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USAID Wadata
Integrated Social and Behavior Change Strategy

USAID DU PEUPLE AMERICAIN
Save the Children
NCBA CLUSA
THE KAIZEN COMPANY
DEMI-E

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Acknowledgments

This integrated Social and Behavior Change/ Communication (SBC/C) strategy has been developed for the U.S. Agency for International Development-funded Wadata Development Food Security Activity being implemented by a consortium led by Save the Children (SC), with partners, National Cooperative Business Association/ CLUSA International (NCBA CLUSA), The Kaizen Company, and Dévelopement pour un Mieux-Être (DEMI-E). It was drafted by Lenette Golding and Meghan Pollak from Save the Children with input from Aboubacar Sale and Na Oume Habou Ibrahim and from Save the Children in Niger.

The Wadata team thanks the Breakthrough ACTION Niger team for their thoughtful review of this SBC Strategy.

Acronyms

ASC- Agent de santé Communautaire (Community Health Worker)

CHNL-Community Health and Nutrition Liaison Agent (community health volunteers engaged under Wadata)

CHW- relais communautaire (community health volunteer)

CSI- Centre de Santé Intégré (Integrated Health Center)

COVID 19- Coronavirus disease 19

DFAP-Development Food Assistance Program

DFSA-Development Food Security Activity

FFP-Food for Peace

FFS-Farmer Field Schools

FMNR-Farmer Managed Natural Regeneration Groups

GBV- Gender-Based Violence

GoN-Government of Niger

IGA-Income Generating Activity

IPC- Interpersonal Communication

IYCF-Infant and young child feeding

LAHIA-Livelihoods, Agriculture and Health Interventions in Action

MAM-Moderate Acute Malnutrition

MFI-Microfinance Institutions

MIYCAN- Maternal infant, young child, adolescent nutrition

MIYCF-Maternal infant and young child feeding

ML-Maman Lumiere

MMD-Mata Masu Dubara (Women on the Move)

MMF-Matasa Masu Fusaha (young people with initiatives)

OSV-Observatoire de Suivi de la Vulnérabilité (vulnerability monitoring system)

PLW- Pregnant and lactating women

SAM-Severe Acute Malnutrition

SBC/C-Social and Behavior Change/ Communication

SCAP/RU-Système Communautaire d'Alerte Précoce et de Réponses en Urgences (Community Early Warning System and Emergency Response)

USAID-United States Agency for International Development

VDC-Village Development Committee in Niger VDCs are referred to as CVD-Comité Villageois de Développement

WASH-Water, Sanitation, Hygiene

WPMC-Water Point Management Committee

Key Definitions

Behavior Change Technique (BCT) is a replicable component of an intervention designed to alter or redirect causal processes that regulate behavior (i.e., a technique is proposed to be a potentially "active ingredient"). BCTs are designed to enable behavior change, and can do this by augmenting factors that facilitate behavior change, or by mitigating factors that inhibit behavior change. (Source of definition: Michie, et al., "The Behavior Change Technique Taxonomy (v1) of 93 Hierarchically Clustered Techniques: Building an International Consensus for the Reporting of Behavior Change Interventions" [Ann. Behav. med. (2013) 46:81–95])

Community Capacity Strengthening (CCS) is the process through which communities obtain, strengthen and maintain the capabilities to set and achieve their development objectives over time. Community Capacity is the set of assets or strengths that community members individually and collectively bring to the cause of improving the quality of life. (Source of definition: Howard-Grabman, L & Snetro, G., 2003)

Community Service Delivery is by a cadre of community health volunteers or paid community health workers who are identified/ hired by their communities and trained (training varies), equipped (depends on resources), and supervised health workers.

Community Influencers

· **Direct influencers,** also known as the secondary audience, are individuals or groups who play key roles in influencing the primary audience positively or negatively (secondary). This group can be essential in changing behaviors since sometimes the primary audience has little agency to change themselves.

· **Indirect influencers,** also known as tertiary audiences, are individuals or groups that indirectly influence the primary audience by shaping social norms, influencing policy, or offering financial and logistical support (e.g., formal and informal civil society NGOs, faith-based groups, community and business leaders, authors, activists, entertainment and sports personalities).

Community Natural Resource Management (CBNRM) is a people-centered approach to the integration of conservation of the natural resource base (water, soil, trees, and local biodiversity) and development to overcome poverty, hunger, and disease. (Source of definition: World Neighbors)

Female Empowerment is achieved when women and girls acquire the power to act freely, exercise their rights, and fulfill their potential as full and equal members of society. While empowerment often comes from within, and individuals empower themselves, cultures, societies, and institutions create conditions that facilitate or undermine the possibilities for empowerment. (Source of definition: USAID)
Female Economic Empowerment is the capacity of women and men to participate in, contribute to and benefit from growth processes in ways that recognize the value of their contributions, respect their dignity and make it possible to negotiate a fairer distribution of the benefits of growth. (Source: Organisation for Economic Co-operation and Development)

Gender is the socially defined set of roles, rights, responsibilities, entitlements, and obligations of females and males in societies. The social definitions of what it means to be female or male vary among cultures and change over time. (Source of definition: USAID)

Gender Equality is a state in which both men and women have equal opportunity to benefit from and contribute to economic, social, cultural, and political development; enjoy socially valued resources and rewards; and realize their human rights. (Source of definition: USAID)

Gender Integration involves identifying and then addressing gender inequalities during strategy and project design, implementation, and monitoring and evaluation. Since the roles and power relations between men and women affect how an activity is implemented, it is essential that project managers address these issues on an ongoing basis. (Source of definition: USAID)

Integrated SBC refers to SBC programming designed to cohesively address more than one health or development issue within the same program.

Intensity- The average number of times individuals or households are exposed to a specific message.

Participatory Governance consists of state-sanctioned institutional processes that allow citizens to exercise voice and vote, which results in the implementation of public policies that produce some sort of changes in citizens' lives (1). Government officials should also be responsive to this kind of engagement. In practice, participatory governance can supplement the roles of citizens as voters or as watchdogs through more direct forms of involvement. (Source of definition: Wampler, B., & McNulty, S. L. (2011).

Phasing- Dividing implementation of an intervention into several stages over time.

Reach – The number of individuals or households exposed to the program's interventions and/ or messages.

Sequencing – The order in which activities are implemented.

Small doable action is a behavior that, when practiced consistently and correctly, will lead to household and public health improvement. It is considered feasible by the householder, from their point of view, considering the current practice, the available resources, and the particular social context.

Social and Behavior Change /Communication (SBC/C) is the systematic application of interactive, theory-based, and research-driven processes and strategies to address social and behavioral change at the individual, community, and social levels, including the crosscutting use of strategic communication. (Adapted from FHI360 2012: C-Modules)

Very young adolescents are girls and boys between the ages of 10 to 14.

Youth are people in the 10 to 29-year age range, with a general programmatic focus on those aged 15 to 24. (Source of definition: USAID)

Youth Engagement is the active, empowered, and intentional partnership with youth as stakeholders, problem solvers, and change agents in their communities." (Youth Leadership Institute 2009, p.13).

Project Background

The U.S. Agency for International Development funds the Wadata Development Food Security Activity, which translates to "prosperity" in Hausa, through the Office of Food for Peace. It is implemented by a consortium led by Save the Children (SC), with partners, National Cooperative Business Association/ CLUSA International (NCBA CLUSA), The Kaizen Company, and Développement pour un Mieux-Être (DEMI-E).

Project Goal: Sustainably improved food and nutrition security and resilience among extremely poor and chronically vulnerable households and communities in the Zinder region of Niger.

Project objectives

- **Purpose 1:** Enhanced collective action to address food, nutrition, and water security shocks and stresses
- **Purpose 2:** Increased capacities, assets, and agency for improved access to adequate and diverse foods at all times.
- **Purpose 3:** Improved nutrition, health, hygiene, and sanitation for pregnant and lactating women, adolescents, children under five years of age (CU5), and their families.

Wadata will work through four identified **leverage points** that have the highest potential for positive, sustainable impact:

1. Female and youth empowerment (youth engagement) for inclusive development
2. Improved community natural resource management with a particular emphasis on water
3. Participatory governance of community-based organizations (CBOs) and their institutional counterparts
4. Engagement of community influencers as drivers and supporters of change

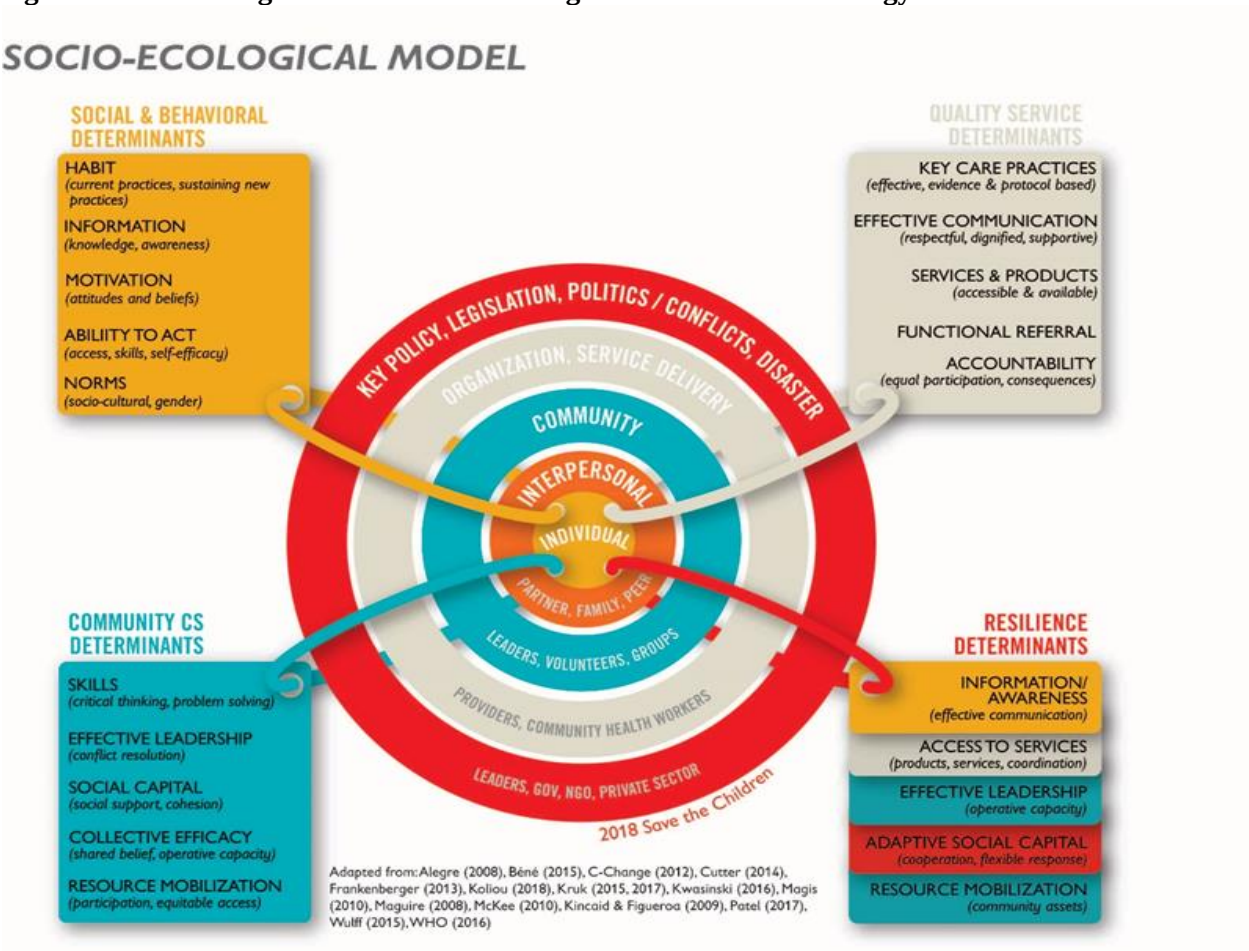
Wadata will focus on several topical areas and priority behaviors based on evidence from formative research studies covering SBC, Cost of Diet, gender and youth, WASH Markets, community consultations, and crops and livestock.

Overall SBC/C Approach: Social and behavior change/ communication (SBC/C) activities are an essential program component for improved development, health, and wellness outcomes (e.g., gender equality, livelihood, nutrition, and hygiene, etc.). The Wadata Project will incorporate a systematic application of interactive, theory-based, and research-driven processes and strategies to address social and behavioral change at the individual, community, and social levels, including cross-cutting use of strategic communication. Specifically, the Wadata project will use a multi-pronged, integrated approach to enable changes in norms and behavior. The project will use four approaches to address multiple topics and/or behaviors simultaneously and engage stakeholders from different sectors (1. Building/ strengthening community infrastructure; 2. Community SBC/C; 3. Community capacity strengthening; and Community service delivery). Furthermore, the project will use a diverse set of activities that reinforce each other. Interventions will be based on consistent, locally adapted actions aimed at improvements in behavior and outcomes in the short term and sustainable progress in the long term.

The Wadata SBC/C Strategy is based on a socio-ecological model (**Figure 1**) that suggests an individual's behavior is influenced and shaped by interactions with different actors and structures in the social environment (in the rings) and various types of determinants (the colored tags). This model emphasizes the need for programs to implement strategic interventions and complementary communication activities using a wide variety of mutually reinforcing activities and communication channels. The Wadata SBC/C strategy focuses on all four sets of determinants, as seen in Figure 1. As

outlined further in this strategy, some of the determinants listed in the model will carry more weight than others in the context of the project's implementation areas.

Figure 1. Socio-ecological model used for design of Wadata SBC Strategy



Vision for the Wadata SBC interventions: Wadata will deliver cohesive and logically packaged SBC interventions that unite divergent health and development areas and contribute to long-term social change, beyond the lifetime of the project.

