Government of India
Ministry of Drinking Water and Sanitation
W/11042/34/2011-CRSP

12th Floor, Paryavaran Bhavan,
CGO Complex,Lodhi Road,
New Delhi- 110003

16th November 2011

**Subject: Meeting for formulation of WASH Communication and Advocacy Strategy for Ministry of Drinking Water and Sanitation**

Dear Sir,

The Ministry of Drinking Water and Sanitation (MDWS) is organizing a meeting of State Secretaries in-charge of Rural Drinking Water and Sanitation of 7 States namely Bihar, U.P., Haryana, Maharashtra, Karnataka, Kerala and Himachal Pradesh **on 25th November, 2011 from 10.00 A.M. onwards at the Conference Hall, 12th Floor, Paryavaran Bhavan, New Delhi** to finalize the formulation of WASH Communication and Advocacy Strategy for Ministry of Drinking Water and Sanitation. **The meeting will be presided by Secretary MDWS.**

Your inputs shall be of immense value for formulation of a focused and planned IEC strategy, thereby strengthening the programme implementation to meet the vision of an open defecation free India.

The Ministry invites you to participate and provide your valuable inputs in the meeting. A detailed draft Plan for the WASH Communication and Advocacy Strategy is also enclosed herewith.

With regards,

Yours sincerely,

(Vijay Mittal)
Director/CRSP

To,

State Pr. Secys/ Secys incharge of Rural Water Supply (U.P., Haryana, Kerala and Himachal Pradesh)
Copy to- Ms. Lizette Burgers, Chief WASH, UNICEF House, 73 Lodhi Estate, New Delhi-03
Copy also to: DS (Admin)-For necessary arrangements

# Campaigning for improved sanitation in India

***From Strategy to Action***

While access to improved sanitation is steadily increasing in India[1] with almost 20 million new toilet users a year since 2000 the use of improved sanitation remains at one of the lowest rates in Asia, standing at just 31%[2]. Progress is hardly keeping with India's population growth and without acceleration the MDG target of 59% is expected to be missed by over 25%. Over half of the total population, more than 600 million people, still practice open defecation. Although open defecation rates fell from 91% to 67% between 1990 and 2010, still two third of the rural population do not use toilets.

Despite the increase in access to toilets, many of the toilets built are not being used. Recent studies also confirm that there is slippage in the open defecation free status in Nirmal Gram Puraskar winning villages[3]. Limited household toilet designs are used, they tend to be expensive and often the heavily subsidised latrines are poorly constructed and are neither hygienic nor durable. In the absence of affordable, popular, good quality alternatives people tend to slip back to open defecation.

The effects of poor sanitation seep into every aspect of life - economic, health, education, nutrition, dignity and empowerment. It perpetuates an intergenerational cycle of poverty and deprivation. To meet the country's sanitation and hygiene challenge, there is an urgent need to refocus our efforts, not only on building affordable and durable toilets, but on stopping the practice of open defecation. The two to go hand in hand, as achieving either one, without the other, will result in failure of achieving the overall goal. Investments need to be made in raising awareness and motivating people as well as in having good quality and affordable latrines.

**Moving from strategy to action**

UNICEF, together with other partners, is working with the Ministry of Drinking Water and Sanitation (MDWS) on a comprehensive communication strategy to bring about this change.

A framework for a five-year communication strategy (2012 – 2017) for improved hygiene and sanitation has been developed and is ready to be turned into an action plan. The strategy, which includes specific campaigns, will be coordinated by the Ministry of Drinking Water and Sanitation with the support of UNICEF and other partners.

The strategy is designed to roll out a number of activities in a phased manner, with the first phase focusing on awareness-raising, the second on advocacy and the third on social and behaviour change.

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[1] Up to 65% in 2010 as per the Ministry of Drinking Water and Sanitation reporting system: http://ddws.nic.in

[2] UNICEF and WHO (2010). Progress on Sanitation and Drinking Water: Joint Monitoring Programme and National Sample Survey Organisation 2008/2009.

[3] MDWS study conducted by CMS in 2010 and UNICEF study conducted by TARU in 2009.

- **Phase 1, Awareness-Raising:** Designed to raise visibility of the importance of good sanitation and hygiene behaviours and to build public support, creating an enabling environment for change.
- **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:** 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.

Through these three overlapping phases, the campaign will reach out to children and mothers, influencers and decision-makers, across the country, at strategically appropriate times, to build up a momentum of supportive public will and a movement for positive change.

UNICEF suggests **a joint planning session on 18 October** to chart out the next steps in translating strategies into action. It is proposed that during this session, the campaign goals be clarified and finalized, campaign strategies and elements be coordinated and aligned, and a timeframe be developed for the strategic roll-out of each of the campaign phases.

As a part of this planning exercise, primary and secondary audiences will be defined for each phase, as well as the expected change and possible campaign activities identified.

**Suggested agenda and deliverables of meeting on 18 October**

*Agenda:*

- Review of the Agenda and clarification of the meeting objectives
- Key steps in developing a communication strategy (group work)
- Review of the work done so far (Draft strategy presented and related framework)
- Refining the specific (SMART) objectives of the strategy (what do we want to achieve in three years) group work
- Operationalizing the communication strategy (validating communication objectives, audiences, approaches and basic media products)

*Deliverables:*

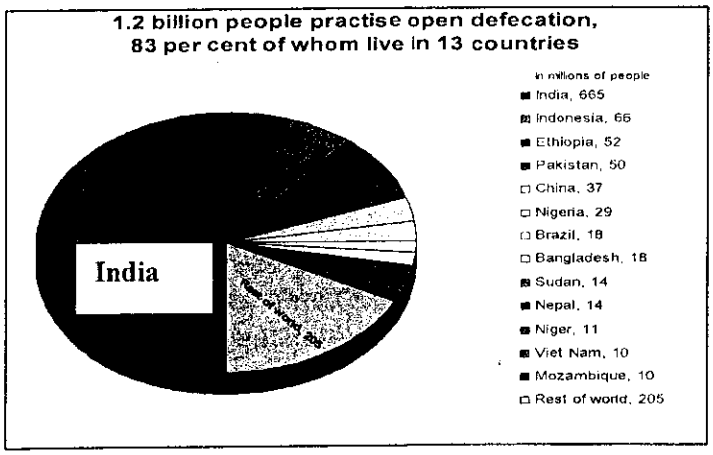
- Finalised timeline for each phase
- Finalised communication objectives
- Finalised on key group of messages to be used

# WASH Communication and Advocacy Strategy
# DRAFT July 10, 2011

## Context

Globally, 1.1 billion people practicing open defecation. India hosts the largest population practicing open defecation globally with more than 638 million living in India (JMP, 2010). The Government of India has been investing in promoting sanitation. The national budget for the Total Sanitation Campaign (TSC) has increased 13-fold from Rs 1.5 billion to Rs. 20 billion in 2008/09. Progress is being made and the positive news is that 366 million people in India are using an improved sanitation facility in 2008, more than doubling since 1990 when it was 155 million. However, the proportion among the rural population using an improved sanitation facility in 2008 is still only 21%, or 176 million people and evidence indicates that many more toilets were built in rural areas but are not being used. If the current trend continues, the India will miss the MDG target for sanitation. Without India, the world will not be able to achieve the MDG sanitation goal.

## Sanitation in India: the scale of things




Young children, girls and women pay the highest price for this situation. Over 80% of all deaths due to diarrhea are among children below five years of age and the lack of safe toilets in schools is also a main factor for girls' drop-out rates. Improved sanitation frees girls and women from "imprisonment by daylight" as still many women in India can go for defecation only after dark.

