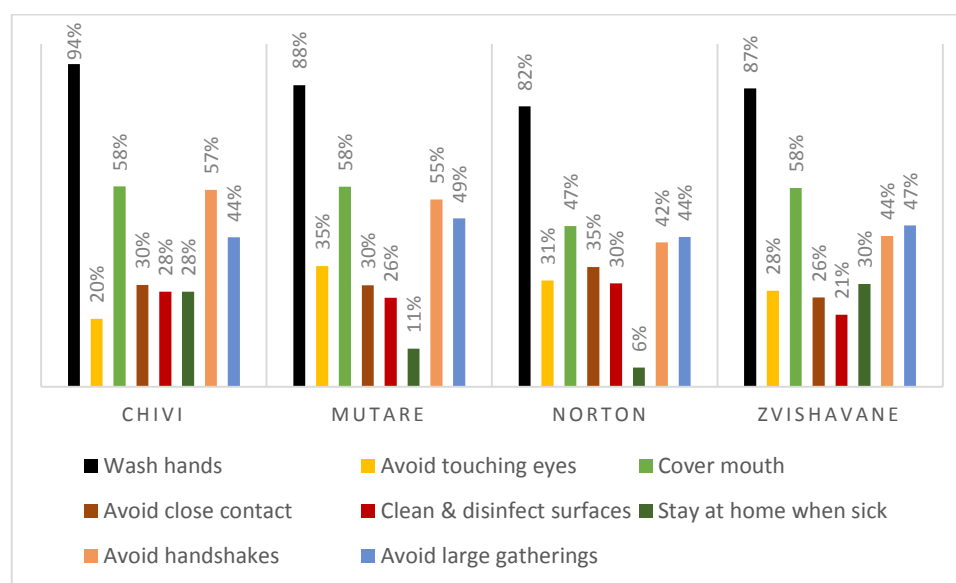


Figure 8: Measures to prevent the spread of COVID 19

Communities in Zvishavane, Chivi, Mutare and Norton are aware of various response mechanisms to deal with new cases of COVID 19. These response mechanisms are provided in Figure 9. However, visiting the hospital is the most well-known action that member of communities in all the districts will undertake in responding to new cases of COVID 19. Ignorance of the need for separation and quarantine when infected by COVID is a cause of concern. Less than 10% in all the districts are aware of need to separate or quarantine infected individual/s, hence putting members of communities in the target districts at risk of spreading the disease in the case of new infections.

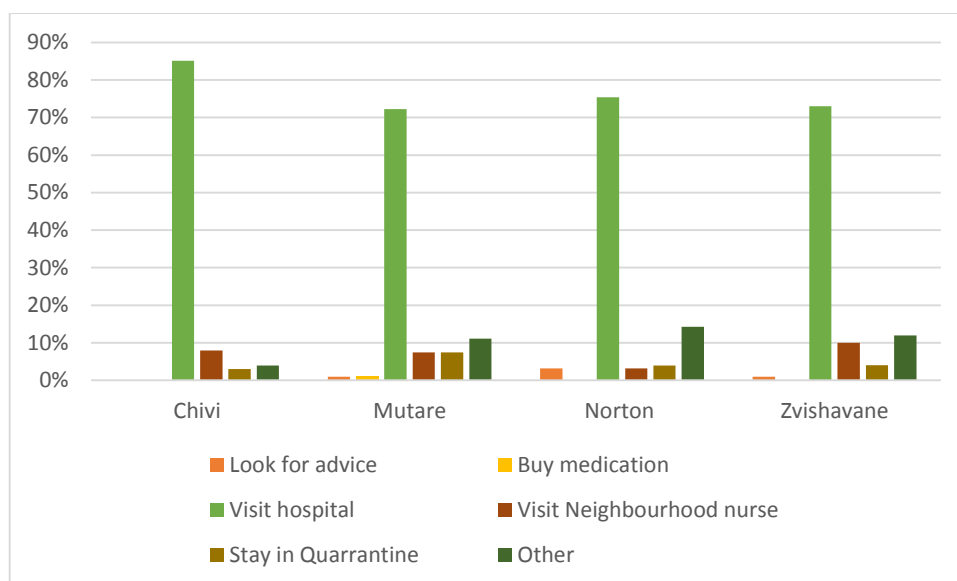


Figure 9: Community responses to new cases of COVID 19

4.3. Hand washing facilities

4.3.1 Knowledge of importance and timing of hand washing

Communities are much aware of the importance of hand washing practices to prevent the spread of diseases. They are aware that it is important to regularly wash hands with running water and soap or sanitizing hands to prevent spread of COVID 19. Community responses indicate that washing hands is critical in eliminating or destroying the disease-causing agents such as bacteria (Figure 10).

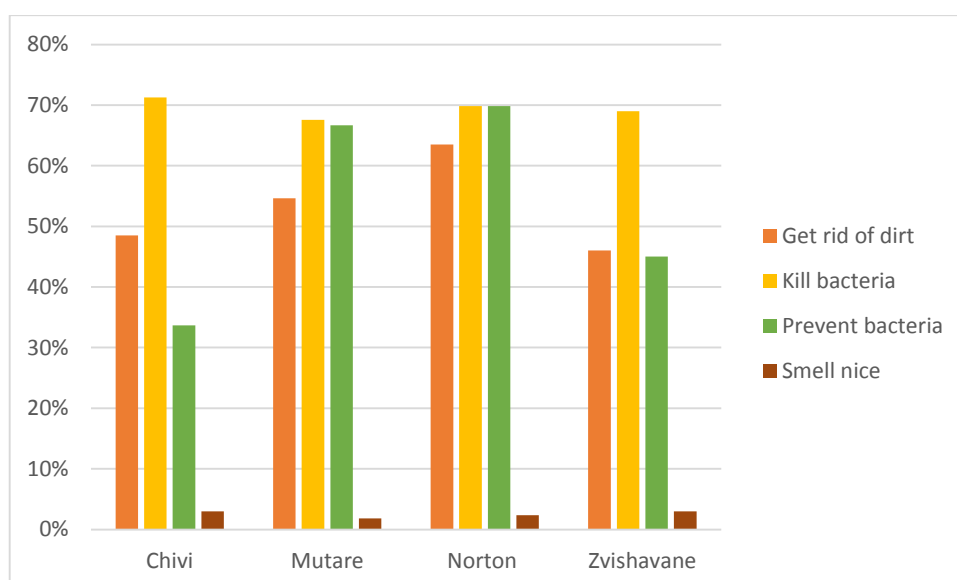


Figure 10: Knowledge of the importance of hand washing

More importantly, the communities are aware of the most important timing on which hand washing is supposed to be done. In most cases (more than 70%), communities indicated that hand washing should take place when hands are dirty, before eating and after defecation or using the toilet. However just above average (50%) are aware that they should regularly wash their hands when caring for the sick. This puts over 40% of people who care for the sick at risk of contracting COVID 19. In addition less than 40% in urban districts and less than 20% of people in rural districts are aware that they should wash hands before feeding babies or after changing child nappies. The level of ignorance put minors at high risk of COVID 19 infection and other hygiene related diseases such as diarrhea Figure 11. Very few people less than 40% in urban districts and less than 25% in rural districts were aware that they should wash their hands after coughing or sneezing as recommended by WHO. Discussions with some participants revealed that most of them especially in urban areas are aware of covering mouth and nose with fixed elbow or tissue when coughing but not washing hands whenever one coughs. Rural districts (Zvishavane and Chivi) are the most affected with limited access to information and knowledge.

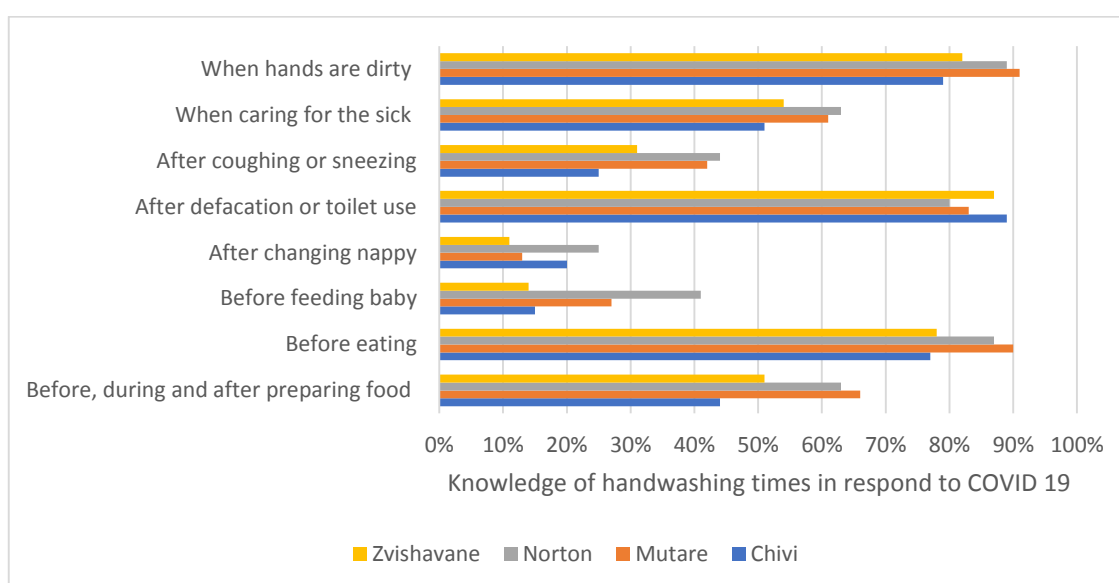


Figure 11: Knowledge of when hand washing should take place

4.3.2 Existence and location of Hand washing facilities

Knowing the importance and when to wash hands is not enough. Knowledge is important, but applying the acquired knowledge is more important. Even though majority of respondents said

they are aware of COVID 19, and importance of hand washing (Figure 3 and Figure 10), 67 % of people in the rural area have no hand washing facilities near their kitchen or toilets (Figure 12).