Assessment

Wadata conducted nine formative research studies to inform project design and rollout and to identify community platforms and actors interested in engaging with the Project's overall goals and objectives. In consultation with Breakthrough ACTION, Wadata conducted an SBC formative research study to inform the development of the SBC Strategy.

The SBC formative research consisted of a situational analysis and qualitative research. The goal of the situational analysis was to review relevant literature and data, analyze the information, and contribute to

the Theory of Change adaptation to help focus our strategy within the implementation area context. The formative research built on what was learned under LAHIA and other projects in Niger, information gathered through embedding social and behavior change (SBC) queries into other Wadata research pieces, and a gap-filling research piece that focused on specific knowledge gaps in behaviors and norms, and barriers and enablers, that influence outcomes across sectors. The gender analysis was conducted and reviewed before the SBC study implementation, and is assisting in the design of the Project's interventions to close gender-based gaps and remove gender barriers, based on the changes we want to see in the lives of girls, boys, women and men.

Situational Analysis

Existing Knowledge & Gaps: Women, girl's and youth disempowerment in the Zinder region

Almost 37% of Zinder's population is between the ages of 10 and 29, and the region's mean age is 18. Yet, both girls/young women and boys/young men face barriers to realizing their full potential and contributing to positive change.[1] Structural barriers include diminished agricultural assets, and young people who often lack the skills and capital to diversify livelihoods or make migration more profitable.[2] According to a 2018 study in Zinder, low education levels, religious intolerance, persistent poverty, and a lack of essential services have contributed to an environment in which extremism among youth is becoming increasingly commonplace.[3] A 2017-8 SC assessment in Maradi and Zinder found that, although the public and private sectors make efforts to offer adult learning and technical/ vocational training,[4] the lives of many young people are defined by unemployment and poverty.

In the Zinder region of Niger, gender norms dictate that men act as the household's primary decision-makers, with final say over the use of financial resources, livestock, family planning, and the mobility of women and girls.[5] Only 21% of women are the primary decision-makers regarding their health, and only 20% of women are decision-makers on essential household (HH) purchases.[6] Women's low decision-making power and control over resources is compounded by normalized gender-based violence (GBV) in the form of sexual, physical, and psychological abuse, with high rates in Zinder (42%, 34%, and 38% respectively).[7]

The rate of child marriage in the Zinder region is among the highest in the country, at 87%.[8] The early nuptiality pattern in Niger is influenced by polygamy that remains widely practiced. More than a third of the married women are living in polygamous unions.[9] Girls' socio-culturally defined roles and domestic responsibilities mean that they face skill gaps, time poverty, and low access to training, information, financial capital, family planning services, and even nutrient-rich foods.[10] [11] The median age at the first union of women is estimated to be 15.7 years old and almost identical to the age at first intercourse sexual

[1] Niger National CensuS, 2012. In Wadata's 4 communes, 37.2% of the population is between the ages of 10-29. .
[2] Shrinking family plot sizes cited in FFP Niger Desk Review (WB data); expansion of crop farming on marginal lands (FEWSNET 2011).
[3] IOM (2018) Youth Violence the Challenges of Violent Extremism in Zinder.
[4] There are 16 adult learning centers and 11 technical and vocational training centers available in the target Departments.
[5] https://www.genderindex.org/country/niger/
[6] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[7] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[8] https://www.savethechildren.org.uk/content/dam/global/reports/advocacy/child-marriage-niger.pdf
[9] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[10] FFP Niger Desk Review.
[11] USAID (2017) Sahel Youth Analysis.

(15.9 years) while the median age of men at the first union is estimated at 24.6 years.[12] In the Zinder region, more than 59% of girls, aged 15-19 have had sex.[13] Over half of adolescent girls give birth by the age of 19 in Zinder.[14]

The use of modern contraception by women 15-49 years of age is 16% in Zinder, which is higher than the national average.[15] The pill is the modern method most frequently used by women (4% of rural women), followed by LAM (4% rural areas) and then injectables (2% of rural women). [16] However, there has been an absence of change in the fertility level in Niger over the recent decades.[17] Niger has one of the highest maternal mortality ratios in the world. Delivering at home is deeply rooted in the country's culture and traditions. ANC attendance remains low in rural Zinder.[18] Although the majority of women (83%) reported seeking ANC at least once during a pregnancy, only 33% of women reportedly attended at least four visits.[19] However, one study indicated that women who reportedly received husbands' advice about attending ANC were more likely to attend ANC.[20] Cultural concerns appear to be paramount in keeping women from receiving care before, during, or after birth. Very young women who are pregnant for the first time often refuse antenatal care out of shame. Often women receive no financial support from their husbands, who sometimes will not let them obtain assistance from a trained provider. Only 17% of women in Niger give birth at health facilities.[21]

The Zinder Region is also home to some of the highest numbers and largest proportions of extremely poor and malnourished people in Niger. Food insecurity increased from 2016-2017 (2017 National Survey of Food Security in Rural Households Preliminary Results), with 29% of the population at risk of food insecurity, another 17.5% already food insecure (WFP VAM). Many households (HH) in Zinder struggle to meet basic food needs. The poorest HH obtain 60% - 80% of their food from purchases or payment in kind and 20% - 30% from HH production, with food purchases ranking among the top two annual HH expenses.[22]

Climate-smart agriculture (CSA) seems to be a suitable strategy for achieving food security while also mitigating and adapting to climate-related risks. Numerous CSA technologies are appropriate for climate change adaptation and risk management in West Africa (e.g., agroforestry (farmer-managed natural regenerations), soil and water conservation technologies (e.g., zai, half-moon, tie/contour ridges, conservation agriculture) and climate information services).[23] While the region produces some of Niger's major oilseed and legume cash crops, traditional sorghum/millet and livestock production is constrained by low yields and shrinking farm sizes. Rising temperatures, extended dry spells, considerable rainfall

[12] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[13] UNFPA, 2019. Retrieved from : https://www.unfpa.org/es/data/transparency-portal/unfpa-niger
[14] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International
[15] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[16] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[17] Spoorenberg, T. & Maga, H.I. (2018). Fertility compression in Niger: A study of fertility change by parity 1977-2011.
[18] Begum, K., Ouédraogo, C. T., Wessells, K. R., Young, R. R., Faye, M. T., Wuehler, S. E., & Hess, S. Y. (2018). Prevalence of and factors associated with antenatal care seeking and adherence to recommended iron-folic acid supplementation among pregnant women in Zinder, Niger. *Maternal & child nutrition*, *14*.
[19] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[20] Begum, K., Ouédraogo, C. T., Wessells, K. R., Young, R. R., Faye, M. T., Wuehler, S. E., & Hess, S. Y. (2018). Prevalence of and factors associated with antenatal care seeking and adherence to recommended iron-folic acid supplementation among pregnant women in Zinder, Niger. *Maternal & child nutrition*, *14.*
[21] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[22] FEWSNET (2017) West Africa Enhanced Market Analysis; and, FEWSNET (2017) Staples Fundamentals Report.
[23] Partey, S. T., Zougmoré, R. B., Ouédraogo, M., & Campbell, B. M. (2018). Developing climate-smart agriculture to face climate variability in West Africa: challenges and lessons learnt. *Journal of cleaner Production*, *187*, 285-295.

variability, lower forage availability, and decreasing soil fertility compound limited crop and livestock productivity while creating conditions conducive to conflict between farmers and herders.[24] [25] A recent review found the prospects of CSA in West Africa hinge on the capacities of farming households and the region's national institutions to understand the environmental, economic, and social challenges in the context of climate change, and consequently self-mobilize to develop and implement responsive policies at appropriate scales.[26]

Intergenerational cycles of undernutrition are a persistent problem in Zinder, whose population continues to suffer from high rates of stunting and wasting among children under five years of age (50.1% and 11.7%, respectively), and high levels of undernutrition among mothers (15.5%). Diarrhea and fever, poor hygiene and sanitation conditions, low access to safe drinking water, and poor infant and young child feeding practices all contribute to child malnutrition.[27] Exclusive breastfeeding is low (25%), as are complementary feeding and dietary diversity. The proportion of children fed according to optimal feeding practices does not exceed 5% in rural areas.[28]

Micronutrient deficiencies and anemia among pregnant women are high (58%).[29] Meeting food-based recommendations will be extremely difficult for pregnant and lactating women.[30] In a recent study, only one in six women reported adequate dietary diversity, consuming at least five of ten defined food groups the previous day and night.[31] These issues are exacerbated by food taboos that restrict pregnant women and children's access to certain foods and supplements and by intra-HH food distribution disparities that limit women and children's access to animal source foods and other sources of protein.[32]

While the Region produces some of Niger's major oilseed and legume cash crops, traditional sorghum/millet and livestock production is constrained by low yields and shrinking farm sizes. Rising temperatures, extended dry spells, more significant rainfall variability, lower forage availability, and decreasing soil fertility compound limited crop and livestock productivity while creating conditions conducive to conflict between farmers and herders.

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[24] USAID (2017) Climate Risks in FFP Geographies: Niger
[25] World Politics Review (2018), Turner, et. al. (2011). Livelihood Transitions and the Changing Nature of Farmer–Herder Conflict in Sahelian West Africa. The Journal of Development Studies, Vol. 47. Oyama, S. (2014). Farmer-Herder Conflict, land rehabilitation, and conflict prevention in the Sahel region of West Africa. African Study Monographs, Suppl. 50.
[26] Partey, S. T., Zougmoré, R. B., Ouédraogo, M., & Campbell, B. M. (2018). Developing climate-smart agriculture to face climate variability in West Africa: challenges and lessons learnt. *Journal of cleaner Production*, *187*, 285-295.
[27] FEWSNET (2017) Nutrition Causal Analysis Study Report
[28] Institut National de la Statistique (INS) et ICF International, 2013. Enquête Démographique et de Santé et à Indicateurs Multiples du Niger 2012. Calverton, Maryland, USA : INS et ICF International.
[29] 2012 DHS, dietary diversity score for CU2 was 8.7%; minimum meal frequency 52.4%; and minimum acceptable diet 5.8%. UNICEF (2016). *Analyse de coût-efficacité de la mise à l'échelle des interventions spécifiques à la nutrition au Niger*.
[30] Assessment of Dietary Intake and Nutrient Gaps, and Development of Food-Based Recommendations, among Pregnant and Lactating Women in Zinder, Niger: An Optifood Linear Programming Analysis, 2018.
[31] Assessment of Dietary Intake and Nutrient Gaps, and Development of Food-Based Recommendations, among Pregnant and Lactating Women in Zinder, Niger: An Optifood Linear Programming Analysis, 2018.
[32] Faye, A. (2014) Niger DFAP PASSAM TAI, LAHIA, SAWKI, *Analyse Genre dans les Regions de Maradi et Zinder*.
[33] Niger Demographic Health Survey (DHS) 2012. 15.5% of women with a body mass index (BMI) of 18.5 or lower.
[34] FFP Desk Review for Niger.
[35] Horton, 2013; SUN, 2016; Thurnham, 2013; Black et al., 2013; Finlay et al., 2011.
[36] FEWSNET (2017) Nutrition Causal Analysis Study Report

anemia among pregnant women are high (58%).[37] [38] These issues are exacerbated by food taboos that restrict pregnant women and children's access to certain foods and supplements and by intra-HH food distribution disparities that limit women and children's access to animal source foods and other sources of protein.[39]

Village Development Committees (VDC) are key actors in the GoN decentralization process, along with Commune and Municipal authorities, yet less than 50% of villages in Zinder Region have functional VDCs Region, and none in Wadata targeted villages.[40] Women, girls, and boys have limited access to community forums. Commune planning and action cycles are under-resourced and not representative of local priorities due to weak linkages between VDCs and Communes. While the GoN's commitment to decentralization and donor-funded interventions have made some progress, current levels of participation, accountability, skills, linkages, and resources are inadequate to address community-level food, nutrition, and water security challenges. Similarly, while Zinder is home to several officially recognized industries (tanning, food processing, and non-timber forest products), the Region's economy remains mostly agriculture-based, and formal sector job creation remains weak.[41] Many products and services have not yet reached "last mile" markets.

Gaps in services provided by local government and community-based organizations (CBOs) fail to meet the multiple and related needs of vulnerable households. Persistent barriers to improved health outcomes in Niger include constrained geographic and financial access, shortages and mal-distribution of health workers, stock-outs of essential medicines and supplies, weaknesses in human resources management, lack of responsive, high-quality services, inadequate availability of data and use of data for decision-making, and weaknesses in governance and community capacity to hold the health system accountable. Health management committees (COGES) led by community members often lack the capacity to create action plans to address bottlenecks and challenges at the service delivery level.

Data that affects programming in the current COVID-19 context[42]

The current World Health Organization's (WHO) guidelines call for the public focus on handwashing with soap, social distancing, communication with CHWs, and staying abreast of latest updates to mitigate the spread of COVID-19.[43] However, practicing these recommended behaviors may be difficult for families living in Zinder due to physical barriers along and pre-existing social norms and habits.

Recommendations encourage people to stand one to two meters apart and avoid physical contact as much as possible. According to the 2012 Niger DHS,[44] an average of 6 people live in the same household, and at least three people share the same room. Families may also not be able to avoid contact with community members outside the family since most basic water and sanitation services are shared, or nonexistent, which can lead to a multitude of health and security issues on top of COVID-19. According to the Wadata formative research WASH study, handwashing with soap is rarely practiced. However, handwashing is linked to ablutions before prayers.

