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COMMUNICATION STRATEGY

MDC
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06th July, 2020

To,

The Program Director
Program Management Unit (PMU) – Sindh MSDP
Planning & Development Department
Government of Sindh, Karachi
D-18 Block 2, Kehkashan, Clifton, Karachi

SUBJECT: SUBMISSION OF COMMUNICATION STRATEGY FINAL VERSION DEVELOPED UNDER LGSA PROJECT, MSDP.

Dear Sir,

We are thankful for your approval of Communication Strategy during the Quality Assurance Committee (QAC) meeting held on June 29, 2020.

We are pleased to submit final version of this Strategy document for your record.

We will be glad to provide any additional information if required.

Looking forward to cooperating with you.

With Best Regards,

Muhammad Ali Mahesar
Team Leader, (LGSA) MSDP
Management & Development Center (MDC)

Cc to:

- Director General (Works), PMU-Sindh MSDP, Karachi.
- Director (Reforms), PMU-Sindh MSDP, Karachi.
- Deputy Director (Reforms), PSU- Sindh MSDP, Jacobabad
- Assistant Director (Reforms), PSU-Sindh MSDP, Jacobabad.
- Office Record.

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ABBREVATION

USAID	US Agency for International Development
BCC	Behaviour Change Communication
HANDS	Health and Nutrition Development Society
MSI	Management System International
UC	Union Council
WASH	Water, Sanitizations and Hygiene
LHWs	Lady Health Worker
FGDs	Focus Group Discussion
NGOs	Non- Government Organization
DCO	District Coordination Officer

1. Introduction and the Context Analysis[1]

Jacobabad district is in the north of Sindh province of Pakistan. It has 2667.98 square kilometre area.[2] The district is one of the hottest place in the South Asian region with maximum temperature 51.9 degrees Celsius recorded in May 2018. The tribalism is predominant characteristic of the district; thus, the tribal system is the core of it. People are divided into tribal groups and clans. The majority of these tribal groups and clans are Baloch. The political landscape of the district is also dominated by the tribal chiefs, sardars and feudal lords. The majority of the population was Muslims (96.3%), whereas Hindus (3.56%) and Christians (0.06%) were religious minority groups. The majority (73 percent) population of the district was living in rural areas and 27 percent in urban areas.[3]

Table 1: Estimated district Jacobabad's population 2013

	Total	Male	Female
Rural	808,349	424,302	384,047
Urban	294,813	154,060	140,753
Total	1,103,162	578,362	524,800
Source: US Agency for International Development and iMMAP (2014)[4]			

The district is largely comprised of rural areas. According to Mouza Statistics of Sindh 2008, Agriculture Census Organization, Jacobabad district has 3 tehsils (named as Ghari Khairo, Jacobabad and Thul), 40 union councils, 272 Dehs and 214 mouzas (202 rural (94.4 percent), 4 urban and 8 partly urban).

1.1 What Happened in 2010, 2011 and 2012?

In 2010, 2011 and 2012, Jacobabad was consecutively hit by heavy floods. The flood in 2010 was devastating for life, livelihoods and infrastructure in the district. In 2010, 214 villages in 33 union councils were affected which affected lives of 938,659 people. It had resulted in 70 deaths and 78 injuries.[5] In 2011, only 2 persons were reported dead. In 2010, 117,879 and in 2011, 1,620 houses were affected. The flood in 2012 had destroyed and damaged the leftover things from the floods in 2010 and 2011 in the district. About 939,500 people (85% of the total population) were directly and indirectly affected in all 40 Union Councils. There were reported

[2] US Agency for International Development and iMMAP. 2014. Pakistan Emergency Situation Analysis: A profile of district Jacobabad, at http://reliefweb.int/sites/reliefweb.int/files/resources/PESA-DP-Jacobabad-Sindh.pdf

[3] US Agency for International Development and iMMAP. 2014. Pakistan Emergency Situation Analysis: A profile of district Jacobabad, at http://reliefweb.int/sites/reliefweb.int/files/resources/PESA-DP-Jacobabad-Sindh.pdf

[4] US Agency for International Development and iMMAP. 2014. Pakistan Emergency Situation Analysis: A profile of district Jacobabad, at http://reliefweb.int/sites/reliefweb.int/files/resources/PESA-DP-Jacobabad-Sindh.pdf

[5] UNOCHA. 2011. Pakistan Floods 2010- Jacobabad district profile, at http://floods2010.pakresponse.info/Portals/0/Pakistan/District_Profiles/District_Profile_Jacobabad_11Jan.docx.

57 deaths and 45 injuries. In all three floods, thousands of houses and most of the infrastructure were destroyed in the district including water and sanitation infrastructure and system.[6]

In addition to the worst impact of the floods on the life, livelihoods, infrastructure and the entire communities in Jacobabad, there was another dark social, medical, political and structural context. In result of many serious problems primarily structural, a large number of people in Jacobabad and entire country were lacking health, water, sanitation and hygiene-related facilities and services. Merely 48 percent people of the country had availability of sanitation facilities and[7] around 43 million people were practising open defecation. In result of lack of access to safe drinking water and sanitation facilities and poor hygiene practices (such as the use of contaminated water), mother and children especially newborn babies remained victims of diseases. Pakistan Demographic and Health Survey (PDHS) 2017-2018 shows the national infant mortality rate at 74/1000 live births and for under 5 years old child the mortality figure goes up to 89 per 1000 live births. Diarrhoea (mostly stem from the contaminated water) was the second largest contributor to the infant and under 5 child mortality. The Survey also shows that every year 53300 children died in Pakistan because of diarrhoea. The main cause of the disease were the unsafe disposal of child faeces, lack of access to safe drinking water, and unhygienic health practices. The survey also showed that people in Sindh were using unhealthy and unhygienic sanitation methods in which they were in continuous contact with faeces. It also revealed that in Sindh 87 percent households had hand washing stations/places, and overall, merely 45 percent households had all the hardware essentials to have proper handwashing practice. Pakistan's National Drinking Water Policy 2009 showed 112 billion rupees were for WASH-related diseases and of this amount 52 were related to diarrheal diseases.[8]

In Jacobabad, the very infrastructure (although it was very nominal) related to water and sanitation was completely devastated by continuous floods 2010, 2011 and 2012. Before floods, it was reported in 2009 that the district's population had reasonable access to improve drinking water; 65 percent households used hands and 2 percent used motor pumps.[9] In order to address the issues related to water and sanitation, in 2014, USAID started supporting the Government of Sindh's Municipal Service Delivery Program that was intended to deliver or provide municipal services that included water, sanitation, sewerage, and solid waste

