SANDHYA SINGH
JOINT DIRECTOR(STATS)

भारत सरकार
Government of India
पेय जल एवं स्वच्छता मंत्रालय
पर्यावरण भवन, बी-1 विंग, 8वीं, 9वीं एवं 12 वीं मंजिल
सी.जी.ओ. काम्पलैक्स, लोधी रोड़,
नई दिल्ली-110 003
Ministry of Drinking Water and Sanitation
Paryavaran Bhawan, B-1 Wing, 8th, 9th & 12th Floor,
C.G.O. Complex, Lodhi Road,
New Delhi-110 003

D.O. No. W-11018/11/2012-WQ(IEC) Dated: 1st March , 2013

Sub: Invitation for Consultative workshop on National Drinking Water Communication and Advocacy Strategy in India being held on 11th and 12th March, 2013 at New Delhi

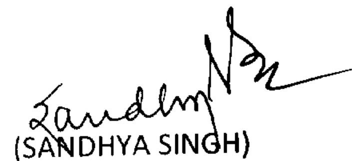
Dear Sir/Madam,

As you are aware the Ministry of Drinking Water & Sanitation is developing common understanding and agreement On key messages for a National Drinking Water Communication and Advocacy strategy focused on social behavior change in drinking water. In order to finalize the strategy, a National workshop is being held on 11th and 12th March, 2013 at New Delhi. The workshop will focus on finalizing the key messages and the approaches used for overall behavior changes in drinking water. It will also be discussing on building a consensus in way forward along with roles and responsibilities for different key stake holders.

You are therefore requested to kindly make it convenient to attend the Consultative workshop on 11and 12th March, 2013 at New Delhi. The venue will be informed subsequently.

The agenda and the programme for the workshop is enclosed.

Encl: As above



(SANDHYA SINGH)

To

As per list

<u>List</u>

1. Directors WSSO/CCDU of all States
2. Secretary, Information & Broadcasting Ministry,Shastri Bhawan, N.Delhi.
3. Director General, DAVP, Ministry of Information & Broadcasting, Shastri Bhawan, New Delhi.
4. Chairperson, Prasar Bharti, 2nd Floor, PTI Building, Parliament Street, N.Delhi.
5. DG,Akashvani, Akashvani Bhawan, All India Radio, N.Delhi.
6. Secretary, PIB
7. Secretary, Rural Development, Krishi Bhawan, N.Delhi.
8. Country Representative, UNICEF,74
9. Country Representative, WSP
10. Country Representative, World Bank
11. Country Representative, JICA
12. Country Representative, UNDP

Agenda for National Drinking Water Communication and Advocacy Strategy in India
Consultative Workshop
March 11 and 12 March, 2013

Target Audience –MDWS key officials , State Principal Secretaries, Chief Engineers, WSSO/CCDU, Directors, Other WASH stakeholders

Objective

Develop a common understanding and agreement on the key components and messages for a National Drinking Water Communication and Advocacy Strategy focused on Behavior Change on Drinking Water (2013-2017)

This will be achieved by

1. Understanding the types of approaches used for behavior changes using Advocacy and Behaviour Change Communication
2. Understanding the implications of these approaches for planning and rolling out strategies
3. Presenting of the current knowledge on communication around water
4. Identification and consensus on key behaviours and understanding of an advocacy and communication strategy design
5. Building consensus on the way forward including roles and responsibilities of different stakeholders (government – local , State, Central,; support agencies; CSOs, private sector, academia) to contribute to implementation and institutionalization of the communication strategy