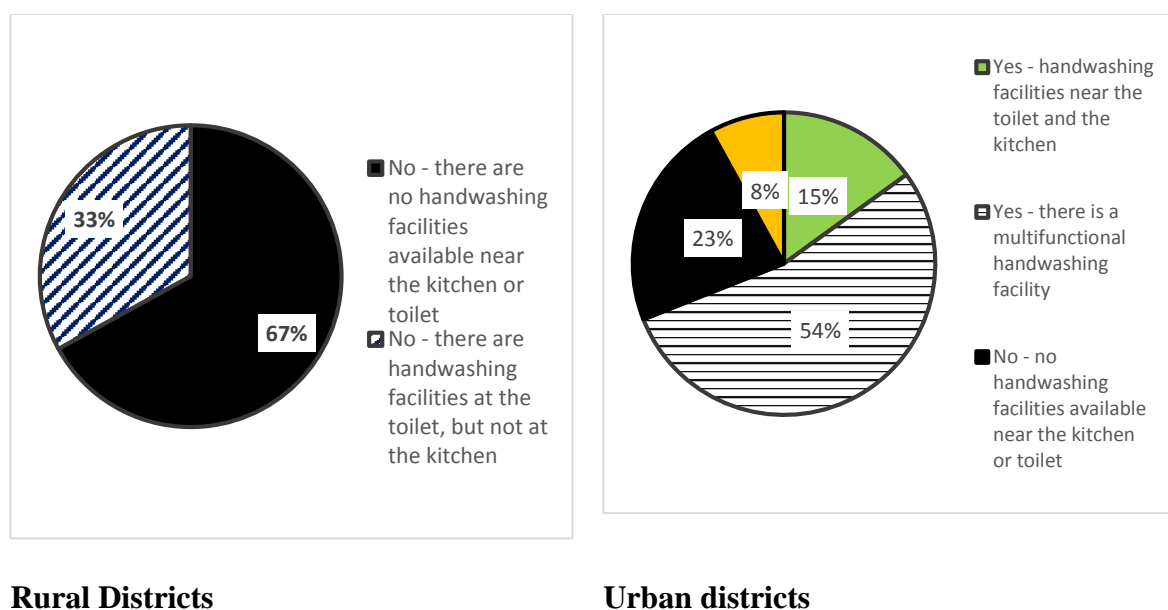


Figure 12: Existence of hand washing facilities in urban districts

Figure 12 also show that 54% of those in urban districts like Norton and Mutare use multifunctional and only 15% have hand washing facilities near the kitchen and toilets hand washing facilities. It was observed during household demonstration that majority of people wash their hands using a wide range of facilities such as dish and cup, plastic containers and reused juice bottles. During hand washing demonstrations some participants were hesitant, for example one participant was not sure whether to wash her hands using a 10 liter empty bucket or empty dish that was available. It can be concluded that such kind of people may not be washing their hands after using toilets or before preparing food in the kitchen.

Among the rural districts, Zvishavane was the worst with, 71% of people have no hand washing facilities near the toilet or kitchen. Table 2 show existence/ non-existence of hand washing facilities in all the four districts. A lack of hand washing facilities can be a major barrier preventing regular hand washing, especially in Chivi and Zvishavane Districts. People are almost 70% more likely to wash their hands if there is a specific place for hand washing.

Table 4: Existence of hand washing facilities in each district

Rural Hand washing	Norton	Mutare	Chivi	Zvishavane
--------------------	--------	--------	-------	------------

Yes - there are hand washing facilities near the toilet and the kitchen	33%			
Yes - there is a multifunctional hand washing facility (a basin or tap that is used for hand washing, and is used for other things like laundry, too)	67%	29%		
No - there are no hand washing facilities available near the kitchen or toilet		57%	67%	71%
No - there are hand washing facilities at the toilet, but not at the kitchen		14%	33%	21%

Figure 13 show that more than 80% of the available hand washing facilities are located where others can see. However only 33% of the sampled hand washing facilities in Mutare were located where others can see. One of the strongest motivators for hand washing is thinking that other people are watching you and may judge you. Since majority of households have no hand washing facilities/places at all, they are unable to regularly wash their hands and people living in those homes may not be motivated to wash hands.

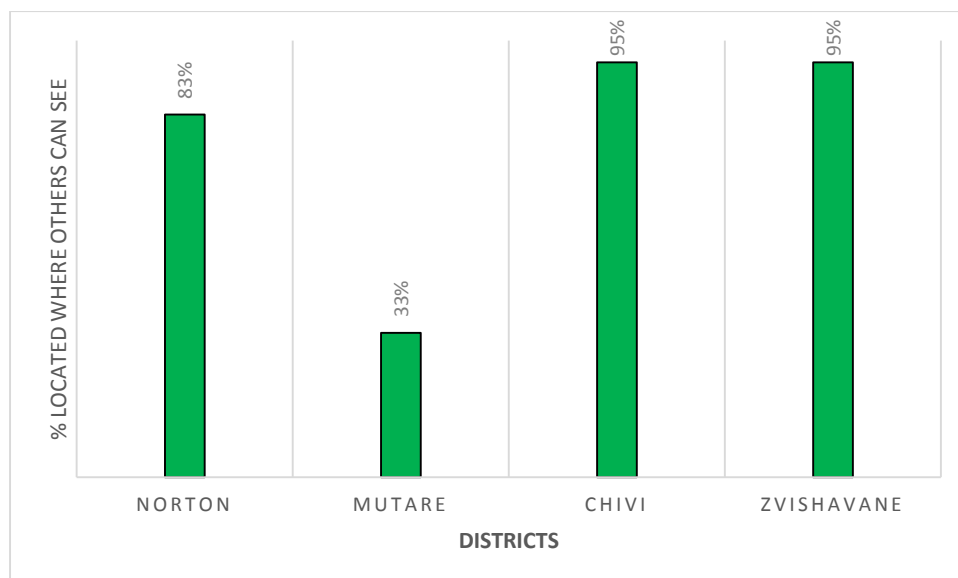


Figure 13: Location of hand washing places

In the urban districts, using multifunctional hand washing facilities may affect the effectiveness of hygiene practices. If the basin and/or water facility is used for multiple purposes then they may not always be free for people needing to hand wash. If the facilities are used for other

purposes people are also likely to view them as being less clean and find the facility less desirable for hand washing.

4.3.3. Sharing of hand washing facilities

Figure 14 show that majority of the available hand washing facilities 75% in the rural and 88% in the urban areas are being shared by members of the families only at household level. Shared facilities are often less clean because no one feels ownership over them and this can put people off hand washing.

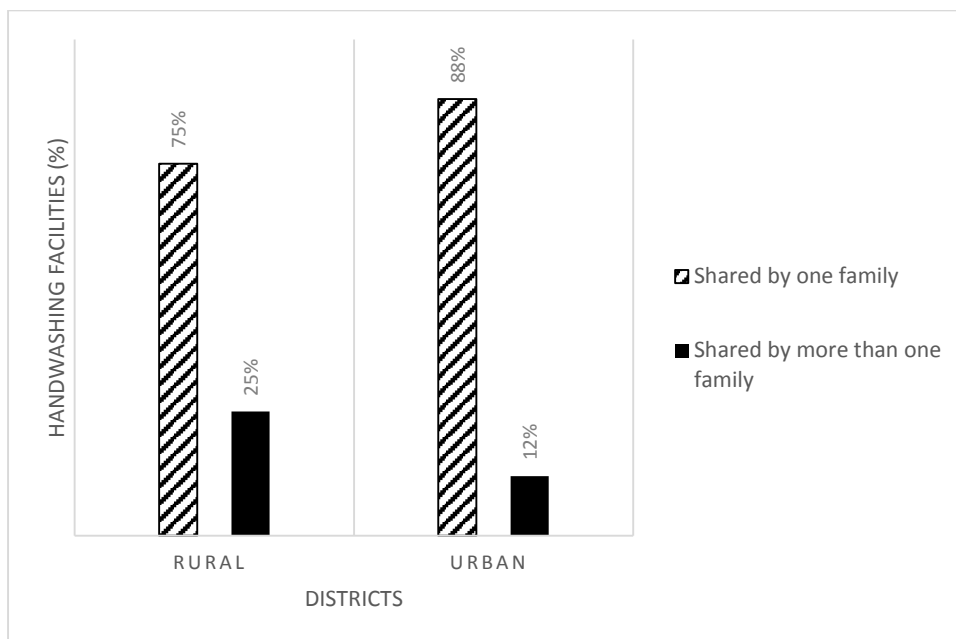


Figure 14: Hand washing facility sharing

Plate1 show examples of some hand washing facilities that were observed in Rural and Urban districts. It should be appreciated how innovative were some households in developing handmade hand washing facilities using recycled empty 5 liter containers and soap tied close to the facility (Plat 1 a).



Hand washing soap, tied with string

Plate 5: Types of Hand washing facilities

4.3.4 Availability of Soap for hand washing

According to Table 3, majority of hand washing places, 69% in rural areas had no soap. During the demonstration people washed their hands with water only and neither did they use ash. Soap is a very common and cheap product and is available in most parts of the world. However, because of socio-economic challenges in Zimbabwe, majority of rural families are finding it difficult to regularly afford soap. But failure to use ash in hand washing during hand washing demonstrations also showed that people in the rural area do not consider it so important to disinfect their hands using ash during hand washing.

Table 5: Availability of soap or ash for hand washing in the home

Is there soap or ash in the home? If so where is it kept	Rural District	Urban Districts
Yes - Near the toilet or in the kitchen		23%
Yes - Elsewhere in the house	31%	54%
No soap of any kind or ash is available	69%	23%

Approximately 54% of households in the urban areas had no readily available soap or ash near the toilet or kitchen but participants had to go and collect soap somewhere in the house during demonstrations. Soap is often kept elsewhere because it is highly valued and people do not want it to be wasted or stolen. Some participants during hand washing demonstration reported that they do not leave soap at the hand washing place due to threats of soap being stolen by thieves. Some had to secure the soap by tying it to hand washing place (Plate 6). But if the soap is not kept at the hand washing facility, then it is likely hands are only being rinsed. Some took some time looking for soap. This shows that such kind of people rarely use soap when washing hands. At least 23% did not use soap or ash during hand washing. Chivi district with 86%, had the highest record of hand washing facilities without soap or ash.

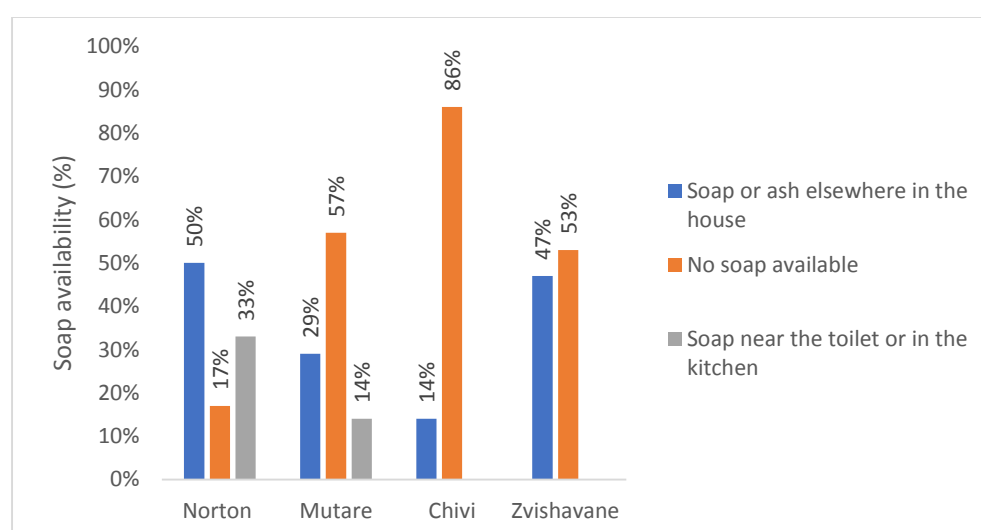


Figure 15: Availability of soap at the hand washing facilities

4.3.5 Availability of water at the hand washing place

Figure 16 show that majority of hand washing facilities 75% in rural areas and 54 % in urban area had no water at the hand washing facilities/ places/. Water is a key enabler of good hygiene. During hand washing demonstrations, majority of participants had to fetch water from somewhere for washing hands.