[6] USAID and iMMAP. 2014. Pakistan Emergency Situation Analysis: A profile of district Jacobabad, at http://reliefweb.int/sites/reliefweb.int/files/resources/PESA-DP-Jacobabad-Sindh.pdf
[7] UNICEF and WHO. 2010. Joint Monitoring Programme Report, at https://www.unicef.org/eapro/JMP-2010Final.pdf
[8] The Government of Pakistan, Ministry of Environment. 2009. National Drinking Water Policy 2009. Islamabad, at http://www.urckarachi.org/downloads%5CPakistan%20approved%20National%20Drinking%20Water%20Policy-6092009.pdf
[9] US Agency for International Development and iMMAP. 2014. Pakistan Emergency Situation Analysis: A profile of district Jacobabad, at http://reliefweb.int/sites/reliefweb.int/files/resources/PESA-DP-Jacobabad-Sindh.pdf

management.
USAID implemented the project through UNICEF (and its implementing partner HANDs), UN-Habitat and WaterAid. On the ground, HANDs executed the project. Specific activities of the project include restoring and expanding the water supply system, rehabilitating and restoring the sanitation system, and creating solid waste collection and disposal infrastructure. In addition to the hard component, the project has social mobilisation, capacity development and behaviour change communication (BCC) that aim to:

1. Mobilise community support for, and participation in, the USAID-funded Municipal Services Program;
2. Promote improved hygiene behaviours; and
3. Document the processes used to generate lessons for replicating the activity in other urban areas."

The project had ended in 2016; however, the one-year extension has been granted to HANDs to execute more activities mostly related to the BCC campaign. By the end of the project, Management Systems International (MSI) had conducted the rapid assessment to inform and help USAID to design the possible and potential bridge mechanism so that the communities own the infrastructure and use the underpinning message of the project, which is to live a protected and healthy life. In December 2014, UN-Habitat had conducted a baseline survey of 1,960 households in 8 union councils (UCs) of the district. MSI had picked a sample of the UN Habitat's surveyed households to determine (one of the aspects) the extent to which the BCC campaign was able to bring change in people's behaviour over the 18 months of the project time. MSI conducted interviews (and also made observations) with household members in 160 households in different UCs of the district. The rapid assessment addressed four questions and questions number 2 and 3 were related to the BCC campaign. The questions 2 and 3 aimed to see the extent (to the fullest extent, to a significant extent, to a limited extent, etc.) to which the BCC campaign was successfully implemented and whether the BCC campaign was able to achieve its desired goals and objectives.[10]

With regard to questions 2 and 3, in the rapid assessment, MSI found that the BCC campaign had effective results and it reached out to the majority of households in the project area, and the campaign had effectively transferred the messages related to water, sanitation and hygiene. MSI also noted and observed a changing and improving behaviour of people towards a healthy lifestyle; however, it also reported that one of the main practices of washing hands before eating food and after defecation was declining but the at the same time, MSI confessed that this finding may not be the real behaviour of households members.[11]

[10] USAID. 2016. Jacobabad Urban Wash: Rapid assessment, page 2 at http://pdf.usaid.gov/pdf_docs/PA00MPD6.pdf.
[11] USAID. 2016. Jacobabad Urban Wash: Rapid assessment, page 2 at http://pdf.usaid.gov/pdf_docs/PA00MPD6.pdf.

2. Why the Revised BBC Strategy for the Project?

Implementation of the community mobilisation and the BCC campaign was the prime task of HANDS, which claimed that it had successfully done the job in the first phase of 18 months. HANDs had created the community mobilisation structures which included one city forum, 16 ward committees (2 ward committees in each UC) and 128 the neighbourhood committees (50 percent male and 50 percent female).[12]

MSI reported that 64 communities were using the low-cost WASH technology options, 05 communities had developed water safety plans, 20 school WASH clubs were established and 390 children were trained and given School WASH booklets. Additionally, in 64 communities, 60,000 leaflets, 8000 posters were distributed. MSI also found that "proportion of people NOT using any water treatment method declined from 94% to 44% (50 percentage points), Proportion of school going children washing hands after defecation rose from 63% to 71% (8 percentage points), Proportion of various categories of people washing hands before eating, improved; Men from 86% to 93.6% (7.6 percentage points), School going children from 53% to 85% (33 percentage points), Non-school going children from 45% to 65% (20 percentage points)."[13]

In the rapid assessment, MSI has reported that the vast majority of respondents from the sample households had heard the BCC messages from the project's home visitors, television and/or lady health workers (LHW). It also said that around 15 percent respondents had heard a particular message only from one kind of source such as television.[14] In light of these two findings related to the BCC campaign, MSI believed that a variety of communication sources, especially LHWs, home visitors and television, would serve the purpose in an effective way to meet the objectives of the BCC campaign. Additionally, MSI found that the weaknesses (or severe compromises) in the effective implementation of the BCC campaign may have been the outcome of delays in the infrastructural development and improvement activities. MSI, thus, recommended focusing on the BCC campaign through home visitors, television and LHWs. [15]

In view of MSI's recommendations, USAID and its technical and implementing partners felt a compelling need to address the weak areas in the BCC Campaign and Social Mobilization Campaign strategy. Therefore, this strategy aims to revise the existing strategy on BCC campaign and Social Mobilization campaign to further improve health and hygiene practices in the targeted areas in the district.

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[12] HANDs. Terms of Reference (ToR): Conduct Revision and Develop Revised Behavior Change Communication and Social Mobilization Campaign Strategy, at http://www.hands.org.pk/CV/ToRRevisedBCC&SMStrategyHANDS.pdf.

[13] HANDs. Terms of Reference (ToR): Conduct Revision and Develop Revised Behavior Change Communication and Social Mobilization Campaign Strategy, at http://www.hands.org.pk/CV/ToRRevisedBCC&SMStrategyHANDS.pdf.

[14] USAID. 2016. Jacobabad Urban Wash: Rapid assessment, page 2 at http://pdf.usaid.gov/pdf_docs/PA00MPD6.pdf.

[15] USAID. 2016. Jacobabad Urban Wash: Rapid assessment, page 2 at http://pdf.usaid.gov/pdf_docs/PA00MPD6.pdf.

3. Communities' Perspective

3.1 Water and Sanitation Situation in Jacobabad

In UC 6, in Muhalla Kareemabad, FGD was conducted with 7 women participants. Women complained that they had no water for drinking and other household purposes. Therefore, they got water from a local vendor who fetched it from other places on donkey carts, and the residents of the Muhalla paid 20 rupees per cane and each family bought around 5 to 5 canes. They also said that water supply lines were not placed in their Muhalla. They also said that they had no draining system. They said that new water supply scheme was about to start but they were not confirmed about it. They complained that they had never seen any sanitation workers and in the absence of these workers, garbage was scattered everywhere. One lady added that there was nothing structured thing. Most of the people had constructed drains on personal interests and expenses. Another lady said that mosquitos and flies were common and these were causes of diseases among children. They said they did not know about Jacobabad district but they knew about their Muhalla which was without water and sanitation system. However, these all women were hopeful that they would have water and sanitation facilities too.