Day 1 March 11,2013

Time	Topics	Responsible Person	Objective of session
1:45-2:00P.M.	Tea/Coffee and Registration of participation	Organizers	Registration
2:00-2:10 P.M.	Welcome speech from UNICEF to introduce the workshop topics and specific outcomes expected	Sue Coates, UNICEF Chief WASH	Welcome
2:10 PM-2.20PM	Key note address by Secretary MDWS on importance of communication in water programs	Secretary, DWS	Setting the context
2:20P.M.-2:30P.M.	Introduction of participants	All	Introductions
2:30-3.15 P.M.	Why technical solutions often do not work – introduction to Advocacy and Social and Behavioural Change Communication	UNICEF Chiefs A&C, c4D	To provide an understanding of SBCC and Advocacy
3:15 P.M.-3:30 P.M.	Tea Break		
3:30 P.M.-4:00 P.M.	Situational analysis and evidence review into communication interventions as applied to water quality and supply, including what is currently in place	Aidan Cronin UNICEF	Understanding the Indian context based on studies etc.
4:00P.M.-5:00P.M.	Key focus of the communication strategy and presentation on the focus behavior; how this ties in with IEC guidelines	Director Water MDWS	Review of the behaviours to be focused on

Day 2 March 12, 2013

Time	Topics	Responsible Person	Objective of session
9.00A.M.- 9.30A.M.	The Polio approach to advocacy and behavior change –the key factors to success with Q&A session	UNICEF Polio/WASH	What are the key factors in a behavior change strategy and campaign
9.30A.M.- 9.45A.M.	Introduction to the Group work to map current behaviours, desired behaviours, barriers and enablers	UNICEF C4D	Clear understanding of all on how to prioritize the behaviors via group work
9:45-10.00 A.M.	Tea Break		
10:00A.M.- 12.00P.M.	Group work to map current behaviours, desired behaviours, barriers and enablers + tea break	UNICEF	Matrix to be developed and filled so clear understanding by all of the task in hand
12.00P.M.- 13.00P.M.	Plenary presentations & Discussions on Group work	UNICEF C4D	Key actions to take & channels to use
13.00P.M.- 13.20P.M.	Introduction to strategy design (behaviours, audiences, approaches, channels, inputs etc.); introduction to implementation and monitoring frameworks	Paolo UNICEF C4D	Clear understanding of the components and planning needs around transforming the agreed behaviours into a framework and then into rollout
13:20-14:00	Lunch		
14:00P.M.- 15:00P.M.	State Sharing Session of Best practices	All States	Current way forward defined with roles & responsibilities
15:00 P.M.- 15:15P.M.	Tea Break		
15:15 P.M.- 16:15 P.M.	State Sharing Session of Best practices	All States	Current way forward defined with roles & responsibilities
16.15P.M.- 16.55P.M.	Panel Discussion on way forward	Chaired by JS Water	Clear way forward defined with roles & responsibilities
16:55P.M.- 17:00P.M.	Wrap and Vote of Thanks	MDWS	Key action points summarized and shared

WSSO & CCDU List

1. To,
   Executive Engineer,
   CCDU, Water Works ,
   Phase –II,
   Mohali.

2. Ms. Yasmin Singh
   Director,
   CCDU, Neer Bhawan ,
   O/O Engineer - in - Chief,
   PHED, Raipur.

3. Shri, Mir Najibullah,
   Ex. Director,
   CCDU, Jammu & Kashimir,
   Room No. 114,IMPA Complex, MA,Road,
   Srinagar , J& K.

4. Shri, R.K. Sinha ,
   Co-Ordinator
   CCDU, Jammu & Kahsimir
   Jammu.

5. Shri, Robin George
   State Co-Ordinator,
   Total Sanitation Campaign (TSC)
   D/o Rural Development
   Govt. of Himchal Pradesh.

