UNICEF Sudan

Communication for Development Strategy for Water, Sanitation and Hygiene and Water-Related Disease Outbreaks Management

1. INTRODUCTION

Situation of Water, Sanitation and Hygiene and Water-Related Outbreaks:
Sudan has daunting challenges from lack of inadequate physical facilities for water and sanitation and and bad hygiene practices with their consequences on health and wellbeing. As well, in Sudan, outbreaks of water borne, water related, and water associated diseases such as AWD, Chikungunya, Dengue, and Malaria are commonly occurring, which put great burden and setback on humanitarian and development efforts.

Adoption of key hygiene & health behaviour:
Apart from UNICEF's plan to support the Government of Sudan with physical infrastructure on water and sanitation, it also plans to reach about 4,313,406 individuals with a programme on behaviour change. These individuals reside in 52 high risk localities in the 14 states, and will primarily focus on caregivers at house hold levels, older women, youth, water & food vendors at community level and their sources of influence including traditional leaders, local authorities, teachers, health care staff at different gateways such as schools, health facilities at community level.

With C4D technical speciality, UNICEF can play an active role in leading technical support on behavioural and social communication for improvement of WASH practices, outbreak readiness, and outbreak response. The development of this document is guided by the C4D Cross Cutting Strategy Developed in 2019.The strategy aims at improving capacity of the government at all levels and the communities while focusing on working with adolescent and youth as strategic change agents to promote and achieve the desired results:

2. GOAL AND OBJECTIVES

Goal
The overall goal of the strategy is to increase the adoption of safe water, sanitary, and hygiene practices among families and communities in Sudan at all times including outbreak emergencies and to increase the capacity of the country at all levels in water-related diseases outbreak management.

Objectives:
By 2021, children and caregivers in target communities are regularly practicing safe water, sanitary, and hygiene practices and the capacity of the country at all level in water-related diseases outbreak management is adequate and up-to-date.

Participant Groups

From UNICEF's AWD Plan[1], there are pre-determined individuals caregivers at HH levels, older women, youth, water & food vendors at community level, traditional leaders, local authorities, teachers, health care staff at different gateways such as schools, health facilities at community level.

Participant Group an Relationships	
Primary Participants: (Individual level) Those who will adopt the recommended behaviours	• Children • Men / Women/ Parents • Food / Water Vendors
Secondary Participants: **Those** with **the** most influence on the primary participant	Family members. Peers, Neighbours teachers, health care staff
Tertiary Participants: Those whose actions influence social norms either negatively or positively	(Local/ Leadership/ CSOs/ NGOs) i.e prominent traditional and religious leader, Youth and Adolescent Clubs, Women and men groups
Meso Participants (institutions)	Staff of relevant institutions at District and Regional levels. - Commissioners, Health Officers, Community Health Director, HP focal point etc.
Macro Participants	
Influencers and Institutions at this level that can influence behaviour through, resources and legislation or their pronouncements	Parliament, Cabinet, Media, Celebrities

Table 1

The ultimate purpose of this strategy is to ensure behavioural change among Primary Participant groups i.e. Children, their Parents and Food and Water vendors. From Table 1, it is seen that for this to happen, there are others, such as Teachers, Community leaders/religious leaders, Community Health Promoters etc. who are at the secondary group level, and who directly influence the behaviour of Primary Participant groups. They also have to be engaged as well.

To illustrate, if CHPs decide to motivate parents to adopt the use of latrines and safer water practices, and community leaders facilitate the access of families to latrines and safe water, the parents would be motivated to adopt positive practices. The Involvement of Community and Religious Leaders in the process may also help demystify the barriers inhibiting the adoption of new behaviours and practices due to social norms. The dynamics of all these actions taking place will help parents adopt more positive behaviours related to WASH.

Further more, a great deal of advocacy would also need to be carried out with the meso/macro level Participant groups such as policy makers / technical staff of Ministries and Departments and the media as they directly or indirectly influence the intention/ability of the secondary participant group as well as primary participant groups. For instance, if the policy makers /implementers improve the implementation of water and sanitation facilities and the media / community radio association vigorously highlight the issue and associated harms of not adopting recommended practices, families and communities would be motivated to follow proper sanitation and hygiene practices.

[1] Integrated Acute Watery Diarrhoea (AWD) Plan Jan 2018 – December 2019

3. GUIDING FRAMEWORK

The Socio Ecological Model (SEM)[2]

The SEM guides and helps target the design of C4D strategies, interventions and activities by helping conceptualize behavioural dimensions (i.e. attitudes, perceptions, norms etc.) and by analysing barriers to, and opportunities for change. It also highlights the cross-sectoral nature of effective behaviour and social change programming and extent to which C4D can be a platform for synergistic interventions across programme sectors.

The figure below highlights the levels of influence of the SEM and the corresponding C4D strategies:

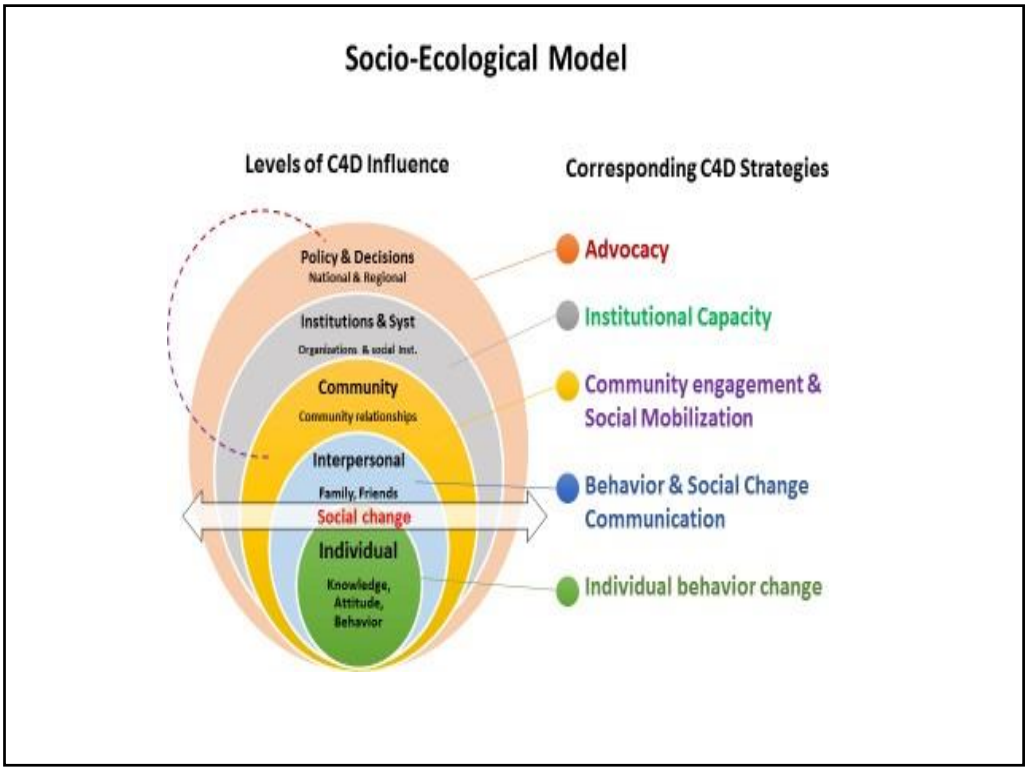

Fig1

BEHAVIOURAL AND SOCIAL COMMUNICATION IN OUTBREAK RESPONSE

Behavioural and social interventions are essential component of efforts to mitigate the effects of outbreaks[3]. Disease outbreaks can have enormous economic costs and equally devastating social costs. Understanding of behaviour and society can help to find effective ways for mitigating, preventing and controlling disease emergence and transmission. Outbreak response focuses on behaviour as human behaviour is the common denominator for epidemic risk and ultimately prevention and control;

[2] The SEM is a conceptual tool that analyses human behaviour within its social and cultural contexts and highlights the multiple, multi-level and cross-cutting influences that can either facilitate or obstruct a desired behaviour, cultural practice, social norms or collective action. It also assumes that the most effective and sustained change in behaviour takes place when all levels are addressed: *micro* (individual, family, community); *meso* (civil society, institutional) and *macro* (policy - national, international).
[3] 2012, WHO, UNICEF, FAO: Communication for Behavioural Impact (COMBI): A Toolkit for behavioural and social communication in outbreak response

understanding of behaviour and society can help to find effective ways for mitigating, preventing and controlling disease emergence and transmission.

Fig2

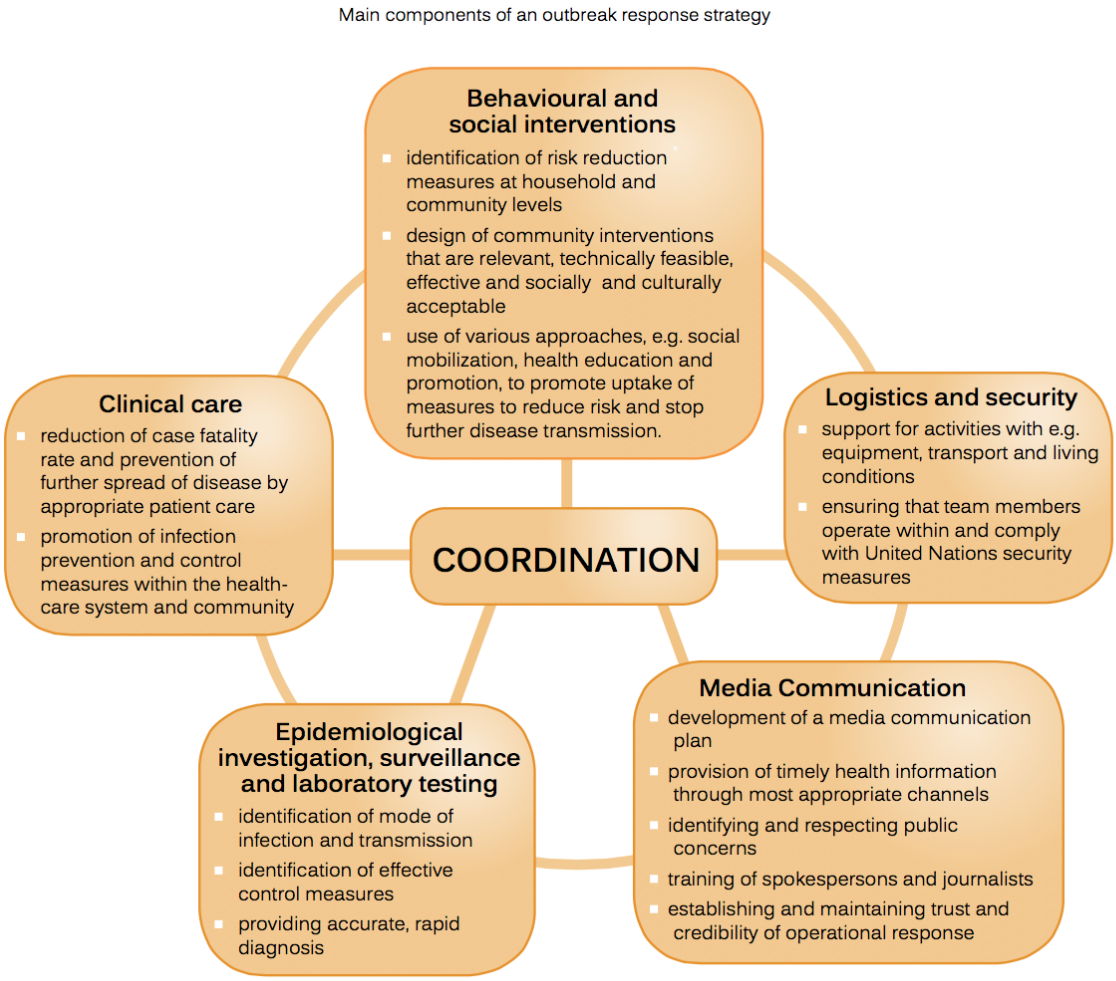

Figure above shows the main components of an outbreak response strategy, their functions and their role. This document aims to provide strategic direction, specifically, in the **Behavioural and Social Interventions** component of an outbreak response.