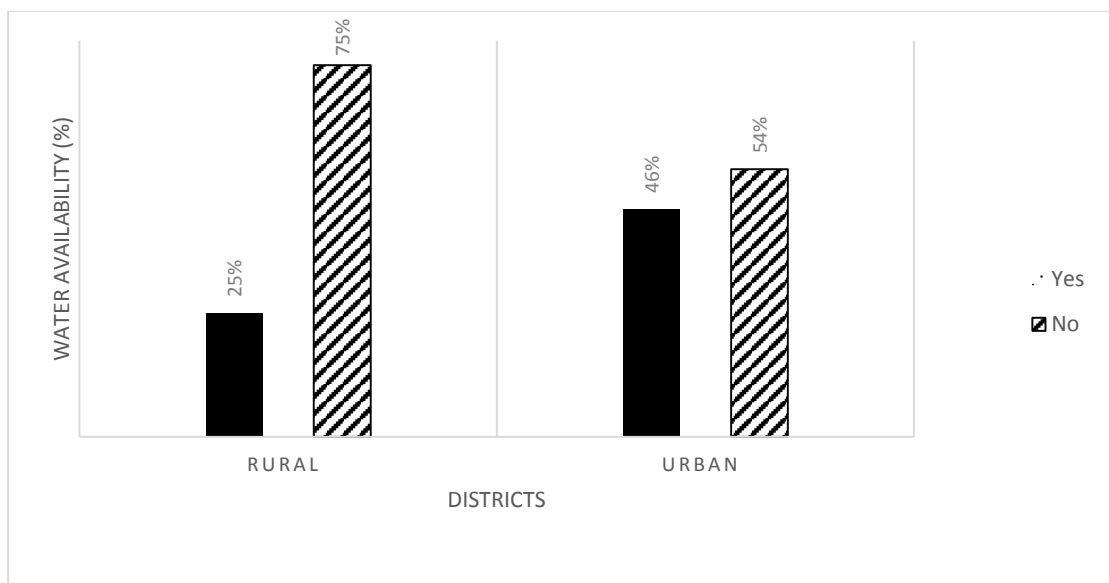


Figure 16: Availability of water at hand washing facilities

Rural districts, Chivi (67%) and Zvishavane (86%) had majority of cases where water had to be fetched from somewhere for hand washing. In urban area water is a serious challenge in Norton where 50% had to fetch water from somewhere for hand washing. Most visited households are connected to city council for water supply lines, but local authorities are failing to provide water as service delivery. As a result, majority of households in urban areas, especially in high density suburbs depends on community water points or wells dug at household level. Unfortunately, because of recurrent droughts and increased ground water demand, most wells are drying up. For example, a well in Plate 2 has dried up and now members of the household have to join long queue at community water points to fetch water. As the water is become more and more scarce its value is appreciating and hand washing become least of the priorities.

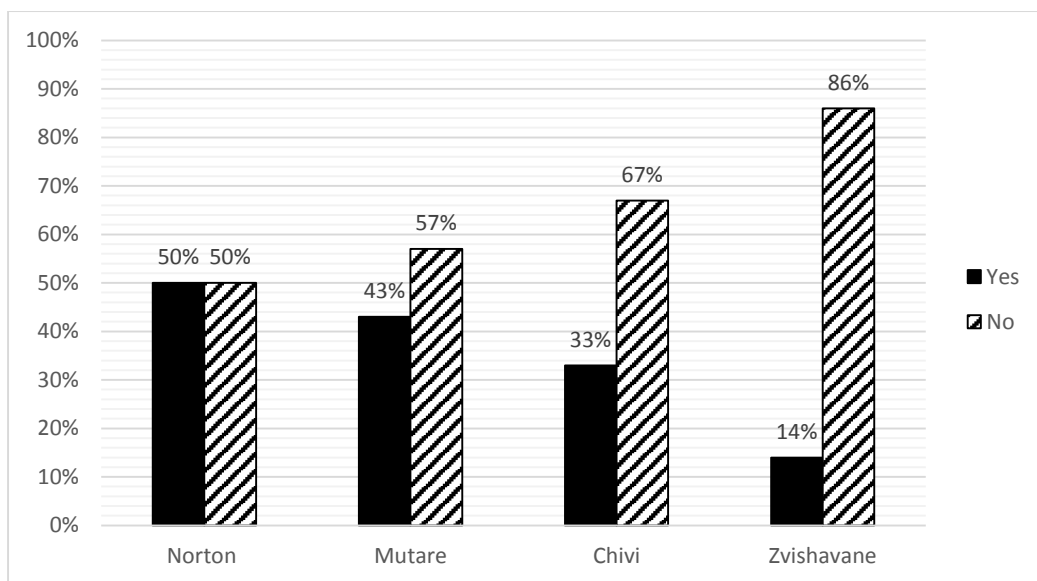


Figure 17: Availability of water at hand washing facilities in each district



Plate 6: Well that is now dry at household in Norton District

4.3.6 Attractiveness of hand washing facilities

Previous studies (USAID, 2016)¹² show that when hand washing facilities are clean and welcoming, people will find hand washing more rewarding and will spend more time at the

¹² USAID (2016). WASH Baseline Assessment, Highlands Harare

facility. Figure 18 show that just above 50% of hand washing facilities in urban areas are clean but not attractive. Hand washing facilities that were desirable and attractive are less than 30% in all the districts. It was also observed during hand washing demonstration that some hand washing facilities especially handmade ones were difficult to operate. Some had signs that they had not been used for days. If hand washing facilities are unattractive and unpleasant, people will only wash their hands briefly and many may not bother at all. Therefore, it can be concluded that the poor condition of the available hand washing can be a barrier to hand washing practice by people in all the districts.

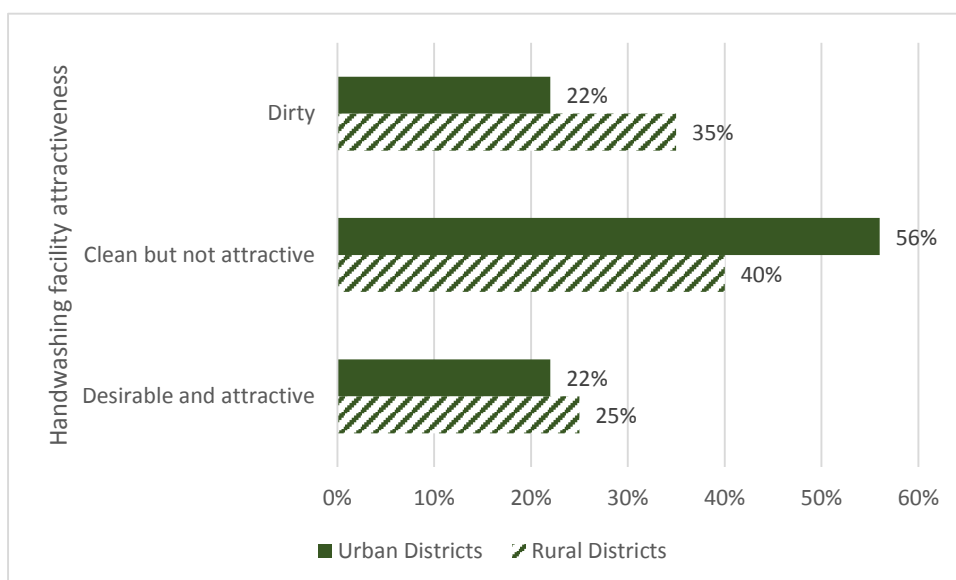


Figure 18: Attractiveness of hand washing facilities

4.3.7 Convenience or easy to use

Studies have found that 30% of people don't wash their hands because they feel it created additional work. If hand washing with soap is made easy, it is more likely to be practiced (WASH'Em, 2020). Table 4 show that more than 50% of hand washing facilities in rural district are not convenient, either they were too far from the toilets or kitchen, difficult to operate or fragile and easy to break. Urban districts have more convenient hand washing facilities (approximately 50%) than rural districts. In urban areas e.g. Norton as example, majority of hand washing facilities were placed at the entrance gate to ensure everyone who enters the household cleans their hands. In some cases hand washing facilities are there in toilets but there was no water and people were washing hands outside the house. Majority had

multipurpose sinks outside their houses. In some cases, during hand washing demonstration, effective cleaning was not possible because participants had to pour or scoop water onto their hands. Such practices are a barrier to effective hand washing in that one who wash hands will not be able to rub them together well. In most schools hand washing facilities are only located at school entry. During key informant interviews it was established schools have inadequate number of hand washing facilities and soap to ensure regular washing of hand s by school children.

Table 6: Convenience and easy to use of hand washing facility during hand washing demonstration

Hand washing Convenience	Chivi	Zvishavane	Norton	Mutare
Yes- Hand washing facility is convenient	22%	29%	57%	49%
No - the person doing the demonstration found it difficult to reach (too high or too low) or other people in the family might find it hard to reach	22%	0%	0%	0%
No - people can only wash one hand at time	11%	0%	17%	14%
No - it is fragile or easy to break	11%	14%	0%	14%
No – it is too far from the toilet/kitchen (for example, more than 10 steps away)	44%	57%	26%	23%

4.4. Disease Perception

A combination of focus group discussions and individual questionnaires helped to solicit information on the perception towards COVID 19 and other hygiene related diseases by people in the targeted districts. Results in Table 5-7 were generated using WASH'Em¹³ diseases perception standard tables. Four disease perception FGDs (men, women, boys and girls) were held in each of the two rural districts and three FGDs (men, women and youths) were held in each of the urban districts. For each FGD, a score of '1' was given to each question if the answer did emerge and was left blank if the answer did not emerge. Given that rural districts had four focus group discussions each, 4 became the highest total score that most closely reflects the answer that participants gave, 3 became the highest score for urban districts since 3 focus group discussions were held in each. Responses that are likely to be more important are highlighted in yellow and were selected in this analysis.