6. Shri , Vishal Chand
   Consultant
   D/oRural Development,
   G/o Himchal Pradesh.

7. Shri,A. Ibohal Singh ,
   Assistant Engineer,
   PHED, Monitoring , Khuyathong,
   Imphal-786001.

8. Shri, Lalrothanga ,
   Director, CCDU
   PHE,Department, Mizoram ,
   Aizal.

9. Shri. K. Kharse,
   Director, CCDU,
   O/o Chief Engineer,PHED,
   Nagaland, Kohima.

10. Shri, Vpncallianzuala,
    Chief Engineer,
    PHED, Mizoram,
    Aizwal.

11. Shri, Geyum Padu,
    Chief Engineer,
    PHE, Department,
    Itnagar.

12. Shri, L. Swauci Kanta.
    Director,
    CCDU, PHE, Department,
    Imphal, Manipur.

13. Shri, Dheeraj Kumar,
Jal Swarajya Office,
CIDCO Bhawan ,
New Mumbai.

14. Shri, S.R. Shinde,
SC, Govt. of Maharashtra,
CCDE, CIDCO, Bhawan,
New Mumbai.

15. Shri, S. R. Nalli
WES Officer, UNICEF,
Lodhi Estate, New Delhi.

16. Shri, B.M. Hota,
Chief Engineer, SWSM,
Jal 'O' Parimal Bhawan,
Bhubneshwar, Unit -5

17. Shri, B.N. Mahapatra.
Chief Ex. Officer , WSSO,
Jal 'O' Parimal Bhawan, BBSR,
Unit -5, Odisha.

18. Shri R.M. Tripathi,
Joint Director,
UP , Jal Nigam, 6 Rana Pratap Marg,
Lucknow.

19. Shri,R. N. Singh,
Spl. Secretary,RD&ED, SWSM,
60, Adhikari Bhawan, UP Civil Sectt.
Vidhan Bhawan, Lucknow.

20. Shri, Dr. D. K. Das,
Director, CCDU,
Betnuchi , Guwahati,
Assam.

21. Shri, N.V. Ahmed,
State Co- Ordinator,
O/o Director, CCDU, PHED,
Betkuchi , Guwhati
Assam.

22. Shri,S.P. Selvan,
Executive Engineer,
CCDU,31 Kamarajan salai,
Chennai-5, Tamil Nadu.

23. Shri, Arumugakevumal,
Director,WSSO
WSSO,31 Kamarajan Salai ,
Chennai-5, Tamil Nadu.

Shri, Asheem Srivastav,
Rural Development Coam, G
NGR

24. Shri, M. M. Khaira,
Chief Engineer, PHE,Department,
Government of Madhya Pradesh,
Gwalior.

25. Shri, S.K. Khare,
Executive Engineer,
O/o Engg-in Chief, PHED,
Bhopal.

26. Shri. B. K. Jha,
Director, PMW
Water Tower Complex,
Ranchi.

27.,Consultant (Planning).
Government of Meghalaya,
Megahalaya Bhawan,
New Delhi.

28.Superintending Engineer,
S.E. P&I-I, Jal Nigam Bhawan,
Shimla-9

29.Shri, Narender Chauhan,
Pr. Secretary, (IP-4),
PHED , Department,
Shimla-02.

30..Shri, Kapil Lal,
Director, WSSO,
Mussoorie Dimension , Makkawala,
Deherdun.

Introducing the National Nutrition Campaign

In pursuance of the decision of the first meeting of the Prime Minister's National Council on India's Nutrition Challenges, a Nationwide Information Education & Communication campaign against malnutrition is being launched.

The campaign has the pro-bono services of Sh. Aamir Khan and technical support from UNICEF. The **objectives** of the nationwide information, education and communication campaign against malnutrition are:

1. **Creating awareness about nutrition challenges, malnutrition symptoms and the importance of optimal nutrition** to creating an enabling environment around an important issue.
2. Reinforce the four key issues around optimal nutrition in the first two years of life.

Target Audiences:

The **priority audience of the campaign** is mothers of children under two years, families of young children and adolescent girls. In general, the target audience is:

1. Men and Women (Pregnant women, mothers of children under two years of age)
2. Heads of Households (in laws, decision makers)
3. Service Providers
    - AWW, ASHA, ANM, Supervisor and CDPO
    - Teachers
    - Program functionaries
4. Enablers in the community
    - Self Help Group Members
    - Adolescent groups
    - PRI's and community leaders
5. Opinion leaders and Influencers (Media, policy makers, the urban middle classes)

Campaign approach

At a national level, the campaign will be carried out employing different forms of mass media for reaching the audiences.