4. Strategic Directions:

The strategy would have three segments.

- promoting social and behavioural change among families and communities
- ensuring community engagement and participation
- synergizing WASH and Outbreaks Management for effective engagement

Promoting social and behavioural change among families and communities:

This will include the use of interpersonal communication (IPC), community dialogue, and community theatre, supported by video and mass media using news, call-in talk shows and other interactive and/or

participatory formats. The use of the social media such as Facebook, Twitter and WhatsApp could be explored especially by adolescents and youth via their involvement in school and community-based clubs as well as working with young, talented game designers offer new possibilities in education.

Ensuring community engagement and participation:
Communities need to own the development programes coming out of the interventions in their areas. This will involve building rapport with communities through existing formal and non-formal groups, including

i) men's groups;
ii) ii) Local partners working with UNICEF Sections/Programs particularly adolescent volunteers
iii) iii Formation of new male and female groups if possible.

Engagement and participation of women is critical in WASH behavioural intervention and outbreak management. They are often the biggest sufferers and and are involved in ensuring availability of water and maintaining hygiene in families as well as taking care of the sicks.

Synergizing WASH and Outbreaks Management for effective engagement:
Achieving a high impact for an intervention like a WASH Communication programme as this goes beyond UNICEF's capacity, size and resources. There is the need for policy at the national level to ultimately high level of financial, technical and human commitment as well as a commitment to grassroots community efforts at development. There is also a need for closer coordination between the ministries, which demand a strong policy support as well as development partners, community leaders, private sectors, and the media .

Notably, Outbreaks management of different diseases have different approaches and messages that must be communicated separately i.e. vector control for mosquito-borne diseases, hand washing and hygiene practices for AWD. Therefore, this is an opportunity to synergize the intervention effort of partners to work together on the many different but related issues. In addition, confusion and unnecessary repetition of work can be avoided when planning and designing activities with this approach in mind.

5. PREVENTION AND MANAGEMENT OF OUTBREAKS OF WATER-RELATED DISEASES

Through a combination of interventions in the water, sanitation, hygiene, and health sectors, water-related disease outbreaks can be prevented. Successfully controlling an outbreak requires the collaboration of different stakeholders and the implementation of a variety of different interventions. Effective communication in varying forms (advocacy, hygiene promotion, behaviour change communication, communication with patients, etc.) is at the heart of outbreaks preparedness and response.

Behavioural Communication interventions around an outbreak need to be divided into two distinct phases: preparedness and response. (See details in Annex)

Preparedness Phase

- Enhancing Coordination through the Sub Committee on Health Promotion: Effective prevention, preparedness, and response for an outbreak require coordination and communication across sectors and at different levels. Under the leadership of The Ministry

of Health, the Health Promotion division would coordinate the working of the sub - committee on health promotion, with representation from relevant ministries / departments, Faith Based Organisations, Religious and Traditional Leaders, Local Authorities, CBOs, Sudanese Red Cross Similar committees would also need to be formed at the district and sub district levels. and district levels

- Development of an action plan, which defines the objectives, the approaches, the resources required including human resources, the participant groups and the communication channels, to deliver the messages.
- Sudan shares a long border with a number of countries. A coordination mechanism will have to be established between government authorities at national and local government levels with these countries to prevent the spread of diseases across borders.
- The plan should begin with literature review or formative study, and assessment to identify the knowledge, attitudes, perceptions, beliefs and practices of the people on the issue and understand the different means for bringing about change. If there is a regular programme, then this information most probably will be available. However on-going assessment, monitoring and listening to communities will also be vital during the outbreak.
- Identifying communication channels: It is advisable to use both interpersonal methods and mass media methods for addressing outbreaks.
- Standardization of messages, preparing action oriented communication materials and keeping them ready for dissemination: Messages and materials that have been pre-tested would have to be developed, produced and prepositioned in advance so that during an outbreak they can be immediately distributed in the field. This will save precious time and resources.
- Training service providers / community level workers on Interpersonal Communication (IPC) skills: In times of stress and trauma caused by an outbreak, health workers and specially community level communicators such as Community Hygiene Promoters need to possess and maintain good IPC skills to inform, motivate, counsel and encourage affected people and communities.
- Engaging communities in preparing and planning for emergencies: Supporting communities in areas particularly vulnerable to the outbreak, to develop community action plans themselves would be a key preparedness activity. This would ensure effectiveness as well as sustainability.
- Testing action plan through simulations of outbreak.

Response Phase

- Developing a communication protocol and partnerships for collaboration: A plan would need to be developed with key partners, which outlines how intervention efforts will be coordinated. This would help effective implementation and also help prevent and manage rumors, misinformation and unwanted results that often happen during outbreaks.
- Participation in sectorial rapid assessments: It is very critical for C4D to participate in the assessments conducted by WASH and Health in the initial phase of an emergency It will allow the practices that have implications for communication among affected caregivers and communities to be detected
- Revisiting and activating the action plan (designed and discussed by all stakeholders during preparedness phase)
- Focusing on re-establishing existing behaviours and norms: In the initial phase, the focus

would be on re-establishing positive behaviours and social and cultural values that existed prior to the outbreak. However, depending on the situation, emergencies might also provide opportunities to promote new behaviours.

- Forging additional alliances: The outbreak might provide opportunities to build additional alliances to include relief workers, service providers, journalists and others so that they are able to directly support desired behaviours of affected people.
- Facilitating community and children's participation: Through established community level committees, pro-active efforts would need to be made in creating opportunities for affected families and communities, including children and young people, to participate in the response.
- Working with the media: As a priority, decision makers should come together and decide on what to communicate to the media. The communication would need to be frequent and effective through a dedicated spokesperson.
- Listening through Dialogue and Tackling rumors: During an outbreak, it would be crucial to set up a rumor tracking system to identify, investigate and address misperceptions or misunderstandings through community workers, and the media.
- Reaching the poorest and those in particularly vulnerable, hard to reach or special circumstances – Equity perspective: Particular attention should be paid to people who are more vulnerable or marginalised in a given context or those who are harder to reach through special outreach activities.
- Dealing with psychosocial impact: Outbreak of diseases such as AWD or Chikungunya can have a variety of psychosocial impacts. People may have strong feelings of fear, insecurity and helplessness; patients may be stigmatised; people might not be allowed to undertake usual funeral and mourning practices. Thus community workers would have to be trained to deal with this and community leaders oriented to help reduce stigma in the community.
- Behavioural dimensions of C4D Challenges in Emergencies: In a crisis, affected people are in an emotional roller coaster. They are confronted with fear, anxiety and dread. Rumours thrive, which eventually leads to resistance. Under these circumstances, affected communities process and act on information differently than they would during non-crisis times. They believe the first message or dialogue they are involved in, holding on to their beliefs. At the same time, they look forward to additional information and opinions.

  Affected communities' concerns have implication's for C4D. It means that information/messages must be simple accurate and released timely. The source must be credible so as to discourage people from relying upon less trusted ones. Lastly the messages must be consistent. During training, it is important to stress these implications. (See Annex 2 for details}

6. IMPLEMENTATION, MONITORING, AND EVALUATION.

At the National Level, coordination for outbreaks interventions are mainly done by the GoS' Ministry of Health (MoH) and Drinking Water and Sanitation Unit (DWSU), and, at state level, by State Ministry of Health (SMoH), State Water Corporation (SWC), and Water and Environmental Sanitation (WES). UNICEF supports and strengthens the GoS capacity to respond to water-related diseases outbreak such as AWD. To do so adequately, UNICEF works through the GoS capacity at National and State levels and provides a complementary support[4]. Work plans for implementation is attached as Annex 3.

[4] Integrated Acute Watery Diarrhoea (AWD) Plan Jan 2018 – December 2019

Monitoring and Evaluation

Continual and careful monitoring of relevant indicators and processes generates information for evaluation and more importantly, for corrections that may be needed as the program or an emergency response unfolds. A detailed M&E framework is provided in Annex 4.

Type of evaluation	Broad purpose	Main questions answered
Baseline Analysis/ Formative Evaluation Research	Determines concept and design	Where are we now? Is an intervention needed? Who needs the intervention? How should the intervention be carried out?
Monitoring/Process Evaluation Outcome/Effectiveness Evaluation	Monitors inputs and outputs; assesses service quality	How are we doing? To what extent are planned activities actually realized? How well are the services provided?
Assesses outcome and impact	Assesses outcome and impact	How did we do? What outcomes are observed? What do the outcomes mean? Did the response make a difference?

Table 2

It is recommended that that in order to validate key knowledge, attitudes, perceptions, barriers and practices related to water, sanitation and hygiene, a formative study be carried out. Further, a midline and end of term assessment would also have to be carried out to establish effectiveness.

If an outbreak occurs and the formative and KAP have not been carried out, in order to obtain data on household and community hygiene practices it will be necessary to carry out household surveys using a random population sample. It can be a challenge to accurately measure some outcomes e.g. the proportion of people who are washing their hands with soap. Self-reports of hand washing often overestimate actual rates and so should be supported by structured observations and spot checks. Data should, therefore, be cross-checked using a variety of tools (triangulation). Some of them could include:

- Discussions with families
- Interviews with key informants
- Focus group discussions
- Observations
- Physical measurements

Responsibilities for monitoring and evaluation

Undertaking joint monitoring and evaluation with partners and across sectors in support of the programme is important. Clear indicators and means of verification would have to be identified and agreed upon. Standardized tools and formats for monitoring would have to be developed. Although different agencies might be involved in carrying out particular types of studies and evaluations, they should conduct the activiites in consultation with all stakeholders. This would ensure coherence and minimise duplication of efforts.