Improved hygiene is also key. According to the Public Health Association, only 53 per cent of people in India wash hands after defecation, 38 per cent wash hands before eating and only 30 per cent wash hands before preparing food. Many people don't wash their hands, because they believe that hands that look clean cannot make them sick or that water alone is sufficient to remove visible dirt from hands.

To meet the sanitation and hygiene challenge, there is a need to re-focus on stopping open defecation rather than only building of facilities, investing heavily in hygiene promotion and social intermediation, particularly at household level, and providing improved and affordable design options for the poor. Supply and demand must be linked. Till date, the focus has been on below poverty line families (BPL). A huge number of families above the poverty line (APL) who don't follow adequate sanitation

and hygiene practices should also be covered in a comprehensive advocacy and communication strategy.

Barriers at the community level need to be identified, analyzed and addressed for sustainable behavior change to be achieved over the long-term. Understanding Individual and community perception is essential to change behaviors. Effective communication is about building trust, listening and finding out what people think. All partners must work together to understand challenges faced by communities for effective communication objectives and messages to be achieved.

**Objective**

UNICEF is supporting the Department of Drinking Water and Sanitation in the Ministry of Rural Development along with other partners to develop a long-term communication and advocacy strategy for 2012-2017 in order to raise awareness of the importance of sanitation and resulting in increased usage of toilet facilities. Indicative process objectives in achieving this will include to:

- Initially create a movement to increase awareness on the importance of sanitation and hygiene and their health implications with rising urban, middle classes
- Generate media interest to promote visibility and sway public opinion
- Convince elected officials and policy makers to advocate for improved sanitation and hygiene standards
- Increase public demand for quality sanitation services
- Promoting safe hygiene and sanitation behaviours and practices at household level
- Achieve hygiene and sanitation as an aspirational goal for families, communities and society for a "Rising India"

A strategic, targeted campaign will be developed nationally with SMART indicators developed to measure progress. This will focus on eight key states, i.e. Rajasthan, Uttar Pradesh, Bihar, Madhya Pradesh, Chhattisgarh, Jharkhand, Orissa and West Bengal. The campaign will encompass three areas: awareness, advocacy and behavioral change communication, all within the framework of achieving lasting social and behavioral change.

The link needs to be made with improved sanitation and hygiene's impact on overall health. Practicing open defecation creates an environment in which diseases can transmit easily. One gram of faeces alone can contain 10 million viruses, 1 million bacteria, 1,000 parasite cysts and 100 parasite eggs. Though the associated burden to children in terms of morbidity and mortality is extremely high, most communities do not view diarrhoea as life threatening. The simple, cost-effective solution of washing hands with soap after defecation and before meals would greatly reduce that number. Proper handwashing with soap can reduce diarrhoeal cases by 47 per cent and acute respiratory illnesses by 30 per cent.

The major challenge will be to change behavior that has been established over centuries. Communities find open defecation an acceptable solution in their setting. There is no social discrimination regarding open defecation.

This framework is intended to provide guidelines for communication and advocacy strategy development at the state level. Although the framework has been divided into distinct phases which build upon each other and some may even overlap, state level implementers should be aware that communities are not homogeneous and not everyone is at the same stage of behaviour and social change. For instance, there are individuals in the communities that are not aware of the importance of practicing key sanitation and hygiene behaviours, whereas others could be aware but not doing anything and others could be in the process of adopting some of the desired practices. Therefore, it would be important to first analyse and understand in which phase individuals or communities are before communicating with them.

Thus, the strategy has been purposely divided into distinct phases to facilitate strategy design and implementation at the macro level in a logical sequence. However, when working at the micro level i.e. at the level of individuals/communities, the above-mentioned element of understanding which phase the individual / community is in, needs to be taken into account to make the communication more relevant to their needs.

**Phase 1: Communication for Raising Awareness**

**Objective**

The purpose of a targeted awareness campaign and communication strategy is to ensure that the stakeholders are aware of the issues surrounding hygiene and sanitation using evidence, capacity building and policy influencing. An effective strategy requires a clear definition of the primary and secondary audiences[1] (**the who**), the content of the information (**the what**) and the methods to be employed to convey the information (**the how**). This is the first component of the overall campaign and will be implemented first and continue through its completion in 2015.

**Who - Audience**

The success of the communication strategy will be partially gauged by its ability to create awareness and knowledge related to hygiene and sanitation. Increasing visibility will keep the issue firmly in the national spotlight. Increased awareness is, however, not a means in itself but rather a stepping stone towards advocacy and, ultimately, changing behavior to embrace hygiene standards for improved health. It is important to fully understand the key stakeholders as well as to define the audiences as specifically as possible. Audience segmentation allows for better designed, more focused and more effective messages.

[1] In this context, primary audiences are those which are directly addressed by the awareness campaign, while secondary audience are those capable of influence, becoming channels to reach more effectively the primary audience.



2

The strategy will include issues of equity and social inclusion. This is not only a rights-based issue, but also a practical issue, since very often the most vulnerable and marginalized groups are those most at risk. Inducing change in these groups can have a major impact in the overall intervention. By segmenting the audience, the communication strategy should develop customized initiatives for those communities most often excluded by social activities and basic services.

Partners will include governments and parliamentarians, donors, civil society, the private sector, UN / International organizations, Global Initiatives, professional organizations, academic and think tank institutions, media and the general public with the aim of translating commitments into action and ensuring hygiene and sanitation remains a high priority issue.

**Table 1: Primary and Secondary Audiences**

| **Stakeholder group** | **Members** |
|---|---|
| *PRIMARY AUDIENCE*: | |
| General public and civil society | Individuals (Middle class Indians, youth, affected populations)<br>CSO & CBOs (i.e. local level NGOs) |
| *SECONDARY AUDIENCE* | |
| Media | International media<br>National media<br>Regional media<br>Local media |
| Programme managers | National governments, state governments |
| Policy makers | Parliamentarians<br>Governments & senior civil servants (Ministers, Secretaries, Directors, members of policy task forces/ committees)<br>Local government authorities |
| Implementing agencies | INGOs (Save the Children, CRY, Actionaid, CARE, Oxfam, etc)<br>UN agencies<br>National NGOs |
| Bilateral donors and sister UN | DFID, USAID, World Bank, UNDP |

**What – Range and Content of Information**

The intended audience for the strategy is both large and diverse. As a result, existing levels of awareness of issues around hygiene and sanitation will vary considerably. One size does not fit all. The communication strategy must employ a wide range of products, communication approaches and dissemination that serve the particular needs of the intended audience. The awareness campaign will raise awareness and knowledge. Behavior change will come at the end of a longer and more complex communication strategic process.

The strategy for the awareness campaign includes a varied set of communication mechanisms. While each is distinct and serves an individual purpose, they are inter-related and together form a holistic package. Examples of a range of awareness building products/approaches are summarized below:

- **Viral Advertisement** – If we are honest, sanitation has a certain "yuck" factor that we can use to our advantage. A viral ad can be developed with an advertising agency that is funny, provocative and clever that we promote through mass media, social media and the internet. Facebook pages, YouTube, SMS campaigns and other social networking tools are also ways to engage youth in promoting the campaign and generating awareness. We need to get the issue of open defecation, sanitation and hygiene out in the open and talked about.

- **Media Pack** – This communication package consists of human interest stories, fact sheets, photo essays and stand-alone pictures on sanitation. The package creates awareness among all stakeholders on sanitation and its health implications. A CD containing photo images and graphics on sanitation for easy replication will be included.