In FGD, in UC 5, Muhalla Family Line, the participants said that urban areas in Jacobabad were without proper water and sanitation systems; the old system was dysfunctional; water lines were broken and damaged and contaminated drain water was mixed with drinking water lines. They said that in most areas in the city, water was stagnant in drains or streets. They all clearly said that all people in Muhalla were willing to pay for the services to the municipal authorities. They shared they purchased drinking water or brought it on donkey carts from distant places. They paid around 300 rupees per month. They used water without purifying it. Generally people in Muhalla get water once in a week but influential people had special lines thus they had water every day. They complained that municipal authorities sold water to factories and water tanker owners, who sold water to the public at their own rates. The tanker mafia sold water to people in Balochistan, and many people used this water for agriculture purpose when people had no water for drinking. They said that drains were filled with plastic bags and other material, and people cleaned it themselves; and sanitation workers seldom come to clean drains; when they come, they take out bags and material from the drains and keep these on the edge of drains, which after some time go back to drains and is scattered all around streets; and sanitation workers served in the houses of tribal and political chiefs and bureaucrats. One participant added that waters supply machinery was stolen and no technical staff members were operating the water supply system.

In FGD with males in UC 7, in Jat Muhalla, the participants shared that water supplied through lines was not drinkable and even one could not take bath because it was contaminated. They said that water lines were choked, broken and damaged, and were placed along with sanitation pipelines. They also said that sanitation system was in worst condition. The water supply

schemes did not function well because of the absence of technical staff to deal with technical issues such as the operation of valves. They hoped that the new water supply scheme was under construction with the help of USAID, which would start soon and benefit them. One of the participants said that he was satisfied with the drainage system; however, the poor management and maintenance made it useless, and often drains were blocked which resulted in water across the streets. Another participant added that he did not see any fixed spots or dustbins where people could drop their garbage; thus, most people threw garbage anywhere on the streets, and the plastic bags flew to drains and blocked these. All participants complained that the municipal staff hardly took away the garbage. The staff visited merely once in a month. One participant claimed that the drainage system was in good condition, but it always overflows because the municipal staff did not clean it and also did not take away garbage from the streets. He also suggested that the USAID project should not be handed over to the municipal officials who would not take care of it rather destroy it. Another participant claimed that so far the drains were functioning on self-help basis; they paid workers to clean the streets and drains.

3.2 Communities Behaviours

In Jat Muhalla, all participants claimed that most of the people in Jacobabad especially in the project areas were willing to have water and sanitation system that should provide them with clean water, clean streets and clean environment. They claimed that they having health and hygiene practices in their homes. They washed hands with soaps before eating food and after coming from toilets. They said that most people in the area keep their water utensils covered because most of them were aware of the dirt and pollution which could contaminate their water. They complained that municipal authorities were not willing to address the issue of water and sanitation. People were paying to get their drains cleaned through workers and were also willing to pay bills to municipal authorities for all the services. One participant added that most of the people had waters through water suppliers, who brought them water canes on donkey carts, and often they found insects in the water. He also said that in the future, Muhalla committees would collect bills and pay to the municipal committees. Another participant claimed that many of the residents were paying water bills despite the fact that they received contaminated water. One participant added that previous water lines were damaged through which they received dirty and smelly water once or twice a week. Mostly the participants shared that people did not treat water.

In Kareenabad Muhalla, women participants claimed that they cleaned their hands before eating food or else and after using toilet or cleaning bottoms of babies. They also said that they used to store water in clean pots. However, they said that they had no other option to dump garbage outside of their houses; since no one collected the garbage; thus, it was scattered across the community. Three women said that they kept the front area of their houses clean. They swept those places regularly. Two ladies out of the way suggested that if the government provided them water and sanitation services. They would pay for it. One woman shared that

many people had a habit of throwing garbage in the middle of the streets, and no one dared to stop them because they were ready to fight for every minor thing. The majority of women shared that they kept their houses clean; however, they did not use any water treatment method to purify water.

In Muhalla Family Line, the participants said that they used to cover utensils (or pots) in which they had kept water. They always washed their hands with soap after using the toilet and they were ready to pay water bills. They said that their Muhalla has open drains filled with plastic bags; neither local people nor municipal authorities had taken care of these. They were worried that most people threw garbage on the streets and there were no dustbins; and no one collected them from there; the files of garbage gathered for weeks cause the staunch smell. A participant claimed that about 30 percent people were boiling water for drinking purpose. He added that neither all people were all times good to take care of health and hygiene practices nor all good people were taking care of health and hygiene all times. They said that most people stored water in plastic drums which they cleaned once in a week.

3.3 Health and Hygiene Practices and Sources of Motivation

In Kareemabad Muhalla, all women said that they wanted to change and improve their hygiene practices. In the past, they were unaware of good hygiene practices; even if they were aware they were not sensitised about hygiene practices and willing to improve their personal and family members' hygiene and the surrounding environment. They said that they were willing to improve outside streets but there were no dustbins and if these were built then who would have taken garbage from these. They added that if they did not improve their behaviour and practices, these would create problems for them. One lady said that in 2012, they had rain water their Muhalla, which was standing for many weeks, which resulted in smell and mosquitos. Then, Muhalla people together removed that water, and then they had little issue of mosquitos and smell.

In Muhalla Jat, all participants said that that people had changed and they were willing to change and adopt healthy water and sanitation practices because most of the people in urban areas were educated and sensitised but they had not services and facilities to change their attitudes. One of the participants shared that they have Government Girls High School in Muhalla. The School Management Committee of the School complained that most of the girls were getting sick and were absent from the school. SMC and parents jointly investigated and found that girls were getting sick because of chips and other such things. Therefore, the school banned entry and consumption of chips inside the school and then they had positive results. One participant complained that some people were not serious but if there were serious efforts by someone they could change. One participant added that they had formed Muhalla committee, which would ensure that streets were clean. Another participant shared that if there arise water and sanitation issue, people had no knowledge where to lodge a complaint about it.

In Muhalla Family Line, the participant shared that people were willing to change their unhygienic and unhealthy practices which were harmful to their health and money. They said that they were willing to pay for water and sanitation services because people were extremely disturbed with the absence of proper water and sanitation. However, all together they blamed municipal authorities for all the unhygienic practices in the city. They also said that under the North Sindh Urban Service, dumping sites were constructed but the municipal authorities stopped collected garbage from the sites. One participant added that people were willing to change but they needed more motivation and support. They wanted to have the real and physical existence of water and sanitation system in their areas, which could convey them.