Involving communities in monitoring

Involving communities in monitoring activities can be a useful way to mobilise action. Monitoring plans can incorporate indicators that different participant groups can help to monitor. For example:

- Children could do structured observations outside the school latrines to identify hand washing rates.
- Communities could monitor the cleanliness of public latrines or the presence of hand washing facilities.
- Where chlorine levels in drinking water are monitored at the household level, community members could help to do this and the results could be shared with them as a way to trigger discussion on remedial actions.

It is important to instigate a system for on-going dialogue with communities to be able to actively listen to their concerns. This will help to identify problems with the response, such as groups that are not being reached, misconceptions and misunderstandings, abuses of power and poor quality interventions from partners. Standards of service provision both in the community and health settings should be made available publicly and every effort should be made to be open to suggestions for improvements. Regular discussions (weekly then monthly) with different participant groups are useful and these could be supplemented by the use of suggestion boxes, phone-ins or complaints mechanisms.

Target Indicators:

- Increase in the percentage of families and communities that practice safer water, sanitation and hygiene behaviours by end 2021
- Increase in the collaboration between various stake holding government ministries/ departments, development partners, media and civil society organizations at all levels to advocate for as well as address issues related to WASH and water-related disease outbreaks by end 2021
- Increase in the number communities actively participating in the management of WASH and water-related disease outbreaks in their areas by end 2021
- Increase in the percentage of families and communities who practice recommended water, sanitation, hygiene and treatment seeking practices during outbreaks by end 2021.
- Increase in the number of communities with active social norm mechanisms supporting outbreak management in high risk areas by end 2021

Annexes

Annex 1: Key Strategic Directions - Interventions

Promoting Social and Behavioural Change among Families and Communities

This segment would focus on using various means of communication to reach families and communities both directly through interpersonal / social contact and indirectly through mass and mid-media in order to help change knowledge, attitudes, beliefs, mind sets, perceptions and practices. Some of the key interventions in this segment would be:

1. Radio / Television Spots

Radio and Television spots would be developed and aired, focusing on promoting key water, sanitation and hygiene practices and the risks associated with not following them. The focus would however be on using radio as radio has greater penetration and reach as compared to television. Apart from that UNICEF has a history of working with radios in the past with the establishment of Listening groups by both women and men The spots would have a positive, motivational feel aiming to address both knowledge gaps as well as enhance self-efficacy among listeners in order to be able to try the recommended behaviours. The spots would also help in creating public visibility around the issue.

2. Radio Soap based on Entertainment-Education (E-E)

While the spots would highlight some key issues/ behaviours, there are several issues in water, sanitation and hygiene that require longer duration programming. Thus it is recommended that a weekly, 52-episode radio soap be developed and aired. The soap would be based on E-E principles making it informative, inspirational, engaging and entertaining. It would have real, believable characters that follow a trajectory of ups and downs but are ultimately able to achieve positive outcomes in their lives by adopting safer water, sanitation and hygiene practices. The radio soap would have an interactive component through phone-ins SMSs and panel discussions that would help people resolve queries that they have and also better engage with the programme. The linkage with the Listeners groups would facilitate community listening and mobilisation. Further, embedding messages in existing popular shows on radio and television could be explored.

3. Working with Cellular service providers

Mobile telephony has reached large parts of the country. With increase in network coverage area, substantial drop in the prices of handsets and call charges, even in very remote, rural areas people are nowadays using mobile phones. Further, in terms of the advertising space on television, a huge portion is occupied by advertising by cellular service providers. In recent times, there have been instances of cellular companies in many parts of the world, taking up public service campaigns as part of their corporate social responsibility as well as image building activities. It is proposed that the following could be done in collaboration with a cellular service provider as part of their corporate social responsibility as well as social business plan.

A. TV/Radio spots - The cellular service provider could support the development of co-branded television and radio spots mentioned above. It would facilitate the development of the public image of the company as a socially conscious and responsible company. The 'self-efficacy' route mentioned above would also aid in the process. The programme would benefit in terms of the huge exposure that would be generated through the airing of the spots on national as well as

county level channels/ community radio stations

B. SMS – Push SMS's could be sent to mobile subscribers with messages having a definite call to action such as "Am sure you have washed your hands with soap after doing *'pupu'* today right?". Further, recorded voice messages using a celebrity could also be used.
C. Outdoor activities such as mobilizing youth in market places, schools and colleges around the issue could also be promoted along with the company's promotional activities.

4. Outdoor Media and IEC materials

The IEC materials/outdoor media will support interpersonal communication and give credibility to the household and community level communicators. Outdoor media in the form of hoardings at the capital, county and district level at strategic locations and wall paintings at slum/ town/village level would be put up in order to create visibility as well as an enabling environment.

IEC Materials such as posters and banners would need to be developed and supplied to the counties / districts well in advance. The materials would need to be put up according to a predetermined micro plan at strategic locations and not on an ad hoc basis for ensuring maximum effectiveness. In the development of outdoor media and the IEC materials, the following principles will be followed:

Branding – All Outdoor media and IEC materials in support of the campaign would need to follow a branding guideline i.e. all materials should have the same 'look and feel'. It should not seem that the materials are not connected with each other.

D*esign* - IEC materials should be taken as part of an entire package and not seen on an individual stand –alone basis. The material would need to have recall value, brand identity, and easy recognition and association with the campaign. The materials would also need to be field tested before production

5. Community Drama

Community Drama as a local media can be effectively used to disseminate key information as well as promote behavioural change. Further, it would also prove effective in media dark areas to reach out to families and communities. Community drama is entertaining, engaging and if followed by a well facilitated discussion, can help promote deeper understanding and positive attitudes among audiences.

6.Town Criers'

Town Criers' serve as an important source of information for communities. They usually go from house to house making announcements about key events happening in the town/ village. They can be used to disseminate information about mobilisation activities happening in the community as well as key messages.

7. Working with Musicians

People listen to music and there are popular ones whose music is even adored more. These musicians could be partnered with to include themes on water, sanitation and hygiene in their songs.

8. Communication through Community Front Line Workers

Community level frontline communicators provide a great opportunity for carrying out interpersonal communication with families and communities. There is no better way to counsel, motivate and follow-up with families and communities than interpersonal communication as it provides a platform for two-way dialogue in which people can have their doubts, queries, concerns and needs addressed. Thus training community level workers on interpersonal communication skills in order to effectively communicate with families and communities would be carried out.

9. Communication through Nurses, Physician Attendants, Environmental Health Technicians and Doctors

Service providers are also a group that come in contact with families and are a respected and reliable source of information. Directives would need to be provided to them to discuss with clients their water, sanitation and hygiene behaviours while providing them clinical services as often, reasons behind illnesses lie in poor hygiene and unsanitary practices. Communication materials would also need to be provided to them to put up / keep for distribution in their facilities.

10. Communication through Teachers

Teachers form the basis of the education system. Issues related to infrastructure often do not have the kind of impact that the quality of a teacher has on the overall development and well-being of children. Children often look up to teachers as role models and try to emulate them. Thus promotion of good habits among children would be a key responsibility for the teachers. As part of the strategy, a great deal of work in envisaged with and through the teachers. Workshops with teachers on their role in promoting good sanitation and hygiene would be carried out. They would be provided with the necessary tools and materials to integrate components of sanitation and hygiene in the school learning environment. Teachers would also be motivated to meet parents of children and community elders/ leaders to encourage them to adopt positive behaviours.

11. Working with Children

Interventions for children often neglect the importance of involving the most important stakeholder – children themselves. Working with and motivating children can greatly contribute towards bringing about change within themselves as well as in their families and the larger community. Some activities with children proposed as part of the strategy are:

A. Peer Counsellors and Buddy Pairs

Peer groups play a very important role in shaping personalities as well as determining life preferences and choices. Sanitation and Hygiene behaviours among children are often influenced by peers. Teachers would be encouraged to identify (maybe on a rotational basis) 'Peer Counselors'- students with leadership skills and qualities to counsel/ follow-up with children. Other children would be grouped into 'Buddy Pairs' with each having the responsibility of looking after each other. (These would have to be done based on a consultation with children). 'Buddy Pairs' would keep motivating each other to practice recommended behaviours. The progress of these pairs would be monitored on a regular basis by the teachers as well as the 'Peer Counselors'Well performing 'Buddy Pairs' would be publicly acknowledged. It is envisaged that this system would make children feel that there is someone who if supporting/ following up/ monitoring him or her as often, the lack of constant support /follow-up and reminders could result in reversal to old practices. Also by being responsible for another child and helping the child maintain his or her positive behaviours, children would be able to help themselves sustain their behaviours as often, a good way of ensuring responsible behaviour is to give responsibility. The sense of, ownership, control and pride that this process would generate, would help children maintain their positive behaviours.

B. Special Classroom Activities

Teachers would be encouraged to carry out special classroom activities to promote sanitation and hygiene among children. Classroom activities such as discussion around vignettes or picture stories, stories with a gap, demonstrations etc. would need to be carried out.

C. School Health Clubs

Some schools already have health clubs where children are engaged in health promotion activities in their schools. This would need to be stepped up and children motivated to also carry out community mobilisation activities. Further, clubs for out of school children would also need to be formed.

12. Working with Community Influencers and Religious leaders

Almost all communities have individuals / institutions that community members look up to and trust. Identifying these individuals / institutions (some of them could be having religious affiliations) would need to be done and used strategically for community mobilization as well as need-based family – level engagement. Town / Village Heads would be important to consider in this regard. Further, religious leaders such as the Imams could be motivated to include discourses on water and sanitation in their sermons and religious preaching's as most religions talk about the importance of cleanliness and hygiene.

13. Working with Food and Water Vendors

Food and water vendors form an important link when it comes to preventing outbreaks of food and water borne diseases such as diarrhoea and cholera. They would need to be oriented on the need to follow hygienic practices in order to prevent outbreaks.

13. Showcasing Cases of Positive Deviance at the Community Level

In all communities there are cases of 'Positive Deviance' – norm changers who defy prescribed or accepted ways of behaving. In this context, these would be families which are practicing recommended water, sanitation and hygiene behaviours. Families which realize that not following these behaviours can seriously affect their health. Such families would be identified and given due recognition at their local community. These families would be asked to share their motivational cues as well as coping mechanisms with the community. This would motivate such families as well as other families to adopt positive behaviours.

Ensuring community engagement and participation

Community engagement and participation is a critical element behind the success of any developmental programme. Unless communities realize the importance of water, sanitation and hygiene and take the management of them into their own hands, the programme will not be successful. Hand pumps may be installed and toilets may be built, but unless the community uses and maintains them they will not sustain. So, more than the hardware, it is important to focus on community attitudes, perceptions, mind sets and motivation.

1. Rapport Building with the Community

Each community is diverse and different with varying community structures, power dynamics and means of functioning. Before one can begin work with a particular community substantial time and energy must spend in getting acquainted with the community, identifying community leaders/ influencers and power structures that might facilitate or hamper work. Care must be taken to ensure that leaders and / or contact points are truly representative of all sections of the community as communities are rarely, fully homogenous. If leaders/ contact points are not fully representative then, special efforts must be made to include those with a possibility of being left out of the process. Once rapport and trust has been built and leaders identified, work can commence in the community.