- **Digital Campaign** – Similar campaign as *Awaaz Do* raising awareness on Right to Education to be planned in 2011-12 for launch in 2012-13. The aim of the campaign would be to build awareness and create a national movement demanding adequate sanitation and hygiene standards for India, stop of open defecation and reaching the Millennium Development Goal 7. The campaign will increase state, national and even global media visibility. Strategic use of viral messaging will help build awareness and gain new members.

- **Child-Friendly Booklet on Sanitation and Health** – A child-friendly version of a booklet to communicate hygiene and sanitation messages to schools through the WASH in schools program. The booklet would build on the extensive experience and existing materials around WASH in schools and would act as an introduction to children as well as teachers and parents. Working with MHRD, the booklet would be distributed across India to children and will also be shared with key stakeholders as an advocacy tool.

3

- **Private Sector Partnerships** – Corporate and other partnerships could be cultivated to assist in campaign development, messaging and dissemination (i.e. Westport initiative on clean water).

- **Thematic Summaries** – A thematic summary on WASH issues should be developed. The summary will describe the issues, proposed action and outcomes achieved so far.

- **Human interest stories** – Human interest stories are a powerful medium to communicate and provide a human face on hygiene and sanitation and how it impacts communities. Stories can also generate media interest and can be targeted to specific media outlets and modes of communication. This will be a continuous process with a target of one story each month using evidence from the field to also address policy makers and programme managers.

- **Audio-visual communication** – Video packages can be used as advocacy tools and can also serve to generate media interest. Partnerships with key media (in print, radio, television and internet) should be leveraged to promote hygiene and sanitation issues over the duration of the campaign.

- **Process documentation** - Four distinct process documentation products will be developed: 'Good Practices', 'Lessons Learned', 'Innovations', and 'From the Field.' The focus will be to choose one or two particularly valuable examples on hygiene or sanitation. The write-ups need not represent an entire intervention or programme e.g. an overall programme may not be completely successful but there may be valuable lessons and good practices in a particular component. The process documentation is an important component of monitoring and evaluating the strategy.

- **Celebrity Spokesperson** – A celebrity spokesperson could be identified to promote the campaign. The spokesperson needs to be someone of national stature who will be comfortable talking about the issue and recognized at all levels of society. The spokesperson should also be available for the duration of the campaign.

- **Government Spokesperson and Experts** – There must be a government spokesperson who will be available for comment and get back to journalists in real time so that they can meet their deadlines. A mobile telephone number should be made available to the media and comment on the record given out. A roster of experts should be developed as a resource for media available for interviews, television or radio appearances and media workshops.

**It is key to stress here that Interpersonal communication at grass-roots level is <u>THE KEY COMPONENT</u> to support the above initiatives in order that once the rural community are aware of the importance of sanitation that there is a face-to-**

**face mechanism to support the increased interest and willingness to uptake sanitation.**

**How – Ensuring Effective Implementation**

Certain products are intended for broad dissemination, such as brochures or leaflets and will be written in a style that will enable widespread understanding. Other products, such as thematic briefs or process documentation are intended for an audience that already has a good understanding of the issues and who desire more substantive and sophisticated analysis. As a general principle, however, all publications will be written using a plain and straightforward style and translated into local languages.

To gain and hold the attention of the intended audience, the products will:

- Express ideas that are "outside the box", daring, challenging and new,
- Stimulate debate grounded on experience and/or evidence,
- Package key messages succinctly and clearly,
- Enable the intended audience to engage.

In this respect, certain products of the strategy, notably the use of the website and visibility events, will employ an innovative style. In all cases, however, these products will be based on solid experience and/or evidence to raise awareness and stimulate interest as an essential precursor for change. Materials will be pro-actively pitched to the media to disseminate messages to the wider public. A Media Briefing Kit will be developed and made available through government websites and on www.unicef.in.

**Phase 2: Advocacy**

**Objective**

The purpose of the advocacy strategy is to mobilise government, international organisations, civil society, implementing agencies and other stakeholders to strengthen sanitation programming and policies – translating commitments into concrete actions. The advocacy strategy builds on the platform created through communication but is intended to influence the attitudes and behaviour of key identified decision-makers. This will be implemented in the medium term in 2012-13 and will then continue to its completion.

**Who - The primary and secondary audience**

The Partnership will target social and behavioural change communication at the rural community. In addition it will focus much of its advocacy work around leaders and decision-makers, within governments and influential bodies, and constituencies who can assist in this drive for change, such as civil society, the media and communities.

Activities will be divided across four fundamental advocacy approaches:

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| | |
|---|---|
| **UNITE**<br><br>This approach aims to encourage partners to speak with one voice regarding sanitation and hygiene.<br><br>**Examples of activities:**<br>-Key message development and dissemination<br>-Initiation of core advocacy advisory groups at state level | **IMPROVE & INFLUENCE**<br><br>This approach focuses on influencing existing programmes, development initiatives and agendas to strengthen the position of sanitation and hygiene within country.<br><br>**Examples of activities:**<br>-Enhanced collaboration/activities with regional and country level bodies and partners |
| **SUPPORT & SHARE**<br><br>By collating, publicizing and promoting programme progress, challenges and solutions, 'Promote and Share' will leverage momentum and increase interest.<br><br>**Examples of activities:**<br>-Development and dissemination of branded publications and advocacy products including reports, thematic summaries, one-to-one interactions, policy briefings and process documentation<br>-Media and public relations | **BUILD**<br><br>This approach aims to build not only the profile of the issue the building of a sanitation 'community.'<br><br>**Examples of activities:**<br>-Targeted advocacy and communications around key global/regional and country-level events<br>-Development of 'Goodwill Ambassadors' and 'Special Advocates' for the campaign Development of country and regional-level advocacy and communications activities<br>-Enhanced communication exchange and flow<br>-Capacity building of programme managers |

**Other activities can include:**

- Stakeholder mapping will be conducted in targeted states to identify key policy and programme influencers. Based on the mapping of stakeholders, an advocacy strategy will be developed that is specific to the needs of the state.

- Develop specific strategies and plans for the districts where the interventions will be implemented. Annual action plans will be developed in consultation with the district and state administration with key result-based measurable indicators.

- One of the key focus areas of the advocacy strategy would be to strengthen the existing institutions in the state working on sanitation and hygiene.

- Strengthen the capacity of key opinion builders and policy makers, including NGO workers and nodal institutes at the state level.

- Develop an evidence-based advocacy package, including fact sheets, using census and other data. Once the baseline data is available from the districts, it will be complied into a brief summary and a presentation will be made to the state and central government counterparts, particularly for district collectors. "Advocacy asks" will be clearly defined.

- The package will also be used for the orientation of elected representatives (i.e. PRIs and legislators) in order to garner their support in the implementation and lobbying with the government on hygiene and sanitation issues.

- Sensitise the community about the importance of hygiene and sanitation. Women and adolescents, including girls and children networks, will be formed to create an enabling environment contributing to improved hygiene and sanitation practices.

- Conduct advocacy initiatives for policy influencing and leveraging of resources. While working in the districts, state level policies and budgets will be leveraged to facilitate benefits to vulnerable state populations.

- Partner with media both nationally and regionally as well as lobbying. Create Public Service Announcements by local/national celebrities on hygiene and sanitation for broad dissemination through radio and television.

- Conduct field visits for media, celebrity advocates and elected officials to increase civil society participation.

- Organize a national conference for scaling up nationally and regionally best practices on hygiene and sanitation.

- Organize district collectors from the states to meet and share initiatives at both state and district level. Lessons learned will help inform and improve implementation.

- A sustained national campaign to bring on board a diverse group of national faith leaders on a common platform to initiate a conversation emphasizing cleanliness within their respective communities through Sunday sermons, *pravachans* and Friday *qutbahs*.