The Media campaign will include **four** stages:

Stage 1: Make aware/ Raise alarm- Generate awareness about devastating consequences of Malnutrition (8 weeks)

Stage 2: Clarion call/ Take Pledge - Mass Mobilization– revolutionary call. Uniting masses for a cause (6 weeks)

Stage 3: Action Points- Suggest 'things-to-do' in fighting Malnutrition – seeding the messaging in popular culture (8 weeks)

Stage 4: Community using tools/ services- Introduction of Mother & Child Protection Card & actions to be taken (8 weeks); the first 4 weeks overlapping with the sub stage of stage 3

As part of the nationwide campaign, other mediums for IEC will carry out nutrition related activities parallel to the above campaign. Moreover, the thematic focus will be in tune with the campaign phases and themes.

Media and PR support:

Besides mass communication, **media coverage** plays a critical role in the success of any communication campaign. Simply said, readers should be able to gather information on malnutrition through non-paid forms of communication too. Media space, which is neither a press advertisement, nor a television commercial, will go a long way in influencing public opinion and driving the point home to the target audience.

Our plan for media engagement has a three-pronged approach.

1. It ensures mass awareness
2. It creates an enabling environment towards the campaign via the media

A media kit is currently being developed, which carries details on the key messages being conveyed through the campaign. The master kit is being developed in English & Hindi languages.

Support from State Governments:

1. **Local Media Channels:** The campaign is largely using national mass media channels including print, radio and television but since the reach of each medium is different in each state there would be a need to also use local media and channels including all possible conventional and traditional mediums.

The approach will be to increase efficiency and efficacy of mass media by adding multiple touch points and contextually align media where the audience is more conducive to listening and participating. The campaign will give priority to the states where the prevalence of undernutrition amongst children is high (Madhya Pradesh, Jharkhand, Bihar, Meghalaya, Chhattisgarh, Gujarat and Uttar Pradesh). For this, relatively higher concentration of communication delivery will be extended into demonstration and activation. Vernacular content will be used through local media in order to reach out stronger in such states.

State Government Action: Identify relevant and efficient local media channels in order to reiterate the messages from the national campaign. Local cable operators, local government media channels should be used to reinforce the messages from the campaign.

2. **Discourse in the state government media to create an enabling environment**: During the launch of the campaign, there will be state-wise press conferences through PIB to launch the campaign. The ten states selected by the Ministry (Delhi, Mumbai, MP, Jharkhand, Bihar, Rajasthan, Orissa, West Bengal, Gujarat, UP, Meghalaya), wherein PIB will host and manage the conferences. The respective Directors of State will be the spokespersons at these conferences. The idea is to sensitize local media about the key issues related to Malnutrition, and to develop their capacity to provide correct information to their readers.

   The master media kit is being developed in English & Hindi languages and will be circulated within the states. If translations in regional languages are required, the State Government is free to go ahead with the same. This will not only ensure the education of media persons regarding malnutrition, but will also ensure that every State office has a ready information base to refer to. This will result in synergy in the communication between the various Ministry officials and the media.

   State Government Action: Engage with local media to develop their capacities around the issue of malnutrition and also make them responsible partners in generating an important discourse around the issue. This will help in generating an enabling environment through the media.

   Access to stage wise communication materials: To help the State offices to leverage the campaign locally, all television spots and print ads will be uploaded on the internet portal www.akshayaposhan.gov.in. The state offices will be able to download the files in their required language and utilize their local media for effective dissemination. We have also developed some tools to be used by communities, like Aanganwadi workers, the panchayat, teachers, etc. The objective is to not only ensure that the campaign message percolates down to every individual possible, but also that it lasts with each of those it did reach. Therefore, the following have been developed:

   a. Street theatre scripts
   b. CDs carrying a message from Mr. Aamir Khan, intended for Aanganwadi workers, ASHAs, ANM workers, Health Centre workers, and other administrative officials
   c. Posters
   d. Local signages/ kiosks, which will be executed through DAVP also
   e. Banners, which will be executed through DAVP also
   f. Bus Panels, which will be executed through DAVP also

   State Government Action: After the state governments access relevant communication materials they can convert mass awareness tools into inter-personal communication. Using the above tools, the state governments can reach out to communities and frontline workers in the most innovative way. Multiple innovation options/ ideas will be shared with the state governments.