2. Participatory Community Needs Assessment

Communities need to be involved and engaged in identifying their problems as well as solutions for them. Rarely do solutions given from outside sustain as there is no ownership towards them.

Community needs assessment can be done using various participatory methods and techniques such as Transect walks, social mapping, timelines, seasonal calendar, Venn diagrams, focus group discussions, role playing etc.

3. Development of Community Work Plans

Once, the problems have been identified, agreed upon and the possible solutions defined, the community would have to develop a work plan to set the work in motion. The work plan would have to clearly identify the key tasks to be performed, timelines, responsibility, external support required and risks. Further, a participatory system of monitoring the progress of the plan would also have to be institutionalized.

4. Capacity building

Before people can start acting on the work plan, they might have some capacity building needs. These would have to be identified by the facilitators and addressed.

5. Formation of a Community Level Committee on Water, Sanitation and Hygiene

In order to oversee and manage the implementation of the plan, a committee comprising of community leaders and representatives from all sections of the community would have to be formed. The Community Health Development committees could also be used in this regard.

6. Ensuring Community Participation in the rollout

The committee would have to ensure that people contribute to the rollout of the plan through financial/ material /human resources, however small it may be. The initiative might be supported by an external agency, but contribution from the community for the execution of the plan would be vital. Further, once water sources/ latrines etc. have been constructed, the committee would have to also ensure the participation of people in their maintenance.

7. Creating new social norms

The committee would also need to implement certain checks and balances to ensure that people do not revert back to their old behaviour and are engaged in the programme. Social sanctions against people not following the recommended practices such as defecating in the open, not participating in the maintenance of community toilets, etc. would have to be implemented. Children's groups could play a key role in this regard, by acting as 'eyes and ears' of the committee and /or community leadership.

8. Engaging Women

Women are often the biggest sufferers when it comes to issues of inadequate water and sanitation facilities. Further, they are the ones who are involved in ensuring availability of water and maintaining hygiene in their families. Experience world over has shown that projects that focus on involving women have greater chances of success. Thus going by the fact, that the perceived need among women and their motivation is higher, community projects would have to ensure that women are provided significant roles in them.

Advocating and synergizing WASH and Outbreaks Management for effective engagement:

The purpose of this segment of the strategy is to mobilize government ministries/ divisions, media, civil society, implementing agencies and other stakeholders to converge and strengthen sanitation programming and policies. Further, it will help to bring focus and attention to the issue. In addition, to increase effectiveness and avoid confusion and redundancy, an effort to harmonise and synergise

activities for the different themes in WASH and water-related diseases outbreak.

1. Advocacy

While the government and partners have undertaken many measures on water, sanitation and hygiene, it has lacked priority among people. Amongst the general public as well as people's representatives, other social and economic issues have taken precedence. Therefore, the first step should be to *highlight water, sanitation and hygiene* at various levels, more prominently among communities, implementers and the policy makers and relevant office bearers. Political support is crucial to establish priority and commitment for the issue and ensure favourable policy. The endorsement by the Government would also help relevant office bearers to prioritize their plan of action. Advocacy will play a key role in ensuring that there is a positive environment in which the water and sanitation programme can be implemented effectively. The primary area for advocacy focus would be on working with partners (like stake holding ministries/ divisions, elected representatives, media, celebrities etc.) who can increase performance, visibility and credibility of the programme.

In order to extend the reach and impact of the strategy there should be a focused effort to bring in new partners who can increase visibility and impact. Partnerships can be initiated and be strengthened by making efforts to engage the partners actively in communication interventions. Advocacy at the national, county and district level will play a very crucial role. The thrust of Advocacy will be to establish the context and relevance of the cause. An effective advocacy campaign can also get support from media and can keep the issue alive for a longer period of time in the public domain.

Advocacy through media

Media is poised to play a significant role in improving the status of water, sanitation and hygiene. The media's reach is significant, and the investments made for advocacy through media are cost- effective. Media enjoys a high degree of credibility with the people and can be an effective partner for dissemination of information. Working with the media is also important from the point of view of averting possible negative coverage, which can be counter-productive. Some of the possible activities for media partnership are:

1. **Preparation of quality briefing package:** The starting point for media advocacy is often a good briefing note which presents the information correctly and with lucidity. The briefing note would help in keeping the media community informed about issues around water, sanitation and hygiene.

Workshop at the national and county level: In order to sensitize and orient journalists around the issue it would be important to have media workshops at the national as well as in counties. This would help in increasing informed coverage and reporting on the issue.

Working with the Ministry of Information,: The ministry already has links with the media and is the main source of information dissemination on governmental affairs. Thus they would be an extremely important ally in advocacy related work with the media.

Media visits: In order to bridge the gap between theoretical knowledge and ground reality, media exposure to the realities of water, sanitation and hygiene will help in keeping them interested in the programme. The result will be regular media coverage and media monitoring of the programme at the ground level. It is proposed that for each county, two to three media visits are organised every year. It is proposed that partner NGOs are identified for organizing field visits of journalists.

Media Fellowships: There are many keen journalists who are willing to take some time off, travel with a purpose, and bring back a rich haul of stories for their newspapers. This can be made possible through media fellowships. Media fellowships will involve the signing of a Memorandum of Understanding between UNICEF and concerned media house. The MoU will specify the nature of grant, the conditions governing it such as how many days the journalist will travel for, which subject or geographic areas he/she will cover and how many stories he/she will come back with. The paper will be committed to publishing at least a certain number of stories. A panel comprising editors, UNICEF and Government will judge applications and award fellowships.

Media Awards: A media award announced for a specific subject area leads to a spurt in activity among all media houses. A UNICEF award to journalists for effectively covering water, sanitation and hygiene issues is likely to lead to increased media interest. The awards could be announced in partnership with the Ministry of Health or the Ministry of Information Culture and Tourism. An award function at the national level will be an opportunity to discuss the importance of water, sanitation and hygiene and its connection with child survival and development as well as recognize the work of journalists. A panel comprising UNICEF, Government and Editors will be constituted to judge the awardees, which itself will strengthen the partnership for the water, sanitation and hygiene programme and renew editors' commitment to the programme.

Programmes focusing on water, sanitation and hygiene could be supported on radio and television. This will help in bringing the issue in the public domain, generating awareness and action. This would also motivate the political leadership to take the issue up as a priority. Success stories could also be broadcast. News channels can be roped in to do dedicated programming on water, sanitation and hygiene. It could be a series in which each episode or a cluster of episodes deals with water, sanitation and hygiene issues. Regular columns or articles in leading dailies would also be a way of bringing the issue into the limelight.

B. Advocacy through Celebrities

Celebrities add great credibility as well as visibility to any programme. Celebrities would be particularly useful for image building and visibility. They could also visit few sites to monitor the activities and this could be covered by the media to raise the profile as well as seriousness of the programme.

C. Advocacy with policy makers

Mailers on the issue of water, sanitation and hygiene could be sent to the policy makers and implementers. The mailer would reiterate the context and relevance of the issue in the present scenario. It would also underline specific roles and responsibilities vis-à-vis partners. Screen Savers on water, sanitation and hygiene could also be developed and installed on the computers of political leaders and decision makers in order to buy ‘mindshare’ and assist the process of engaging them in the issue. Workshops with senators and legislators on the issue would also help in generating positive action.

D. Advocacy with State / District Administration and relevant authorities responsible for water, sanitation and hygiene

Getting a buy-in and partnership with authorities at the county and district level would be crucial in order to ensure proper and smooth implementation of the programme. Developing a joint agreed- upon plan of action with communication related components incorporated would be essential. Thus coordination meetings with District Commissioners, Health Officers, Environmental Health Officers, WASH coordinators, Community Health Service Directors, Health Promotion/Officers focal points would

need to be carried out.

F. Advocacy with Partners for Coalition building

Partners from all quarters such as INGOs NGOs, community networks, Religious organizations(like the all faith association), and occupational groups etc. would need to be brought into the fold in order to help in the process of mobilization through their networks. They could also be utilized to support county/ district-specific social mobilization activities. Once they have been identified, orientation programmes would need to be carried out for them to clearly lay out specific roles and responsibilities of each.

G. Sensitization / Training of County / District Level staff

Since at the county and district level, there are no dedicated resources for health promotion, it would be critical to sensitize representatives from stake holding ministries on the importance of water, sanitation and hygiene promotion and their respective roles and responsibilities in relation to the same.

H. Advocacy with Municipal authorities /market owners associations / vendor associations

Solid and liquid waste at markets places attracts breeding of flies and vermin. Municipal authorities/market owners associations/vendors associations need to give priority to maintaining hygienic conditions at market places. Advocacy with these groups through meetings and workshops would be essential to get their commitment around the issue.

2. Setting up / Strengthening Coordination Mechanisms for Health Promotion at National / County and State Levels

Under the leadership of The Ministry of Health, the Health Promotion division would coordinate the working of a committee on water, sanitation and hygiene promotion, with representation from ministries / departments. Similar committees would also need to be formed at the county and district levels under the leadership of the county superintendent and district commissioner with support from the county and district health officers and health promotion focal points. These committees should meet at least every quarter to plan, monitor and review progress.

Harmonisation:

Intervention activities such as training or communication materials design and distribution must be planned in a way that takes into account the inherent difference of approaches and messages for different diseases and WASH issues.

Annex 2 : Preparedness & Response Phases

1. Enhancing Coordination through the Sub Committee on Health Promotion

Effective prevention, preparedness and response for cholera require coordination and communication across sectors and at all levels. The following figure highlights the potential impact of a rapid public health response, including coordination and pro-active communication, to reduce the size and scale of an outbreak.

The purpose of coordination would be to:

Ensure coherence of the prevention, preparedness or response activities through the development of plans and agreement on approaches, channels, messages and materials.

- Avoid gaps and duplication
- Make the most effective use of partners and resources
- Undertake
- Effectively share information
- Build capacities
- Mobilise resources
- Instigate timely monitoring and reporting
- Develop a common, agreed upon plan of action

Ideally, coordination for preparedness activities should be included as part of long- term structures in water, sanitation and hygiene. Under the leadership of The Ministry of Health, the Health Promotion division would coordinate the working of the sub- committee on health promotion, with representation from ministries / departments such as Community Health, , Nutrition, Education, Internal affairs, Information and development partners. It is recommended that the same committee that is created for Water, Sanitation and Hygiene promotion be used for outbreak preparedness and response as well so that it can be integrated into the larger initiatives around Water, Sanitation and Hygiene promotion.

Similar committees would also need to be formed at the county and district levels under the leadership of the county superintendent and district commissioner with support from the county and district health officers and health promotion focal points. These committees should meet at least every quarter to plan, monitor and review progress.