[37] 2012 DHS, dietary diversity score for CU2 was 8.7%; minimum meal frequency 52.4%; and minimum acceptable diet 5.8%.
[38] UNICEF (2016). *Analyse de coût-efficacité de la mise à l'échelle des interventions spécifiques à la nutrition au Niger*.
[39] Faye, A. (2014) Niger DFAP PASSAM TAI, LAHIA, SAWKI, *Analyse Genre dans les Regions de Maradi et Zinder*.
[19] Wadata Community Consultation Report, 2019
[40] Wadata Community Consultation Report, 2019
[41] Ministère de l'Emploi, du Travail et de la Sécurité Sociale, Observatoire National de l'Emploi et de la Formation Professionnelle. Recensement des Emplois Créés: Rapport sur les Emplois Créés au titre des années 2013, 2014, 2015, 2016
[42] For tips on how to engage communities during COVID-19 in low-resource settings, remotely and in-person refer to this guide: https://communityengagementhub.org/wp-content/uploads/sites/2/2020/05/CE-low-resource-settings-distance-April-2020.pdf
[43]Retrieved from: https://blog.dhsprogram.com/data-should-drive-covid-19-mitigation-strategies-in-lower-and-middle-income-countries/
[44] Retrieved from: https://www.statcompiler.com/en/

Additionally, more than 80% of respondents report no latrine built in their compound, and more than 85% of respondents report currently practicing open defecation (OD). To access water, 60% of households need to travel at least 30 minutes (roundtrip).[45] In the Local Water and Sanitation Plan (PLEA), which the municipalities developed in 2019, it is reported that the commune of Damagaram Takaya has a household access rate to the basic sanitation service of 5.39% and an open defecation rate of 94.61%. The other intervention municipalities of Wadata have the same characteristics.

The WASH formative research found that communities in Zinder mainly wash their hands without soap, and only 28% of participants interviewed were willing to purchase soap. Direct observations and responses to key informant interviews and focus group discussions indicate that a vast majority use soap for cloth cleaning and not for handwashing, and the presence of soap was observed in only 23.5% of households. Hence, current barriers around handwashing with soap already in Zinder need to be considered in the COVID-19 context.

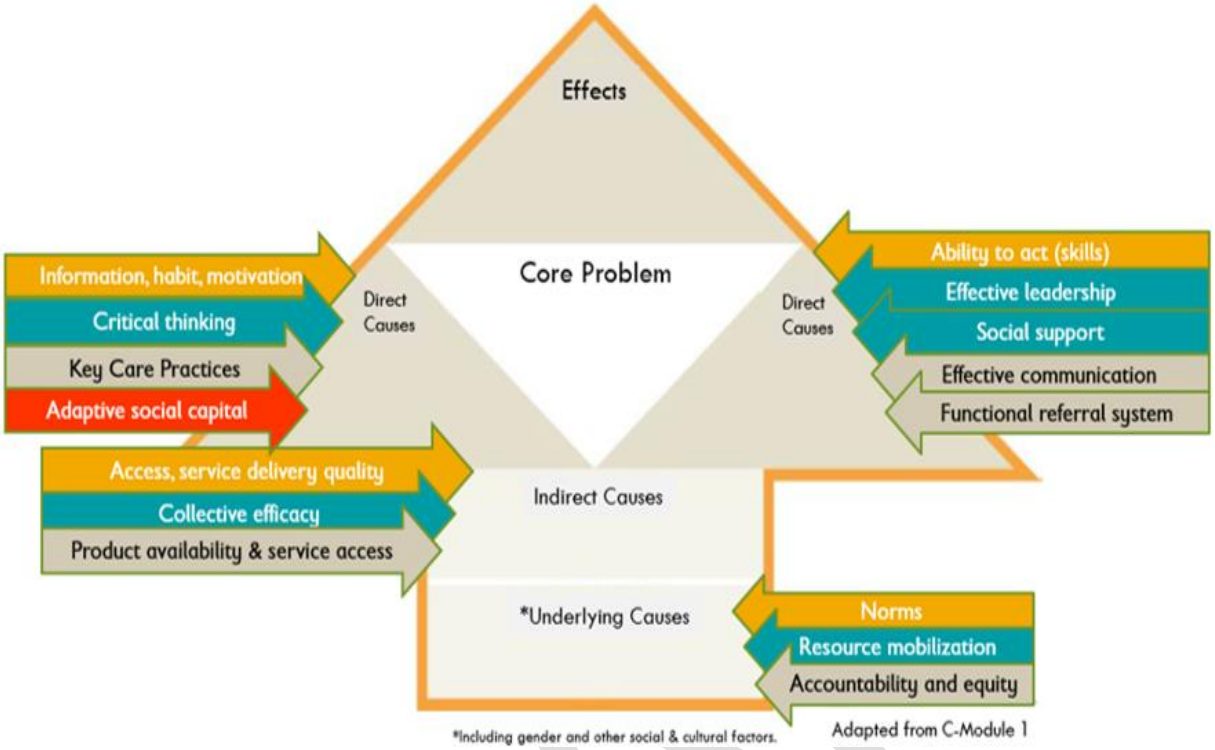
As shown in Wadata formative research and many studies in Niger, women have little autonomy, and GBV is high in households. With decreased mobility during the COVID-19 context, we expect gender-based violence to increase in households. Timely introduction of health topics and activities will be essential for more effective programming; GBV and female disempowerment discussions with community platforms may need to be prioritized during the recovery phase of COVID-19 to ensure that these behaviors do not become normalized.

Problem Tree

A problem tree is used to help us identify problems and find solutions by mapping out the anatomy of cause and effect around health outcomes, food and nutrition security, and resiliency in the Zinder region. The problem tree is based on the determinants of social and behavior change included in the SBC Integrated Framework. **Figure 2.** provides an outline of the SBC determinants and where they fall on a problem tree.

[45] WASH Study in four communes in Zinder Region, Niger: 2019: USAID/WADATA Project.

Figure 2. Problem tree based on the SBC Integrated Framework



The determinants of behavior that lead to poor health, malnutrition, and a lack of resiliency are complex and interrelated. Wadata undertook multi-sectoral formative research to analyze the situation for all the key areas that the project needs to address. While it is challenging to identify significant, discrete causes of what is driving social and individual behavior, it is possible to identify trends and likely contributing factors that affect health outcomes, nutrition, and a range of development issues. **Table 4**. provides a context-sensitive problem tree for Wadata.

Table 4. Problem Tree for Wadata

Effects: Poor health outcomes, food and nutrition insecurity, lack of resiliency

Core problem: Poverty and gender inequality

Direct causes:

- Low literacy and education for most
- Low health and financial literacy for most
- Poor health and nutrition practices
- Lack of autonomy, agency, and decision-making ability of women and girls
- Social isolation and limited mobility for women and girls, especially young married women
- Inequitable participation of women and youth in community life
- Very few options for young people, especially young women, to be productive within their communities
- Men and to a limited degree boys have more social power than women and girls
- Women and girls have less access to sources of information
- Lack of female leadership models/ men hold most leadership positions in their communities
- Preferential food allocation patterns based on economic contribution, social valuation and other factors play a role in limiting the intake of animal source foods consumed by adolescents, women and children 6-23 months
- Concepts of governance and social cohesion not well understood

Indirect Causes:

- Weak health system
- Lack of access to healthcare services and interventions
- Few social safety nets or social protection services for vulnerable households
- Lack of access to sufficient, high quality, and diverse food due to entrenched poverty, exacerbated by ongoing cycles of shocks and crises
- Lack of cooperation between community members to work together to develop community
- Lack of resource mobilization among community groups
- Segregated meeting places

Underlying Causes:

- Discriminatory gender norms, age discrimination against the youth (social hierarchy)
- Gender-based violence against women and girls
- Lack of vocational training and economic strengthening opportunities for women, girls, and boys
- Women and girls perform the bulk of unpaid domestic and care work that leads to time and income gaps between men and women
- Agricultural productivity gap between men and women
- Lack of essential services such as electricity, sanitation, or water
- Diminishing agricultural returns affecting food security and livelihoods
- Isolation of communities/ long distance to main transportation routes
- Women and children are at higher risk of malnutrition than men due to reduced access to nutritious foo and their differing nutritional needs
- Structural and environmental constraints on individuals' actions may play equally important roles in determining behaviors (e.g., such as the lack of water may affect WASH behaviors)
- Child marriage widely accepted/ Girls have tremendous pressure put on them to get married and have children

Problem Statement

Based on the problem tree exercise, a problem statement was developed. We used the following questions to help us write the overall SBC problem statement.

1. What is happening? (Taken from "core problem" part of the problem tree.)
Poverty and gender inequality appear to be the major driving forces affecting all aspects of health, nutrition, WASH, food security, livelihoods, use of health, hygiene and nutrition services, and resilience in the Zinder region.

2. Where and to whom? (Taken from the formative research.)
A high percentage of people live in extreme poverty in the Zinder region leading to a lack of both income and assets and interrelated, chronic deprivations, including hunger and malnutrition, poor health, limited education, and marginalization or exclusion. Women, girls, and boys are the most marginalized and excluded.

3. With what effects? (Taken from the "effects" part of problem tree)
Poverty and gender inequality (among other factors) leads to poor health outcomes, food and nutrition insecurity, lack of resiliency.

4. Who is influencing the situation? (Taken from the formative research.)

Husbands/Fathers (direct influencer)

Husbands/fathers have tremendous potential to be either a positive or a negative presence within the family ecosystem. Within his own home, he can help create a supportive environment with caregiving, encouraging his wife, helping with chores, and easing the burden of care for the older children. He can also ensure adequate monetary resources for purchasing high-quality foods for his wife and children to consume. The father can mitigate the influence of others, particularly older, females, on his wife's/wives choices. His formal power as the husband and father rivals that of the trust and relationship his wife may have with other females in her life.

Family members (direct influencers)

Most households are composed of a mother, father, and children, and many include grandparents, uncles, and aunts as well. Family dynamics significantly impact health in both positive and negative ways. Having a close-knit and supportive family provides emotional support, economic well-being, and increases overall health. However, the opposite is also true. Wadata's formative research did not capture data on who influences whom within the family, power dynamics between all the various family members, and decision making between various members of the family.

Traditional and faith-based leaders (indirect influencer)

In Niger, traditional and religious actors have deep and trusted relationships with their communities and connections to disadvantaged and vulnerable members. As such, they are particularly well placed to address inequity related to societal factors – such as social norms, behaviors, and practices that affect access to services or fuel discrimination and deprivation – and thus facilitate efforts towards the realization of the rights of the most disenfranchised.

Community health agents

Community health agents function in multiple roles: bridging communication between patients and providers, providing health education and counseling, and monitoring health status. Thus, community health agents have a tremendous potential to influence and improve health outcomes.

These key influencers will be engaged in SBC activities, including land, water management and conflict resolution, intra-HH economic decision-making, and family planning, and WASH. Community influencers will also help to reinforce women's involvement in marketing activities through SBC activities.

5. And as a result of what cause? (See the "direct," "indirect," and "underlying causes" sections of the problem tree.)

Problem statement

Poverty and gender inequality appear to be the major driving forces affecting all aspects of health, nutrition, WASH, food security, livelihoods, use of health, hygiene and nutrition services, and resilience in the Zinder Region. According to the World Bank (2019), over 40% of the country's 22.4 million people live in extreme poverty. Additionally, there is an inadequate availability of sufficient, high-quality, and diverse foods due to shocks, climate change, challenging agro-ecological conditions, population growth, and underdeveloped food systems. Families often have insufficient purchasing power to access sufficient, high-quality, and diverse food, which is exacerbated by ongoing cycles of shocks and crises. Poverty limits access to formal health care, while hierarchy and power limit access to community resources.

In terms of gender, pre-existing gender inequalities resulting from unequal access to opportunities contribute to the limited access to resources and skills among women and girls, which in turn increases their vulnerability. Women do not necessarily have the knowledge and agency to provide for their well-being, nor the well-being of their children. The extremely disadvantaged position of women, including inadequate care of mothers and young children, coupled with high levels of early marriage and pregnancy, leads to an intergenerational cycle of poverty, malnutrition, and poor health. In addition, cultural and social norms prevent the uptake of practices that could lead to improved health, nutrition, WASH. Imbalances in power and lack of resources also lead to more significant problems such as maternal, adolescent and infant malnutrition, water-borne diseases, adolescent pregnancies, poor agricultural yields, lack of opportunities for youth livelihoods, and inability to prepare appropriately for shocks and stresses. Husbands/fathers have tremendous potential to be either a positive or a negative presence within the family ecosystem as well as other influencers such as religious leaders, traditional leaders, community health agents, and other family members.

Addressing this problem calls for:

Identifying and targeting the most affected and vulnerable audiences open to and able to react to the need for behavior change (e.g., openness to discussing and challenging risky social and gender norms or willingness to explore and adopt new solutions to long-standing problems). Reaching these audiences will involve working with established local governance structures as well as interpersonal communication (IPC) structures, such as community nutrition platforms and Village Development Committees, to identify and mobilize those most affected (primary audiences, which are listed below) to participate in the planned SBC interventions.

Identifying and addressing the various gender inequitable norms, myths and misconceptions, and the prevailing harmful attitudes that prevent the uptake of promoted services and practice of recommended behaviors that increase the vulnerability of households to poverty, poor health outcomes, malnutrition, and food insecurity. Gender inequality manifests itself as harmful and discriminatory norms, attitudes, and behaviors. Furthermore, gender inequality limits opportunities for women and girls, as well as puts pressure on men and boys. These inequalities are reinforced by discriminatory systems and

structures that prevent women and girls from reaching their potential. Wadata's approach to addressing gender inequality will include developing a platform for small group discussions, mentoring, and dialogue to explore, challenge, change harmful norms, and find locally grown solutions.

Identifying, working with gatekeepers and influencers to create an environment that supports the uptake of the promoted services and of recommended behaviors. This will involve establishing partnerships with community gatekeepers and influencers, and working with established traditional structures and government by enhancing their capacity to facilitate the change process.

Additional formative research needs

Although Wadata SBC formative research painted a vivid picture of Zinder, it also shed light on additional questions that should be answered to spur more systematic and anchored behavior change. Additional research needs or potential program activities for each program sector and potential methods of collecting information are shown below. Some potential methodologies or activities could be added to the Wadata learning agenda or implementation plan.