- Record a mobile voice message with a celebrity with pan-India appeal, from the world of entertainment or sports, emphasizing cleanliness and hygiene, which can be sent out to citizens via partnership with an Indian mobile telephone company. The message will be interactive by giving options to the mobile phone user. This will help in collecting data in real-time about water availability, usage of

toilets, which can be mapped on Google Maps – this targeted data can be used as advocacy material by UNICEF with the Indian government officials. Example: Toilet Report Card.

- Compose a secular ecumenical prayer in multiple languages in consultation with faith leaders that emphasizes on cleanliness. Bring a songwriter and music composer on board. This prayer can be introduced in all state schools as part of their morning assembly.

- Organise a webinar video-conference with WASH experts addressing India's policymakers.

**How – Ensuring Effective Implementation**

Advocacy efforts need to be adapted for each state using the basic advocacy framework as discussed above. Each state will identify relevant state level partners and stakeholders to implement the advocacy strategy to achieve the desired outcomes.

**Phase 3: Social and Behavior Change to Address Demand**

The next phase (which will complement the above phase, as already mentioned) will aim specifically at promoting behavior change around total sanitation. In order to be successful, the behavior change strategy will need to make sure a high level of awareness and understanding among the broader public has been achieved and that a supportive environment has been created to support change. This often means challenging existing norms and mobilizing communities and opinion leaders in support of change. Potential influencers to motivate communities could include in-laws, peers, frontline workers, *Gram Panchayats,* religious leaders, teachers and students and District Magistrates.

Demand needs to be created for basic services in the water and sanitation sector. Communities need to know their rights and entitlements. When not addressed by service providers, mechanisms need to be put in place to meet community demand. Enhancing demand presupposes a level of awareness and empowerment that allows stakeholders at the local level to seek information and follow-up with action whenever that demand is not met.

Improved hygiene standards and practices should not be perceived as behaviors prescribed from outsiders, but should be internalized by the various stakeholders, through discussion and understanding of the risks and benefits that such behavior can bring if adopted. In rural settings, opinion leaders and influential sources can play a key role. Annex 1 gives a mapping of Behavioral Analysis & Stakeholder Segmentation.

In the previous phases, the key questions were 'who' and 'what.' In this phase, the key question is 'why.' In order to devise effective strategies and convincing appeals there is

the need to know why certain sanitation and hygiene practices are adopted or not adopted. Based on the knowledge of the "whys", this phase will envision a multi-pronged strategy that will comprise a number of different approaches:

***Interpersonal Communication (IPC)***

Training frontline workers and community leaders such as PRIs, religious leaders etc. to communicate effectively on sanitation and hygiene can increase knowledge and understanding among family members on the importance of sanitation and hygiene. Interpersonal communication should make effective use of existing social networks or interpersonal relationships (family, friends, acquaintances, neighbors and colleagues) that bind people together to enhance the communication process. IPC is a key tool in the drive for not only increasing awareness but actual toilet construction AND usage.

Suggested Interpersonal Communication Activities

- Conduct face-to-face and small group counseling sessions to negotiate and discuss:
    - Traditional beliefs and practices that might prevent families from adopting toilets or hygienic practices
    - Link between unsanitary practices and diarrhoea and other illnesses
    - Toilet options and subsidies
- Train frontline workers to improve interpersonal communication skills, in particular in counseling/negotiation and storytelling.
- Strengthen interpersonal communication skills among community volunteers so they can give information and counsel effectively during home visits.
- Produce a health education tool box for frontline workers.
- Organize community volunteer-led home visits, small group educational meetings, and other interpersonal communication activities.

**Community Mobilization**:

Most effective in rural settings, where communities form closely intertwined units and if supported by opinion leaders and other influential sources, change can be effectively introduced form within, making it stronger and more sustainable. Frontline workers can also play an instrumental part in promoting the mobilization in favor of certain practices. The limitation of this approach consists in the time needed and the difficulty in ensuring quality control given the huge number of communities in India.

Suggested Community Mobilization Activities:

- *Activate social networks* (community leaders, volunteers, women groups) and encourage peer communication to reach remote areas in order to disseminate information about the benefits of sanitation and hygiene.
- Create mobile communication units (MCU) to mobilize communities on sanitation and hygiene issues. MCU includes basic equipment to implement educational activities in community settings.
- Train community leaders in facilitating public educational talks and dialogues in their communities about sanitation and hygiene issues.
- Produce a tool box, including a how-to guide for community leaders.

6

- Promote and implement participatory planning processes to involve local stakeholders in supporting key interventions.
- Reinforce information given through other channels at religious gatherings

**Dialogue Fora (an integral part of Community Mobilization):**
These are open meetings, both at community or block level where some of the key stakeholders can participate and dialogue above the new practices and behaviors. Here no messages are imparted, but rather themes are raised and knowledge is shared about what will the adoption of the proposed behavior imply and also what are the implications if those changes are not adopted. This approach aimed at having stakeholders face the issue themselves and realize the need to change. Once this happens they will become agents of change providing valuable support to the overall intervention.

**Mass Media (in support of community level activities)**
Although there are several media dark areas in the country, there has been rapid progress towards increased TV and radio coverage and penetration. In this strategy mass media is expected to provide the type of support that has been extensively documented in public health. It can:

- Support community mobilization and interpersonal communication efforts.
- Promote specific behaviors through multiple activities and products such as radio and TV public service announcements, radio and TV magazines, and radio and TV shows.
- Enhance the credibility of non-professionals such as community volunteers as reliable sources of information and services.
- Convey important logistical information easily, e.g. about where applications for toilet construction can be submitted.

Suggested Mass Media Activities

- Promote sanitation and hygiene issues on radio and television using drama, TV-Radio PSAs and magazines.

**Multi-Media Campaigns**
According to the context, the stakeholders and the resources available, a mix of different media will be used to sensitize on key aspects of the TSC and promote key behaviors. The media to be used can range from the more common ones, such as television and radio to more innovative ones such as mobile phones as well as traditional ones, such as folk arts and theatre. Literature review shows that a mix of media is generally more effective in producing the intended change.

**Entertainment-Education (E-E)**
The most important element in any form of communication is that it has to appeal to the recipient. The make or break of any communication lies here. The more aesthetically appealing and engaging the communication is, the higher the chance of its acceptance by the recipient. Often, subtle hints, rather than overtly detailed and 'clinical' communication serves the purpose better.

E-E Operates at tactical and strategic levels within the broader context of development communication. Tactically, E-E comprises the production and dissemination of messages that are educational in substance, entertaining in structure, and popular in style. Strategically, E-E functions at the nexus of culture and development to achieve behavioural results through an interwoven package of mass, small-group, and one-to-one communication outputs that complement, supplement, and/or preface programme

Community-based and mass media entertainment-education (EE) activities have been widely used in the country. Several organizations have used street theater, radio dramas, school plays, songs, games and written stories to promote public health messages. The nature of E-E interventions will facilitate bringing together messages from all sanitation and hygiene components included in this strategy.

Some important elements of entertainment-education include:

- E-E interventions use narratives to emotionally engage the audience in the lives of believable characters in an entertaining way, rather than using didactic rational appeals.
- E-E uses elements of communication and behavioral theories to reinforce and promote specific values, attitudes, and behaviors
- E-E uses self-efficacy (feeling of personal empowerment to perform a particular behavior) and modeling (observing others performing a behavior either in real life or in a drama) to promote particular behaviors.
- E-E projects acknowledge the structural barriers to behavior change and in addition to individual behavior, address society's role in change.
- New E-E projects have introduced participatory approaches, seeking to empower individuals and communities to create social change.