Table 7: Perception on COVID 19 illness and spread

Question	YES/NO	Total Score				Interpretation
		Chivi	Zvishav	Norton	Mutare	
Was COVID19 one of the 5 illnesses of greatest concern to your population?	Yes	4	3	2	3	People who perceive COVID19 to be an important health issue affecting them are more likely to be receptive to hygiene promotion programs and more likely to practice good hygiene. Other illness cited are cholera, diarrhoea, typhoid, cancer and high blood pressure (BP). Therefore, people in all the districts are likely to be receptive of HBCC hygiene promotion programs.

¹³ WASH'Em Diseases Perception: <https://app.washem.info/rapid-assessments>

Do you think that someone in your family could get COVID19 in the next 6 months?	I think it might happen	4	4	2	2	Participants in most focus group discussions thought that someone in their families could get COVID 19. Two focus group discussions in Norton and Mutare actually scored that it will happen. It was however established during focus discussions that there are myths that are influencing communities, e.g. someone said because of high temperatures in Zimbabwe people were feeling that they were not going to get COVID, some thought that black people are resistant to the disease. Such kinds of beliefs can be a barrier to COVID 19 hygiene behaviour change. If people think they might get COVID19, they could be open to learning how to take preventative action.
If someone in your family did get COVID19, do you think it could result in serious illness or death?	I think it might happen	4	4	1	2	Participants in all rural districts focus group discussions felt that if their family members did get COVID 19 they can be serious ill. Two FGDs in urban in each of the Norton and Mutare district were of the view that if someone in their family's member gets COVID 19, definitely it will result in serious illness. If people do not consider COVID19 to be serious then they will be less likely to want to take preventative action. Results therefore show that people in the target districts are most likely to want to take preventative action.
If you compare your family with other families who live near you, who is more likely to get	Everyone is at the same risk	4	4	3	3	This may indicate that people feel their circumstances are similar to those around them and that who gets COVID19 is random. Perceiving that everyone is at risk is likely going to encourage people in all Districts to respond positively to HBCC hygiene promotion.

COVID19 in the next
6 months?



Table 8: Perceived impacts of COVID 19 and local community`s ability to act on them

Question	YES/ NO	Total Score				Interpretation
		Chivi	Zvishavane	Norton	Mutare	
What were some of the perceived impacts of COVID19? (more than one answer may be true for this question)	Physical or mental health impacts for the individual or family.	3	3	1	1	75% of the focus group discussions in both rural districts perceived physical and mental health impacts of COVID 19 to individuals and families. People are predominantly worried by the health impacts of COVID 19.
	An economic impact loss of income while sick	4	4	3	2	People are not only worried about the health impacts of COVID 19. Heightening the economic impact of COVID 19 could be an effective way to motivate hand washing.
	A social impact — other family members or friends have to fulfil the	0	0	2	3	People are not only worried about the health impacts of covid19. Heightening the social impact of covid19 could be an effective way to motivate hand washing.

	responsibilities of the sick person					
Did people think that they can take action to prevent COVID19? (more than one answer may be true for this question)	Yes — people feel like they have the ability to reduce their chance of getting COVID19 (including by washing their hands)	4	0	4	3	This means people know what they should do and feel that there are no major barriers to hand washing. It means people will respond positively to hygiene promotion. However, people in Zvishavane district did not feel that they have the ability to reduce their chances of getting COVID 19.
	Yes — people can identify things that would prevent COVID19, but feel they don't have the means or ability to do them (including hand washing)	0	3	4	0	This means people know what they should be doing, but find it difficult to practice for a variety of reasons. People in Zvishavane said they find it difficult to wash their hands because they cannot always afford soap; and majority had no hand washing facilities. In Norton water is a serious challenge- intermittent water access, and like any other urban district keeping social distance in public places like public transport and market places is a challenge because some work away from home where there are no facilities.
	Yes — people think it is possible to prevent COVID19, but do not	4	2	0	3	This means there may be some knowledge barriers preventing people from regularly hand washing. Some questioned the link between the virus and hand washing, e.g. 'I do not think such a

think hand washing is an effective mode of prevention.



deadly virus which up to now has no cure can be washed away by just hand washing with soap'. It could also mean people know they should wash their hands, but there are local beliefs preventing them from practising.

Table 9: Perceived relationship of COVID 19 and hand washing practices

Question	YES/ NO	Total Score				Interpretation
		Chivi	Zvish	Norton	Mutare	
Do people think their hand washing practices have changed? (more than one answer may be true for this question)	More often because they are afraid of disease	4	3	1	3	Majority in all focus group discussions except in Norton thought their hand washing practices changed because they are afraid of disease. Further discussions however revealed that all people were so much afraid of the disease during the first three months of lock down announced by the government, but now they are a bit relaxed. Heightened rates of hand washing can be a coping mechanism when people have experienced trauma. Lock downs traumatised people in all districts and they reported high frequency of hand washing, sanitisation and steaming hot water.
	Less often because of a lack of water	4	0	3	3	Majority of participants reported that hand washing practices changed more often during the early days of the pandemic but because of serious water challenges in some urban districts such as Norton all the rural districts, washing of hands is no longer so often. When people only have access to a small amount of water, they are likely to prioritize it for tasks other than hand washing.

An equal amount — people report that the times they wash their hands are the same, but they no longer use soap

4

1

Rural districts such as Chivi revealed that it's difficult to say there is increased change or not. Lack of soap and hand washing facilities acted as barriers for desired change in households where soap is available, it is prioritised for other use such as laundry and washing of dishes.

Participants reported that during the first 1-3 months (March-May 2020) of lock down strict hygiene practices were adhered to such as temperature checks, wearing of masks, and applying hand sanitizers to every passenger and observing social distancing on public transport. COVID 19 response measures including related hygiene measures are enforced by statutory instrument (SI), for example there is a fine of Z\$20 000 or jail sentence. Participants reported that they always washed their hands with soap or using hand sanitizers upon arrival at home from work during that period. However, by the time of discussion enforcement of most of the measures were now relaxed. It can be concluded that even though participants viewed COVID 19 as one of the 5 illnesses of greatest concern situation on the ground are forcing people to treat the disease as a low risk. One participant said most people now only wear face masks because of fearing the police, social distance is no longer being observed and people are not washing their hands as frequent as during the lockdown period. Shortage of public transport, high costs of masks and hand sanitizer and harsh economic environment that saw many people losing their jobs are some of the barriers. To some it's better to risk getting infected by COVID 19 than starve at home. Other participants reported that they do not feel comfortable wearing masks whole day, especially during the hot season. Most people use handmade masks because they can't afford to regularly buy officially recognised masks. Handmade masks are usually not well designed are uncomfortable to put on for long period.

4.5 Touch points

All of the ways one can touch the lives of the population in the project area were assessed. Understanding touch points is important because HBCC project can use existing social structures and ways of sharing information as some of the delivery channels for intervention. WASH'Em touch point guide and touch points data collection tool were used¹⁴. In each FGD, any touch point that reaches to lot of people was given a core of “5”. If the touch point is used by few people it was given a score of 2 and a score of “0” when no one was using the touch point. Scores were added according to number of FGDs in each district to give total score for each touch point (Figure 19 and Figure 20). Touch points with highest scores are likely to work in each respective district or target group.

Most popular touch points in both Mutare and Norton are radio, mobile phones, religious institutions, hairdressers and public transport (buses) (Figure 19). It was revealed during focus group discussions that majority of young people do not watch the national television, but prefer certain sessions that appeal to young people on radio stations. Men and women also have preferred programs on radio. Men reported that they only watch TV during prime news time. All the groups reported that they use mobile phones and youths are more on social media than adults. Youths reported that they are limited from using social media by high costs of data. Majority of people in all the sampled districts use public transport. Because of the government regulations on COVID 19 ZUPCO¹⁵ buses and its affiliated partners are only allowed to operate urban commuter routes.

¹⁴ WASH'Em Touch Point tools: <https://app.washem.info/rapid-assessments>

¹⁵ Zimbabwe United Passenger Company (ZUPCO) is the only authorized public transport for commuters in the cities since the announcement of the first lockdown in April, Zimbabwe

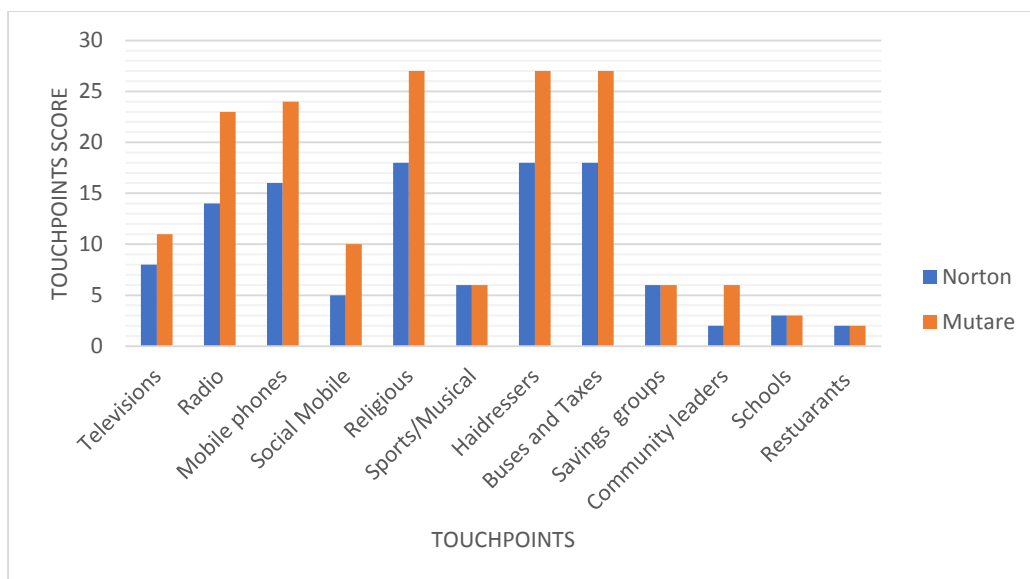


Figure 19: Touch points in urban districts

Figure 20 show that radio, religious institutions, community health workers and mobile phones are the most popular touch points in both rural districts. Like in urban areas religious institutions plays a pivotal role in shaping the behaviour of people. Rural communities rely more on rural community health workers on good hygiene and behaviour change issues.