Nutrition Gaps

Community health workers' roles-In the doer/non-doer analysis on breastfeeding practices, participants identified community health workers as being an approver of exclusive breastfeeding of children 0-6 months of age. However, the analysis and overall formative research collected little information on what types of information health service providers are disseminating on exclusive breastfeeding in Zinder. The Project could conduct key informant interviews of health center staff and community health workers and also look at some of their job aids. Additionally, the Project could target study participants who cited community health workers as approvers of exclusive breastfeeding and ask them what types of information they received.

Conflicting beliefs around breastfeeding- Wadata's formative research data indicates many conflicting beliefs regarding breastfeeding. For instance, it is thought that breastfeeding can cause or doesn't cause babies to get sick. Accurate information should be provided during implementation.

Lactating moms are hungry- During doer/non-doer analysis, participants cited "maternal malnutrition" and "moms are hungry" as barriers to practicing exclusive breastfeeding. It is important to ensure a mother's health since she is a vital part of the mother-infant feeding twosome, or dyad. Supporting breastfeeding means caring for her as well as for her infant. The mother's nutrition affects her health, energy, and well-being. The mother's dietary intake is not directly linked to how much breastmilk she can produce in a day; nevertheless, mothers may think this is the case. If a mother is moderately malnourished, she will continue to make milk of good quality, better than infant formula. If she is severely malnourished, the quantity of breastmilk produced for each feeding may be diminished. In both cases, for the health of the mother and the child, it is safer and better to feed the mother adequately while helping her to continue breastfeeding. There is a belief that lactating women need to eat soft food that should be explored. Wadata needs to focus on making it obtainable and acceptable for pregnant and lactating women to eat more highly nutritious food. Because the formative research did not ask specific questions about maternal malnutrition, Wadata could conduct Trials for Improved Practices in sample villages to find out if it is possible to increase the diversity and adequacy of food in the mothers' diet.

WASH Gaps

Water Treatment-The WASH formative research suggests that more than half of the households interviewed received information on water treatment, but only a third of them treat water at home. The Project could conduct a Knowledge, Attitudes Practices (KAP) study to assess the psycho-social

determinants of WASH further (e.g., why villages express overall satisfaction with access to water while systems break down often).

Gender

Communication between couples- Both the SBC Strategy and Gender and Youth analysis point to very little communication about household finances, chores, family roles, and livelihoods between couples in Zinder. The only time where we have a clear indication that couples talk is when a woman is seeking approval from her husband to leave home, or around what food to buy at the market for household consumption. We need to learn more about whether and when couples discuss other matters at home, how tasks are divided, and how communication influences breastfeeding and health seeking behavior. The Project could search for positive deviants in target communities and conduct key informant interviews to understand the motivating factors around open dialogue among couples.

Participation in community activities by women and girls- Women and girls want to be involved in community development projects; however, they need permission to speak at public gatherings and are not able to access certain meeting places like men and boys can, which limits their ability to participate in community-wide events and advocacy on a larger scale. Additionally, heavy daily workloads affect the time and resources that they have to put towards activities outside the family. It will be necessary during the early phases of the Project to find out how feasible it is for women to participate in community groups, especially if they are mixed. Any female members who participate in community activities could be interviewed after initial group meetings to understand their motivation for attending and to gauge their feelings in participating.

Agriculture Gaps

Nutrition-Sensitive and Climate Smart Agriculture- Planting nutritious foods in community and/or household gardens could significantly reduce the cost of a nutritious diet for households, pregnant and lactating women, children under 2, and adolescent girls. However, Wadata's formative research did not explore the feasibility of farmers planting nutrition-sensitive crops on community land, or the acceptance of this practice by community leaders. The Project needs to identify the barriers to this behavior in implementation areas and could conduct an additional doer/non-doer analysis in two to three villages to gather more information on barriers and facilitating factors.

The formative research did not explore specific barriers to practicing climate-smart agriculture, nor did research define climate-smart agriculture. However, the crop and livestock research did find that there was a lack of training and awareness on the use of certified seed and limited seed distribution at the community level, which could impact decisions to practice climate-smart agriculture. The Project should first define climate-smart agriculture and then conduct a focus group discussion among farmers to determine if this practice is feasible and why. Because community platforms need to be established in the first year of implementation (year 2), this behavior could be explored in year three of Project implementation.

Behavioral Focus

Theory of Change

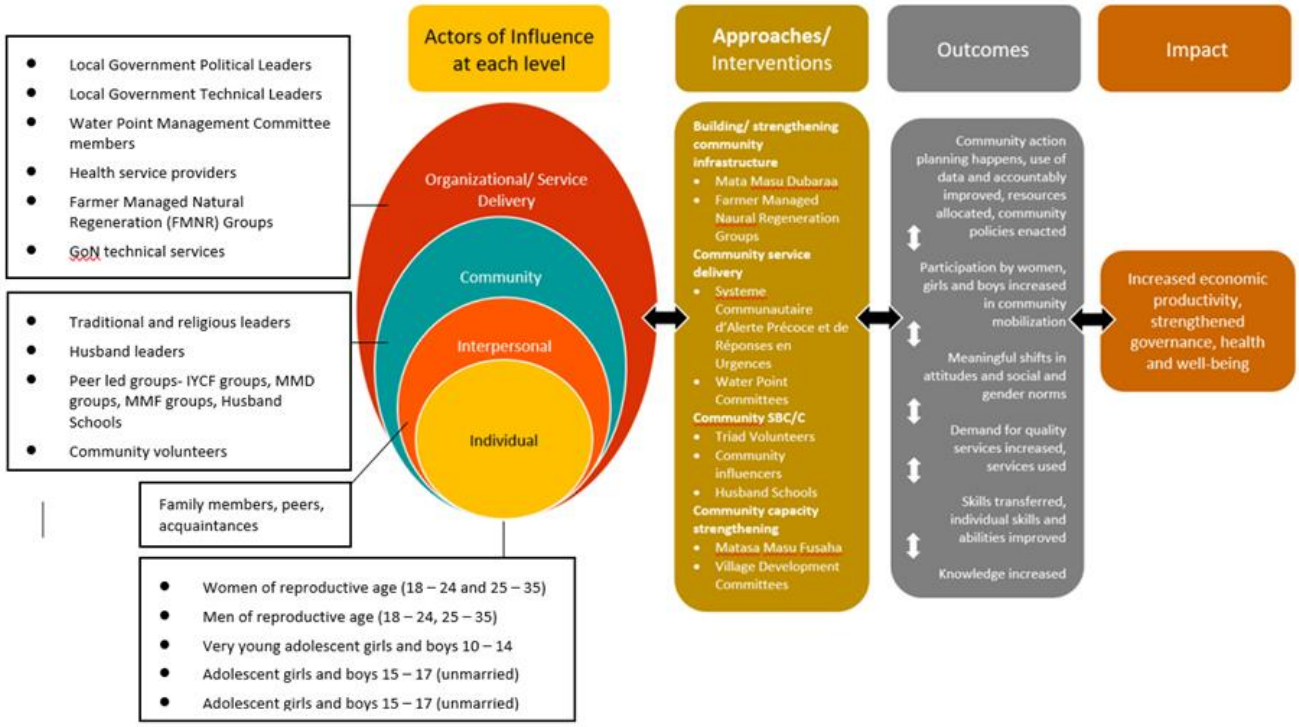
Please note that Wadata has an overall Theory of Change (ToC); however, the Theory of Change shown in **Figure 3** is different from the Wadata overall ToC. The ToC shown in **Figure 3** lays out a "map" of how and why we expect social and behavior change to happen. We will use this Theory of Change to focus and guide every aspect of the SBC strategy – from design to implementation and M&E.

The Wadata SBC Theory of Change is based on an ecological model of social and behavior change. The project's ToC considers changes that must take place at the individual, intrapersonal and community levels, and at the organizational/ service delivery level to improve gender equality and social inclusion, increase economic productivity for females and males, and strengthen governance, resilience, health and well-being.

Our Theory of Change is based on the assumption that the combination of building/strengthening community infrastructure, the demand for service provision at the community level, communication for social and behavioral change and community capacity strengthening and will result in opportunities for change including:

- Equitable access to, control over and benefit from community systems, structures and resources
- Increased engagement of women, girls and boys in meaningful participation in community life
- A shift in perceptions, social norms among individuals, families, community members towards a social environment more conducive to healthy health, nutrition, WASH behaviors and practices
- Transformation of discriminatory gender norms, attitudes and behaviors
- Increased demand and ability to use and to request health and agricultural services thanks to improved support and mobilization from community health workers (CHAs), agriculture extension agents and various community groups such as nutrition triads, Husband Schools, MMDs/MMFs, VDCs, SCAPRU, WPMGs
- Improved governance and accountability for community infrastructure
- Provision of life skills training for women, girls and boys, which includes leadership development, confidence building, conflict management and negotiation skills to enable females and males to work together as equals
- Improved knowledge, motivation, and ability of individuals to adopt and practice appropriate health, nutrition, agriculture, resilience and livelihoods behaviors

Figure 3. Wadata SBC/C Theory of Change



Audience Segmentation

Audience segmentation will help us align messages, message delivery channels, products, and services with the needs and preferences of the primary audiences to maximize the impact of the project. The audiences listed in **Table 5** were selected based on the fact that they cannot be reached effectively with the same messages, interventions, and channels given the context.

Wadata is working with three sets of audiences: 1) the adolescents, women, and men directly affected, 2) their direct influencers such as peers, family, community leaders (e.g., village chief, religious leaders), and 3) indirect influencers, often to be found at the service point and local government. **Table 5** shows the audience segmentation for the Wadata SBC strategy.

Table 5. Audience segmentation for Wadata

Directly affected	Direct influencers	Indirect influencers
• Women of reproductive age (18 – 24 and 25+) • Couples (18-35) • Men (18 – 24 and 25+) • Very young adolescent girls and boys 10 – 14 • Adolescent girls and boys 15 – 17 (unmarried) • Adolescent girls 15 – 17 (married)	• Family members (especially grandmothers, husbands for nutrition and parents for unmarried girls under 18) • Traditional and religious leaders • Husband leaders • Peer-led groups- IYCF groups, MMD groups, MMF groups, Husband Schools • Community volunteers: Triad volunteers (Community Health and Nutrition Liaisons (CHNLs), Mamans Lumieres (MLs) and IYCF group leaders)	• Local Government Political Leaders: village chief, VDCs, commune administrators • Local Government Technical Leaders: VDCs, SCAP/RU • Water Point Management Committee members • Health service providers • Farmer Managed Natural Regeneration (FMNR) Groups • GoN technical services • Regional Directorates • Private sector actors

In **Table 6**, the audiences are further aligned to the various programmatic areas of the Project (i.e., governance, resilience, gender equality and social inclusion, agriculture & livelihoods, nutrition, WASH) and the priority behaviors the Project will focus on. Each audience will be targeted with different, ongoing interventions. To avoid duplication of activities for multiple thematic areas and activities targeting and competing for the same audiences, this strategy will aim to guide implementation through an integrated approach. Please note that men 18 years and older and married are both directly affected and direct influencers of the priority behaviors that Wadata is focused on.

Table 6. Audience segmentation by programmatic area of Wadata

	Audience	Governance	Ag& Livelihoods	Use of health, hygiene and nutrition services	WASH	Nutrition	Gender Equality and Social Inclusion	Resilience
Directly affected/ Priority	**Women of reproductive age (18 – 24 and 25 and older)**		Most affected	Most affected	Most affected	Most affected	Most affected	Most affected
	Men of reproductive age (18-24, 25 and older)		Most affected	Most affected	Most affected		Most affected	Most affected
	Adolescent girls and boys 10 – 14			Most affected	Most affected		Most affected	
	Adolescent girls and boys 15 – 17 (unmarried)		Most affected	Most affected	Most affected		Most affected	
	Adolescent girls 15 – 17 (married)		Most affected	Most affected	Most affected	Most affected	Most affected	
Direct influencers	**Husbands/ fathers**		Directly influencing	Directly influencing	Directly influencing	Directly influencing	Directly Influencing	
	Family members		Directly influencing	Directly influencing	Directly influencing	Directly influencing	Directly influencing	
	Peer Led Networks: IYCF groups, MMD groups, MMF groups, Husband Schools	Directly influencing	Directly influencing	Directly influencing	Directly influencing	Directly influencing	Directly influencing	
	Health workers		Directly influencing	Directly influencing	Directly influencing	Directly influencing	Directly influencing	
	Religious Leaders: Imam			Directly influencing	Directly influencing	Directly influencing	Directly influencing	
	Triad volunteers: Community Health and Nutrition Liaisons (CHNLs), Mamans Lumieres (MLs)		Directly influencing	Directly influencing	Directly influencing	Directly influencing	Directly influencing	
Indirect influencers	**Local Government Political Leaders:** village chief, commune administrators	Most affected	Indirectly influencing				Indirectly influencing	
	Local Government Technical Leaders: VDCs, SCAPRU	Most affected					Indirectly influencing	Indirectly influencing

	Water Point Management Committees (WPMCs)				Indirectly influencing		Indirectly influencing	
	Farmer groups: Farmer Managed Natural Regeneration (FMNR) Groups		Indirectly influencing				Indirectly influencing	Indirectly influencing
	Agro-Input Dealers/ Agriculture Village Agents		Indirectly influencing					Indirectly influencing

Directly Affected Audience Profiles

Data from Wadata's various formative research studies has been used to develop the following audience profiles.