Suggested Edutainment Activities

- P*romote* the value of sanitation and hygiene, model key behaviors, and engage the public around sanitation and hygiene through theater, storytelling, games, and TV/ radio dramas.
- Produce a radio / TV soap opera dealing with key behaviors on sanitation and hygiene issues to be broadcast and replayed over local radio and TV stations and at community gatherings.
- Use edutainment products in small group discussions with tape recorder/CD player, loud speakers in public gatherings.

**Social Marketing**

This approach can be applied to promote the adoption of specific practices and products aimed at improving the sanitation and hygiene situation. It usually adopts the diffusion of innovation model, identifying early adopters and then gradually promotes the diffusion of the new practice/behavior.

7

Social marketing is the name given to the approach of applying lessons from commercial advertising to the promotion of social goals (in this case, improved hygiene behavior). Social marketing is not merely motivated by profit but is concerned with achieving a social objective. It goes beyond marketing alone as it is also concerned with how the product is used after it has been sold. The aim is, for instance, not only to promote latrines but to encourage their correct use and maintenance.

Suggested Social Marketing Activities

- Gaining an understanding of customer behavior and drivers of consumer demand; developing, testing and delivering the marketing campaign to mobilize the community for behavior change.
- Making products, services, or behaviors fit the felt needs of the different consumers/user groups - identifying and standardizing a range of good quality options
- Developing methods for effective distribution (such as sanitary marts) so that when demand is created, consumers know where and how to get the products, services, or behaviors with the different groups.
- Ensuring availability of competent service providers, building their capacities and certifying them
- Ensuring that consumers / users are willing to contribute something in exchange and keeping the pricing reasonable so that the product or service is affordable.

**Phase 4: Strengthening Behavior and Practices to Enhance Supply**

This phase will be implemented in parallel with phase 3. The objective here is to ensure that while the demand for improved hygiene and sanitation is created and enhanced, there is a corresponding capacity to satisfy such demand. Infrastructure must be available and in good order, that institutions are functional (i.e. able and willing) and that human resources are able to provide the needed service and have the skills to interact with public demand.

Much of the strategy will be based on an institutional strengthening (after a review of existing capacity) with a strong focus on training on how to address rights-based demand and how to ensure that needed corrective action will be addressed and reported in a timely way. This part of the strategy is probably the most crucial, because if the previous phases are successful and then there is no satisfactory delivery of services or even no customer service orientation, the increased demand can become a boomerang and hamper any future communication initiative. If planned and implemented effectively, institutional strengthening will complement the overall strategy and greatly strengthen the chances of achieving the agreed objective within the set timeframe.

**Mapping and Budget**
Once the draft strategy is agreed to, a comprehensive mapping should be completed outlining roles and responsibilities, deadlines and proposed budgets for the duration of the strategy.

**Monitoring and evaluation**
A system for monitoring and evaluation of the communication and advocacy strategy should be put in place so that modifications can be made to the strategy as needed. Qualitative analysis will be implemented to guide advocacy efforts and assess progress towards enriching the discourse on sanitation issues. Partners agreed that a greater emphasis must be placed on analyzing budget allocations to make sure that money is spent appropriately and effectively and that implementers should be held accountable for their role and responsibilities.

Advocacy initiatives and campaigns will have clearly defined outcomes developed jointly and agreed indicators for measuring and monitoring progress. Key tools to monitor the implementation and impact of the communications and advocacy components will include:

- Bi-annual reporting – to inform on the strategy's progress and implementation
- Small-scale stakeholder surveys (For example, policy makers, programme managers) – to understand whether the strategy is having the intended impact
- Media monitoring tools – to identify the number of articles appearing in the media on hygiene and sanitation as a result of the campaign

The Advocacy and Communication M&E framework may be organized in hierarchical levels, starting with:
1. Outcomes indicators
2. Output indicators
3. Process indicators

**1. Outcome evaluation**
Outcome evaluation is used to assess the effectiveness of a Communication and Advocacy strategy in meeting their stated objectives. Outcome indicators can be defined by behavioural results, policy change or changes in social norms specified from the very outset.
Example:

- By the end of the communication strategy action plan (date), to increase the number of mothers/fathers/ caretakers who [always/usually] wash their hands with soap (ashes or sand) after going to toilet/bathroom or after having contact with feces, before eating or cooking, or when cleaning the bottom of the baby, starting from X to X.

- By the end of the communication strategy action plan (date), to increase the number of mothers/caretakers/fathers who [always/usually] safely dispose of

children's faeces and family's feces in a latrine/toilet or burying a set distance from home, starting from X to X.

## 2. Output Indicators

Output assessment refers to early results of the Communication interventions, while the assessment of long-term indicators may be thought of as outcome evaluation of the communication strategy. The indicators for intermediate results can be made up from elements/variables drawn from well-known theories of health behavior, which can be used as predictors of behavior change, for example:

*- Changes in knowledge and awareness regarding the importance of handwashing with soup:*

% of primary audiences who are able to make linkages between handwashing with soap and diarrhoea

% of primary audiences who stated perceive benefits of washing their hands with soap

*- Perception of treat:*

% of primary audiences that stated perceive risk of not washing the hands with soap after critical times

*- Changes in attitudes and perceived benefits:*

% of primary audiences that stated positive attitude towards handwashing

*- Self-reported intention to perform the selected behaviour:*

% of primary audiences who report positive intention to wash their hands with soap at critical times

## 3. Process Indicators

It is used to assess how well the advocacy and communication plan have been implemented and to adjust communication/advocacy activities and tasks to meet their objectives. Process evaluation assesses whether inputs and resources have been allocated or mobilized and whether activities are being implemented as planned. Here are some examples:

- The number of people among the intended audiences exposed to communication activities.
- The type and amount of resources spent.
- Frequency and type of Media response.
- Intended audience participation, inquiries, and other responses.
- Meeting of deadlines on material production/distribution/media broadcast schedule.
- Number of printed material distribution and estimated number of viewers.
- Number of community meetings/ home visits.
- Number and frequency of radio and television PSAs broadcast.

Annex 2 presents a summary of the core elements of the Communication and Advocacy WASH Strategy.

## Annex 1 - Behavioral Analysis & Stakeholder Segmentation

| Current Behavior | Primary Stakeholders (PS) | Reasons for Behavior/s (benefits/risks) | Socio-cultural norms/Beliefs on behaviors/s | Secondary Stakeholders (SS) | Desired Behavior/s |
|---|---|---|---|---|---|
| Open defecation | Head of the family, women and children | Socializing and the need to connect with each other | Traditional practices | In-laws, Peers, SHGs, Frontline workers, Gram Panchayat, Religious leaders, Teachers and students, Doctors, Para health professionals, Gram Sewak, Village Council, Masons, Block Extension Officer, BDO, MLAs, Counselors, District Magistrate | All family members use toilet every time they need it |
| | | Lack of awareness of the linkages between health and sanitation | No stigma associated with open defecation | | |
| | | Quality of infrastructure and sustain maintenance of infrastructure | Social discrimination while using community spaces | | |
| | | Subsidy motivation | | | |
| | | Lack of legal norms | | | |