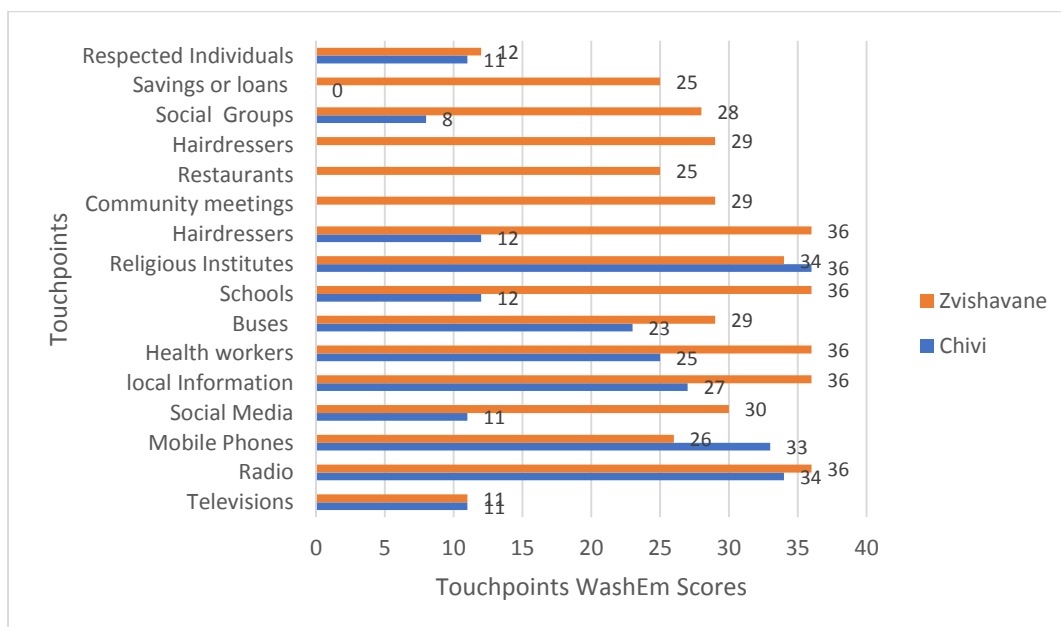


Figure 20: Touch points in rural districts

Over 65% of people across all districts in the 25-34 years and 35-60 age groups can be reached on radio, mobile phones, social media, hairdressers/saloons and religious places. The most important touch points for the elderly across all districts are 82% radio, 48% religious, 45%

community leaders. The youths (18-24) years of age prefer the use of mobile phones (75%) radio (65%), and above approximately 48% of them can be reached through public transport and religious places.

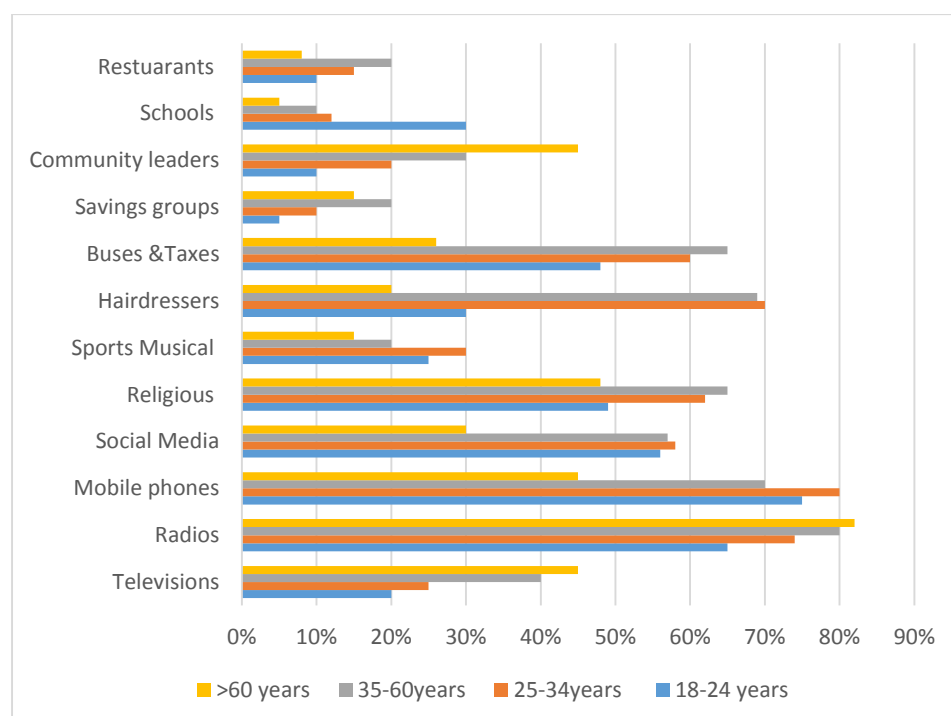


Figure 21: Touch points according to age groups

HBCC program should therefore think of ways of taking advantage of popular touch points to promote hygiene behaviour change in both urban and rural districts.

4.6 Underlying Reasons and Barriers to Hygiene Practices

During the hand washing demonstration, key informant interviews, touch points focus group discussions and diseases perception discussions, a lot of barriers to hygiene practices were identified. The identified barriers are;

Urban Districts

- No reliable access to water in the case of Norton district. Most households are connected to municipal water supply but the water authorities are failing to provide
- High use of multifunctional hand washing facilities
- No soap on some hand washing facilities

- Ignorance of COVID 19 pandemic for example one participant said ‘I do not think such a deadly virus which up to now has no cure can be washed away by just hand washing with soap’.
- Placement of hand washing facilities on places that are not convenient
- Using hand washing facilities that are difficult to operate, dirty or fragile for example tip tap facilities in most rural areas
- Shortage of resources at homes and public places (no adequate hand washing facilities in schools, bus stations, clinics and market places, shortage of desks and chairs in schools to ensure social distance, inadequate PPE in clinics and soap/ hand sanitizer)
- School children do not observe social distance and they do not like wear face masks unless they are forced to do so
- Negative attitudes by some people towards COVID 19 prevention measures .e.g. some felt wearing masks irritates them
- Shortage of public transport leading to congestion in bus terminus and in buses- difficult to observe social distance
- Failing to see the link between hand COVID 19 and hand washing by some communities

Rural Districts

- No reliable access to water. Majority of rural household depends on community water points. Where water points are far away e.g. more 5km away allocating water to hand washing facility becomes a challenge
- High use of multifunctional hand washing facilities
- Shortage of resources at homes and public places (no adequate hand washing facilities in schools, bus stations, clinics and market places, shortage of desks and chairs in schools to ensure social distance, inadequate PPE in clinics and soap/ hand sanitizer)
- Ignorance of COVID 19 pandemic e.g. belief that COVID is for European countries and China
- Belief that there is no COVID 19 in rural areas
- Placement of hand washing facilities on places that are not convenient
- Using hand washing facilities that are difficult to operate, dirty or fragile for example tip tap facilities in most rural areas

- School children do not observe social distance and they do not like wear face masks unless they are forced to do so
- Failing to see the link between hand COVID 19 and hand washing by some communities

4.7 Existing Communication channels

Men and women in all the participating districts predominatly get information about COVID 19 from mass media (radio and TVs) and Health staff as shown in Figure 22 and Figure 23. There is no signifcant difference in the way men and women receive information in all the districts.

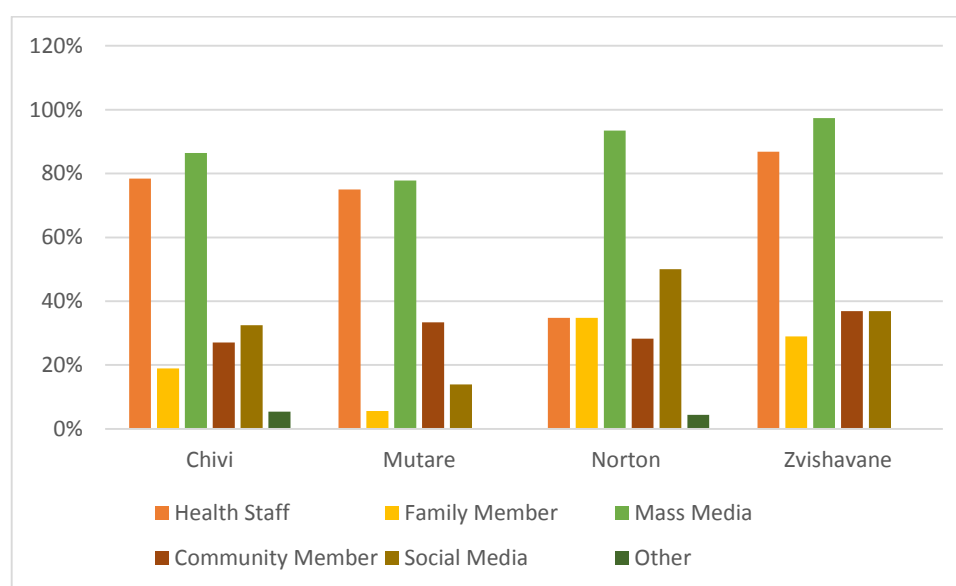


Figure 22: Information channels on COVID 19 amongst men

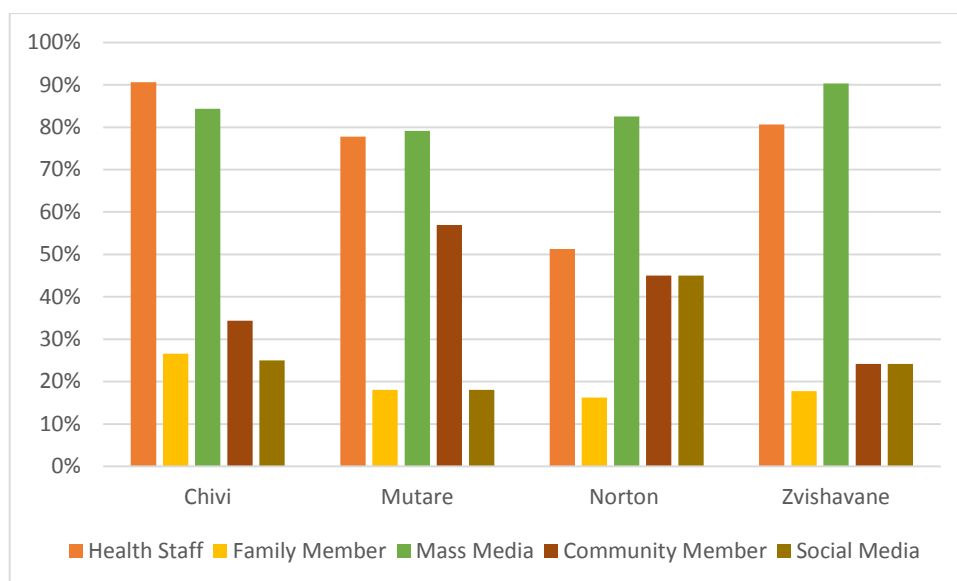


Figure 23: Information channels on COVID 19 amongst women

Radios are the most predominant channels used by communities to access health related information as shown in Figure 24. Other channels of communication include community hygiene promoters, health facilities and television. In urban areas because of gathering restrictions, many religious people created online social groups which they use to worship and share relevant information. Churches have been the main source of hope for many people¹⁶. Churches played a crucial role in counselling, raising awareness on COVID 19, on gender based violence (GBV), faith and reduce fear, stress and pressure that COVID 19 pandemic was causing in people¹⁷. It was established during focus group discussions that people who go to church respects and follow their leaders, as such any hygienic promotional or education programs that is mainstreaming through the change is most likely to be adopted.