Table 2: In FGDs, the participants selected tools/channels of communication to target audiences for changing their behaviour

Muhalla Family Line (male)	**Jat Muhalla (male)**	**Muhalla Kareemabad (female)**
Television	School wash clubs	Pamphlets
FM Radio	Muhalla meetings	FM Radio
Cable Networks	Print and electronic media	Cable Networks
Community meetings, training sessions	Pamphlets and banners	Television
Rallies/awareness walks	Awareness walks and rallies	…

Table 2 shows that the majority of the participants in FGDs in Family Line and Kareemabad picked up the mass media related tools and channels to communicate the messages to the target audience. These tools include television, FM radio and local cable networks. In Muhalla Jat, the participants did not directly mention which tools but they generally indicated that print and electronic media would be appropriate for spreading the messages. For female participants in Kareemabad and male participants in Jat Muhalla, pamphlets were also a good source of communicating the messages for the desired changes.

4. Scope of this Work

This BCC campaign and social mobilisation campaign strategy aim to:

- provide evidence-based global best practices for WASH and propose an optimal strategy to be adopted in Jacobabad
- review and develop a revised document for Behavior Change Communication and social mobilisation campaign strategy in view of identified key audiences and communication channels.

5. Methodology

This BCC campaign strategy is prepared primarily based on the existing review of the project documents that includes a proposal, baseline survey, project progress reports and the rapid assessment. There were also conducted informal interviews with the project staff members to learn their experience while implementing the project activities and also their suggestions to improve steps, practices, exercises and models to spread the messages widely and effectively and bring an effective change in the target population's behaviour. There were conducted three Focus Group Discussions: In UC 6, in Muhalla Kareemabad, FGD was conducted with 7 women participants. In UC 7, Muhalla Jat Muhalla, FGD with 6 male participants. In UC 5, in Muhalla Family Line, FGD was conducted with 7 male participants.

Table 3: The list of participants in three FGDs

Name	Age	Gender	Education	Muhalla	Position
N	42	F	Nil	Kareemabad	Housewife
B	26	F	Inter	Kareemabad	Housewife
P. D.	48	F	Nil	Kareemabad	Housewife
A	22	F	BA	Kareemabad	Housewife
A	20	F	Middle	Kareemabad	Household
B	29	F	Matric	Kareemabad	Housewife
M. K.	32	F	Nil	Kareemabad	Housewife
G. H.	72	M	MA B.Ed	Jat	Ex-Assistant District Officer
J. K.	62	M	Matric	Jat	Rtd. police officer
K.B.	75	M	Deeni Taleem	Jat	Molvi
D. A.	50	M	Primary	Jat	labourer
Z. H.	36	M	Inter	Jat	Member
I.A.	40	M	MA	Jat	Teacher
S. A.	36	M	Nil	Family Line	Labourer
N. A.	40	M	Middle	Family Line	Chairman
M. A.	65	M	Matric	Family Line	Labourer
G. M.	28	M	Inter	Sheikh Muhalla	Labourer
N. A.	25	M	primary	Family Line	Member
N. A.	18	M	Matric	Family Line	Member
A. M.	42	M	Primary	Sheikh muhalla	driver

6. The Behavior Change Communication (BCC)

The BCC has various roles especially in the health sector, which include: increases knowledge; encourage dialogue between and within the communities; stimulate necessary changes in the attitude; helps to address stigma and discrimination; generates demand from the community for information and services; advocates and connects with the policy makers; promote positive behavior and services for support, care and prevention; advances personal and professional skills; and improves 'sense of self-efficacy'. [16]

6.1 What is the BCC?

The BCC "can include any systematic effort to communicate messages to audiences with the intention of affecting their behaviour".[17] In Some regions, it heavily depends on the direct interpersonal communication (IPC). It could be more effective if the direct interpersonal communication interventions and initiatives are supported by the mediated communication to reach out the target population repeatedly which should be guided by regular feedback.[18] The BCC is defined as "An interactive process with communities (as integrated with an overall program) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community and societal behaviour change; and maintain appropriate behaviours."[19]

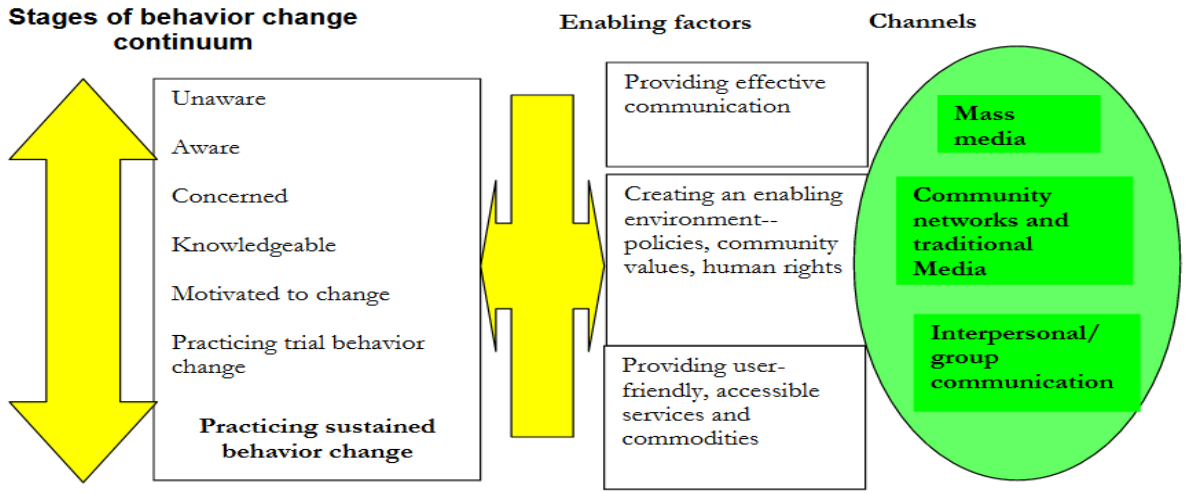

Figure - 1: A framework for the BCC design20

[16] Family Health International Institute for HIV/AIDS. 2002. Behavior change communication (bcc). For HIV/AIDS: a strategic framework, at http://www.hivpolicy.org/Library/HPP000533.pdf

[17] Hornik, Robert, Danielle Naugle, William Smith, and Tanya Trevors. 2015. Investing in Communication for Nutrition Related to Agriculture in India, at http://repository.upenn.edu/cgi/viewcontent.cgi?article=1433&context=asc_papers

[18] Hornik, Robert, Danielle Naugle, William Smith, and Tanya Trevors. 2015. Investing in Communication for Nutrition Related to Agriculture in India, at http://repository.upenn.edu/cgi/viewcontent.cgi?article=1433&context=asc_papers