9

| Desired Behavior/s | Intended Stakeholders/Audiences (ISAs) | | | |
|---|---|---|---|---|
| | **Primary Stakeholders (PS/A)** | **Direct Support Network/Sources** | **Social Mobilization Network/Sources** | **Advocacy Network/Sources** |
| All family members use toilet every time they need it | Head of the family, women and children | In-laws, Peers, Teachers, Religious Leaders, Doctors, Para Health professionals | SHGs, Frontline workers, Gram Panchayat, Village Council, Counselors, Village motivators, Masons | Block Extension Officers, BDOs, MLAs, District Magistrate |

| Current Behaviors | Primary stakeholders (PS) | Reasons for behavior (benefits/risks) | Socio-cultural norms/beliefs on behavior | Secondary stakeholders (SS) |
|---|---|---|---|---|
| Poor handling and disposal of excreta | Mothers | Accepted norm/custom | **Norm** -Accepted social norm/custom- | Panchayats |
| | Grand mothers | Non availability of facility | **Belief-** Child's feces not perceived as dangerous/harmful | ASHA's |
| | Elder siblings | Child's feces not perceived as dangerous/harmful | **Belief**-Not for us- urban phenomenon/practice | Teachers |
| | Aangan Wadi-Helper (as the child also stays there during the day) | Diarrhea not linked to unsafe disposal practices-it's usually perceived as a part of the process of child's growing up | | AWW |
| | | Toilets unsafe for young children- as no availability of children friendly toilet seats | | SHGs |
| | | Cost/effort of toilet construction-usually perceived as not important or waste of money and effort | | Religious leaders |
| | | Not convenient for PS as it consumes a lot of their time in monitoring child in the toilet– especially in case where the no. of children are many | | House hold males |
| | | Not for us- urban phenomenon/practice | | NGOs |
| | | Rationalization of act-low risk perception | | Neighbors |
| | | | | Media |

| Desired behavior | Primary stakeholders | Direct support Network/sources | Social mobilization network/sources | Advocacy Network/ Sources |
|---|---|---|---|---|
| Mothers/care givers safely dispose child excreta | Mothers | *Panchayats | SHGs | Teachers |
| | Grand mothers | ASHA's | House hold males | *Religious leaders |
| | Elder siblings | Aangan Wadi Workers (AWWs) | Neighbors | NGOs |
| | Aangan Wadi- Helper (as the child also stays there during the day) | | | Media |

## Desired Impact of communication and advocacy strategy

| Audiences | Short-term impact | Medium-term impact | Long- term impact | Key communication/advocacy mechanisms |
|---|---|---|---|---|
| **General public and civil society** | Awareness of sanitation and hygiene and impact on their communities | Awareness of sanitation and hygiene and impact on their communities and achievement on MDGs | Awareness of how to engage sanitation schemes at a local level | -Interpersonal Communication<br>- Radio, national and community<br>- Television<br>- Newspaper articles<br>-Website<br>- Bus Backs campaign<br>- SMS campaign<br>- Folk theatre<br>- Goodwill ambassador visits<br>- Community mobilisation activities like forming girls collectives, women's groups, youth groups, child reporters, children's assemblies |
| **Media** | Knowledge and disseminatio n of hygiene and sanitation messages | - Awareness of hygiene and sanitation and its importance to health and addressing the MDGs as | -Features and articles appearing regularly in media | - Press pick-up<br>- Photo library<br>- Human interest stories<br>- Evidence-based data<br>- Media package<br>- Website<br>- DVD news clip<br>- Films<br>- Publications |



10

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| | | a key media message | | - Media visits to the field<br>- Goodwill ambassador visits<br>- Local media<br>-Digital Campaign |
| **Policy makers** | Enhanced knowledge about sanitation and hygiene and health implications | Enhanced knowledge about sanitation and hygiene and health implications | Evidence of change in policy (link to advocacy strategy) | - Stakeholder mapping<br>- Policy briefings<br>- Evidence-based data<br>- Process documentation products<br>- Thematic summaries<br>- One-to-one interactions<br>- Press releases<br>- Field visits<br>- Films<br>- Human interest stories<br>-Articles in key national publications<br>National and regional workshops<br>- Website |
| **Implementing agencies and bilateral donors** | Enhanced knowledge about sanitation and hygiene and health implications | Enhanced knowledge about sanitation and hygiene and health implications | -Evidence of change in practice by implementing agencies | - Policy briefings<br>- Process documentation<br>- Thematic summaries<br>- One-to-one interactions<br>- Press releases<br>Human interest stories<br>-Articles in key national publications<br>-National and regional workshops |

## Annex 2 - Summary of Core elements of the Communication and Advocacy WASH Strategy

| Channel | Interpersonal Communication (IPC) | Community Mobilization (CM) | Advocacy | Entertainment-Education (EE) | Mass Media & Mid Media | Social Marketing |
|---|---|---|---|---|---|---|
| **Context** | Frontline workers, multiple social networks, including religious groups, clubs and community gatherings will promote sanitation and hygiene using IPC (inter-personal communication - talking and discussing). It will be crucial to involve community leaders, volunteers, and frontline workers. | Communities will be invited to actively participate in planning and implementing BCC activities to promote improved sanitation and hygiene. CM is essential for desired practices to become "normal behavior" in the community. | A number of key actions are needed to influence high-level decision makers to provide commitment, funding, policies, and organizational support for the sanitation and hygiene initiatives, including the implementation of this BCC strategy. | Street theater, radio dramas, school plays, songs, games, and stories will be widely used to promote sanitation and hygiene messages. This communication approach presents opportunities for building on and coordinating these efforts. | Penetration of Television and Radio is rapidly increasing and becoming available to many people and communities. Further, areas that are still media-dark would be reached out through Mid Media such as Folk theatre, wall paintings, hoardings etc. In this strategy, Mass and Mid Media are closely linked with EE, and reinforce other communication efforts. | Social Marketing would be crucial in order to promote adoption of new behaviors and also create demand for services that help practice the behavior. |
| **Examples of Key Activities** | —Train frontline workers on the use of counseling and storytelling to promote desirable sanitation and hygiene practices. | —Implement a coordinated process for participatory planning with communities to promote sanitation and hygiene | —Seek endorsement from government and partners at all levels to incorporate the BCC strategy into | —Use theater, storytelling, games and radio dramas to promote key behaviors related to sanitation and | —Broadcast a weekly radio show on sanitation and hygiene with the participation of frontline workers | - Gaining an understanding of customer behavior and drivers of consumer demand; |

| | | | | | | |
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| | —Strengthen the skills of community volunteers to serve as effective communication and change agents in their communities, through counseling and other communication activities<br><br>—Produce a health education *tool box*, including sanitation and hygiene messages for frontline workers and volunteers | — Train community leaders such as PRIs, Religious leaders etc. and equip them with a communications *tool box* tailored to their needs<br><br>— Give the same information at religious places ,community events and other community forums | their work plans.<br><br>—Negotiate with public and private mass media to identify mutually beneficial opportunities for designing, producing and broadcasting creative and relevant programming.<br><br>—Lobby for the support of government programs outside the MORD to promote desired practices. | hygiene<br><br>— Produce a soap opera for local radio stations that addresses key sanitation and hygiene issues<br><br>—Use a range of EE products in small group discussions and in large public gatherings, to keep things lively and maintain local enthusiasm and interest. | and community leaders.<br><br>—Broadcast regular public service announcements on radio and TV that reinforce community mobilization events | develop, test and deliver the marketing campaign to mobilize the community for behavior change.<br><br>- Develop methods for effective distribution (such as sanitary marts) so that when demand is created, consumers know where and how to get the products, services, or behaviors with the different groups.<br><br>- Ensure availability of competent service providers, build their capacities and certify them |

# Draft Implementation Framework for WASH Communication and Advocacy Strategy, July 2011

This implementation framework builds on the WASH Communication and Advocacy Strategy developed by UNICEF in collaboration with the Ministry of Rural Development and development partners. It intends to provide a framework for states to develop state-specific action plans for rolling out of the strategy. The time frame for the rollout of the strategy would need to be developed by the states in consultation with other development partners.