¹⁶ Castillo, F., Brianna, H.T & Joaquin, J.J (2020). Church in Action: the role of religious interventions in times of COVID 19

¹⁷ Gurungweni, (2020).COVID 19: Zimbabwe church expands awareness to border community

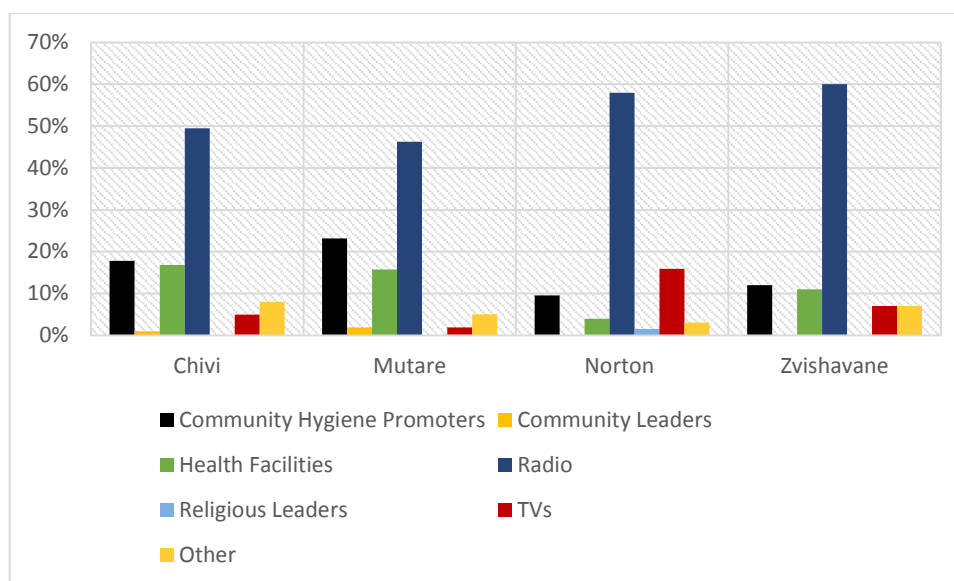


Figure 24: Channels of communicating health related information

One of the provincial radio stations consulted in this study; YA FM provided further details on existing communication channels. The results show that there are radio stations in the targeted locations currently promoting COVID 19 awareness and hygiene behaviour. These include at national level, National FM, Star FM, and Power FM; at provincial level HAVOI FM (Masvingo) 98.4 (Midlands -Gweru), YA FM (Zvishavane- Midlands) and Diamond FM Power (Mutare- Manicaland).

Most media houses are aspirational meaning communities they broadcast in aspire to follow trends that are pushed by the media house besides mass media has an effect on many aspects of human life be it politics individual views or knowledge of a specific issue. Each radio stations have target audience and captures the attention of different age groups (men, women and children). Each radio stations can reach out to more than 2 million people. Different mass media platforms have been active in the fight against COVID 19 since the announcement of the first national lockdown in March 2020.

YA FM with target audience of 4 million reported that;

- They had COVID 19 hygiene promotion talk shows program every Thursday prime time 1830 pm which ran for 8 weeks where they spoke to health authorities including the Zvishavane COVID 19 Task Force for tips and updates regarding COVID 19.
- They had health promotion program with the theme Wellness Thursday every Thursday to promote good health in relation to COVID 19.

- They carried out Community COVID 19 awareness tips using an outside broadcast van that regularly went into the community to give awareness tips
- Had programs for children where they promoted hygiene behaviour change and COVID 19 awareness. Ran programs in partnership with Oxfam and Betany project
- YA FM have a COVID WhatsApp hotline number that provides tips and answers to regularly asked questions.
- They have a COVID 19 jingle in the three major languages (Shona, Ndebele and English) of Zimbabwe that run every hour at the end of each bulletin

However, all the COVID 19 and hygiene promotion programs do expire. There is need for more partners to promote radio stations to ensure continued support for broadcasting COVID 19 and good hygiene programs.

4.8 Recommended Potential Communication channels

Table 8 show HBCC can influence preparedness and prevention capacities of people in the targeted districts.

Table 10: Recommended interventions and potential communication channels

ISSUE	RURAL DISTRICTS	URBAN DISTRICTS
Hand Washing facilities	Get people to build hand washing facilities so hand washing is more convenient and desirable? Give soap to those with facilities as a reward.	Promote urban communities to have dedicated hand washing facilities and if possible, to reduce multifunctional use. HBCC can run a promotional competition for best hand washing facilities etc. and reward the winners in different categories e.g. with hygiene kits
	Design hand washing facilities that are attractive, user friendly	Design hand washing facilities that are attractive and user friendly ¹⁸
	Locate hand washing facilities at convenient places.	Locate hand washing facilities at convenient places.
Hand washing practice	Encourage pride in hand washing facilities so people keep them clean. HBCC can run promotional	Encourage pride in hand washing facilities so people keep them clean. HBCC can run promotional

¹⁸ WASH'Em (2020). How to design hand washing facilities that change behavior

	<p>programs with respected people in communities</p> <p>e.g. musician, church leaders or business leaders</p>	<p>programs with respected people in communities e.g. musician, church leaders or sport persons</p>
No reliable access to water in the case	Support by drilling of more protected wells or boreholes	<p>Support by drilling of more community boreholes in the short term</p> <p>Support city council to reliably supply water to residents in the long term</p>
No soap hand washing by some communities	Promote use of soap or ash in washing of hands	Promote use of soap or ash in washing of hands
COVID 19 disease and hygiene perception	<p>Help people to view COVID19 as something that is affecting many people in their community and there are things, they can do to reduce their risk.</p> <p>Help people to realize that COVID19 is a serious disease, but one that can be prevented</p> <p>Heightening the cognitive impact of covid19 could be an effective way to motivate hand washing.</p> <p>Help people to channel the temporary fear they are experiencing into long term changes in hand washing behaviour.</p>	<p>Help people to view COVID19 as something that is affecting many people in their community and there are things, they can do to reduce their risk.</p> <p>Help people to realize that COVID19 is a serious disease, but one that can be prevented.</p> <p>Help people to understand the cognitive consequences of a family member getting covid19</p> <p>Help people to channel the temporary fear they are experiencing into long term changes in hand washing behaviour.</p>
Motives	Engage with respected people influential leaders/people and institutions to promote hygiene behaviour change. For example, church leaders and local celebrities, local business people. Religious leaders are often trusted people within the community, so doing activities through a religious	<p>Engage with respected people influential leaders/people and institutions to promote hygiene behaviour change. For example, church leaders and local celebrities, musicians, business people,</p> <p>Religious leaders are often trusted people within the community, so doing activities through a</p>

	institution can help build acceptance.	religious institution can help build acceptance.
Touch points and Communication	<p>Think of ways to use to radio to deliver hand washing intervention. This could be through short radio advertisements or interviews with people who recovered from COVID. Can try to create short radio dramas that tells guiding story. Timing and language of the program should be convenient to different target groups e.g. elderly, youths and disabled</p> <p>Think of ways to use mobile phones to deliver hand washing intervention. Can reach people through targeted SMS messaging or WhatsApp hot lines. Consider differences in target groups such as age for example the elderly and youths</p> <p>Think of ways to use to use public transport to deliver your hand washing intervention. Public transport, or places where people wait for public transport, can be a great way to reach people in those vehicles or as they wait for their ride.</p> <p>Think of ways to use health workers in rural areas to deliver hand washing intervention. Hygiene behaviour change requires more than education about disease, so health workers may need training or refresher courses in behaviour change.</p> <p>Think of using community water points to deliver hand washing and hygiene behaviour change intervention</p>	<p>Think of ways to use to radio to deliver hand washing intervention. This could be through short radio advertisements or interviews with people who recovered from COVID. Can try to create short radio dramas that tells guiding story. Timing and language of the program should be convenient to different target groups e.g. elderly, youths and disabled</p> <p>Think of ways to use mobile phones to deliver hand washing intervention. Can reach people through targeted SMS messaging. Or WhatsApp hotlines. Consider differences in target groups such as age for example the elderly and youths</p> <p>Think of ways to use to use public transport to deliver your hand washing intervention. Public transport, or places where people wait for public transport, can be a great way to reach people in those vehicles or as they wait for their ride.</p> <p>Think of ways to use to use hairdressers/ saloons to deliver your hand washing intervention. Most people in urban areas go to the saloons for hair cut or hairdressing and the places have high traffic of people. Hairdresser may need training on hygiene behaviour change</p> <p>Think of using community water points to deliver hand washing and hygiene behaviour change intervention</p>

4.9 Unexpected emerging issues

- Water points is an unexpected touch point that can be utilised to reach out to most women and young people in both rural and urban districts. Most people in the rural areas and urban districts like Norton fetch water from community water points
- Hairdressers is another touch point with huge potential especially in the urban districts. Over 70% of urban women regularly visits hairdressers in public places
- Majority of people (>78%) in all the sampled districts use public transport. ZUPCO¹⁹ is the main bus company that provides transport to the members of the public and can be a useful touch point
- National lockdown as a result of COVID 19 caused high level of pregnancies of school children. For example 40 girls in one school in Norton District fell pregnant during National COVID 19 lockdown period (April 2019- August) when all schools were closed. There is need to capacitate children and respective caregivers to protect the girl child from early pregnancy or contracting sexually transmitted diseases during and after full/ partial lockdown

¹⁹ ZUPCO- Zimbabwe United Passenger Company – Government Bus Company only authorized to be commuter transport in cities and towns.