2. Development of an action plan

The development of an inter-sectoral action plan is the first step in ensuring effective strategy implementation. The plan would define specific objectives, approaches, resources, and actions to be taken to reach the goal according to the strategy. It aims to:

a. Provide useful, consistent and timely information to participant groups on measures to be taken to protect themselves and access services as and when required
b. Mobilize key stakeholders including government departments, civil society, media and affected communities to contribute to addressing the outbreak.
c. Provide timely information to people, media and key stakeholders on the course of the outbreak and the measures being taken to address it.
d. Provide a platform for transparent feedback and suggestions from affected communities with regard to the effectiveness of AWD interventions.

3. Coordination across borders

Sudan shares a long border with its neighbours. Hence coordination will be required between government authorities at national and local government levels with these countries to prevent the spread of AWD across borders. The main linkages are likely to be between the ministries and authorities responsible for health. Coordination may be undertaken to develop joint surveillance and early warning plans and communication channels and procedures.

4. Investing in research

Designing an action plan should begin with a formative study and assessment of the context in which cholera occurs including the people involved, those who produce the information, those who disseminate it and those who receive it, resources available and any barriers to implementation. The study identifies the knowledge, attitudes, perceptions, beliefs and practices of the people involved on the issue and helps to identify the different means for bringing about change. A more detailed assessment of specific hygiene practices, motivations and beliefs in relation to cholera will also be required and ideally should be carried out before a cholera outbreak. However on-going assessment, monitoring and listening to communities will also be vital during the outbreak

The assessment should try to identify the:

a) Key practices that are putting people at risk of cholera
b) Alternative or safer practices that would help to mitigate cholera
c) Barriers that prevent people from adopting safer practices
d) Key motivating factors that will enable change
e) Preferred communication channels for different participant groups
f) Particularly vulnerable or high risk groups

The assessment process involves working with and listening closely to the different participant groups. Focus group discussions and interviews with key informants are the key assessment methods for understanding what is happening in the affected population. Such 'qualitative' methods also aim to understand why something is happening and what can be done about it. It may also be useful to undertake a simple household questionnaire survey to obtain some 'quantitative' data on the coverage of specific practices in order to monitor the effectiveness of communication efforts. Even where an in-depth assessment has been carried out before the outbreak, it will still be necessary to identify a specific team to conduct a rapid assessment in the early stages of a large epidemic to review what is known and to amend the draft communication strategy and plans. Preparing a monitoring and evaluation (M&E) plan would be important as well. M&E enables to track progress and impact at given periods of the emergency response in terms of message and channel reach, resource use and most of, all in terms of desired results.

5. Identifying communication channels

It is advisable to use both interpersonal methods and mass media methods during a AWD outbreak. The mass media (e.g. radio, television, text messaging via mobile phones) helps quickly inform large numbers of people but they often do not provide the opportunity for feedback. Working with communities through a process of dialogue, can help identify the barriers to change and specific cultural and social beliefs and practices which might act as impediments. Sustained dialogue can help bring about community involvement and participation in addressing the outbreak.

6. Standardization of messages, preparing action oriented communication materials and keeping them ready for dissemination

Sample messages and materials that have been pre-tested would have to be developed, produced and prepositioned in advance. These would have to be stocked at the county/ district level, so that during an outbreak they can be immediately distributed in the field. This will save precious time and resources. In the eventuality that new materials need to be produced and disseminated, it would also be helpful to create a database of graphic designers, media producers, radio /TV Channel contacts etc. for SEP

A. Developing messages

One-way messages, alone, may not be effective in bringing about behaviour change. However, all those involved in cholera prevention and response should be providing consistent information to the participant groups in order to avoid confusion and misunderstandings. Different agencies need to coordinate so that there is consistency in the messages that are reaching communities. Agencies need to come together and draft a common set of messages before developing any communication materials. It might also be helpful to decide which partner is going to develop which kind of materials in order to avoid duplication of efforts and promote sharing.

B. Developing audio visual aids

Materials such as banners, leaflets, posters, flipcharts, flashcards, films and interactive materials such as games and activities can be very useful for health workers, community workers or volunteers in carrying out effective dialogue with families and communities. The materials also help in reducing 'transmission loss' while communicating with people as they also serve as reference for the communicator. Audio-visual aids such as TV and Radio spots are also useful in reaching out to large number of people. However, aids need to be rigorously pretested to ensure that they are communicating what was intended to be communicated. Sometimes, instead of reinventing the wheel, it might be helpful also to review existing materials and adapt/modify them as required. Further, communications materials must be seen as one of the means towards reaching the end and not something that can guarantee change on their own.

7. Training service providers / community level workers in interpersonal communication skills

In times of stress and trauma caused by an outbreak, health workers etc need to possess and maintain good interpersonal communication skills to inform, motivate, counsel and encourage affected people and communities. They would also need to know how to deal with the distress and anxiety experienced by people who come for assistance as well as among themselves. Thus training them on interpersonal communication would be an important preparatory activity. This could be combined with the suggested interpersonal communication skills training for general water, sanitation and hygiene promotion.

8. Engaging communities in preparing and planning for emergencies

The human rights-based approach stresses on participatory approaches that engage communities in planning, implementation and monitoring processes. This means that programs should build on what people already know and that their social and cultural strengths are recognized. However, communities are not homogeneous. Vulnerabilities related to age, gender inequalities, ethnicity, caste, socio-economic status and disability, are factors that may affect people's ability to take part in decision-making processes. Supporting communities in areas particularly vulnerable to cholera, to develop community action plans themselves is a key preparedness activity. The Community Health /Development Committees could be instrumental in developing and supervising the implementation of the plan.

Community action plans could detail:

a) Specific actions to improve water, sanitation and hygiene practices of different groups in the community (e.g. Tippy – Tap's).
b) How to make sure that all community members know what to do if someone in their family or neighbourhood gets AWD.
c) How to support people in seeking services
d) Where an ORS corner could be located and who would manage it in the event of an outbreak.
e) What precautions would be taken at mass gatherings such as funerals and weddings?
f) What improvements could be made to markets or public institutions such as schools?
g) Who is available to help and what communication will be necessary in the event of an outbreak e.g. with authorities, health personnel etc.

Response Phase

1. Developing a communication protocol and partnerships for collaboration

When an emergency strikes, it is likely that there would be a great deal of anxiety, confusing formation emerging from multiple sources. This would be expounded if there is weak coordination among different partners serving communities. A plan would need to be developed with key partners, which outlines how communication efforts will be coordinated, with clearly defined roles and responsibilities. Agreement on how information will be managed should be clear. This should also help to prevent and manage rumours, misinformation and unwanted results that often happen during outbreaks. The subcommittee on health promotion for cholera should meet frequently (at least weekly) during the outbreak period. During the peak of an outbreak, the task forces or committees managing the direct responses, such as at the county and district level, will need to meet daily to discuss the progression of the cholera, progress in the response and gaps and to prioritise actions.

2. Participation in sectoral rapid assessments When health, water and sanitation assessments are conducted in the initial phase of an emergency, it is critical that the assessments also identify any high risk practices that have implications for communication among affected caregivers and communities. This information is critical to map out the detailed communication responses. Further, a clear understanding of the geographical areas that need priority intervention is essential as it will help focus and target communication initiatives.

3. Conducting a rapid appraisal of communication channels and resources Soon after an outbreak is announced, efforts would need to be made to find ways to reach the vast majority of affected people quickly with information and key messages. Hence, Assessing the availability and reach of media and other communication channels would need to be carried out (in many ways, it might be a validation of the channels identified in the preparedness plan). Along with mass media approaches, low cost and low-tech communications systems might be the most practical and effective during such difficult circumstances. Megaphones, car battery-operated public address systems, community radio (also powered by battery or generators) would be good ways to quickly disseminate messages to affected families and communities. Public gatherings and community or camp meetings would provide further opportunities to quickly share information. Choosing more than one communication channel to help reinforce the information would be important. Beyond using mass and small media, interpersonal and participatory community based media are very useful channels to lead communication efforts. To choose the right mix of channels in the different phases of an emergency response, the following need to be considered:

- How do affected families and communities get and share information?
- Who are seen as trusted and credible sources of information in the community?
- Which groups have access to mass media and other sources of information and which groups do not?
- What traditional and local means of communication are available?

4 Revisiting and activating the detailed communication plan

a) Activating coordination with stake holding divisions/ ministries and partners at national, county and district levels
b) Engaging with the media
c) Developing a media plan for mass media initiatives and a dissemination plan for print and AV materials
d) Refresher/ orientation of community workers as required
e) Deployment of animators in affected areas
f) Activating community level structures for community mobilization activities- community meetings, household visits, drama shows, film shows, megaphone narrowcasts, demonstrations, communication material distribution
g) Developing a monitoring and evaluation plan

5. Focusing on re-establishing existing behaviours and norms

In the initial outbreak phase, the focus would be on re-establishing positive behaviours that existed prior to the outbreak. Focus would not only be on individual behaviours and actions, but seeking to re-establish positive social and cultural values that might exist. However, depending on the situation, emergencies might also provide opportunities to promote new behaviours.

6. Forging additional alliances for communication

The outbreak might provide opportunities to build additional alliances to include relief workers, service providers, journalists and others so that they are able to support directly desired behaviours of affected people. Committees at all levels would have to actively search for such potential alliances

7. Facilitating community and children's participation

Through already established community level committees and structures, pro-active efforts would need to be made in creating opportunities for affected families and communities, including children and young people, to participate in the response. Particular care would have to be taken to include especially vulnerable groups, whether this requires inviting representatives from children and young people's organizations, women representatives, religious leaders, asking vulnerable populations nominate spokespersons or advocating with community and local authorities to consult affected communities.

8. Working with the media

Establishing a good working relationship with the media and with the Ministry of Information, Cultural affairs and Tourism before the outbreak will be of great importance as timely dissemination of information to communities during an outbreak is of the essence in order to control the outbreak. Along with being timely, the information also needs to be accurate as news of an outbreak can lead to a lot of tension and anxiety among people. Thus, as a priority, decision makers should come together and decide on what to communicate to the media. The communication would need to be frequent and effective.

Although the media might sometimes end up distorting or misrepresenting facts, this more often than not happens due to lack of clear communication with them. Once, a good working relationship has been established with them, they can be a very good and powerful ally. The first step in ensuring a constructive relationship with the media is to have a designated, skilled spokesperson who can represent the situation on behalf of the government and partners in relation to cholera. Authority would need to be delegated to this person for holding regular media conferences and issuing press releases. Many countries have a public service requirement for radio / TV stations, through which the government can channel announcements at no cost. For example, in Tanzania the government regularly announces outbreak news during a regular weekly slot on one radio station. Key information on how to prevent cholera and where to go for treatment should be broadcasted, as well as information on the status of the outbreak and what different stakeholders are doing.

9. Listening through Dialogue and Tackling rumors

During an outbreak, it would be crucial to set up a rumor tracking system to identify, investigate and address misperceptions or misunderstandings. This could be done by developing a feedback mechanism through volunteers and community level service providers, who on a periodic basis could report back on issues in the community. This would need to be incorporated into the regular monitoring system. Further, a strong relation with the media would also be very important to deal with rumors.