## Preparatory Activities

While developing the state implementation plans, certain preparatory activities need to be carried out. These are as follows:

1. State level consultation to:
   a. Gain consensus on key behaviours/ issues to be addressed
   b. Understand the local context/situation using secondary data
   c. Adapt the communication strategy to the state context taking into account socio-cultural and geographical diversity, media penetration and reach, social exclusion etc.
   d. Develop a state-specific implementation plan
   e. Adapt monitoring and evaluation plans
2. Development of training modules and communication materials
3. Identification / Development of partnerships for advocacy and community mobilisation
4. Issuing of relevant directives and guidelines to Rural Development Department functionaries and other stake-holding departments
5. Capacity building of partners / frontline workers to effectively engage with communities
6. Development and implementation of media plans/material dissemination plans and its execution

## Suggested Monitoring and Evaluation Framework

| Results | Indicators | Means of verification |
|---|---|---|
| **Outcome level** | | |
| Increase number of individuals (men and women, including adolescent girls and children) who use toilets regularly in their homes. | • Number/.percentage of households having toilets.<br>• Number/percentage of men/women/children reporting regular use of toilets. | • Base line, mid line and end line survey reports.<br>• Progress reports.<br>• DDWS on line monitoring reports/MIS |



12

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| Increased number of children (girls and boys) who use toilets in schools and Anganwadi centres | • Number/ % of schools having separate functional toilets for girls and boys, which are being used. | • DISE data reports<br>• ASER report<br>• School based monitoring reports<br>• Base line, mid line and end line survey reports |
| Increased number of mothers/fathers/caretakers who wash their hands with soap (ash or sand), after defecation or after having contact with faeces, before eating or preparing food, or after cleaning the child's bottom, from X to X. | • Number/percentage of mothers/fathers/caretakers who wash hands after defecation, after handling child's faeces, before eating or preparing food.<br>• Number/percentage of mothers/fathers/caretakers, who understand the need for Hand washing and can articulate benefits of HW at critical times. | • Base line, mid line and end line survey reports.<br>• Sales reports of soaps. |
| Increased proportion of mothers/fathers/caretakers safely dispose of child's faeces in a latrine/toilet or safely bury it at a distance from home, from x to x | • Number/percentage of mothers/fathers/ caretakers who understand and can articulate the need for safe disposal of child's faeces.<br>• Number of / Percentage of mothers/fathers/ caretakers who safely dispose of a child's faeces. | • Baseline, midterm and end term evaluation survey reports<br>• KAP reports. |
| **Output level** | | |
| Increased levels of knowledge and awareness regarding the importance of hand washing with soap. | • District specific baseline surveys conducted.<br>• Number of message and communication design workshops conducted on Hand washing with soap.<br>• Availability of soap close to latrines in houses and in schools. | • Baseline survey reports<br>• Mid line reports<br>• Activity progress reports |

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| Increase in the number of primary audience who are able to make linkages between hand washing with soap and diarrhoea. | • Number of people who are able to articulate the linkage between HW and diarrhoea.<br>• Number/percentage of primary audience able to explain at least two critical times for hand washing. | • KAP studies and reports.<br>• Hygiene surveys. |
| Increased number of people who stated perceived risk of not washing hands with soap at critical times. | • Number/percentage of primary audience able to explain the risks of not washing hands with soap at critical times. | • Base line, mid line and end line survey reports |
| Increased number of people, who can identify the benefits of regular use of toilets | • Number of HH having toilets.<br>• Number of HHs where every member uses the toilet regularly.<br>• Number of people able to articulate the benefits of using a toilet for safe disposal of child's faeces. | • Online monitoring system of DDWS.<br>• Base line, mid line and end line survey reports |
| Increased number of parliamentarians, district level functionaries who stated perceived risk of not washing hands with soap at critical times. | • Number of parliamentarians and district level functionaries who are able to explain the risks of not being able to wash hands with soap at critical times | • Base line, mid line and end line survey reports |
| Increased number of faith-based leaders who stated perceived risk of not washing hands with soap at critical times. | • Number of faith-based leaders who are able to explain the risks of not being able to wash hands with soap at critical times | • Base line, mid line and end line survey reports |
| Increased number of parliamentarians, district level functionaries who can identify the benefits of regular use of toilets. | • Parliamentarians, district level functionaries who can identify benefits of using a toilet for safe disposal of child's faeces. | • Base line, mid line and end line survey reports |
| Increased number of faith-based leaders who can identify the benefits of regular use of toilets. | • Number of faith-based leaders able to articulate the benefits of using a toilet for safe disposal of child's faeces. | • Base line, mid line and end line survey reports |



13

| **Process level** | | |
|---|---|---|
| Policy makers and stakeholders | • No. of questions raised in parliament and assemblies<br>• No of times the issue of sanitation and hygiene brought up in public speeches | • Monitoring of parliamentary and assembly debates<br>• Media reports on public engagement of concerned public figures |
| Media sensitised and motivated to report on sanitation and hygiene issues and set the policy agenda and different levels of governance | • No. Of news stories and their prominence in International, National, Regional and Local media | • Media monitoring and analysis |
| Elected representatives are engaged and motivated to spread messages and coordinate and monitor programmes. | • No. of public and coordination meetings held by elected representatives (Z.P. Adhyakshyas) in which issues concerning sanitation and hygiene are discussed | • Local media reports, minutes of meetings of district administration |
| Frontline workers, School Teachers, Self Help Groups members and influential volunteers equipped with the knowledge and skills to conduct interpersonal communication (IPC) and community mobilization to promote use of toilets. | • Number of frontline workers, school teachers and volunteers trained on use of IPC and community mobilization techniques.<br>• Number of tools developed as a part of the multimedia campaign.<br>• Number of transmission programmes organized.<br>• Number of printed material distributed. | • List of tools developed<br>• Assessment reports.<br>• Training reports. |
| An education-entertainment mass media intervention strategy developed, to complement the IPC strategy. | • Number of programmes of education-entertainment organized. | • Assessment reports.<br>• Listed number of audiences. |
| Trainings and capacity building of key stakeholders to implement the strategy, organized | • Number of trainings and consultations organized.<br>• Number of people trained in use of communication techniques. | • Training reports.<br>• List of participants. |

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| Men/women/front line workers/community leaders trained and oriented about benefits of hand washing and use of toilets. | • Percentage of primary audience, able to identify key risky practices related to sanitation.<br>• Percentage of primary audience, who stated positive attitude towards hand washing.<br>• Percentage of primary audience who are able to make linkages between hand washing with soap at critical times and diarrhoea | • Base line, Mid line and End line surveys. |
| Adolescent girls and women start using and sustain utilization regularly of sanitary napkins during menstrual cycle. | • Number of women actually using sanitary napkins | • KAP reports<br>• Sales reports. |

**Sample Messages**

**Use of toilets:**

1. Always use a toilet for defecation.
2. If you do not have a toilet pl. use mud/soil to cover your faeces.
3. Always throw a child's faeces in a toilet, or cover with mud.
4. Use of toilet minimises risk of diarrhoea.
5. Construct a toilet in your house- it's a question of your wife's, daughter's, mother's dignity.
6. Use of toilets have minimises your expenditure on health.

**Hand washing:**

1. Always wash your hands with soap after you clean yourself post defecation.
2. Always wash hands with soap before you eat or touch food or prepare food.
3. Always wash hands with soap after you have washed a baby's bottom.
4. Wash your hands with soap after you touch cow dung or any animal excreta.
5. If you haven't used soap or ash, you haven't washed hands.
6. Remember, you need only one mug of water and soap to wash hands.
7. HW with soap prevents diarrhoea.