SECTION 5: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

It can be concluded based on the findings from the four sampled districts that members of the community are facing hygiene related challenges. Majority people are aware of COVID 19, and reported that the pandemic caused socioeconomic impacts to their lives. The main challenge that majority of people face in the targeted communities is lack of capacity, limited knowledge and perceptions of COVID 19 infections. Lack of capacity is caused by lack of resources (face masks and hand sanitizers are expensive to majority, there is shortage of hand washing facilities and water). Majority of people still use crowded public transport system and crowd at water points because of water shortage. Perception of the seriousness of COVID 19 pandemic has diminished over the course of the year. Many people used to be so afraid and were using wide range of sanitation and hygiene methods of preventing against the disease such as washing of hands with soap, social distancing and wearing of masks. This study established that even though the participants still think COVID 19 is a serious pandemic and can affect anyone, their hygienic behaviour has changed, and it is now business as usual for the majority. Some are no longer washing their hands, sanitize their hands or and wear face masks in public. Certain myths/ beliefs acted as barriers to behaviour change. These include the thinking that people in high temperature area do not get affected by the virus and also that majority of people recovered from the virus.

Of major concerns is that majority of households have no hand washing facilities close to the toilets and kitchens. Rural districts are the most affected. Where the hand washing facilities are available, some of them especially the handmade are not user friendly and fragile. Majority of people in the urban districts use multifunctional hand washing facilities. Urban districts like Norton have no access to reliable water supply. Even though they are connected to city council water supply system, they can go for months without any supply. In the rural communities like Chivi, water access is a challenge as well. Lack of water is a barrier to hand washing.

Another observed barrier during hand washing demonstration is lack of soap close to the hand washing facilities in majority of cases. In most cases where water was used during hand washing demonstrations, soap was taken somewhere in the house showing that people are not usually using soap during hand washing. People are also not using ash as an alternative. Failing to see the link between hand COVID 19 and hand washing by some communities.

Various forms of media (radio, TV, social media and mobile telecommunication companies) played a pivotal role in raising awareness of COVID 19. It can be concluded that there are

various touch points and communication channels can be used to enhance effectiveness of HBCC project.

Communication channels that can be used include provincial radio stations, community broadcasting van, WhatsApp hotline, running promotional programs in public place such as public transport, hair salons, water points and market places.

5.2 Recommendations

Hand washing

- Design and construct hand washing facilities for use at household level and for use at public places (water points, bus terminuses, schools and market places among others). They should be located at convenient places accessible by all (men, women, children and people living with disabilities)
- Design hand washing facilities that are attractive, durable and user friendly. The household hand washing facilities should be affordable to ensure high adoption and sustainability
- Improve water access by developing more water points (drilling more protected wells or boreholes)
- Design and secure hand washing soap storage place at hand washing facilities.

Hygiene Behaviour change

- Use the most preferred touch points to raise awareness and reverse the diminishing perception on the COVID 19 pandemic. Help people to view COVID19 as something that is affecting many people and there are things, they can do to reduce their risk. These include mass media (radio) for all age groups, mobile and social media for the young people and community health workers.
- In terms of targeting women should be the main target because they are the majority. Furthermore because of mostly family set ups in Zimbabwe, women have much capacity to influence men especially their husbands and children if they are capacitated. The second target group is people living with disabilities and the elderly because they are often neglected. Urban districts are more at risk because people are highly mobile and congested, however they have better capacity to respond than the rural districts.
- Develop and circulate on social media hand washing demonstrations including demonstrating use of soap/ and or ashes in effective hand washing

- Consider use of provincial radio stations that use local language to deliver COVID 19 awareness and hand washing intervention. This could be through short radio advertisements or interviews with people who recovered from COVID. Can try to create short radio dramas that tells guiding story, talk show for the elderly targeting man and women, music and entertainment program using musicians popular to the youths or radio competitions. Talk show with the people living with disabilities.
- Engage with respected and influential people and institutions to promote hygiene behaviour change (encourage hand washing, social distance and use of face masks). For example, church leaders, hairdressers and celebrities. HBCC can run promotion with hairdressers that encourage hand washing with soap, run some competitions and awarding winners. Religious leaders are often trusted people within the community, so doing activities through a religious institution can help build acceptance.
- Consider use of mobile phones to deliver hand washing intervention. Can reach many people especially young people through targeted SMS messaging or WhatsApp hot lines.
- Consider use of face masks promotional competitions. For example competition in designing of affordable, comfortable but effective face masks
- Consider use of other communication channels to educate the people in public places (bus stations, market places) for example COVID 19 awareness and prevention bill boards and social distance markings at public transport queues.
- People are not only worried about the health impacts of COVID 19. Heightening the economic impact of COVID 19 could be an effective way to motivate hand washing
- Consider ways of capacitate children and respective caregivers to on health and hygiene behaviour change that help protect the girl child during from early risks associated with early sex such as early pregnancy and contracting sexually transmitted diseases such as AIDs

APPENDICES

Appendix 1: WASH'Em data collection tools

- a) Hand washing demonstration guide and data collection tools <https://washem.info/rapids-assessments>
- b) Touch points guides and data collection tools <https://washem.info/rapids-assessments>
- c) Disease perception guide and data collection tools <https://washem.info/rapids-assessments>

Appendix 2: Household Questionnaire



Individual Survey - Baseline Assessment Tool for the Hygiene Behaviours Change Coalition-HBCC Project

Information sheet and Consent guide

I <name of interviewer> am from the CARE International Zimbabwe. We are conducting an assessment on the community's level of current hygiene practices and their determinants knowledge and preparedness on the COVID19 pandemic. The assessment will help CARE and its partners understand current hygiene practices and how this community access information regarding COVID19 pandemic and share among them. It will also inform CARE on the strategic areas to focus on their programs to help this community access reliable information to protect themselves from the pandemic

You have been selected by a random lottery to participate in this interview. In this survey, we will collect information on your knowledge and understanding of the COVID19 disease its causes and the effect, how you are preventing yourself from contracting the disease including hand washing. In order to get true perceptions of you, we would like to do the interview without others influencing the responses. If you accept to complete this survey, your answers will be used to get a better understanding of the community preparedness on the prevention and mitigation of illness.

The survey will take about 30 minutes to complete. You will neither benefit nor lose anything personally, but the information you provide will be very valuable to our programing. All information you provide will be used only for research purposes. It will remain confidential and known to those dealing with the survey only.

I would like to notify you that some of the questions are quite personal. Your participation is voluntary, and you can stop giving information at any time or choose not to answer a particular question.

If you have questions, we will be happy to answer them now or at any point in the survey. If you have questions about the study or participation after we have completed today's session, please contact [Emergency accountability officer, at XXXX or XXXX].

Do you agree to participate in this survey?

1=Yes

0=No

1. General				
Date of interview:	Name of interviewer:	Region:	District:	Village:

Sn	Questions	Response
2. Demography		
1.	Name of the respondent	[Text]
2.	Age of the Respondent	[Number]
3.	Sex of the respondent	1=Male

		2=Female
4.	Educational status of the Respondent	1 = Illiterate/No schooling 2=Informal School 3=Lower Primary 4=Upper Primary 5=Secondary 6=Tertiary
5.	Household size	[Number]
6	Are you a parent or caregiver?	1 = Parent 2= Care giver 3= None of the above
3. Knowledge and Understanding of hygiene related diseases and the COVID 19		
1.	What are the illnesses of most concern to your community (with Number 1 being the most serious concern):	1=..... 2=..... 3=..... 4=.....
2.	Have you heard about the new coronavirus disease? (If the interviewee is unresponsive, the facilitator asks a clarification question: It is also called COVID-19 Have you heard of that?)	1= Yes 0=No
3.	If yes, from whom or from where did you hear about the new coronavirus disease? (Multi select) (Facilitator should ask for all different sources from which the interviewee heard about coronavirus disease.)	1=Family member 2=Health staff including CHW 3=Mass media (Radio, TV) 4=Community member 5= Social media Others:_____ specify
4.	What do you know about the new coronavirus disease COVID-19? (multiple choice) (Facilitator prompts interviewee's responses related to what they know about protection steps, symptoms, transmission, self-care, risks/complications, government action, etc. Facilitator should prompt the interviewee until he/she says "that is all the information I have heard about coronavirus.")	1=Protection steps 2=Symptoms 3=Transmission 4=Self-care 5=Risks/complications 6=Government action
4 Perception of the COVID 19		
5.	Do you think that someone in your family could get COVID 19 in the next 6 months	1= I think it will not happen 2= I think it might happen 3= I think it will happen
6.	If someone in your family did get COVID 19, do you think it could result in serious illness or death?	1= I think it will not happen 2= I think it might happen 3= I think it will happen
7.	If you compare your family with other families who live near you, who is more exposed to COVID 19 in the next 6 months?	1=Other families 2= We are all at risk 3= My family
8.	What would you do if you or someone from your family gets sick? (Facilitator should first let interviewee respond freely, and then probe on each of the following)	1=I will look for a more experienced relative to advise me on what to do 2=I would go to the hospital / health unit

		3=I would go to the neighbourhood nurse 4=I would go to buy medicines at the market 5=I'm going to look for the traditional healer 6=I would stay in quarantine 7=Other(specify)		
9.	Do you think hand washing can reduce the spread of diarrhoea and COVID 19?	1= Yes 2= No		
10.	Imagine a child in your family got COVID 19. How would it impact your life or the life of others in your family? a) Effect on your social life Effect on your income or productivity:			
11.	What can families like yours do to prevent spread of COVID 19?			
5 Access to information and communication				
12.	Do you have access to the following media and information sharing channels? 1=Radio 2= TVs 3= Social media 10=Posters	1=Yes 2=No		
13.	Do you watch television? Who uses this?	1=Yes 2=No		
14.	What is your favourite station?		
15.	Do you listen to radio often?	1=Yes 2=No		
16.	What is your favourite station		
17.	Are you on social media?	1=Yes 2=No		
18.	If yes tick the social media platform that you regularly visit	1= Watsup 2=Facebook 3= Twiter 4 =Sasai 5=Youtube Other Specify.....		
19.	What are the different ways of receiving information about coronavirus that you would prefer? Are there some people, information sources or channels that you trust more than others to give you good information about the coronavirus? Why? (multiple)	<table border="1"> <tr> <td> 1=Radio 2=Social media 3=Health care worker 4=Family members 5=Friends 6=Community leaders 7=Government public health officials 9=Religious leaders </td> <td> Trust Level 1=Low 2=Medium 3=Low </td> </tr> </table>	1=Radio 2=Social media 3=Health care worker 4=Family members 5=Friends 6=Community leaders 7=Government public health officials 9=Religious leaders	Trust Level 1=Low 2=Medium 3=Low
1=Radio 2=Social media 3=Health care worker 4=Family members 5=Friends 6=Community leaders 7=Government public health officials 9=Religious leaders	Trust Level 1=Low 2=Medium 3=Low			