Adolescent females 10-17 unmarried and married

- The most vulnerable girls in Niger are characterized by suffering from one or more of the following five conditions: 1) being an early mother (36% of girls aged 15-19 have given birth or are pregnant); 2) getting married early (76% of girls are married before 18); 3) not having access to prenatal care by a skilled provider; 4) being illiterate (27 % literate); 5) not having access to a source of information. In Zinder, 20% of girls suffer from these five conditions simultaneously (UNICEF).
- Adolescent girls have little agency and very few opportunities to participate in events outside of their homes.
- Men hold most leadership positions in their communities.
- Young women have a lack of female leadership models compared to young men. Female role models are often external to the village or restricted to women-only settings (e.g., trainers for women's groups or leaders in women's groups).
- In mixed structures, men usually occupy important positions; women are usually allocated specific female-only positions that are known in advance.
- Young women need to seek the approval of their husbands or fathers to speak in front of men or take on a leadership position.
- Adolescent girls and boys have vastly different circles of trust and differ where they get their information. Where girls and boys seek information is gender and topic-specific. For instance, girls report finding information on reproductive health primarily on the radio as well as their cell phones and on televisions. Boys access information from a broader range of sources, including in social settings with peers at school and youth groups. Whereas for climate change, young women primarily access information through the radio, including weather forecasts; young men also primarily use the radio as a source of information on climate change, but also access information on their phones, through television, and in discussions with the village elders.
- Very few structured interventions aimed at adolescent females.

Strategies:

- Target adolescent girls (before they are married/and or pregnant) with structured interventions. This would help in shifting girl's beliefs around, continuing their education, the ideal age to marry, have a baby, and toward contraceptive use.

- Address cultural and social norms that promote child marriage by including the topic in activities with adolescent girls, men, religious leaders, and mothers-in-law to eliminate bias and misconceptions that can prevent healthy timing and spacing of pregnancy.
- Educate girls about reproductive health services and rights and where to access contraception services for themselves.
- Work with adolescents, parents, religious leaders, and the local community to address child early and forced marriage.
- Make sure that girls feel safe and welcomed in the activities they participate in. Reach out to their families to facilitate the girl's attendance.
- Engage community leaders to speak out in favor of girls reaching their potential.
- Advocate for the rule of law to protect girls' rights and prevent child, early and forced marriage etc.
- Include sessions in MMF, MMD, and EdM activities that provide adolescents and parents with a script or discussion guide to speak with each other about reproductive health issues, questions, and needs such as contraception, communication and consent in relationships, and how to avoid sexually transmitted diseases outside of abstinence. Include time for parents and adolescents to practice asking and answering questions in a safe environment. Discuss common negative responses and practice the use of positive responses.
- Consider hosting community dialogues on the practice and prevention of child marriage, engaging school directors, teachers, village leaders, religious leaders, parents, and adolescent girls and boys in the identification of root causes and possible solutions. Address the influence of peer pressure on parents and adolescent girls as well as the need for educational and vocational opportunities for young women outside of marriage.
- MMF groups, in which adolescent females will be invited to participate, will be trained in functional literacy, functional numeracy, financial literacy, career planning, positive self-concept, communication skills, family planning topics. MMF groups linked to MMDs and VDCs for support and mentorship.

Adolescent males (aged 10-17)

- Poverty and rigid gender norms, attitudes, and structures are preventing boys from reaching their potential in the Zinder region.
- There is enormous pressure to conform to notions of masculinity (e.g., a man's social status is tied to virility and ability to have children).
- Male adolescents have minimal livelihood opportunities, and because of this, they often think about migrating and/or begging to make money.
- Male adolescents have more agency and access to places in the community than female adolescents.
- Barriers to leadership for young men primarily come from elders and older men in the village.

Strategies:

- Include activities that provide adolescent males the opportunity for intergenerational dialogue on migration, marriage, fatherhood
- Promote models of masculinity that are not defined by dominance, aggression, and lack of emotion.
- Connect young people (male AND female adolescents) to decision-makers and influencers so that their participation in local society translates into positive change in policies, practices, and attitudes.

- Male adolescents need more vocational skills and economic strengthening opportunities. Both male and female adolescents would benefit from livelihood training such as small livestock management, gardening, and savings and loan activities.
- Provide adolescent males aged 15-17 opportunities to discuss responsibilities when it comes to preventing pregnancy, as well as consent, gender equality, and peaceful communication. Take advantage of activities with male peers to discuss reproductive health issues with adolescent boys, who receive most of their advice on puberty, contraceptives, sex, STDs, marriage, and romantic relationships from their friends.
- MMF groups, in which adolescent males will be invited to participate, will be trained in functional literacy, functional numeracy, financial literacy, career planning, positive self-concept, communication skills, family planning topics. MMF groups linked to MMDs and VDCs for support and mentorship.

***Mothers* (aged 18+) with child/children under 2 years**

- Many women lack access to health care, lack of mobility, and lack of agency and are socially isolated.
- Women have limited decision-making power in the household, including on finances, how resources are spent on education/food/health services, distribution of food etc.
- Many women are passive participants in life and practice whatever has been the norm in their community or family.
- Women want to participate in community events, but barriers exist.
- Many women (even older ones) lack agency and require a husband's approval to leave the family compound or participate in community events.
- In some villages, the experience and voice of older women were valued, but in others, it was dismissed due to their sex.
- Women (and girls) have heavy work burdens – heavy agricultural workload, dual work burden of domestic work and income-earning work, childcare, and other caregiving responsibilities.
- Activities for women need to start after their morning chores are finished, around 10:00 am

Strategies:

- Find female positive deviants and role models in communities. Women need to see for themselves the success of someone else.
- Form women's savings and loans groups to enable them to save, form networks and support each other economically, socially, and emotionally.
- Introduce targets and quotas for women's (and girl's) participation in committees and fora which are part of the project. Ensure that women have appropriate roles and decision making power.
- Strengthen couples' communication around finances, how resources are spent on education/food/health services, distribution of food etc.

Fathers (aged 18+)* with child/children under 2 years*:

- Men can facilitate or block his wife's access to healthcare and choice of facility and/or adherence to doctor's advice.
- Men have more social power than women do and they are invested in the wellbeing of their children.
- Rigid gender norms, attitudes and structures also prevent men (and boys) from reaching their potential and living as equals with women and girls.
- Currently, there are very little structured interventions aimed at fathers.
- Men have the highest exposure to messages outside the household.
- Men were more flexible and might be available throughout the day, although afternoon activities after 4:00pm were preferred.

Strategies:

- Husband schools to address early marriage, family size, gender-based violence, women's right to bodily integrity and shared decision making, and how women's economic empowerment benefits whole families and communities
- Provide tailored programming for fathers, such as an evening or weekend class
- Identify and nurture male champions and allies who can support women and girls' privately and publicly in the struggle for gender equality.
- Promote shared decision-making and re-balancing the burdens of unpaid domestic and care work to be more equitably distributed among women and men, girls and boys.
- Disseminate messages around the father's natural responsibility may resonate well, such as taking care of their wife during pregnancy, buying nutrient-rich foods, supporting her choice to breastfeed, and supporting her choice to be involved in community projects.
- Include cooking sessions in the EdM program, tied to learning about the nutritional needs of adult men and women, adolescent girls and boys, children, and pregnant and lactating women. Make sure the cooking sessions are led by men, but encourage men to ask their wives to teach them some of their favorite recipes. In parallel, you will need to encourage women in MMD activities not to reject or make fun of their spouses if they approach them for cooking instructions. Speak to fathers about the benefits of cooking skills in providing flexibility to their wives so they can attend project activities during hours they would usually devote to cooking.

Types of Desired Behaviors

Table 7 outlines the topical areas and priority behaviors based on evidence from the SBC, gender and youth, WASH Markets, community consultations, and crop and livestock formative research. All priority behaviors with the exception of governance behaviors[46] , highlight recommendations for the **directly affected audiences**. Supportive behaviors for directly influencing audiences are detailed in table 9.

Priority behaviors were selected using the following process.

1. The team reviewed existing literature, population data, and data on current practices for the various Wadata areas of focus (e.g., infant and young child feeding practices, water, sanitation, hygiene (WASH), gender equality, livelihoods, etc.) and developed a situational analysis to help guide the development of the SBC formative research and to start identifying the priority behaviors for the SBC strategy.
2. The team participated in an insights meeting in October 2019 and compiled a list of behaviors that, if practiced, would have a positive impact on health and development outcomes.
3. Next, the team reviewed the list of priority behaviors in light of the nine Wadata formative research study results. We refined the list further by selecting the behaviors that seem feasible, given the context of the Zinder region.
4. The team then participated in a culmination workshop in December 2019 and refined the list of priority behaviors further.

[46] Because governance behaviors involve community-wide mobilization, the audiences listed are indirectly infleucning audiences.

Table 7. Wadata Priority Behaviors by Sector

Area	Behavior statement
Nutrition	1. Targeted mothers only give breastmilk to their infants from birth to 6 months of age. 2. Targeted caregivers of children ages 6-23 months feed them at least three cooked meals a day that contain (proteins), vitamins (fruits and veggies) at the recommended quantity and frequency 3. Pregnant and lactating women consume additional nutritious food and liquids during pregnancy and lactation (i.e., one extra meal or snack during pregnancy and two extra meals or snacks during lactation).
WASH	4. Targeted families wash their hands with soap and water at critical moments on a daily basis.[47] 5. Targeted families drink potable water daily
Ag & Livelihoods	6. Husbands and their wife/ wives jointly plan, organize, direct and control household finances. 7. Targeted women, who are not already members, join village savings and loans groups 8. Targeted men and women plant nutrition-sensitive crops on irrigated community land provided to them by community leaders every year during planting season.
Resilience	9. Targeted farmers adopt two or more climate-smart agricultural practices within one year after being introduced to them.
Use of health, hygiene and nutrition services	10. Targeted women who are under the age of 18, or their partners who do not want to become pregnant, use a modern contraceptive method. 11. Targeted pregnant women attend four antenatal care consultations 12. Targeted pregnant women give birth in a health center.
Youth & Adolescents	13. Targeted mothers wait 2 years after giving birth before trying to become pregnant again. 14. Targeted girls under 18 years old delay marriage until they are at least 18.
Gender equality and social inclusion	15. Targeted women and adolescents (boys and girls) participate and speak without permission in sector-specific groups and community-wide meetings 16. Husbands participate in household chores and childcare on a daily basis. 17. Husbands hold an open dialogue with their wives about the nutrition of their family at least once per week (Topics: 1) what crops to grow; 2) how to store crops; 3) what crops to sell; 4) and what food should be purchased for household consumption; and 5) what food should be purchased for children 6-24 months of age).
Governance	18. Targeted VDCs set up social accountability measures to help manage community goods and infrastructure within one year of working with the Wadata project. 19. Communities register their land transactions in the rural file at the Cofos level within six months of the transaction taking place.

[47] Before touching food and after touching feces

Barriers & Facilitators to Behavior Change

It is crucial to know what prevents or encourages the priority audience to practice desired behaviors. Wadata's situational analysis suggested that persistent barriers to improved health outcomes in Niger include constrained geographic and financial access, shortages and misdistribution of health workers, stock-outs of essential medicines and supplies, weaknesses in human resources management, lack of responsive, high-quality services, inadequate availability of data and use of data for decision-making, and weaknesses in governance and community capacity to hold the health system accountable. Additionally, health management committees (COGES) led by community members often lack the capacity to create action plans to address bottlenecks and challenges at the service delivery level.

Wadata collected data on barriers and facilitators during the SBC and other formative research. Barriers and facilitators come in many forms: emotional, social, structural, educational, and habitual. A few examples include the following:

- **Emotional**- Delaying marriage for girls is perceived to bring negative consequences. We heard from participants that it is serious if a girl is not married before 18. People gossip, and there is fear of her becoming pregnant outside of wedlock. Additionally, it results in a lack of peace of mind for the parents and is considered bad luck.
- **Social**-Discriminatory social norms and gender-based barriers and gaps affect all aspects of health, nutrition, food security, agriculture, livelihoods, and resilience in the Zinder region. Gender equality should be addressed using all channels and also by working with local leaders to communicate the necessity of female empowerment. Even though changing gender norms is difficult, it is essential if health and well-being are to improve.
- **Structural**- A large proportion of the population is extremely poor and malnourished. Food insecurity is ever-present. Some foundation of food & livelihood security must exist to adequately capture the benefits of social and behavior change communication and activities.
- **Structural**- Participants stated that some of the most significant barriers to using health services is distance to a health facility, transportation costs, and costs of care.
- **Awareness**- There is a lack of awareness/ acknowledgement of the importance of the roles that youth can play in community development.
- **Awareness-** Participants commented that most people in the Zinder region have little to no exposure to healthcare.
- **Habitual**- We heard from participants that people are comfortable doing things the same way they have always done them. For instance, husbands are an important source of support to mothers and play a key role that can be strengthened to support infant feeding and maternal nutrition. However, their knowledge is grounded in traditional beliefs that are not always supportive of recommended practices.

See the summary table (**Table 9**) for more details on barriers and facilitators in relation to Wadata's 19 priority behaviors.

There are a few things we can do programmatically to bolster the effects of our SBC programming. For instance, we can demonstrate and communicate about the relative advantage of a new idea over what people are already doing. We can ensure that our programming is compatible with our primary audiences' constraints.

Overall Objectives of the Wadata SBC/C Strategy

- Strengthen the empowerment of women and girls, social networks and participation to support informed decision-making
- Decrease discriminatory gender norms, attitudes, and behaviors towards girls and women
- Improve informed decision-making by females and couples
- Increase equitable access to, control over and benefit from community systems, structures and resources for girls and women
- Increase engagement of women, girls and boys in meaningful participation in community life
- Increase demand for and use of quality health, nutrition, WASH and agricultural services by girls, boys, women and men based on a voluntary, non-coercive approach
- Improve governance and accountability for community infrastructure
- Increase girls, boys, and women's leadership development, confidence, conflict management and negotiation skills
- Improve knowledge, motivation skills and ability of girls, boys, women and men to adopt and practice appropriate health, nutrition, agriculture, resilience and livelihoods behaviors

Creative Process

Strategic Approach & Positioning

In this section, we outline the approaches and interventions that will be used for each audience to achieve the SBC/C objectives listed above, as well as which channels and materials will support the activities and reach the primary audiences.