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Ending Polio: the use inter-personal communication

Inter-personal communication (IPC), *together with* targeted Information, Education and Communication (IEC) materials, is a key pillar of the successful eradication of polio. IPC has generated very high parent and caregiver support to end Polio in India.

Issue

While the posters and Public Service Announcements (PSAs) and mass media campaigns have helped to create awareness, communities living in high-risk areas could not be reached through mass mediums alone, especially where literacy levels are low making many posters and banners redundant. IPC allows for the building of trust between a frontline worker and a family or group of mothers – who then change their behavior.

Action

In some populations the Polio Campaign needed to tackle *direct resistance* to the oral polio vaccine. Using local women and key respected influencers, such as PRIs, Imams or Hajjis to discuss immunization, these fears and misconceptions were allayed. The Polio Program now enjoys >99% coverage in high-risk areas of UP.

UNICEF's IPC infrastructure consists of the Social Mobilization Network (SMNet) in Uttar Pradesh and Bihar - an army of nearly 8,500 community mobilisers, spread across 83 high-risk districts, 526 blocks and 5,000 high-risk areas with a combination of high population density, birth rate, poor sanitation and poor hygiene practices. SMNet is at the heart of the approach providing life-saving messages about polio vaccination, RI, nutrition and sanitation messages to India's poorest, most at-risk communities.

Social mobilizers are chosen from the community because of their good communication and networking skills, have a basic education and demonstrate a capacity for social mobilization. These frontline workers – mainly women engage frequently with families during and between polio rounds, informing parents about the immunization activity, addressing their fears and misconceptions, identifying newborns for a birth dose of OPV, and leading community efforts to mobilize religious and community leaders to support the program. They are supported by a management structure at the block and district level of 473 Block Mobilization Coordinators (BMCs), 50 District Mobilization Coordinators (DMCs), 17 District Underserved Coordinators (DUCs), 6 Sub-Regional Training Coordinators (SRTCs) and 12 Sub-Regional

Coordinators (SRCs). In addition, there are 10 polio convergence consultants for strengthening Routine Immunization, Cold Chain management, Water and Sanitation, and Nutrition.

Outcomes

From January-November 2012 in UP alone, 113734 community meetings were held with a focus on IPC. Ongoing monitoring has demonstrated the added value of the SMNet's efforts in ensuring that immunization coverage remains high and opposition to the program is minimized at a local level. Despite working in locations of highest resistance, the data shows that blocks with frontline workers consistently convert 10 percent more missed households to change behavior than in areas with no IPC.

Water, sanitation and hygiene outcomes

In 2012, 872,852 households in UP and Bihar were reached with IPC messages about hand washing with soap. The 2012 KAP Survey showed that almost all parents and caregivers knew how to wash their hand with soap after defecation. More than 60% reported they washed their hands before eating. There is also a positive impact on toilet construction. Twenty two percent of Brick Kilns in Bihar in SMNet areas now have at least one toilet for workers, out of which 79% are functional and in use. In UP, 80% of dry latrines in rural HRAs (65,290 toilets, as of October 2012) and 15% of dry latrines in urban areas were converted to sanitary toilets. Eighty one percent of schools and 95 percent of High-risk Areas have conducted bacteriological water quality testing through SM-Net, with 1822 water samples (out of 4830 sites) found to be contaminated

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SANITATION & HYGIENE ADVOCACY AND COMMUNICATION STRATEGY FRAMEWORK 2012-2017

The National Sanitation and hygiene Advocacy and Communication Strategy is an integral part of the NBA. It supports the NBA which anticipates extensive IPC and IEC will be required for the NBA to meet its objectives. There are still more than 600 million people practising open defecation in India. Although access to improved sanitation is steadily increasing, with almost 20 million new toilet users a year since 2000, the pace of change is too slow, in part due to population growth. So although open defecation rates fell from 75% to 51% between 1990 and 2010, the actual number of people defecating in the open still remained the same.

There is a lack of awareness among the general population of the linkages between using a toilet, the safe disposal of child faeces, and health along with a significant gap between knowledge and hygiene practices. Recent studies also confirm that there is slippage in the open defecation free status in Nirmal Gram Puraskar winning villages.