		10=Posters 11=Other community members	
20.	Are there any hygiene promotion activities that you received through the following communication channels? Tick the ones you know.	1= Television 2= Social Media 3= Radio 4= Newspapers 5= Bill boards/ Posters	
21.	How easy or difficult would you say it is to...? 21.1. Find the information you need related to COVID-19? 21.2. Understand information about what to do if you think you have COVID-19? 21.3. Judge if the information about COVID-19 in the media is reliable? 21.4. Understand restrictions and recommendations of authorities regarding COVID-19? [21.5. Follow the recommendations on how to protect yourself from COVID-19? 21.6. Understand recommendations about when to stay at home from work/school, and when not to? 21.7. Follow recommendations about when to stay at home from work/school, and when not to? Understand recommendations about when to engage in social activities, and when not to? 21.8. Follow recommendations about when to engage in social activities, and when not to?	1=Very easy 2=Easy 3=Difficult 4=Very difficult 5=Impossible	
22.	Do you know how the disease spreads or you can get sick from the new coronavirus? Please explain.	1=Yes 2=No	
23.	If yes, what ways of spread for the virus do you know?	1=close contact with infected person 2=through contaminated object or surface 3= Contacting infected droplets from cough or sneeze	
24.	What are the main symptoms of the coronavirus/COVID-19? (multiple) (Facilitator should first let the interviewee respond freely, and then probe for each of the following symptoms: Fever/Cough/shortness of breath & breathing difficulties/ muscle pain/ headache/ diarrhoea.)	1=Fever 2=Cough 3=Shortness of breath 4=Breathing difficulties 5=Muscle pain 6=Headache 7=Diarrhoea	
25.	What ways do you prevent from contracting COVID19 disease	1= don't know 2= Stay <u>at least</u> 1 metre away from others 3= Clean hands frequently 4= Cover the mouth with a tissue or bent elbow when sneezing or coughing 5=	
26.	During the last 7 days, which of the following measures have you taken to prevent infection from COVID-19?	1=Wash hands regularly using hand rub or soap and	

		<p>water for at least 20 seconds.</p> <p>2=Avoid touching eyes, nose, and mouth with your hand/fingers.</p> <p>3=Covering mouth and nose when coughing or sneezing, and washing hands after.</p> <p>4=Avoid close contact with anyone who is sick, especially those with flu or cold symptoms such as fever, cough, or sneezing.</p> <p>5=Clean and disinfect frequently touched objects and surfaces.</p> <p>6=Stay at home if I am sick, except to get medical care.</p> <p>7=Avoid shaking hands with others.</p> <p>8=Avoid large gatherings.</p> <p>9=Other measures:</p>
4. WASH Behaviours		
1.	In a typical day, how often do you wash your hands	[Number of times]
2.	Why is it important to wash hands? <u>(tick all that applies, do not prompt)</u>	<p>1=Get rid of dirt</p> <p>2=Kill bacteria</p> <p>3=Prevent disease</p> <p>4=Smell nice</p>
3.	Please name at least 3 of the most important times when someone should wash their hands <u>(Check all that apply but do not prompt)</u>	<p>1=Before eating</p> <p>2=Before cooking/meal preparation</p> <p>3=After defecation</p> <p>4=Before feeding children</p> <p>5=After handling a child's stool/changing a nappy/cleaning a child's bottom</p> <p>6=Other (specify)</p> <p>7=Don't know or no response given</p>
4.	What do you use to wash your hands? <u>(choose only one, do not prompt)</u>	<p>1=Water only</p> <p>2=Soap and water</p> <p>3=Water and ash</p> <p>4=Sand and water</p> <p>5=Does not wash hands</p>
5.	Have you receives hygiene promotional messages on hand washing in the past two months?	<p>1=Yes</p> <p>0=No</p>
6.	If yes, through which method did you receive the message from?	<p>1=Radio</p> <p>2=TVs</p> <p>3=Community hygiene promoters</p> <p>4=Community leaders</p> <p>5=Religious leaders</p>

		6=Health facilities 7=Other (specify)
7.	Is there a specific place for hand washing?	1=Yes - there are hand washing facilities near the toilet and the kitchen 2=Yes - there is a multifunctional hand washing facility (a basin or tap that is used for hand washing, and is used for other things like laundry, too) 3=No - there are no hand washing facilities available near the kitchen or toilet 4=No - there are hand washing facilities at the toilet, but not at the kitchen 5=No - there are hand washing facilities at the kitchen, but not at the toilet.
8.	If there is a hand washing place, is it in a location where other people can easily see it? (If someone doesn't wash their hands will people notice?)	1=Yes - others can see 2=No - others can't see
9.	If there are hand washing facilities, are they shared by more than one family or more than 10 people?	1=Yes - the facilities are shared 2=No - The facilities are used only by one family or less than 10 people.
10.	Is there soap or ash in the home? If so, where is it kept?	1=Yes - Near the toilet or in the kitchen 2=Yes - Elsewhere in the house 3=No soap of any kind or ash is available
11.	If soap is available, what type is it?	1=Liquid soap or foaming soap 2=Bar soap that is designed for hand washing/bathing and is scented 3=Laundry powder, laundry bar soap, dishwashing liquid or ash
12.	Was there water available at the hand washing place?	1=Yes 2=No - the person had to go elsewhere to get water before hand washing (for example, into the home to access stored water).
13.	Can you demonstrate how you wash your hands? (Observe & record)?	
14.	Are the hand washing facilities clean and attractive? (For example, through mirrors, better cleanliness or decorations.)	1=Yes – Hand washing facilities are already desirable and attractive

		<p>2=No- Hand washing facilities are clean but not attractive</p> <p>3=No – Hand washing facilities are dirty and unattractive</p> <p>4=No - There are no hand washing facilities</p>
15.	Is the hand washing place convenient and easy to use? (more than one answer can be given per participant)	<p>1=Yes</p> <p>2=No - the person doing the demonstration found it difficult to reach (too high or too low) or other people in the family might find it hard to reach</p> <p>3=No - people can only wash one hand at time</p> <p>4=No - it is fragile or easy to break</p> <p>5=No – it is too far from the toilet/kitchen (for example, more than 10 steps away)</p>
16.	Is there any traditional, social or religious practices in your area that influences your behaviour towards hygiene practices (i.e. hand washing, social distance, wearing masks)	
17.	<p>If 15 is yes can you explain?</p> <p>a) Religious practices</p> <p>b) Traditional/ Cultural practices.....</p> <p>c) Social practices.....</p>	
18.	What are the traditionally routed social, cultural practices among different ethnic and religious group relating to key behaviours	
Touch points		
19.	What mode of transport do you use for travelling?	<p>1=Bus/ Mini buses</p> <p>2=Private</p> <p>3=Bicycle</p> <p>4=Train</p>
20.	Do you sanitize your hands before using public transport?	<p>1=Yes</p> <p>2=No</p>
21.	If you use public transport, are there markings for social distancing at bus/ taxi terminus?	<p>1=Yes</p> <p>2=No</p>
22.	From your views do people practice social distance at public places such as bus terminus, clinics, shops	<p>1=Yes</p> <p>2=No</p>
23.	Do you attend community/ village gatherings? (i.e. church, village leadership meetings, political meetings)	<p>1= Yes</p> <p>2=No</p>
24.	If yes, is there provision for hand washing or sanitizers at such meetings	<p>1=Yes</p> <p>2=No</p>
25.	Do you practice social distance in those meetings?	<p>1=Yes</p> <p>2=No</p>
26.	If the answer to 21 is no can you explain why?	
27.	Do health workers visit homes regularly? Who do they visit?	<p>1=Yes</p> <p>2= No</p>

Appendix 3: Key informant guide-mass media (Radio Station)

1 What is the name of Radio station?

2 What is your average listenership? (On average how many people do you reach out per year?)

3 Who mainly tune in to your station?

- a) Young people (children/ youths)
- b) Women
- c) Old people
- d) Men

5 What is your target audience?

- a) Rural/communal people?
- b) Urban people?

6 What programs do you put during your prime time?

7 Are there any radio stations in the targeted locations currently promoting COVID 19 awareness and hygiene behaviour? Can you state them?

8 Do you have programs/ sessions where you promote COVID 19 awareness and hygiene behaviour as a radio station according to WHO standards?

5 b) If yes what kind of hygiene/ health COVID 19 packages/ messages you are conveying to the public? Can you share with us examples (talk shows, drama, jingles, interviews, teachings call in etc.?)

5 c) What time of the day do you carry hygiene/ COVID 19 awareness/ good hygiene promotions?

5 d) How often do carry out hygiene/ COVID 19 awareness/ hygiene promotion?

5 e) Are there any among the programs specifically targeted at women and children? Explain.....

5 d) How are the people responding to your messages? What is the general behaviour of local people towards the messages? Can you provide any feedback?

5 e) Do you have programs for children where you promote hygiene and COVID 19 awareness?

If yes/no explain why?

6 Do you think mass media can influence hygiene behaviour change and COVID 19 awareness and preparedness?

7 If yes how do you think the mass media can positively influence the hygiene behaviour? What kind of packages can capture different age groups (children, youths, women, adults)?

8 How do you measure the impacts of your programs?

9 In your opinion what is the most effective way of reaching out and influencing behaviour change towards good hygiene and preventing COVID 19

Appendix 4: Key informant interview- Clinics

1 Name of Clinics

2 How many people do the clinic/hospital serve?

3 How prevalent are the cases of diarrhoea, cholera, typhoid in your area? Who are the most affected (woman, children, and men)

4 Do you have hand washing facilities at your clinic? Do they have soap and enough water always?

5 Do you have hygiene/ COVID 19 promotion programs? If yes how are they influencing hygiene behaviour change?

6 What are the barriers to good hygiene behaviour change?

7 What do you think is the best way of promoting hygiene behaviour?

Appendix 5: Key informant interview- School

- 1 Name of School
- 2 How many children are enrolled in the school?
- 3 Are you school children aware of COVID 19 and good hygiene practices?
- 4 If yes, how did they become aware?
- 5 does the school educate children on good hygiene practice and COVID 19 awareness?
- 6 Are there any school health clubs at the school?
- 7 Are there hand washing facilities at the school?
- 8 Do they always have water?
- 9 Do they always have soap/ ash? If the answer is no explain why?
- 10 Where are the hand washing facilities located? (e.g. Close to classroom blocks, close to the toilets)
- 11 Are the hand washing facilities easy to use by school children?
- 12 Is there hand washing facilities user friendly for children with disabilities?
- 13 What is the behaviour of children towards the hand washing facilities? (do they like using the facilities or they avoid them?)
- 14 In your opinion what is the best way of promoting good hygiene in school children