10. Reaching the poorest and those in particularly vulnerable, hard to reach or special circumstances – Equity perspective

Particular attention should be paid to people who are more vulnerable or marginalised in a given context or those who are harder to reach through special outreach activities. People who are vulnerable, harder to reach or living in special circumstances, may be living in extreme poverty, may be malnourished, may have a long-term condition such as HIV/AIDS or may live on the streets. They may also be living in child, elderly or female headed households, or have limited mobility.

11. Dealing with psychosocial impact

AWD can have a variety of psychosocial impacts. People may have strong feelings of fear and insecurity and helplessness during an outbreak; they may be stigmatised if they seek treatment or suffer from severe diarrhoea; their suffering might be expounded by the fact that they might not be allowed to undertake usual funeral and mourning practices. The supportive attitude of medical /nursing staff and community workers is essential in helping to reduce the stigma associated with cholera. Thus, they must be sensitised on this issue. Further, as part of the communication activities, efforts will have to be made for having non-judgmental discussions around cholera and involving community leaders to help reduce stigma in the community.

Annex 3 : Water-Related Vector-Borne Disease Outbreaks: Prevention and Control

Many types of disease virus is transmitted to humans by infected mosquitoes, most commonly from the *Aedes* species: the same mosquito that spreads Chikungunya, Yellow fever, Zika and Dengue viruses[5]. The proximity of mosquito vector breeding sites to human habitation is a significant risk factor for chikungunya as well as for other diseases that these species transmit. Prevention and control relies heavily on reducing the number of natural and artificial water-filled container habitats that support breeding of the mosquitoes.

Aedes mosquitoes usually bite during the day, peaking during early morning and late afternoon/evening.

There are 2 types of *Aedes* mosquitoes known to be capable of transmitting Chikungunya virus:
-In most cases, Chikungunya is spread through the *Aedes aegypti* mosquito in tropical and subtropical regions;
-*Aedes albopictus* mosquitoes can also transmit Chikugunya virus and can tolerate cooler temperatures;
- Both species are found biting outdoors but *Aedes aegypti* will also feed indoors.

A crucial element in vector-borne diseases is behavioural change and **eliminating mosquito breeding sites is key to outbreak prevention and Control**

- Vector control strategies should address all life stages of the *Aedes* mosquito from the egg, to larva and adult. Community engagement is essential for these interventions:
  - Elimination of breeding sites and eggs/larvae/pupae in standing water (e.g. cleaning roof gutters, clean-up campaigns, etc.);
  - Targeted residual spraying of adult mosquitoes (in areas known to be resting sites for *Aedes* mosquitoes) and space spraying when there is an outbreak.

  A study shows that an early use of a combination of massive spraying and mechanical control (like the destruction of breeding sites) can be efficient, to stop or contain the propagation of Chikungunya infection, with a low impact on the environment[6].

Additionally, personal preventive measures such as clothing minimizing skin exposure, use of repellents, as well as windows screens and air conditioning are recommended to avoid mosquito bites. The use of insecticide-treated bed nets is limited by the fact that ***Aedes*** mosquitos bite during daytime.

But, for those who sleep during the daytime, particularly young children, or sick or older people, insecticide-treated mosquito nets afford good protection. Mosquito coils or other insecticide vaporizers may also reduce indoor biting.

Malaria:

Malaria is caused by *Plasmodium* parasites. The parasites are spread to people through the bites of infected female *Anopheles* mosquitoes, called "malaria vectors."

Anopheles mosquitoes lay their eggs in water, which hatch into larvae, eventually emerging as adult mosquitoes. The female mosquitoes seek a blood meal to nurture their eggs. Each species

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[5] 2018. WHO: *Managing epidemics: key facts about major deadly diseases*

[6] 2010, Dumont Y. and Chiroleu F. Vector Control for the Chikungunya Disease

of *Anopheles* mosquito has its own preferred aquatic habitat; for example, some prefer small, shallow collections of fresh water, such as puddles and hoof prints, which are abundant during the rainy season in tropical countries.

Partial immunity is developed over years of exposure, and while it never provides complete protection, it does reduce the risk that malaria infection will cause severe disease. For this reason, most malaria deaths in Africa occur in young children

Prevention: Vector control is the main way to prevent and reduce malaria transmission. If coverage of vector control interventions within a specific area is high enough, then a measure of protection will be conferred across the community. Sleeping under an insecticide-treated net (ITN) can reduce contact between mosquitoes and humans by providing both a physical barrier and an insecticidal effect.

Annex 4 Baseline Information:

WASH and Water-Related Diseases Outbreaks in Sudan - Baseline Information:

- Only a third of the population have access to basic sanitation, which only limited improvement during the last decade. Only 0.8% of the population have access to sewerage services - all in Khartoum Municipality. As a result, nearly a third of households (10.5 million people) continue to practice open defecation. There are wide disparities in sanitation access between urban (57%) and rural (22%) areas. The use of improved sanitation is particularly low in the Kordofan and Darfur States, where coverage is generally less than 20%.
- The safe disposal of animal faeces is another challenge. Households often have one animal per household member living in the same house structure as the family members. This is particularly a problem in IDP camps where space is limited.
- Nationwide, 68 per cent of households in Sudan have access to basic water, however there are disparities in access between rural (64%) and urban (78%) populations and between states. Only one third of households having access to safe water in Red Sea, White Nile and Gedarif states compared to 90% access in Khartoum and Northern States. An estimated 13 million people are still using unimproved drinking water sources.
- There are an estimated 32,233 improved water sources in Sudan. Urban water treatment plants have a functionality rate of 95%, while functionality varies from 69% for hand pumps to 75% for motorized ground water facilities. Lack of funding, inadequate management of water services, poor maintenance and low community engagement are among the main reasons for the low functionality levels.
- About 32% of the population is forced to use unsafe water from unimproved water sources[7]. Most are surface water sources, while some are groundwater (open wells and contaminated aquifers). Chemical and bacteriological contamination is common. Industrial, domestic and commercial waste (mainly excreta, urine and grey water) is washed into surface water bodies or injected into groundwater aquifers. National and State Government regulations to prevent these pollutants exist, but they need to be enforced.
- Access to both improved sanitation and improved water sources is very low. Only 28% of households have access to sanitation *and* water (49% in urban and 19% in rural areas). Service access is correlated with the education and wealth of households.
- Sanitation needs to be safely contained, transported and eventually treated to meet the SDG-6.2 indicator.
- Hygiene practices are low in Sudan, where less than half of households have a specific place for hand washing, and only a quarter have water *and* soap at their hand washing station (34% in urban and 22% in rural households). There is also a large disparity between States ranging from 55% in North Darfur to 2% in Gedaref. Higher levels of education and wealth correlate with improvements in hygiene practices.
- Menstrual hygiene management has not received much attention in Sudan, aside from the provision of pads in humanitarian contexts and in some schools. Globally there is an increased focus on menstrual hygiene management as one way to reduce the barriers to girls' attendance at schools. More efforts need to be made in 2018-2021 to better understand the experiences of girls and women in Sudan and to break the taboo around menstrual hygiene.

[7] MICS 2014

- According to the National School Health Strategy, 75% of schools have access to improved water sources, while only 35% have a reasonable number of improved latrines. Most latrines in schools are unclean and have no water source. Only 20% to 25% of schools have a proper place for hand washing with soap and no school has a programme of group hand washing.
- Low access to improved sanitation and water and poor hygiene practices contribute to the high prevalence of diarrhoeal diseases and malnutrition, especially among children under-5. Sudan is among the 15 countries in the world with the highest incidence of child deaths due to diarrhoea and pneumonia. The strong correlation between the states' increased use of basic sanitation and water facilities and the reduction of medium to severe stunting level for under-five children has been well documented in Sudan
- Adult men are the main fetchers of water in urban and wealthier households, while the main fetchers of water in rural and poorer households are women. In six out of 17 states, more than 60% of households depend on women and girls to collect water with the highest percentage in Central Darfur where 81% of the households depend on women and girls to collect water
- About 70% of the households do not use any means of water treatment. Only 22% let the water stand and settle, and 4% strain the water through a cloth. Most critically, only 4% of those using unimproved water treated it.
- Protracted conflict and other humanitarian emergencies are severely affecting Sudan's ability to provide WASH services. There are currently more than 2 million IDPs in Darfur and about 200,000 South Sudanese refugees in four states who are in need of continuous support for the operation and maintenance of their sanitation and water

As reported in MICS 2014, several proxy indicators on low sanitation & hygiene practices, such as HH access to improved water sources (68%), HHs with improved sanitation (33%), HHs with dedicated places for hand washing (26%) and HHs with soap or other cleansing agent (55%), are all relatively low. Also, there are couple of unsafe behaviours reported that increase the risk and contamination of water-related disease such as AWD. For example, only 53% of 0-2 children's faeces is disposed safely (which may indicate that many caregivers perceive children's faeces as not dangerous) and 42.5% of CU5 with reported diarrhoea were brought to health care facility or provider (indicating low adherence to timely care-seeking behaviour)

With this reported low access to safe water & sanitation commodities, low prevalence of hand washing and unsafe hygiene practices, there is also a concern regarding behaviours related to food preparation & storage and the preparation of AWD victim's corpse (especially as some religious/cultural practices encourages to empty the intestine of dead person before burying); however, such data and others such as acceptance of chlorinated water taste, how the food is handled. The critical times for hand washing practice and other important data are lacking and this highlights the need for rapid formative research to be carried out. It is for this reason that this strategy is being developed and one of its major purposes will be the generation of evidence to support/ validate action.

Water and Sanitation Related Diseases

Water may carry causative agents (pathogens) of communicable diseases of human beings or provide the right environment for the breeding and propagation of their vectors. Common water-based (water

and sanitation-related) diseases can be classified into four major categories relating to the path of transmission, as follows[8]:

Water-borne diseases

Water-borne diseases are the diseases that are transmitted through drinking contaminated water. These diseases include cholera, bacillary dysentery, shigellosis, typhoid fever, salmonellosis, hepatitis A, hepatitis E, leptospirosis, poliomyelitis, campylobacteriosis, and gastroenteritis due to other viruses. The basic intervention to interrupt transmission is through proper treatment and adequate chlorination of drinking water.

Water-washed diseases

Water-washed Diseases: are diseases due to the lack of proper sanitation and hygiene. Water-washed (water-scarce) diseases, such as polio, Ascariasis and Ancylostomiasis. The basic interventions to interrupt transmission is achieved through proper attention to effective sanitation, washing and personal hygiene.