The major obstacles in sustaining open defecation free status include inculcating sustained changes in personal behaviour and inadequate involvement of local self-governments and communities. Poor quality construction or technological failure in the design of toilets also contributes. There is a shortage of skilled human resources for community mobilisation, demand creation, and building and owning toilets is not considered aspirational.

Based on the above evidence Ministry of Drinking Water and Sanitation with the support of UNICEF developed a National Sanitation and Hygiene Advocacy and Communication Strategy Framework for 2012-2017. The overall goal is to make sure that people have access to, and use a toilet and practice good hygiene, including handwashing with soap after the toilet and before food. The strategy aims to raise awareness and motivate people to change their behaviour. The Advocacy and Communication Strategy focuses on four critical sanitation and hygiene behaviours:

- Building and use of toilets
- The safe disposal of child faeces
- Hand washing with soap, after defecation, before food, and after handling a child's faeces
- Safe storage and handling of drinking water

The communication strategy is divided in three phases:

- Phase 1: Raising Awareness – designed to raise visibility of the importance of toilet use and hygiene behaviours
- Phase 2: Advocacy – To arm influencers and decision makers with the information they need, and to encourage them to speak up and to take action for positive change.
- Phase 3: Social and Behaviour Change Communication - To empower individuals and families to make decisions based on correct information and improved understanding and to motivate communities to help create positive social norms

Each phase has specific communication objectives. It clearly defines:

- The audience receiving the information (the who);
- The content of the information (the what);
- The methods to be used to convey the information (the how); and
- The approaches to promote action for change (the action).

This is achieved through advocacy, interpersonal communication and community mobilisation with overall multi-media support including mass media, digital media and social media.

The document has a detailed implementation framework that lists out the key audiences, the activities to be used with each of them and the communication tools required. A monitoring and evaluation framework with regular assessments allows for local modification and refinement of the strategy. Indicators for each of the phases are organised at three levels – outcome, output and process.

A District Communication Plan Template supports the overall framework. It outlines the steps required for the development of a Communication Action Plan and for roll out at the district, block and village /GP level. This includes identifying who will be responsible for driving the communication activities and capacity building at different levels and the communication tools required and undertaking monitoring and evaluation for taking corrective actions.

The behaviours to be promoted under the strategy are home based behaviours and require decision making at family level. Evidence from communication research reveals that interpersonal communication and community mobilisation are the most effective approaches to influence home based behaviour. Hence in this strategy the percentage weightage for IPC has been increased within the IEC budget.

Medium	Percentage of IEC budget
Interpersonal Communication and community mobilisation (including all IPC print material and incentive and training for Front Line Workers recruited for WASH	Up to 60% (Print ceiling for IPC materials – 10%)
Outdoor media – (Wall painting, hoarding), folk media	Up to 15%
Mass media – TV, radio, print and digital media	Up to 15% (Print ceiling 3%)
Monitoring and evaluation of IEC activities	5%
Evidence building (research /KAP studies) for strategy preparation	5%

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Strengthening demand generation for safe water in rural India

Background

Strong grassroots demand for safe water is an essential component in the supply of safe drinking water to people. In 2010, UNICEF India surveyed 60 villages in four districts, namely Tonk in Rajasthan; Rajnandgaon in Chhattisgarh; Vaishali in Bihar and Krishnagiri in AP better understand why people in rural India are not demanding safe water. Primary data was collected from stakeholders comprising households, panchayats, and grassroots & district level functionaries of line departments. This examined perceptions on "safe water", understanding of entitlements to "safe water" and the facilitating & restraining factors in engaging people to demand for "safe water", including communication strategies around this.

It was found that notions of "safe water" are still centered on defining safe water as water that does not contain visible impurities, does not have any odor, and is not yellow or brackish. Regardless of the invisible impurities that might be there in water from a given source, the low incidence of morbidity on account of consumption of water from such a source, was perceived as a safe source of drinking water. Short term health problems such as diarrhea were not categorically seen as a result of consumption of "unsafe water". The overriding concern for availability of water was primary to concerns related to the quality of water. As regards home treatment of contaminated water, boiling was seen as common knowledge, but practice was limited to periods of illness and the boiled water was generally consumed by the person who was advised so by the doctor and not for the entire family. Boiling of water was seen as a tedious and expensive exercise.