**Suggested Planning Framework**

This framework lists out the primary, secondary and tertiary stakeholders, the approaches and activities to be used with each of them and the inputs required.

| Stakeholder | Approaches | Activity | Input/product |
|---|---|---|---|
| **Primary/Secondary:** General audiences- Middle class urban populations, civil society, donors Role: To create an enabling environment by setting public | **Digital Campaign** | • Development and regular management of a campaign website cross-linked to the GoI and UNICEF websites. | • Web agency contracted |
| | **Social Network Campaign** | • Promotion of viral advertisement through social networks<br>• Regular management of webpages to ensure growing membership and robust dialogue | • A viral advertisement that is funny, provocative and clever<br>• Human resource allocated for this activity |
| | **Mobile campaign** | • Partnership can be forged with a service provider for initiating an SMS campaign with messages on handwashing and open defecation. | • An attractive SMS with a defined call to action<br>• Mobile voice message with a celebrity with pan-India appeal, from the world of entertainment or sports, emphasizing cleanliness and hygiene, which can be sent out to citizens via partnership with an Indian mobile telephone company. |
| | **Celebrity Outreach Campaign** | • Broadcast PSA on primetime across the country on hygiene and sanitation for broad dissemination through radio, TV | • 4 PSAs |

| | | | |
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| | | • Field visits by the celebrity accompanied by a mobile toilet and media coverage of the same | • Mobile Toilets with soaps |
| | • **Private Sector Partner-ships** | • Corporate partnerships to be developed for supporting creative development<br>• Corporates to be encouraged to adopt districts for promoting sanitation and hygiene behaviours.<br>• Corporate partnerships to de developed with agencies such as Facebook and NDTV for free promotion | Evidence-based advocacy package, including<br>• Fact sheets,<br>• Powerpoint Presentation<br>• Talking points<br>• Four 5 minute video packages |
| **Secondary:**<br>Media- International media, National media, Regional media, Local media<br>Role: To create an enabling environment by setting public discourse and reporting on the implementation | **Media engage-ment** | • Media Pack<br>• Field visit | Communication package comprising<br>-Human interest stories, fact sheets<br>-Photo essays on sanitation.<br>-CD containing photo images and graphics on sanitation for easy replication will be included. |
| **Primary/Secondary:**<br>Children and youth:<br>Role: Act as messengers and champions as well as lead by example | | • Distribution of child friendly booklet in partnership with MHRD | • A child-friendly version of a booklet to communicate hygiene and sanitation messages to schools |
| | | • Partnerships with NYKS, NSS etc. and Identify youth ambassadors | Evidence-based advocacy package, including<br>• Fact sheets,<br>• Powerpoint |

15

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| | | | Presentation<br>• Talking points<br>• Four 5 minute video packages |
| **Secondary:**<br>Faith-based leaders- All religions<br>Role: Sensitize religious followers and link the issue of hygiene and sanitation to the notion of purity and a calling of the faith as well as lead by example. | • Mapping religious leaders that are early adopters of good sanitation and hygiene behaviours.<br>• A broad based 'all faith' leaders consultation to sensitize them. Followed up with state level consultations<br>• Develop partnership with existing religious development organizations such as CBCI, Art of Living, to ensure that their programs include messaging on appropriate hygiene and sanitation behaviors. | | • Desk Research<br>• Evidence-based advocacy package, including<br>• fact sheets,<br>• Powerpoint Presentation<br>• talking points<br>• four 5 minute video |
| **Secondary:**<br>Policymakers- Parliamentarians, Governments & senior civil servants (Ministers, Secretaries, Directors, members of policy task forces/ committees)<br>Local government authorities<br>**Role:** To sensitize their constituencies on key sanitary/hygiene practices; and to monitor the implementations of hygiene and sanitation programs; sensitization of peers. | • Mapping of Policy makers conducted in targeted states to identify key policy and programme influencers.<br>• Workshops and one on one meetings with identified key stakeholders<br>• Field Visits to best practice areas<br>• Conference of district collectors from the states to meet and share initiatives at both state and district level. Lessons learned will help inform and improve implementation.<br>• National Convention of Zilla Parishad Adhyakshas to sensitize them about the implementation of the program and their key role in its success. To be followed at the state level<br>• Monitor implementation of the program at the state level and develop "toilet report cards"<br>• National level mega event involving celebrities etc. to give away awards to officers, political leadership and civil society organization | | • Desk research<br>• Evidence-based advocacy package, including<br>• Fact sheets,<br>• Powerpoint Presentation<br>• Talking points<br>• Four 5 minute video |

**On-the Ground Implementation Table**

| Stakeholders | Approaches | Activities | Inputs |
|---|---|---|---|
| **Primary:** Mothers/caregivers with children under 5/adult men of the household | Interpersonal communication | • Face-to-face counselling by frontline workers and community level motivators<br>• Small group sessions at home, health centres, community settings and religious gatherings<br>• Encouraging peer to peer communication among mothers and caregivers | • Flipcharts<br>• Leaflets<br>• Posters<br>• Educational videos for small –group discussion |
| | Community Mobilisation | • Mapping and identification of local leaders and influencers<br>• Community dialogue and local meetings / events by community leaders, PRIs, volunteers, religious leaders, and women groups | • Posters<br>• Leaflets |
| | Mass media, Outdoor media and traditional media | • TV and radio spots / TV and radio programmes, cinema slides explaining the need for sanitation and hygiene<br>• Folk media performances along with community dialogue in media dark areas<br>• Outdoor media such as wall paintings and hoardings at strategic locations | • TV/Radio spots<br>• TV/Radio programmes<br>• Cinema slides<br>• Scripts for folk media performances<br>• Hoardings<br>• Wall Paintings |
| | Social Marketing | • Promoting toilet options through community level motivators<br>• Community level events to create demand for toilets and soap<br>• Providing families with necessary linkages to facilitate construction of toilets through | • Flipcharts<br>• Posters<br>• Hygiene kit for demonstration<br>• Leaflets<br>• Caps, T-shirts, Banners, prizes for contests |

16

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| | | community level motivators | |
| School-going children | School-based activities | • Formation of a "task force" of school students to monitor sanitation and hygiene in schools.<br>• Fun-based activities and materials on sanitation and hygiene for children<br>• Wall painting in schools | • Leaflets<br>• Posters<br>• Flipcharts<br>• Activities/games |
| Teachers, VEC members | Capacity Building | • Training for teachers on sanitation and hygiene promotion<br>• Orientation of VECs on importance of sanitation and hygiene and need for sanitation and hygiene facilities in schools | • Training modules for teachers/VEC members |
| Community volunteers, self-help groups, PRIs, community leaders | Capacity Building | • IPC training (also disease transmission and criticality of sanitation and hygiene) for community volunteers<br>• Orientation for SHGs, PRIs, community leaders<br>• Development of IEC/IPC materials on hand washing | • IPC training module for community volunteers<br>• Orientation modules for PRIs/SHGs<br>• Leaflets<br>• Posters |
| | Mass media, Outdoor media and traditional media | • TV and radio spots / TV and radio programmes, cinema slides explaining the need for sanitation and hygiene<br>• Folk media performances along with community dialogue in media dark area<br>• Outdoor media such as wall paintings and hoardings at strategic locations | • TV/Radio spots<br>• Cinema slides<br>• Scripts for folk media<br>• Performances<br>• Hoardings<br>• Wall Paintings |
| Frontline workers such as ASHAs, AWWs/ANMs | Capacity Building | • IPC training (also disease transmission and criticality of sanitation and hygiene | • IPC training modules for frontline workers |