Water-based diseases:

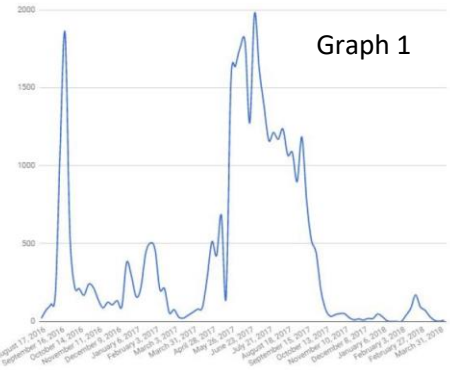
Water-based diseases are infections transmitted through an aquatic invertebrate organism. These diseases include: Amoebiasis, cryptosporidiosis, giardiasis, schistosomiasis and dracunculiasis (guinea worm disease). The principal intervention is through filtration of water.

Water-related vector-borne disease:

Water-related vector-borne diseases are diseases transmitted by insects that depend on water for their propagation e.g. malaria, dengue, chikunguna, zika, lymphatic filariasis, and onchocerciasis.

Epidemiology of the 2016-2018 AWD outbreak:

During the past 50 years, Sudan has faced several outbreak of Acute Watery Diarrhea (AWD) such as in 1966, 1970, 1972, 1980, 1981, 1985, 1988, 1999 and 2006-2007. The current outbreak that took place from August 2016 to April 2018 is unprecedented an affected all 18 states. During this outbreak, AWD affected 36'962 persons and caused the death of 823 persons, representing an attack rate of 0,1% and a case fatality of 2,25%. Graph 1 shows the epidemiological urve from August 2016 to March 2018.



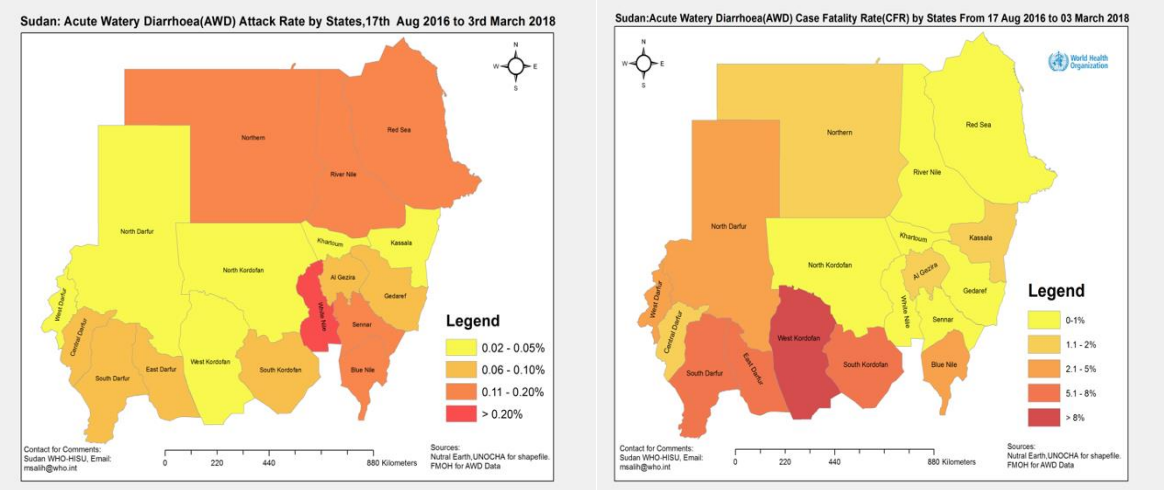
Graph 1

As shown in the left map below, the most affected states, in terms of attack rate, are White Nile, Sennar and Blue Nile. Similarly, on the right hand side, the most affected states are West and South Kordofan as well as South and East Darfur[9]. The outbreak affected all demographics, with

[8] 2018. WHO: *Managing epidemics: key facts about major deadly diseases*

[9] The magnitude of the 2016-2018 AWD outbreak surpassed the planning scenario of the MoH which predicted 0,05% attack rate for 21'900 cases in 12 states.

females constituting 58% and children below 5 years of age accounting for 15%[10].



Spread: According to Federal Ministry of Health (FMoH), the AWD index case was reported in August 2016 in the Eastern state of Kassala with origin from Ethiopia. In September 2016, AWD spread to the other eastern states of Blue Nile, Gedarif and Gezira through the Nile rivers and it finally reached Khartoum. From January to April 2017, AWD further spread to Red Sea, Northern state and White Nile, where the highest number of cases and highest attack rate were recorded. During May and June 2017, the period of Ramadan and Eid, AWD spread to the remaining states of Sudan in Kordofan and in Darfur.

Chikungunya Outbreak:

Recently, Eastern Sudan has experienced an outbreak of Chikungunya. The first case of chikungunya reported in the Sudan was from the Red Sea state on 31st of May 2018 in Suakin locality. The outbreak extended to affect other States; namely, Kassala, Gedarif, River Nile, South Darfur and West Darfur states, with total cases of more than 40,000 as of 07 March 2019. Entomological survey was carried out during this year showing that the Aedes aegypti is prevalent in almost all the states that put other states at risk of spreading of the disease.

Mosquitos from the genus *Aedes*, specifically *Aedes aegypti* and *Aedes albopictus*, are responsible for the transmission of many arboviruses worldwide. *Aedes aegypti* transmits viruses causing Dengue, Chikungunya, Yellow Fever (YF), West Nile, Rift Valley Fever (RVF) and Zika viruses. *Aedes aegypti* is widely prevalent in all over the eighteen states in Sudan although the prevalence of *Aedes aegypti* is relatively low in Khartoum and Northern state. The *Aedes* mosquito breeds in domestic settings such as ''Zeer'', flower vases, water-storage containers, air coolers, etc. and peri -domestic areas such as construction sites, coconut shells, discarded household junk items (tyres, plastic and metal cans, etc.).
Contributing factors for transmission of Arboviral and Hemorrhagic Fever in Sudan includes, but not limited to the following:

- Widespread prevalence and high density of the vector, *Aedes aegypti*, in all 18 States but Khartoum and North States in Sudan.
- Favourable climactic conditions (i.e., tropical rainforests and high humidity).
- A large primate population to sustain foci of sylvatic transmission of Yellow Fever e.g. Nuba mountains of South Kordofan and Blue Nile States.

[10] The latest epidemiological data are reported by MoH and WHO and cover the period of August 2016 to March 2018.

- A large population of unvaccinated people against Yellow Fever.
- Nomadic population traversing South Kordofan and South Sudan.
- Emergence of Yellow Fever outbreak in neighbouring countries.
- Porous borders with countries reporting arboviral and haemorrhagic fevers.
- Sea ports serve as entry point for Dengue and Chikungunya (e.g. Port Sudan and Suwakin).

Administratively, Sudan is divided into 18 States; the declaration of outbreaks is the responsibility of the Federal Ministry of Health (FMOH). The response to major outbreaks is a shared responsibility between the FMOH and State Ministry of Health (SMOH).

The UN agencies (UNICEF, UNFPA, UNHCR, OCHA, including WHO, NGOs, and donors provide technical, financial and logistical support to augment the FMOH outbreak response operations.

While WHO-UNICEF-FMoH's **Comprehensive Epidemic-Prone Diseases Outbreaks Preparedness and Response Plan (2019-2021)** put in place a multi-sectorial preparedness and response plan for all diseases, this document will, specifically, provides clear steps to improve the public awareness on appropriate behaviour practice and preventive measures for WASH and water-related disease outbreak prevention and management.

Annex 5 National and State Plans

Annex 5a

National Level Implementation Plan for WASH communication and AWD Response and Prevention of AWD															
Strategy Component	**Activities**	2019				2020				2021				Budget	Responsibility
Planning/Coordination & Research	Formative study on WASH (including /AWD)		**x**												
	KAP baseline		x												
	KAP midline							x							
	KAP end line												x		
	Formation of C4D Coordinating Committee under the MOH		x												
	Supporting State to develop county communication plans		x												
	Quarterly meetings to review implementation of plans		x	x	x	x	x	x	x	x	x	x	x		
	Establishing linkages with the Health Ministries in Eritria, Ethiopia, South Sudan, Central African Republic, Chad and Libya to develop joint surveillance and early warning plans and communication channels and procedures		x												
	Carrying out mock drills to test communication preparedness and response to AWD		x				x				x				

Advocacy	Preparation of briefing package for media		x												
	Media Workshops		x				x			x					
	Media Visits														
	Programmes on WASH, /AWD on Radio/TV	x	x	x	x	x	x	x	x	x	x	x	x		
	Workshops with Paliamentarions														
	Workshops with State /District Administration		x			x				x					
	Organizing a national summit on WASH to bring relevant partners together and form a consortium														
	C4D actively participates in major national forum on WASH														
	Advocacy workshops with market owners associations / vendor associations		x				x				x				
	Identification and orientation of media spokesperson for media interaction during outbreaks		x												
Mass Media	Development of 4 TV & Radio spots on: WASH, Prevention and Treatment of Diarrhoea		x												
	Airing of the spots on select television channels and through community radio networks in all State		x	x	x	x	x	x	x	x	x	x	x		
	Production of a 52 episode radio Edu-Entertainment programme on WASH including components of /AWD			x											

	Airing of the radio soap through national radio and community radio stations in all State				x	x	x	x	x	x	x	x	x		
Outdoor Media	Entering into a partnership with a national level drama group to develop performances around WASH issues.		x												
	Providing technical support to drama groups in the State through the national level group to develop and execute their performances		x						x						
	Development of film on key WASH behaviours & /AWD along with user guidebook for screening at video parlours														
Interpersonal Communication	Developing a module on training of teachers for WASH promotion in schools		x												
	Developing a group of trainers to train the teachers			x											
	Developing a training module to train Front Line Workers and Volunteers incuding adolescents on IPC skills														
	Developing a group of trainers to train Front Line Workers and Volunteers incuding adolescents on IPC skills		X	X											

	Development of guidelines for orientation of barbers, market sellers, etc		X											
	Development of key message guidelines for Town Criers		X											
Community Participation and Ownership	Development of module on participatory communication techniques for engaging communities		x											
	Identification and establishment of partnerships(State specific)													
	Capacity building of partners on participatory communication techniques		x											
	Supporting State to implement the program		x			x				x				
Development of communication materials/ tools	Review existing communication materials,; identify gaps and and replace		x											

Annex 5b: National Level Communication Plan for AWD Communication Response										
Activity	Month 1				Month 2				Budget	Responsibility
	w 1	w 2	w 3	w 4	w 1	w 2	w 3	w 4		
Development of a communication protocol for coordination of roles and responsibilities among partners	x									
Carrying out weekly coordination meetings	x	x	x	x	x	x	x	x		
Participation in sectoral rapid assessments to understand needs and prioritize affected communities	x	x								

Revisiting and activating the detailed communication plan	x									
Conducting a rapid appraisal of communication channels and resources	x									
Developing a media plan for mass media initiatives and a dissemination plan for print and AV materials		x								
Carrying out dissemination as per plan		x	x	x	x	x	x	x		
Refresher/ orientation of community workers/ volunteers including adolescents as required with a focus on dialogue with affected families, providing psychosocial support and tackling rumors.		x	x		x					
Deployment of volunteers in affected areas for IPC and community dialogue		x	x		x		x			
Activating community level structures for community mobilization activities- community meetings, household visits, drama shows, film shows, megaphone narrowcasts, demonstrations, communication material distribution										
Organizing regular media briefings through the media spokesperson		x	x	x	x	x	x	x		
Making arrangements to reach the poorest and those in particularly vulnerable, hard to reach or special circumstances through partnerships		x								
Developing a monitoring and evaluation plan		x								
Regular collection of data through partners as per developed M&E plan		x	x	x	x	x	x	x		