The responsibility for provision of safe water was largely seen as that of the panchayats. The panchayats in turn, clarified that their role was limited only to repair and maintenance of water sources, subject to supply of materials including testing kits and chlorine tablets. There have been instances of collective action by the people to voice their concern, though confined to certain pockets and mainly in the form of media coverage of the issue. The fact that provision of safe water is seen as a responsibility of the government, the general opinion of the people is to refrain from making any cash or other contribution towards improving the quality of water available at the village level. Lack of quick responses from the sarpanch or the grassroots functionaries of the PHED act as major de-motivating factors for people to assert their demands.

As essential aspect of the analysis was to identify barriers impeding the demand for safe drinking water. The lack of or limited provisions of quality water, has been internalized and accepted as fate by most people. This sense of disenfranchisement both at the individual and community levels creates a sense of passivity around the issue. It also relegates the characteristic of water being an entitlement, among the community. As people allocate the responsibility of drinking water provision to the PRI and PHED functionaries, the responsiveness and grievance redressal of these functionaries had a significant bearing in encouraging or discouraging demand at the grassroots level.

On the other hand, it was seen that access to reinforcing and reiterative information on safe water and safe water practices can give clear understanding on safe drinking water and influence demand in that direction. Also, a transparent and efficient redressal mechanism by the PRI and PHED in upkeep and maintenance of water resources helps build confidence among the community and facilitate demand for an efficient safe drinking water provision system, as can enhancing the capacities of communities in the operation and maintenance of water resources, to inculcate a sense of ownership of these resources. This would not only enhance demand but will also help to reduce risk of bacterial contamination. Evidences of positive practices, though rare, found during the study indicate that enhanced community level capacities in the operation and maintenance of water sources is likely to be accompanied by an heightened community consciousness on safe water and collective action in ensuring safe water resources in the community and can be very effective.

Communication implications

Figure 1 seeks to highlight a comparative picture of an exposure-reliability analysis of different channels of communication, in the study districts

There seems to be a strong preference for communication via grassroots functionaries (e.g. ANMs/ASHAs, teachers and doctors) through which people resolve their queries in real time. It was found that in places where women's groups were active, communication within these groups on matters of community concern appeared to be effective. Such groups were found to have high reliability among members of these groups even though the reach of these groups was not very high. The reach and penetration of traditional media including wall paintings and posters though useful did not seem to elicit a comparable level of recall among the rural people. With the advent of the mobile telephony and its deep penetration, even radio seems to have been relegated to a back seat as a preferred channel of communication. TV is exclusively seen as a mode of entertainment (in areas where cable & satellite penetration is high), and therefore advertisement spots fail to attract the intended viewership as people skip over these to other channels. Community theatre, street plays and campaigns were reported to have generated a particularly enthusiastic response in villages with little or no exposure to TV or other forms of live entertainment to draw a large and attentive crowd. Alternatively, community outreach (by public health workers, doctors/teachers/ANMs/ASHAs etc.) has also proven highly useful. The interesting part of such community outreach methods is that these were viewed as inclusive two-way communication channel, whereby, queries (if any) could be resolved at the time of delivery of the message. In areas where more than one media channel was used for communication on safe water, (particularly where both TV and radio were relied on as preferred communication channels), people showed their ability to triangulate the messages delivered through these channels. It clearly brought out the need to maintain uniformity in the messages delivered through multiple channels, lest it left the target group confused and defeat the entire objective. These can be summarized as in Fig 2.