Wadata's strategic approach outlines how the project's approaches and interventions will be used to achieve the project's objectives. Wadata's strategic approach combines several approaches to allow the project to address multiple audiences across the various social-ecological levels.

Wadata's Strategic Approach

Wadata's strategic approach is a combination of building/strengthening community infrastructure, community service delivery, community social and behavioral change and community capacity strengthening that aims to improve gender equality and social inclusion, increase economic productivity for females and males, strengthen governance and resilience in communities and improve health and well-being for individuals and families.

Approaches

Wadata will implement multiple interventions for the focus areas at the same time. The program will use a phased approach and scale up localized strategies that work. Typically, SBC interventions work better when combined with others. Wadata will use four types of approaches.

1. **Building/strengthening community infrastructure-** Wadata will focus on strengthening specific interdependent institutions and systems of local communities in the context of the natural and built environment in which they exist, thereby increasing their capacity to prepare for, respond to, and recover from disruptions to the systems (e.g., health, agriculture, support, natural resource management) that support thriving human populations.
2. **Community Service Delivery**- Wadata will focus primarily on demand creation for primary health care.

3. **Community Social and Behavior Change/Communication-** Wadata will focus on changing social norms. In particular, the project will work to transform discriminatory gender norms, attitudes, and behaviors and enable individuals, families, and communities to increase control over and improve their health and wellbeing.
4. **Community Capacity Strengthening-** Wadata will work with communities to obtain, strengthen, and maintain their capabilities to set and achieve their development objectives over time.

Each approach and intervention has been matched to program objectives. The interventions that have been selected make it possible to focus on specific topics and personalize the attention and the information they deliver to the various audiences.
An implementation plan (see **Table 10**) that clearly maps out how the different interventions relate to each other is provided in this strategy.

Interventions and Activities

Table 8. provides an overview of the approaches, interventions, focus areas, and related Wadata SBC objectives. There is some overlap in terms of focus area and SBC objectives. For instance, gender equality will be covered by all four approaches, and three of the approaches (i.e., building/ strengthening community infrastructure, community service delivery and community SBC/C) aim to increase demand for and use of quality health, nutrition, WASH and agricultural services by girls, boys, women and men. See **Figure 6** on how Wadata's SBC/C overall approach is integrated.

Table 8. Approaches, Interventions and related objectives for Wadata

Approach and Priority Audiences	Interventions	Focus Area	Related Wadata SBC objectives
Building/ strengthening community infrastructure •Women of reproductive age (18 – 24 and 25 – 35) •Men 18+	Farmer Managed Natural Regeneration (FMNR) Groups Mata Masu Dubara (MMD) (Women's Savings and Loans Groups)	Ag & Livelihoods Gender Equality and Social Inclusion Governance Resilience	• Improve governance and accountability for community infrastructure • Increase demand for and use of quality health, nutrition, WASH and agricultural services by girls, boys, women and men based on a voluntary, non-coercive approach • Increase the engagement of women in meaningful participation in community life • Increase equitable access to, control over and benefit from community systems, structures and resources for girls and women • Increase girls, boys, and women's leadership development, confidence, conflict management and negotiation skills
Community service delivery •Women of	Systeme Communautaire d'Alerte Précoce et de Réponses en Urgences (SCAP/RU)	Gender Equality & Social Inclusion	• Improve governance and accountability for community infrastructure • Increase demand for and use of quality health, nutrition, WASH and agricultural services by girls, boys, women and men

reproductive age (18 – 24 and 25 – 35) •Men 18+	Water Point Committees	Governance Resilience WASH	based on a voluntary, non-coercive approach • Increase equitable access to, control over and benefit from community systems, structures and resources for girls and women
Community social and behavior change/communication • Women of reproductive age (18 – 24 and 25 – 35) • Men 18+ • Very young adolescent girls and boys 10 – 14 • Adolescent girls and boys 15 – 17 (unmarried) • Adolescent girls 15 – 17 married)	Community Influencers Husband Schools Matasa Masu Fusaha (MMF) Young People Groups and MMD Triad volunteers (community health and nutrition liaisons, IYCF groups, Mamans Lumieres) includes growth monitoring	Gender Equality & Social Inclusion Nutrition Use of health, hygiene and nutrition services Youth and Adolescents WASH	• Decrease discriminatory gender norms, attitudes, and behaviors towards girls and women • Improve informed decision-making by females and couples • Improve knowledge, motivation skills and ability of girls, boys, women and men to adopt and practice appropriate health, nutrition, agriculture, resilience and livelihoods behaviors • Increase demand for and use of quality health, nutrition, WASH and agricultural services by girls, boys, women and men based on a voluntary, non-coercive approach
Community capacity strengthening • Women of reproductive age (18 – 24 and 25 – 35) • Men 18 years or older • Very young adolescent girls and boys 10 – 14 • Adolescent girls and boys 15 – 17 (unmarried) • Adolescent girls 15 – 17 married)	CAC MMF Village Development Committees	Gender Equality and Social Inclusion Governance Resilience Youth & Adolescents	• Increase engagement of women, girls and boys in meaningful participation in community life • Increase girls, boys, and women's leadership development, confidence, conflict management and negotiation skills • Improve knowledge, motivation skills and ability of girls, boys, women and men to adopt and practice appropriate health, nutrition, agriculture, resilience and livelihoods behaviors • Increase girls, boys, and women's leadership development, confidence, conflict management and negotiation skills • Increase equitable access to, control over and benefit from community systems, structures and resources for girls and women • Improve governance and accountability for community infrastructure

Interventions

Community Influencers

Priority audience: All

Wadata focal area: gender equality & social inclusion, nutrition, WASH, use of health & hygiene and nutrition services

Description: Most of the norms cited in the SBC and gender/youth studies are recommendations/prescriptions of the Muslim religion (i.e., the fundamental social norms held by the participants are: the practice of the Muslim religion, the respect of others wives, mutual social assistance, the request for consent, obedience to the instructions of husbands.) The Project will, therefore, engage traditional and religious leaders as partners in change, both to enable activities in the short term and to improve conditions for inter-generational changes in the future. Religious and traditional leaders will use religious texts such as the Islamic Argument designed by UNFPA, which identifies verses of the Koran that support family harmony and health. Community Influencers will work hand in hand with Husband Schools on recycling these teachings during informal male tea group (fadas) and community-wide events that implicate other platforms such as triads, MMFs and MMDs.

Related behavior change technique: According to the Source Credibility Model, the effectiveness of a message depends on the perceived trustworthiness and credibility of the endorser. As traditional and religious leaders are perceived to care about people in their community genuinely, their word carries much weight.

Farmer Managed Natural Regeneration (FMNR) Groups

Priority audience: Women of reproductive age (18 – 24 and 25 – 35); Men 18+ years old

Wadata focal area: agriculture & livelihoods, resilience

Description: In a concerted effort to bring back trees to the land and encourage farmers to practice climate-smart agriculture, Wadata will support the adoption of recommended FMNR techniques. To support this, Wadata will establish Farmer Field Schools (FFS) to identify “Lead Farmers” to serve as professional extension workers and as FMNR Committee Members under a joint monitoring agreement between Wadata and the Government of Niger Ministry of Environment. Lead Famers practice FMNR in their fields and encourage other farmers to follow suit. Local farmers will learn how to switch from traditional cultivation approaches of slash-and-burn to selective cutting when preparing for the growing season.

FMNR makes it possible to restore and protect the environment against deforestation and soil erosion. LAHIA relies on FMNR Groups established in each village that are trained on the importance of FMNR in soil fertility management, among other things, to work within their villages to ensure sustainability. FMNR Groups lead discussions on climate-smart agriculture and conduct demonstrations of FMNR on farmer’s fields at the village level. The Committee acts as an intermediary between the village's farmers and the Nigerien Government’s environmental technical services.

Wadata will train FMNR groups on how to graft improved varieties of Jujube fruit tree (Magaria or Sahel Apple). Fruit trees help diversify agricultural production in the Sahel, contribute to the optimal use of land for agriculture, and encourage family consumption of nutritious foods. FMNR groups can also work with triad and MMD groups on planting other nutrition-sensitive crops that have proven to be low-cost and nutrient-rich in home gardens and community group fields.

Related behavior change techniques:

- **Changing the physical environment-** Involves structural changes to the surrounding environment. It also refers to resetting environmental defaults so that a new behavior is easier to sustain due to sympathetic cues and triggers.
- **Shaping knowledge**- This intervention will help people to understand what adaptation behaviors are, how to perform them, and where to acquire the technologies and materials needed.
- **Reward and threat**- Makes the adoption of behaviors seem attractive or makes the failure to adopt practices seem threatening. This is linked to the concept of "value exchange" (i.e., what desirable outcome would the audience receive for its compliance, or what undesirable outcome would it avoid).

Husband Schools

Priority audience: Men 18+ years old

Wadata focal area: gender equality & social inclusion, governance, nutrition, WASH, use of health & hygiene and nutrition services, resilience, youth and adolescents

Description: Husband Schools provide men the opportunity to create a healthier family ecosystem and mobilize their peers to adopt recommended practices. During bi-weekly meetings, members, known as model husbands/husband leaders, learn about important health topics such as antenatal and postnatal visits, assisted births, family planning, and MIYCN and come up with personal and community-wide activities to increase access to health services. Husband leaders gain interpersonal communication skills that give them the tools necessary to communicate effectively with their spouse(s), which allows for more regular and participatory exchanges within households. Husbands are more inclined to discuss sensitive topics (e.g., family planning, sharing of household chores, and health center attendance by women and children) with their families and include their wives in decision-making. Additionally, the generational mix of members in Husbands' Schools provides an opportunity for younger members to express their ideas. Under LAHIA,[48]innovations proposed by the youngest members were often adopted by the group, such as forming satellite Husband Schools in neighboring villages and teaming up with triad volunteers to mobilize community resources for cooking demonstrations. Some husband leaders established savings and credit unions to help pay for medical evacuation, delivery costs, and cleaning campaigns. Other groups raised money to undertake community projects such as the construction of maternity wards, latrines, and fences. Because traditional and religious actors have deep and trusted relationships with their communities and connections to disadvantaged and vulnerable members, husband schools will collaborate with these leaders on organizing sermons at the mosques and community-wide discussions on inequity related to societal factors, behaviors, and practices that affect access to services or fuel discrimination and deprivation.

Related behavior change techniques:

- **Social support**- involves providing resources and facilitating influence. "Seeding" a new behavior with a trusted person or group helps ensure the new behavior appears desirable and starts to become the norm, leading people to want to emulate and model it.
- **Comparisons**- Through this intervention, people will be provided with a choice of options and the opportunity to compare what is available with the options chosen by their peers, neighbors, friends, and family members.

[48] LAHIA was a six-year USAID/FFP Development Food Assistance Program (DFAP) running from August 2012 to September 2018 in Maradi, Niger. LAHIA was implemented by Save the Children and World Vision.

- **Shaping knowledge**- This intervention will help people to understand what adaptation behaviors are, how to perform them, and where to acquire the technologies and materials needed.

Mata Masu Dubara (MMD)

Priority audience: Women of reproductive age (18 – 24, 25 – 35)

Wadata focal area: gender equality & social inclusion, governance, livelihoods, resilience

Description: Wadata's women's savings and loan groups are called "Mata Masu Dubara" (MMD), a Hausa term used to refer to "Women on the Move," because of the social capital and solidarity within these groups. MMD groups have increased social cohesion among women in the same village and created a platform for project-supported income-generating activities (IGAs). The MMD groups and associated IGAs have transformed women's status in the community as participants increase their income, decision-making power, and voices in their households and communities. MMD members meet weekly to reconcile lending accounts; maintain accurate records and loan repayments; engage with local MFIs to explore large loans for MMD more significant ventures such as warehouse credit.

MMD Groups are the primary entry points for building women's economic and social empowerment. One key to this approach is using MMD knowledge on savings and lending to develop business plans and supporting women's income-generating activities that broaden the household asset base and enhance their agency and leadership. MMDs are able to take advantage of men's engagement and support through Husband Schools. Together MMD and Husbands Schools contribute to positive household and community resilience. "Networks" of MMD Groups also allow the free flow of information and sharing.

Related behavior change techniques:

- **Identity and self-belief**- Targets audiences according to their actual or aspirational roles. Gender and other roles determine how we perceive ourselves, how we are perceived, and how we are expected to think and act. Linked to this is the process of increasing people's sense of self-efficacy and building momentum behind a desire to change their behavior.
- **Shaping knowledge**- This intervention will help people to understand what adaptation behaviors are, how to perform them, and where to acquire the technologies and materials needed.
- **Social support**- Involves providing resources and facilitating influence. "Seeding" a new behavior with a trusted person or group helps ensure the new behavior appears desirable and starts to become the norm, leading people to want to emulate and model it.

Matasa Masu Fusaha (MMF) – "young people with initiative" groups

Priority audience: Very young adolescent girls and boys 10 – 14; Adolescent girls and boys 15 – 17 (unmarried); Adolescent girls 15 – 17 married); participants 18 - 29

Wadata focal area: gender equality & social inclusion, livelihoods

Description: MMFs function as smaller, linked versions of MMDs, operating in a similar fashion but for youth and adolescents and with a different skills-building content. Groups will be structured according to marital status, age, and sex so that group activities can address the specific resilience priorities of each demographic, while ensuring a safe and supportive environment where young women can participate actively. Participants will be drawn from the 10-19 age group (with some 20 – 29 aged youth participating as appropriate). Employability and life skills may be applied both by youth remaining in Zinder and by migrating youth. Recognizing that migration is a major component of HH livelihood strategies in Zinder,

representing the second most important source of income for poor and very poor HH, Wadata does not seek to discourage migration but rather seeks to empower youth with knowledge and skills to make migration more profitable while maintaining their social capital and supportive relationships at home. MMFs will also help youth to be better prepared for migration, not only through skills-building but through an understanding of legal requirements, health recommendations, and risks associated with early migration.