[19] Family Health International Institute for HIV/AIDS. 2002. Behavior change communication (bcc). For HIV/AIDS: a strategic framework, at http://www.hivpolicy.org/Library/HPP000533.pdf

[20] Family Health International Institute for HIV/AIDS. 2002. Behavior change communication (bcc). For HIV/AIDS: a strategic framework, at http://www.hivpolicy.org/Library/HPP000533.pdf

6.2 Why the BCC?

1. "To use a variety of mediums and approaches to positively influence the behaviour of target population to adopt hygienic practices related to WASH at the individual, household and community level
2. To facilitate an enabling environment to achieve & sustain those practices
3. To make a dent in the national efforts for reducing morbidity & mortality related to poor sanitation and resulting a dignified and healthy family in urban areas of Jacobabad."[21]

6.3 Communication Channels for the BCC Strategy

For the purpose of this BCC strategy, following four communication channels are identified for delivering the BCC messages to the targeted group:

1) Institutional: Government health and education facilities, NGOs and their outreach workers etc.
2) Personal/interpersonal (sociocultural): individuals, religious leaders, teacher, notables, cadres, intellectuals, and places for festivals and meals distribution (including hotels, hostels)
3) Media: Local cable television network, local FM radio, Traditional printed press, posters, banners
4) Commercial: Sanitary hardware stores, bookshops, kiosks (grocery shops), pharmacies, restaurants and cafes

6.4 Objectives of the BCC Strategy in the Project

The BCC component consisted of a campaign to disseminate messages designed to promote good (healthy and positive) WASH behaviour so that households in the target areas would realise the positive health outcomes associated with improved health and hygiene practices.

The outcome of the BCC campaign strategy is the type and scale of change (in other words, positive improvement in personal and collective behaviour) that is desired to be achieved for a specific segment of pollution within a certain period of time. The desired positive improvement in personal health behaviour aims to benefit society at a large scale. The main objective of the BCC campaign strategy is to:

[21] HANDs. Communication Advocacy and Mobilization Strategy in Urban Context, at http://library.hands.org.pk:8080/jspui/handle/hands-archives/1621

Table 4: Objectives and Outcomes of the BCC Campaign Strategy

Objectives	Outcomes
1) Within the project time span, 100 percent people in the target area will be sensitised and made aware of harms of unhygienic conditions and benefits of hygienic conditions	a) The BCC campaign messages are delivered to all people in the project area b) People in the project area are aware and sensitised about their personal and collective health and hygiene
2) By the end of the project in April 2018, the project will educate the target audience about different health and hygiene practices necessary for a healthy life, which include: (a) 100 percent increase in hand washing with soap practice among all household members in the project area (b) All households in the target area effectively managing their drinking water, (c) All households willing to pay the utility bills/charges (d) All households take measures to improve environmental hygiene (e) All neighbourhood committees will ensure the safety and security of water equipment and lines, and (f) All households apply effective methods to treat water.	a) All adults and children in the project areas were washing their hands with soap before eating food and after defecation in the project area b) People in the target areas were properly handling drinking water by storing it in clean utensils c) All households in the project area were willingly (and regularly) paying bills or charges against water and sanitation utility services d) People in the project area were keeping their collective environment clean by cleaning streets and open drains e) The neighbored committees were ensuring the water safety and security by immediately getting the damages or punctures to water lines repaired f) The households in the project area were applying effective water treatment methods to purify water from any kind of contamination

6.5 Audiences of the BCC Campaign Strategy

6.5.1 Primary Audience of the BCC Campaign Strategy

Table 5: Identification of Influencers of the Primary Target Audiences

Primary Audience	Who does the Primary Audience discuss their health or WASH related problems with?	Who influences the actions that the primary audience takes to resolve their health or WASH related problems?	Who provides the primary audience with the health or WASH related information, products and services that they need?
School children aged 5-17 years	Teachers, mothers, fathers, guardians, friends, relatives	Teachers, mothers, fathers, peers	Teachers, mothers, fathers, friends, peers and relatives
Mothers, guardians of children under five years old	Husbands, health workers, pharmacists, religious leaders	Husbands, health workers, pharmacists, religious leaders, friends, relatives	Health workers, teachers
People who use shared household latrines	Friends, landlords, health workers, municipal staff, co-tenants, caretakers, relatives and friends	Landlords, health workers, husbands/wives, staff, environmental health officers, municipal authorities	Health workers and environmental health officers, but this information is not currently being provided adequately
Public toilet attendants	Health workers, pharmacists, urban council and town council members, unit committee and town council	Municipal authorities, NGOs, CBOs	Health workers and environmental health officers, but they are currently not being reached
Tenants of compound houses	Friends, husbands/wives, landlords, health workers, religious leaders, cotenants	Landlords, staff, religious leaders, health workers	Health workers and environmental health officers, but they are currently not being reached
People who use public toilets	Friends, health workers, religious leaders, pharmacists, town council /councilors	Religious leaders, health workers, teachers and community heads/leaders	Health workers and environmental health officers, but they are currently not being reached
Fathers, guardians of children under five years old	Wives, health workers, private contractors - pharmacists, religious leaders,	Wives, health workers, staff, religious leaders, social groupings /clubs	Health workers and environmental health officers, but they are currently not being reached

Primary Audience	Who does the Primary Audience discuss their health or WASH related problems with?	Who influences the actions that the primary audience takes to resolve their health or WASH related problems?	Who provides the primary audience with the health or WASH related information, products and services that they need?
	friends and relatives, teachers		
People who use improved household latrines	Friends, health workers, religious leaders	Friends, health workers, religious leaders	Health workers and environmental health officers, but they are currently not being reached, community development officers
Source: Environmental Health and Sanitation Directorate of the Ministry of Local Government, et. al. (2011)			

6.5.2 Secondary/ Tertiary Target Audiences

The secondary target audiences are those who directly and indirectly affect the primary audience:

1. The media (television, radio, social media (i.e. Facebook)
2. The private sector (schools, hospitals, industries etc.)
3. NGOs, INGOs and Faith-Based NGOs
4. Municipal officers/officials (water and sanitation staff/municipal staff members)
5. Lady Health Workers and Lady Health Visitors
6. Students and teachers in public schools
7. Madrasahs (students and teachers)
8. Education department staff/officials
9. Health department staff/officials
10. Social welfare staff/officials
11. Midwives (traditionally trained birth attendants)
12. Councilors
13. Restaurants/cafes
14. Kiosk, small workshops

7. Themes and Messages

7.1 Themes

The BCC campaign strategy would have following six themes:

1- Hand washing with soap (Critical timings and methods of hand washing)
2- Handling drinking water (storage/ cleanness of utensils)
3- Willingness to pay (regular payment of water bills/ charges)
4- Environmental hygiene (cleaning of streets, open drains)
5- Water safety and security (damages or punctures to of water lines)
6- Water Treatment

"Hygiene promotion is not simply a matter of providing information. It is more a dialogue with communities about hygiene and related health problems, to encourage improved hygiene practices" (WHO. Essential hygiene messages in post disaster emergencies, page 1, at http://www.who.int/water_sanitation_health/hygiene/envsan/hygienemessages.pdf?ua=1)

7.2 Key Messages

In this section, the broader BCC campaign strategy is translated into explicit actions. Key themes and ideas related to different messages are important to identify the target groups in a way to incite the desired change in behaviour. The messages are in a logical flow from the objective to expected change in behaviour.