Annex 5c

State Communication Plan implementation steps						
Steps	**Responsible person/ department**	**Time frame**	**Objective of the step**	**Output**	**Output indicators**	**Budget**
State level workshop on the communication plan			Develop Communication plan Shared understanding of key communication approaches Identification of key messages (contextual to the identified participant groups)	Communication Plan	Action plan ready to roll out	
Identify resource teams available for implementing communication activities at State/ district level			To have in place a State/ district resource group to manage/ support communication activities	Key resource team identified and engaged Roles and responsibilities identified and communicated	Team in place and engaged	
In depth training on communication for the identified State/ district resource group			To acquaint the group on the significance and content of the communication plan	Number of resource people trained	Number of resource people skilled on communication Individual plan developed and adopted	
Select and Train town /village level mobilisers on the communication			Increase knowledge on WASH issues, build skills in communication, build familiarity and skills with use of facilitation material	Number of town /village mobilisers trained	Number of skilled mobilisers	

plan and use of materials						
Prioritize towns /villages and prepare detailed micro plan for towns/villages			Based on the assessment identify the level of activity required	Number of town/villages identified Detailed micro-plans in place	Detailed micro plan for identified villages/towns ready for roll out	
Put in place monitoring plan/mechanism			To review progress and get input to feed back in the communication strategy/plan	Monitoring plan and indicators identified	Monitoring plan with roles Responsibilities (reporting lines) and frequency	

Annex 6: Indicators and M&E Framework

Indicators

Indicators provide information on a particular circumstance that is measurable in some form. They can measure tangible things such as service uptake and also the intangible such as community empowerment and also results that were not planned. An indicator gives an idea of the magnitude and direction of change over time. Indicators could be numerical as well as pictorial such as illustrations that show the situation immediately after an emergency that are then compared with illustrations produced some time after the emergency. These can promote greater discussion and lead to a better understanding among communities. It could also include the collection of "stories from the field", which provide meaning to quantitative information or capture real "voices". This technique is known as the Most Significant Change (MSC) and has been developed for the systematic collection and interpretation of stories. Indicators are usually classified into the following types:

Outcome indicators

Outcome indicators tell us whether a strategy has been successful in meeting its stated objectives. Outcome indicators can be defined by results such as behavioural change, policy change etc.

Output indicators

Output indicators measure intermediate results of the communication interventions. The indicators for intermediate results can be used as predictors of behaviour change. These could include changes in knowledge, attitudes etc.

Process indicators

Process indicators are used to assess how well the communication plan is being implemented and to adjust communication activities and tasks to meet their objectives. They help us assesses whether inputs and resources have been allocated or mobilized and whether activities are being implemented as planned.

Suggested Monitoring and Evaluation Framework

Results	Indicators	Means of Verification
Outcome Level		
Increased number of individuals (men and women, and children) who use toilets regularly	Number/percentage of communities/ households having toilets. Number/percentage of men/ women/children reporting regular use of toilets.	Base line, mid line and end line survey reports.
Increased number of children (girls and boys) who use toilets in schools	Number/ percentage of schools having separate, functional toilets for girls and boys, which are being used.	Base line, mid line and end line survey reports, Education ministry reports
Increased number of mothers/fathers/caretakers who wash their hands with soap after defecation or after having contact with faeces, before eating or preparing food, or after cleaning the child's	Number/percentage of mothers/fathers/caretakers who wash hands with soap after defecation, after handling child's faeces, before	Base line, mid line and end line survey reports, Education ministry reports
Increased number of mothers/fathers/caretakers who safely dispose of child's faeces in a latrine/toilet or safely bury it at a distance from home	Number of / percentage of mothers/fathers/ caretakers who safely dispose of a child's faeces.	Base line, mid line and end line survey reports,
Increased number of individuals (men women and children) safely collecting, storing and handling drinking water	Number of /percentage of individual who collect water from safe sources and store and handle drinking water safely	Base line, mid line and end line survey reports,
Increased number of individuals (men, women and children) who have vomiting and diarrhoea are effectively treated/ rehydrated	Number of / percentage of individuals who use ORS when they have diarrhoea/ vomiting Number of / percentage of individuals seek medical help when they have severe diarrhoea/ vomiting	Base line, mid line and end line survey reports,

Increased number of individuals (men and women) who take necessary precautions at funerals and when handling dead bodies	Number of / percentage of individuals who follow prescribed safety practices at funerals / while handling dead bodies	Base line, mid line and end line survey reports,
Increased number of water / food vendors who practice hygienic behaviours	Number of food / water vendors following recommended practices	Base line, mid line and end line survey reports,
Increased number of individuals (men, women and children) who keep their surroundings clean	Number/ percentage of individuals who take active measures to keep their surroundings clean	Base line, mid line and end line survey reports,
Issuance of favourable policy and making of necessary administrative changes in the WASH sector by policy makers	Favourable policy / administrative guidelines issued	Policy documents, ministerial guidelines
Output level		
Increased levels of knowledge and awareness regarding the importance of hand washing with soap.	Number/percentage of mothers/fathers/caretakers, who understand the need for hand washing with soap and can articulate benefits of HW at critical times. Availability of soap close to latrines in houses and in schools.	Base line, mid line and end line survey reports,
Increase in the number of individuals (men, women and children) who are able to make linkages between hand washing with soap and diarrhea / Cholera	Number of people who are able to articulate the linkage between HW and diarrhea/ Cholera. Number/percentage of individuals able to explain at least two critical times for hand washing	Base line, mid line and end line survey reports,
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 communites/ HH having toilets. Number of people able to	Base line, mid line and end line survey reports

	articulate the benefits of using a toilet even for safe disposal of child's faeces.	
Increased number of individuals (men, women and children) who understand what to do when they have vomiting and diarrhoea	Number of / percentage of individuals who can demonstrate how to use ORS and when Number of / percentage of individuals who know where to go for medical help when they have severe diarrhoea/ vomiting	Base line, mid line and end line survey reports,
Increased number of individuals (men and women) who know the necessary precautions to be taken at funerals and when handling dead bodies	Number of / percentage of individuals who can articulate prescribed safety practices at funerals / while handling dead bodies	Base line, mid line and end line survey reports,
Increased number of water / food vendors who understand hygienic behaviours to be followed	Number of food / water vendors who can state recommended hygienic practices	Base line, mid line and end line survey reports,
Increased number of individuals (men, women and children) who know the importance of keeping their surroundings clean	Number/ percentage of individuals who can state what they can do to keep their surroundings clean	Base line, mid line and end line survey reports,
Increased number of senators, legislators, county / district level functionaries who stated perceived risk of not washing hands with soap at critical times and their role in relation to promoting the same	Number of senators, legislators, county / district level functionaries who are able to explain the risks of not being able to wash hands with soap at critical times Number who can explain their role in promoting WASH	Base line, mid line and end line survey reports,
Increased number of community and faith-based leaders who stated perceived risk of not washing hands with soap at critical times and their role in relation to promoting the	Number of community/faith-based leaders who are able to explain the risks of not being able to wash hands with soap at critical times Number who can explain their	Base line, mid line and end line survey reports,

same	role in promoting WASH	
Increased number of teachers who stated perceived risk of not washing hands with soap at critical times and their role in relation to promoting the same	Number of teachers who are able to explain the risks of not being able to wash hands with soap at critical times Number who can explain their role in promoting WASH	Base line, mid line and end line survey reports,
Increased number of senators, legislators, county / district level functionaries who can identify the benefits of regular use of toilets and their role in relation to promoting the same	Number of senators, legislators, county / district level functionaries who can identify benefits of using a toilet even for safe disposal of child's faeces Number who can explain their role in promoting WASH	Base line, mid line and end line survey reports,
Increased number of community/ faith-based leaders who can identify the benefits of regular use of toilets and their role in relation to promoting the same	Number of community /faitbased leaders able to articulate the benefits of using a toilet, even for safe disposal of child's faeces. Number who can explain their role in promoting WASH	Base line, mid line and end line survey reports,
Increased number of teachers who can identify the benefits of regular use of toilets and their role in relation to promoting the same	Number of teachers able to articulate the benefits of using a toilet, even for safe disposal of child's faeces Number who can explain their role in promoting WASH	Base line, mid line and end line survey reports,
Increased numbers of communities involved in the planning, implementation and monitoring of WASH programmes in their communities	Number of communities with WASH (including diarrhoea/ cholera) management plans Number of communities involved in the implementation and maintenance of WASH facilities in their communities Number of communities where members have contributed resources (financial, human, material) for WASH initiatives Number of communities where WASH initiatives are led by	Baseline, midterm and end term evaluation survey reports Partner implementation reports, Field visit reports

	members of the community chosen democratically	
Process Indicators		
Policy makers and stakeholders are sensitized to the issues of WASH	Number of questions raised in house of senate and house of representatives Number of times the issue of sanitation and hygiene brought up in public speeches	Monitoring of debates in house of senate and representatives Media reports on public engagement of concerned public figures
Media sensitized and motivated to report on sanitation and hygiene issues and set the policy agenda and different levels of governance	Number of news stories and their prominence in International, National, State and Local media	Media monitoring and analysis
Elected representatives/stake holding ministries/department and partners are engaged and motivated to spread messages and coordinate and monitor programmes	No. of public and coordination meetings held by elected representatives in which issues concerning sanitation and hygiene are discussed WASH Coordination committee formed and functioning	Local media reports, minutes of meetings of national/ county /district administration
Community level communicators, school teachers, women's groups etc. are equipped with the knowledge and skills to conduct interpersonal communication (IPC) to promote adoption of safer practices.	Community level communicators, school teachers, women's groups etc. are equipped with the knowledge and skills to conduct interpersonal communication (IPC) to promote adoption of safer practices.	Training reports List of participants Pre and posttest reports
An entertainment-education intervention developed and executed	Number of entertainment-education programmes organized / conducted. Number of people reached through the programmes	Assessment reports, media/audience reports/surveys

Trainings and capacity building of key stakeholders to implement the strategy, organized	Number of trainings and consultations organized. Number of people trained in use of communication techniques.	Training reports List of participants Pre and posttest reports
Capacities of communities built to manage WASH in their areas	Number of communities where participatory communication processes have been carried out Number of community members / resource groups trained on identified capacity gaps	Partner implementation reports
Communication materials and tools developed and disseminated	No. of materials and tools developed No. of copies disseminated and effectively used No. of mass media materials developed No. of times/ frequency of airing	List of materials, Dissemination and utilisation reports, broadcast logs, audience surveys