Related behavior change techniques:

- **Identity and self-belief**- Targets audiences according to their actual or aspirational roles. Gender and other roles determine how we perceive ourselves, how we are perceived, and how we are expected to think and act. Linked to this is the process of increasing people's sense of self-efficacy and building momentum behind a desire to change their behavior.
- **Shaping knowledge**- This intervention will help people to understand what adaptation behaviors are, how to perform them, and where to acquire the technologies and materials needed.

Systeme Communautaire d'Alerte Précoce et de Réponses en Urgences (SCAP/RU)

Priority audience: Women of reproductive age (18 +); Men of reproductive age (18+)

Wadata focal area: governance, resilience

Description: The GoN's Community Early Warning System and Emergency Response (Système Communautaire d'Alerte Précoce et de Réponses en Urgences or SCAP/RU) has the potential to equip communities threatened by disasters with the necessary capabilities to disseminate early warning bulletins and to prepare themselves and take actions in a timely fashion to mitigate shocks and stressors. This preparation mechanism will make individuals feel capable of responding to food insecurity (perceived response efficacy). The SCAP/RU mechanism however, has been underutilized, and in some cases, never used, mostly due to a lack of funding. In the target Communes, only nine (9) SCAP/RU currently exist. Meanwhile, in two of the target Communes (Guidimouni, Guidiguir), long-standing traditional community-based early-warning committees, called Houtchia, do exist.

A SCAP/RU is a group of designated persons who head up a village's emergency preparedness action plan. It consists of the village chief, select VDC members, and other concerned individuals from community organizations and structures. Wadata will build the skills and capacities of key VDC and SCAP/RU members on how to regularly collect and analyze data across five key sub-sectors as part of the commune-level disaster vulnerability monitoring. The SCAP/RU team will brainstorm how data is to be collected at the rural level, processed, analyzed, and then passed up to the commune level, called the Vulnerability Monitoring System (Observatoire de SuIVI de la Vulnérabilité or OSV). This is done so that a higher-level response can be deployed, if needed. Where SCAP/RU are non-functional, the Project will assist communities to put in place SCAP/RU and/ or assist Houtchia to evolve into government-mandated SCAP/RU.

Related behavior change techniques:

- **Reward and threat**- Makes the adoption of behaviors seem attractive or makes the failure to adopt practices seem threatening. This is linked to the concept of "value exchange" (i.e., what desirable outcome would the audience receive for its compliance, or what undesirable outcome would it avoid).
- **Regulation**- Regulatory mechanisms include standards. They are a measure of enforcement as opposed to persuasion, and can amplify "softer" behavior change techniques.

Triad Volunteers

Priority audience: Women of reproductive age (18 – 24 and 25+); Couples (18-35)
Men (18 -24 and 25+); Adolescent girls 15 – 17 married)

Wadata focal area: nutrition, WASH, use of health & hygiene and nutrition services

Description: Triads work through 3 key platforms: 1) **Community Health and Nutrition Liaisons (CHNLs)**, 2) **IYCF groups**, and **3) Mamans Lumieres (MLs)** to improve household-level maternal, infant and young child nutrition knowledge, attitudes and practices to prevent stunting and wasting and promote optimal nutrition. Pregnant women and mothers are followed through the lifecycle: CHNLs refer pregnant women to antenatal care, and post-delivery to IYCF groups for breastfeeding and care support until the child is 6 months. Mamans Lumieres will then follow children's development until they reach five years of age, focusing on optimal complementary feeding and prolonged breastfeeding. MLs conduct growth monitoring and promotion (GMP) for CU2, and MUAC screening and referral for malnutrition for children 3-5 in the target geographies. They also conduct community-wide cooking demonstrations using locally available and nutritious ingredients working in close collaboration. See **Figure 5** for a specific breakdown of tasks and how triads work. Triads build self-efficacy among members (able to detect, screen for and refer malnutrition cases, able to cook nutritious recipes for families, know how to negotiate for behavior change among community members, know when to visit a health center), and social support during group-wide activities.

Related behavior change techniques:

- **Shaping knowledge**- Helps people to understand what adaptation behaviors are, how to perform them, and where to acquire the technologies and materials needed.
- **Social support-** Involves providing resources and facilitating influence. "Seeding" a new behavior with a trusted person or group helps ensure the new behavior appears desirable and starts to become the norm, leading people to want to emulate and model it.
- **Goals, planning and monitoring-**Working with an audience's goals involves unearthing its aspirations, ambitions, and intentions, reframing the new behavior as a way of achieving the goals, and helping the audience realize its goals through the medium of the new behavior.

Figure 5: How the triad of community nutrition members works

Village Development Committees (VDCs)

Priority audience: Women of reproductive age (18 – 24 and 25 – 35); Men of reproductive age (18 – 24, 25 – 35)

Wadata focal area: gender equality and social inclusion, governance, resilience, youth and adolescents

Description: This committee ensures coordination and synergy among all community platforms and monitors progress made. Led by a president, often the village chief, the VDC directs the community action planning process that establishes the village's goals in addressing nutrition, WASH, and

agriculture, among other activities. These government-mandated groups have the potential to address community priorities and elevate the voices of women, adolescents, and other marginalized groups in development and management. Although they are an integral actor in the GoN decentralization process, along with Commune and Municipal authorities, less than 50% of villages in the Zinder Region have functional VDCs.[49]

Wadata staff will use the **Community Action Cycle (CAC)** process to build the capacity of VDCs and ensure they are socially inclusive. VDCs will identify priority community challenges, create action plans, carry out activities and evaluate progress on a participatory and sustained basis. They will weave priority challenges identified by other community platforms such as triads, Husband Schools, and MMDs into their integrated community action plan. VDCs will strengthen social cohesion and improve community coordination among different platforms while also opening lines of communication and collaboration with Commune administrations, GoN technical services, Regional Directorates, and the private sector.

- *VDCs will use the Community Action Cycle process*

  The Community Action Cycle (CAC) is a proven community mobilization approach that fosters individual and collective action to address key health and development program goals and related outcomes. The CAC approach fosters a community-lead process through which those most affected by and interested organize, explore, set priorities, plan, and act collectively for improved health. The CAC has distinct phases. Each phase and its related steps lead to greater community ownership and sustained collective action after the end of the project through the capacity-building of community groups. By working through the CAC cycle, communities and individuals will identify the socio-cultural barriers/facilitators, resources, risk factors, and begin to work towards positive change. The CAC approach recognizes that people do not change their behavior based on information alone; it is a combination of having the information as well as the confidence and enabling environment to make positive choices, collectively and individually, while addressing underlying social norms that ultimately lead to changed behaviors.

  Wadata will use the Community Action Cycle (CAC) approach to address certain behaviors whose solutions are local. During the first two years of implementation, we will pilot CAC with under ten VDCs in collaboration with BA. Once revisions are made to the approach, it will be scaled up and used as the main community-led development approach for other VDCs, the Water Point Management Committee, Community Early Warning and Emergency Response System (SCAP / RU) and Husband Schools. It will be a multi-stakeholder approach that helps the community to move towards collective actions.

<u>Related behavior change techniques:</u>

- **Shaping knowledge**- Helps people to understand what adaptation behaviors are, how to perform them, and where to acquire the technologies and materials needed.
- **Social support**- Involves providing resources and facilitating influence. “Seeding” a new behavior with a trusted person or group helps ensure the new behavior appears desirable and starts to become the norm, leading people to want to emulate and model it.
- **Goals, planning and monitoring**-Working with an audience’s goals involves unearthing its aspirations, ambitions, and intentions, reframing the new behavior as a way of achieving the goals, and helping the audience realize its goals through the medium of the new behavior.

[49] Refine Year Community Consultation and CBO Census

- **Identity and self-belief-** Targets audiences according to their actual or aspirational roles. Gender and other roles determine how we perceive ourselves, how we are perceived, and how we are expected to think and act. Linked to this is the process of increasing people's sense of self-efficacy and building momentum behind a desire to change their behavior.

Water Point Management Committees (WPMCs)

Priority audience: Women of reproductive age (18 – 24 and 25 – 35); Men of reproductive age (18 – 24, 25 – 35)

Wadata focal area: governance, resilience, WASH, use of hygiene services

Description: The main role of WPMCs is to manage water points. This includes resource mobilization, operations and maintenance, business planning for water user fee collection and use, and capacity building of Commune and private sector maintenance technician counterparts. Also, recognizing that Commune level technical service providers currently have low capacity to maintain and repair water points, Wadata will work directly with commune-level technicians to improve their technical skills and their communication with responsiveness to WPMGs. It will be essential to connect demand generation activities in Wadata through integrated social and behavior change activities such as handwashing discussions and demonstrations, water treatment demonstrations, and community-wide cleanups led by community platforms such as triads with supply-side activities led by Village Salubrity Committees (CVS) in collaboration with WPMCs.

Related behavior change techniques:

- **Shaping knowledge**- Helps people to understand what adaptation behaviors are, how to perform them, and where to acquire the technologies and materials needed.
- **Reward and threat**- Makes the adoption of behaviors seem attractive or makes the failure to adopt practices seem threatening. This is linked to the concept of "value exchange" (i.e., what desirable outcome would the audience receive for its compliance, or what undesirable outcome would it avoid).
- **Regulation-** Regulatory mechanisms include standards. They are a measure of enforcement as opposed to persuasion, and can amplify "softer" behavior change techniques.

Wadata will **position** a few issues and approaches the project is promoting so that they stand out from other options and motivate specific emotional reactions and changes in attitudes and behaviors.

Women's empowerment*- Position women as capable of having control over their own lives and futures, their bodies, relationships, health, education, protection, livelihoods, and wellbeing.*

Desired outcomes

- Women and girls' empowerment, including increased confidence, capabilities, access and agency.
- Increased knowledge, skills, and opportunities.
- Expanded networks, increased social capital, and meaningful participation supporting collective action.

Activities

- Small group discussions, mentoring, and dialogue to explore, challenge, and change harmful and discriminatory gender norms.
- Peer-led community forums support women to develop leadership skills.

- Peer-led community forums support men and boys to develop collective critical consciousness about women's fertility, family size, SGBV, women's right to bodily integrity, and shared decision-making.
- MMDs facilitate microenterprise start-up/ operations
- Work with girls, communities and legal systems to eliminate child, early and forced marriage, so girls have the power to decide if, when and who to marry.
- Specialized community-based engagement facilitated to increase the participation and leadership of women and youth.
- EdMs and community influencers involved in activities on the importance of women's engagement in household economic decision-making
- Community influencers reinforce women's involvement in marketing activities

- ***Leveraging the Will of Allah-*** *Position each member of the community as a gift from Allah.*

Desired outcomes

- Religious leaders engaged in creating more peaceful, stable, and secure communities that are better equipped to meet challenges.

Activities

- Incorporate Islamic teachings in the Koran that focus on thriving physically, economically, and educationally, the responsibility to provide for one's family, and to maximize the voice of reason.
- Leverage community dialogues, radio, and community leaders points to spark discussions around how to live a harmonious family life, where to get certain agricultural products, or mobilize people for community-wide events such as cooking demonstrations, or health screenings.

Community Health Workers (Agent de Santé Communautaire), Integrated Health Center (Centre de Santé Intégré) *and health platforms-* *Position health service providers as accessible, friendly, reliable, and providers of life-saving information*

Desired outcome: Individuals trust health workers, health workers promote optimal behaviors, and individuals practice optimal behaviors

Activities

- Promote health workers as trusted sources of education and support
- Triad members work with CSI staff during Growth Monitoring and Promotion sessions and discuss the growth status of children with caregivers
- Head of CSI moderates Husband School meetings and offers insights and health topics being discussed

Collective Efficacy for Change- Position collective action as a potential solution to improving the community

Desired outcome: Community members will believe that through their unified efforts, they can overcome challenges and produce intended results.

Activities

- Strengthen the capacity of communities via the Community Action Cycle to reinforce groups' ability to target key problems and work together to find solutions.

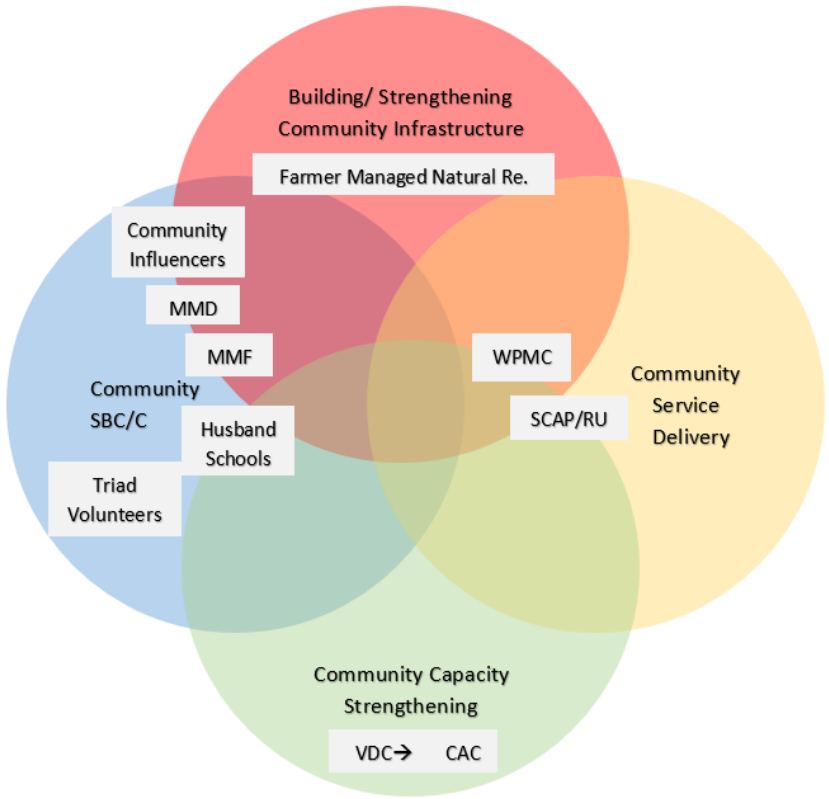
Working with Youth- Position youth as an untapped resource for community development

Activities

- Prioritize empowerment activities that treat both male and female youth as intentional partners, problem solvers, and change agents in their communities, including as representatives in larger community groups like VDCs.
- Provision of life skills training (via MMF) to adolescents and youth (females and males), which includes leadership development, confidence building, conflict management, and negotiation skills to enable girls and boys to work together as equals.
- Reduction of barriers to girls to participate in MMF activities and training.