In the rapid assessment, MSI reports that the majority of household members had received messages from televisions, LHWs and visitors. Television is not the face to face source of communicating messages although available in almost all houses in the target areas but other two modes of communication (i.e. LHWs and visitors) are the primary and reliable face to face sources of information; thus, utilising these would be vital in convincing the audience. Additionally, the local media outlets such as FM and cable networks are popular in the area; these could be a prime source of spreading the key messages.

It is very important to ensure that health needs, indicators and priorities at different levels of water and sanitation sector are consistent and commonly shared.

While messages may vary during the lifetime of the project however strategic targeting and consistency are the keys to any BCC strategy. Here it will discuss the comprehensive case covering all the key messages, and emphasise the different elements of HANDS project for a different audience.

7.2.1 Hand Washing With Soap (Critical Timings and Methods of Hand Washing)

7.2.1 (a): Hand Washing

1. "Good hygiene (cleanliness) is important to avoid diarrhoea and other illnesses.
2. Wash your hands with soap and water before preparing foods and feeding baby.
3. Wash your hands and your baby's hands before eating.
4. Wash your hands with soap and water after using the toilet and washing or cleaning baby's bottom.
5. Feed your baby using clean hands, clean utensils and clean cups." [22]
6. "Wash hands properly with soap and water
7. Follow the proper hand washing procedure." [23]

7.2.1. (b): Personal and Family Hygiene

1. "Use a clean spoon or cup to give foods or liquids to your baby.
2. Do not use bottles, teats or spouted cups since they are difficult to clean and can cause your baby to become sick.
3. Store the foods to be given to your baby in a safe clean place." [24]
4. "Keep body clean
5. Take a bath at least once a day if possible
6. Wash hands before food preparation
7. Trim fingernails and toenails regularly
8. Change into clean clothes before going to sleep
9. Cover mouth when sneezing, coughing
10. Brush teeth after every meal.
11. Give oral rehydration solution (oresol) to replace lost body fluid. A homemade solution composed of a teaspoon of salt, 8 teaspoons of sugar mix to a litre of water.
12. Drink water only from safe sources, if unsure, boil water or do chlorination.
13. Eat only foods that are well cooked and properly prepared.
14. Avoid eating street vendor food.
15. Keep the food away from insects and rats by covering them using food cover.
16. Wash fruits and vegetables with clean water before eating or cooking.
17. Use toilet when defecating." [25]

7.2.2 Handling Drinking Water (Storage/ Cleanness of Utensils)

1. Wash/clean your hands with soap before filling in waters into utensils, drums or tanks

22 UNICEF. Key Message Booklet, at https://www.unicef.org/nutrition/files/Key_Messages_Booklet_for_counselling_cards.pdf

23 Daf Zurcaled. Key Messages (Health and Hygiene Promotion), at https://www.scribd.com/document/254678274/Key-Messages-Health-and-Hygiene-Promotion

24 UNICEF. Key Message Booklet, at https://www.unicef.org/nutrition/files/Key_Messages_Booklet_for_counselling_cards.pdf

25 Daf Zurcaled. Key Messages (Health and Hygiene Promotion), at https://www.scribd.com/document/254678274/Key-Messages-Health-and-Hygiene-Promotion

2. Wash/clean big tanks regularly once in a week/month
3. Store water in clean tanks/drums and utensils
4. Keep tanks, drums or other water storing utensils covered with lids
5. Keep all water utensils (pots, water coolers, jugs, bottles) covered with lids or caps
6. Wash/clean glasses, utensils once used by a person

7.2.3. Willingness to Pay (Regular Payment of Water Bills/Charges)

1. Water supply schemes are run with the help of people
2. More the people pay the charges/bills, more the good quality of water and sanitation services
3. Regular payment of bills by all
    a. save all from the expensive and unhygienic water supply
    b. ensures that your sewerage system runs well
    c. ensures that your drains are not blocked
    d. ensures that garbage is collected swiftly and timely
    e. ensures that family of poor water and sanitation workers live a respectable life
    f. ensures that your streets are clean
    g. ensures that your surrounding environment is clean

7.2.4 Environmental Hygiene

1. Dispose of garbage properly
2. Do not throw or dispose of garbage in open fields and bodies of water.
3. Throw garbage in refuse bin when full, dispose of it in designated areas
4. Do not burn waste, including plastic materials
5. Put waste into garbage cans/ receptacles with a tight-fitting cover.
6. Separate biodegradable from non-biodegradable waste materials
7. Collect, store and dispose of waste properly
8. Sell recyclable waste (plastic, glass, paper, etc.) to buyers.
9. Use food wastes as animal feeds.
10. Do not burn wastes.
11. Seek the assistance of [UCs] where to dispose hazardous waste.[26]

7.2.4. (a) Sanitation (Latrine)

1. Dispose of all human waste properly
2. Use a toilet or latrine when defecating and urinating
3. Locate the toilet 15-25 meters away from the source of drinking water
4. Do not practice open defecation
5. Defecate only in designated areas

26 Daf Zurcaled. Key Messages (Health and Hygiene Promotion), at https://www.scribd.com/document/254678274/Key-Messages-Health-and-Hygiene-Promotion

6. Clean toilet& latrines after use
7. Cover the toilet bowl

7.2.5 Water Safety and Security (Damages or Punctures to of Water Lines)

1. Monitor and watch that water lines are not damaged
2. Ensure that thieves are not stealing water by putting illegal connections
3. Putting illegal connections cause damages to lines and results in the contamination of the drinking water
4. Report about the theft of water
5. Report about the illegal connections of water lines.
6. Safe and secure water lines ensure that:
    a. You receive water regularly and on time in your home
    b. You receive water without contamination
    c. You do not need to put extra efforts to clean water before its use

7.2.6 Water Treatment

1. Before use (drinking), make sure that water is clean
2. Before use) drinking, make sure that water is collected or received from hygienic source/point
3. Before use (drinking or consumption) disinfect your water by
    a. Putting it under the sun for five hours
    b. If it's mild cloudy, put it under the sun for two days
    c. Boiling it for 3-5 minutes
    d. After boiling keep it at safe place until it cools down
    e. Use a water purifier/chemical