Ways forward

It is imperative that communication messages are developed around the existing knowledge, awareness and perceptions around safe and clean water- among the community and to build this communication strategy and channels with the following focus:

1. It should be clarified through communication messages that water which appears visibly clean or tastes sweet may not necessarily be safe to drink and so highlighting the health risks posed due to consumption of unsafe drinking water, i.e. build on the perceived threat on health.
2. It is imperative to highlight factors causing bacterial contamination of water - considering that such contamination is a direct consequence of poor operation and maintenance of the area around the water source as well as poor practices in handling water. Households and communities must realize it is within their hands to influence these issues!
3. With regards to chemical contamination of water (fluoride, iron, arsenic etc), it is important to not only communicate about the presence of such contamination, but also to provide awareness on low cost options/solutions for managing/treating such contamination.
4. Safe drinking water as an entitlement - and not just the availability of water to meet daily needs. Community participation is required for safe drinking water - it is an entitlement but personal involvement is needed for realization of this entitlement.
5. Communities in general had little or idea on redressal mechanisms and hence communication should include messages to address these gaps.
6. Although the use of folk media as a channel of communication in study villages was seen to be limited it is recommended that folk media be used for dissemination of messages, as the recall factor is high in such cases.
7. A move to making the wall paintings more pictorial than textual and extensive use of mobile phones for delivering messages on "safe water" coupled with continued emphasis on communications mediated through ANMs/ASHAs. The high status of medical practitioners (private and government) and reliability among the community mean they should be used as potential source for regular and mediated communication on water safety.
8. TV will continue to be a major communication channel, as it was observed to be a significantly accessible medium of communication and information, especially among the younger generations though it has limitations also for message impact.
9. A targeted approach for women groups is essential, to address knowledge practice gaps in terms of adoption of safe drinking water practices and hygienic behavior.
10. There is also a very strong need to actively listen to those who are presently marginalized so as to expand the knowledge and practice relating to safe water.

Hence, while there is a strong need to mainstream communication on safe water into awareness campaigns with targeted messages through specific and multiple channels, it is also recommended to focus on communicating to the rural people about water being a common property resource and making the communities more accountable to the repair and maintenance of sources of water in their villages.

Figure 1

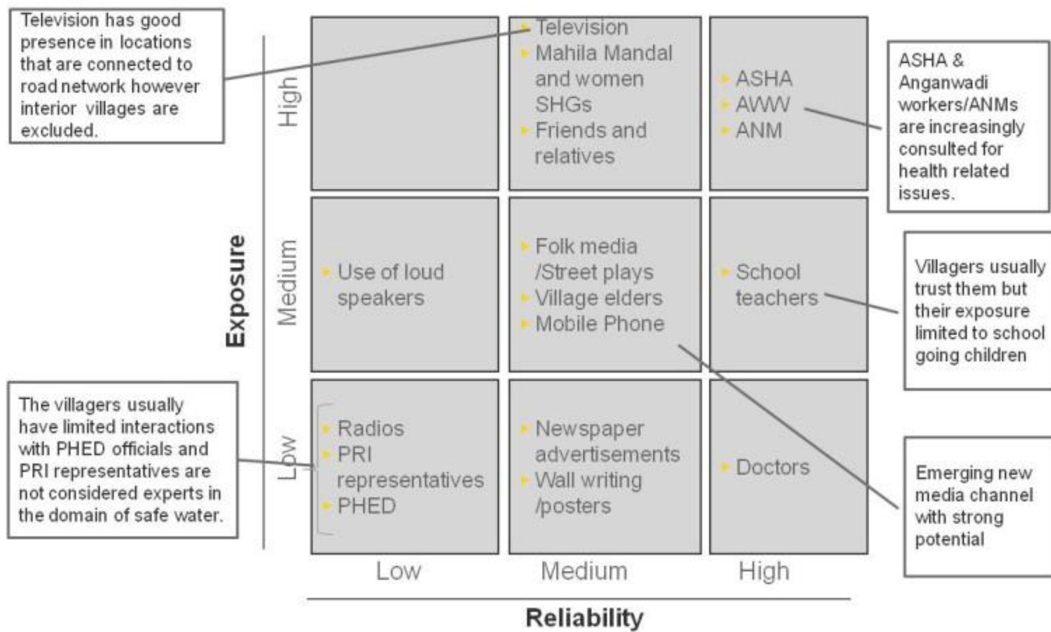

Figure 2