7.2.7 Messages for Promoting Sanitation and Hygiene in Schools[27]

- "Toilets make school compounds clean.
- Toilets are easier to access than the bush.
- You do not have to travel far to use a toilet.
- The bushes might harbour snakes and things, so using a toilet is safer and less scary!
- Good toilets control flies and smells
- Toilets decrease diseases like cholera and help students stay healthy
- Toilets offer more privacy than the bush
- Improved toilets are easier to keep clean than traditional pit toilets
- Improved toilets are safer and the risk of collapse is lower, especially when the pits are lined
- Good toilets are safe for small children to use

[27] World Bank. A toolkit on Hygiene Sanitation & Water in schools, at https://www.wsp.org/Hygiene-Sanitation-Water-Toolkit/BasicPrinciples/HygienePromotion.html

- Messages that should be considered once the toilets have been constructed:
- Cleaning toilets is everyone's responsibility.
- It should also show a teacher cleaning a toilet, as well as young and old children.
- Children clean using mops, rags and water.
- Boys should be shown fetching water to fill hand washing facility and cleaning
- Toilets are safe to use: it should show lined pits and solid construction
- Everyone is responsible for keeping the toilet in good order and use it properly.
- Taking care of school property is everyone's business."[28]

Table 6: In FGDs, the Participants' Views about messages would help to improve behaviours of citizens in the context of Water Governance, Health and Hygiene

Muhalla Family Line (male)	Jat Muhalla (male)	Muhalla Kareemabad (female)
Drink water after boiling or keeping certain time in sun	Wash hands before you get sick	Do not throw rubbish in streets
Keep your children clean	Today's cleanliness is health of tomorrow	Keep clean the street in front of your house
Wash hands with soap after contacting with dirt	Yes to cleanliness no to doctor	Keep dustbins in your home
Do not store rubbish in front of your household's door	No cleanliness hosts germs	Treat water before drinking
Footwear of washroom should be separate	Kill germs by destroying filth	Keep water covered
Do not let water gather in streets	…	Wash hands after touching germy things
Do not let lines get punctured	…	…

[28] World Bank. A toolkit on Hygiene Sanitation & Water in schools, at https://www.wsp.org/Hygiene-Sanitation-Water-Toolkit/BasicPrinciples/HygienePromotion.html

8. Possible Interventions and Approaches

8.1 Areas, Approaches of Intervention and Status of the Interventions

Table 7: Possible Areas of Intervention to Change the Behaviour

Possible areas of intervention to change the behaviour			Status of the project
Access to hardware	Facilities	Water filtration devices, drainage systems, latrine construction, water supply	At the household level, people have access to hardware. At the community level, water and sanitation infrastructure was almost at the final stage.
	Products	Hand washing basins, plastic bottles, sachets, long - handled scoops, narrow necked bottles	At the household level, the products are available
Approach to hygiene promotion	Communication	Radio spots for water purification, posters, songs, clean water demonstrations, dirty hand demonstrations, fliers, flip charts, group discussions, songs, testimonials - experiences of - healthy families, hygiene kit, educational games, banners, soap, the point of purchase advertising	Most of the activities are done; however, there are more efforts to sustain the behavioural change for always
	Training	Create a cadre of hygiene promoters. Train media on hygiene issues. train health staff, teachers, promoters: - Critical hand washing times - basic water purification - how to conduct a community group meeting - negotiation skills - how to effectively communicate with children	Trainings are already provided to the promoters
	Social Mobilization	Support of associations, hygiene groups, etc., champion community contests, clean household promotion contest for - clean household, hygiene management committees, school fairs, water filtration fairs, community micro - finance groups to sell water, soap &/or new point of use products, school science, craft, & water bottle projects, community fairs	Social mobilisation infrastructure is in place; it does not need to work on the social mobilisation.

Possible areas of intervention to change the behaviour			Status of the project
	Social marketing	Soap, tablets, sachets, create sanitary marts, operate production centres, create - basket brigade, create a cadre of outreach sellers.	This aspect is lacking or under-addressed
Enabling Environment	Institutional Development & Capacity Building	Threshold program, skills in: filter maintenance governance, conflict resolution, water quality management, etc	This is partially done
	Policy & Advocacy	Local government participation in hygiene programs & decision making. Review urban policy, sanitation policy, water policy, regulation of tankers & vendors	It is ongoing
	Financing	Adequate budget at national, regional and municipal/city level, resourcing NGOs, micro credit for household latrine construction	It is ongoing
	Private Sector Participation	Private sector participation for distribution of WASH related products and systems	It is at its early stage
Source: Environmental Health and Sanitation Directorate of the Ministry of Local Government, et. al. (2011)[29]. Column four has been added to the table to show the progress against each intervention by the project team.			

8.2 Interventions

A. Face to face Interventions

1) The project team should organise special meetings to improve and increase the role of neighbourhood committees and wards. In addition to regular meetings, the neighbourhood committees should hold special meetings to review and revisit the purpose of forming such committees and whether people at the household and the community levels have changed their behaviour or not. They should set a criterion to observe changes and then report back to the project team.

2) Arrange and organise community level seminars on health and hygiene in water and sanitation system on water day and environment day.

3) Twice a year, the best household award to be given to a household that strictly followed health and hygiene practices. The project team may announce it in advance and also clearly communicate standards and criteria for the best award. The announcement could be done through the mobile message, on A4 size paper (which could be hanged in schools' notice

[29] Environmental health and Sanitation Directorate of the Ministry of Local Government and Rural Development and Water Directorate of the Ministry of Water Resources Works and Housing, Republic of Ghana (2011), page 32, at https://www.globalcommunities.org/publications/2011-ghana-wash-bcc-strategy.pdf

boards), in all kinds of meetings. Over the three months, the female neighbourhood committee may pay three surprise visits to assess the situation. The neighbourhood team will give a score to each household on each surprise visit [The purpose of organising the best household award is to create environment an, competition. The continuous and rigorous publicity of the best household award would create a competitive environment (**MOMENTUM**) that would lead to the success of the project's soft component. The awards should be given in a ceremony or seminar; or large gathering including the media persons. The award should be a certificate and cash prize Rs3000. The award should be handed into women/girls of that best household].

4) Twice a year, the best student award in schools to promote health and hygiene. The project team will announce the award three months in advance, so that students strictly follow the criteria and the relevant committee of teachers will observe them. Over the three months, the project team may pay three surprise visits to assess the situation. The award should be a certificate and cash prize Rs3000.

5) Twice a year, the best school award to promote health and hygiene based on the strict criteria/standards (may announce in advance so that school administration follow the standards strictly and over the three months, the project team should pay three surprise visits to check whether the schools were meeting the standards or not. The award should be a certificate and cash prize Rs3000 to the SMC/wash club/headmaster to be used for the welfare of children.

6) Twice a year, the best neighbourhood committee award for the clean environment on the streets and water & sanitation systems were effectively functioning. The project team may announce it in advance and also clearly communicate standards and criteria for the best award. Over the three months, the project team may pay three surprise visits to assess the situation. The award should be a certificate and cash prize Rs3000 to be distributed among the members of neighbourhood committee.

B. Electronic and Audio-visual (Including Social Media) Interventions

7) Inter-community and intra-community WhatsApp groups to share brief information on health and hygiene. The project team has already collected the contact numbers of participants who participated in different activities/ events. The team will form WhatsApp groups or other groups on mobile, and will share or disseminate key messages on hygiene practices and will also update them about the project activities.

8) Key messages or songs on the local FM radio; these messages would also include brief details about the best student and the best household. Messages will be prepared by the project team in light of the UNICEF's wash key messages and also in light of views of the community participants in Table 4.

9) Short video clips prepared by developed by UNICEF, WaterAid and HANDs on health and hygiene will be aired on the local cable network; the video clips could be shared on WhatsApp groups as well.

10) Tickers on local or regional cable networks: People of the area are found in Indian movies; the project team would take opportunity to send ticker messages;

10.1) Arrange messages for 20 seconds; and for 20 seconds, the movie will be paused. [In FGDs and also in the rapid assessment, television is considered the most important source of receiving messages].

11) Mobilise the print and electronic media: The project team will mobilise the print and electronic media in the district so that these could provide coverage to the project activities, and the media personals would be encouraged to conduct independent investigations to find gaps and issues in the implementation of the project.
11.1 The city forum will issue a press release on the success of the project
11.2) arrange an exposure visit for the media persons

C. Social, Cultural and Religious

12) In each area, the neighbourhood committees should arrange, Friday Sermons (Jumma Prayers) on health and hygiene issue and importance of health and hygiene in Islam. The project team may help the religious leader to find the relevant and authentic religious text on the issue. The project team may seek DCO's support, who could call a meeting of all the religious leaders and may urge them to speak/talk about health and hygiene in their Friday sermons.

13) Wall paintings and wall chalking on the most prominent places in the community; it should include the religious text on the matter: the Prophet said "Cleanliness is half the faith (man); Quran said: "And Allah loves those who make themselves clean and pure" (9:108).

14) The door to door visits for mothers and girls.

15) The projects' volunteer home visitors. In light of the MSI's findings, the project would extensively engage the project's volunteer home visitors to communicate and have a dialogue with household members on the health and hygiene practices.

D. Private Institutions and Places

16) Involve private clinics and hospitals to promote health and hygiene; meetings would be conducted with the staff members of clinics and hospitals so that they could encourage all their patients to improve their personal and collective hygiene practices. The staff members would be handed in pamphlets so that they could provide to each new patient.

17) Engage restaurants/cafes' owners and hang posters on handwashing with soap before eating; the project team would visit all the cafes and restaurants in the project area, and install posters on hand washing and other key messages.

E. Print Based

18) Install billboards at main places
19) Wall paintings: across the communities, wall paintings with key messages. These messages may live for a longer time.
20) Wall chalking: across the communities, wall chalking with key messages at specific places, such as schools, gardens, hospitals, bus stands/stops
21) Handbills for handing in the participants at different events
22) Flyers for handing in the participants at different events
23) Pamphlets for handing in the participants at different events
24) Decoration pieces will be given to the neighbourhood community and WASH members which show dedication and commitments in their communities/clubs.
25) WASH depictive Ludo games for community members
26) 500 WASH messages encrypted on Handicraft for community members
27) Menstrual Health & Hygiene kits for women and girls
28) Posters for the best household award; to be displayed/handed across the communities to create a momentum;
29) Posters for the best neighbourhood community award; to be displayed/handed across the communities to create a momentum;
30) Posters for the best student award; to be displayed/handed across schools in the target areas
31) Posters for the best school award; to be displayed/handed across schools in the target areas.

F. Institutional

20) LHWs: In light of MSI's findings, the project team would seek the help of health department to engage LHWs in spreading the message on personal health and hygiene. LHW would be engaged and encouraged to pay extra visits in the communities. This intervention will primarily focus on women and girls staying at homes.

21) Engage schools and children's clubs on sharing the harms of unhygienic conditions; in a classroom setting, the project team (children club) could share a story of child/children who lived a life without following health and hygiene practices such as he did not wash his hands before eating food, he did not wash his hands after using toilet, he touched his dog but did not wash his hands; and, then he got sick…and how he and his family suffered through the situation. At the end of the story, the students may be asked lessons learnt from the story, and would also ask them to relate the story with children who do not take care of their personal health and hygiene.

22) In association and support of the health and education departments, there should be a celebration of a water and sanitation week. The celebration week may end on World Toilet Day or Global Hand Washing Day. The water and sanitation week celebration activities include:

22.1) Walk by school clubs

22.2) Press release on the last day of the week

22.3) Or may arrange all the best award activities during this week.

a) the best household award
b) the best student award
c) the best school award
d) the best neighbourhood committee

22.4) Or may organise seminars during the week

9. Monitoring, Review & Evaluation

For tracking, measuring and reporting of the results of the activities, initiatives and campaigns under the BCC campaign strategy and its deliverables, it is indispensable to have monitoring, review and evaluation tools and activities. Monitoring, review and evaluation offer details on issues and problems so that the project team should improve its performance and ensure its accountability.[30]

Monitoring is a continuous and ongoing activity, which primarily aims to understand and increase the efficiency, effectiveness, timeliness, and appropriateness of the project's activities in light of its goals. Monitoring systems should also verify a project's compliance with rules and regulations and provide mechanisms to control the level of error. A good monitoring system will support the objective of promoting accountability, transparency and reducing error, in a number of ways. Most fundamentally, good monitoring and proactive management will detect problem areas and address them.

After developing the logical framework, the next step is to define more precisely the indicators to use effective monitoring systems start by building on information that already exists drawing on existing local data collection activities or working with indicators used for projects.

The Monitoring and Evaluation Plan covers the following aspects**:**

- The information sources and data collection tools for each indicator, including time of collection, and responsible person or team
- The information about the project's key outcomes and outputs
- Key indicators for each objective as indicated in the logical framework will be used to collect information on service provision, utilisation, coverage, impact, and efficiency.

[30] Australian Government, Department of the Prime Minister and Cabinet. Cabinet Implementation toolkit, at file:///C:/Users/Abdullah/Downloads/implementation-toolkit-5-monitoring.pdf