Figure 6 outlines how Wadata's SBC/C integrated approach fits together, highlighting the overall approaches and interventions. As shown in **Figure 6**, several of the interventions are a mixture of approaches (i.e., community influencers, Husband Schools, MMD, MMF, SCAP/RU, and WPMC). The VDCs will be trained and coached on the CAC.

Figure 6. How Wadata's SBC/C integrated approach fits together



Additionally, there will be overlap among Wadata's focal areas (e.g., nutrition, WASH, agriculture and livelihoods, resilience, use of health, hygiene and nutrition services, youth and adolescents, gender equality and social inclusion, and governance) with the same topics being covered by multiple interventions. Likewise, some of the same priority audiences will be involved in one or more interventions, and interventions will build off each other. For instance, community influencers will work hand in hand with members of Husband Schools, and members of the Husband Schools will work with triad volunteers on mobilizing community members for community-wide cooking demonstrations and

screenings. Often triad volunteers also partake in MMD activities. Also, VDCs will weave priority challenges identified by other community platforms such as triads, Husband Schools, and MMDs into their integrated community action plan.

Summary Table

Table 9 is a summary table that presents the priority behaviors for each priority and influencing audience, the key behaviors and facilitators, the behavior change objectives, and more specific actions to facilitate the adoption of the behavior by each audience. Specific barriers and facilitators can affect several priority behaviors, hence the repetition sometimes in the table. Also, all the actions here only give a general picture of what can be done to anchor the recommended behaviors. Please refer to the PREP and the operational plan for more details on specific activities to address behavior change.

Table 9. Summary Table

NUTRITION			
Priority Behavior	Barriers	Facilitating Factors	Message and Actions
Directly Affected: Pregnant women and mothers/caregivers (18-35 years old) with children 0-23 months			
Targeted mothers only give breastmilk to their infants from birth to 6 months of age. *Very low prevalence of exclusive breastfeeding for the first 6 months of life in Niger (23 percent) (USAID, 2018)*	*Information* -mothers incorrectly assign certain normal behaviors of her baby as hunger or dissatisfaction at the breast *Motivation* -Mothers have the perception that their babies aren't getting enough breastmilk and that they have insufficient breastmilk -mother's perception of her ability to produce milk even though these feelings are not predictive of milk output, especially if she is anxious -some women think breastfeeding too much causes baby to get sick *Normes* -Babies get thirsty/ babies suffer without additional liquids *Habits* -Mothers may leave their babies with the babies' grandmother, older siblings or another person while engaged in some domestic tasks or fieldwork	-CHWs listed as source of support for exclusive breastfeeding -Husbands are an important source of support to mothers and play a key role that can be strengthened to support infant feeding and maternal nutrition. -Women listen to the radio in their leisure time	*Messages* -Breastfeed within the first moments after giving birth -be sensitive to your baby's cues and signs of hunger -do not give your baby water, tinctures, animal milk -do not practice force feeding -the more you breastfeed, the more milk you will have - Exclusive breastfeeding (by itself) is 98-99.5% effective in preventing pregnancy as long as all of the following conditions are met: 1. Your baby is less than six months old 2. Your menstrual periods have not yet returned 3. Baby is breastfeeding on cue (both day & night), and gets nothing but breastmilk or only token amounts of other foods. *Actions* -Establish triad approach to support breastfeeding approaches • Build skills of Community Health and Nutrition Liaisons (CHNLs) to recognize mothers with children 0-6 months to provide extra support • IYCF groups conduct household visits to breastfeeding moms to provide tailored support • Triad leads breastfeeding demonstrations for community

			• Implicate younger caregivers (ie girls who take care of children when mothers away) in triad activities as they are sometimes the main caregivers -create radio programs/radio theater that encourages mothers to keep breastfeeding exclusively despite taboos and beliefs around babies not getting enough milk
Targeted caregivers of children ages 6-23 months feed them at least three cooked meals a day that contain (proteins), vitamins (fruits and veggies) at the recommende d quantity and frequency *6 percent of children 6–23 months receive a minimally acceptable diet (USAID Niger Nutrition Profile)*	*Information* -Insufficient knowledge and skills to make balanced complimentary meals for their children out of available family foods. *Ability to Act* -Households very rarely buy nutrient-dense foods such as meat, fruit, and vegetables due to the cost. -Many villages are far from a market. It might take an hour to upwards of 1-2 hours by foot. -Some nutrients hard to find and expensive: Pantothenic acid, calcium and iron were limiting nutrients in all markets, along with vitamins B12, A and C in some markets. -Most common family foods are manioc, yellow-fleshed sweet potatoes, cowpeas, peanuts, sorghum, millet, rice, onion, and corn. No animal source foods were listed. *Habits* -When mothers are not available to prepare food for young children, daughters will take on this responsibility, or a neighbor woman or girl. Thus in terms of complementary feeding, it will be important to equip younger girls with knowledge and skills	-Husbands typically ask their wives what food to buy for the family. Sometimes the wife will accompany the husband to the market. -Men and women buy special foods at market on a weekly basis to make their children happy. Special foods that men buy for children include oranges, bread, beignets, candy, cookies, dates, sweet potatoes, and peanuts. -Home production through gardens and small livestock or poultry can provide better access to fresh and nutritious foods, even in small quantities. The cost of the diet for a breastfed child under 2 decreases by 22-31% with 4 fresh eggs per week provided by household production.	*Messages related to quantity and frequency:* •6-8 months: Feed children at least 3 times per day: Two meals and one snack. Feed children 3 tablespoons up to ½ cup of food •9-11 months: Feed children at least 4 times per day: three meals and one snack. Feed the baby ½ cup to 2/3 cups of food •12-23 months: Feed children at least 5 times per day: three meals and two snacks. Feed the baby ¾ cup up to 1 cup of food *Messages related to dietary diversity* •Introduce soft foods into your baby's diet at the start of the baby's sixth month • Enrich porridge and family meals with nutritious foods that include proteins, and vitamins/minerals (milk, oil, groundnut paste, soy, moringa powder, baobob, leafy greens, softened fruits, beans, meat, eggs) *Actions* Triad Support • Caregiver training on how to plan and budget for complementary food for children. • Show mothers better methods of preparing food that are cost effective and save time. This includes steaming food, precooked bean and groundnut sauce, teaching them hygiene so they avoid cross contamination of the food. Additionally, we could encourage women to cook leafy greens such as moringa and baobab, which are nutrient-rich and can be grown locally.

	to provide appropriate complementary feeding. *Norms* -eggs unacceptable food for children 6-23 months	The Wadata Cost of Diet study also found that baobab or moringa consumption can reduce the cost of the diet by 13%. -High awareness of malnutrition in villages	• Triad groups raise money on monthly basis to fund joint trips to market to buy nutritious foods FFS activities -Caregiver training on home gardening where they are trained how to grow their own fresh vegetables using the available space within their compounds.
Pregnant or lactating women consume additional nutritious food and liquids during pregnancy and lactation (i.e., one extra meal or snack during pregnancy and two extra meals or snacks during lactation). *Sixteen percent of women 15–49 years of age are underweight (BMI < 18.5), and among adolescent girls 15–19 years of age, 31 percent*	*Information* Certain foods believed to "increase blood" and reduce anemia. However, the food that participants listed are not rich in iron. *Habits* -mothers noted that they were hungry in doer non-doer survey -potential time constraints due to daily chores and fieldwork limit amount a mother can prepare and consume *Ability to Act* -The requirements of the lactating woman are the most difficult to meet, and therefore the most expensive. The lactating woman represents 22% of the cost of the 7-person household while the adult man is only 15%. -women are not usually the ones who buy the food for themselves or the household -Most common family foods are manioc, yellow-fleshed sweet potatoes, cowpeas, peanuts, sorghum, millet, rice, onion, and corn. No animal source foods were listed.	-The cost for a lactating woman could decrease by 10% with one serving of goat's milk per day. -Some women noted that they make decisions on household food purchases with their husbands	*Messages* -Make it a habit to cultivate and eat healthy foods rich in nutrients (Vitamin A, C and iron)such as legumes and leafy greens, whenever possible for the benefit of you and your baby -Eat foods every day that will help you stay healthy and strong and help your baby to grow. *Actions* Triad Support • Caregiver training on how to plan and budget for complementary food for mothers • Show mothers better methods of preparing food that are cost effective and save time. This includes steaming food, precooked bean and groundnut sauce, teaching them hygiene so they avoid cross contamination of the food. • Encourage women to cook leafy greens such as moringa and baobab, which are nutrient-rich and can be grown locally. Additionally women could learn how to prepare goat milk in collaboration with FFS team (if acceptable in given community) • Triad groups raise money on monthly basis to fund joint trips to market to buy nutritious foods FFS activities

are underweight (USAID, 2018) *Nutrient-dense foods are not commonly consumed (i.e., meat, fish and eggs, vitamin C-rich fruits and vegetables). Thus. meeting food based recommendations will be extremely difficult for pregnant and lactating women. (Wessells, et al. 2018).*	*Norm:* -in polygamous households women are not given preferential treatment regardless of health status		• Caregiver training on home gardening where they are trained how to grow their own fresh vegetables using the available space within their compounds. • Triad and FFS teams work together to raise goats for milk production. Triad leads community discussions around the benefits of goat milk for lactating women
Directly Influencing : Grandmothers/Belles-meres			
Grandmothers/belles-meres support their daughters and/or daughters in-law to only give their 0-6 month old children breastmilk	*Knowledge* -lack of understanding of the benefits of breastmilk - *Habits* -grandmothers didn't breastfeed their children exclusively, so why should anyone else?	Some doers and non-doers cited grandmothers as being supportive of breastfeeding practices	*Messages* -Support your daughters/daughters in law to breastfeed their 0-6 month olds exclusively for healthy happy grandchildren *Actions* -Implicate grandmothers in community discussions managed by the IYCF groups on exclusive breastfeeding -Find positive deviant grandmothers who can testify during community discussions -IYCF groups discuss benefits of exclusive breastfeeding with grandmothers during household visits

Directly Influencing : Fathers and Future Fathers			
Fathers participate in and support their wives in feeding children ages 6-23 months according to IYCF recommendations for quantity and diversity.	*Information* Certain food is believed to "increase blood" and reduce anemia. However, the food that participants listed are not rich in iron. *Motivation* Fathers' knowledge is grounded in traditional beliefs that are not always supportive of recommended practices. *Habits* Women feed the children and fathers earn money for the household	-Fathers buy special foods in the market on a weekly basis to keep their children happy -Many husbands listen to their wives about what foods should be bought for household consumption -All the men's FGDs stated malnutrition exists in their village.	*Messages* -Grow, raise or buy highly nutritious foods for your young children -Participate in the daily feeding of your children 6-23 months to keep children happy and prevent costly health services (by insuring their diet is adequate in terms of quantity and diversity) -Breastmilk makes children strong and able to fight diseases. Families/fathers will pay less for treatment at health center when children are strong *Actions* -Engage Husband Schools • Hold sessions on the importance of joint-household decision making • Hold community-wide sessions with all community members regarding the long-term consequences of infant and child malnutrition. Ideally, this session could be led by traditional or religious leader because of their saying power • Help raise money for cooking demonstrations or female managed community gardens

Fathers and future fathers encourage their pregnant and/or lactating wife/wives to consume additional nutritious food and liquids during pregnancy and lactation (i.e., one extra meal or snack during pregnancy and two extra meals or snacks during lactation)	*Information* Certain foods are believed to "increase blood" and reduce anemia. However, the food that participants listed are not rich in iron. *Motivation* Fathers' knowledge is grounded in traditional beliefs that are not always supportive of recommended practices. *Norm:* -in polygamous households women are not given preferential treatment regardless of health status	-Many husbands listen to their wives about what to buy for household consumption -All the men's FGDs stated malnutrition exists in their village.	*Messages* -encourage and support your pregnant and lactating wives to eat nutritious foods (especially animal source foods) in greater quantities to ensure the health of your wife and child and cut down on medical costs *Actions* -Engage Husband Schools ● Hold sessions on the importance of joint-household decision making ● Hold community-wide sessions with all community members regarding the long-term consequences of maternal malnutrition. Ideally, this session could be led by traditional or religious leader because of their saying power ● Help raise money for cooking demonstrations or female-managed community gardens

WASH			
Priority Behavior	Barriers	Facilitating Factors	Message and Actions
Directly Affected : Caregivers of children 0-5 years old			
Targeted families wash their hands with soap and water at critical moments on a daily basis. *About 100% have a kettle which is not considered as a hand-washing device; hands mostly washed with water (Wadata WASH formative research)*	*Habit* -more than 85% practice open defecation on average; no village has been ODF certified; hygiene & sanitation considered as a second priority by HH; *Ability to Act* -soap is not readily available in the communities	28% of households are ready to purchase soap	*Messages* •Establish a space for hand-washing in the household concession that is accessible to all •Maintain clean water, soap or ash in the space established for hand-washing •Always wash hands at the 4 critical moments: before preparing food, before eating or feeding children, after using the toilet or cleaning a baby or child after defecating Actions -Establish triad approach to support WASH practices Skills building of Community Health and Nutrition Liaisons (CHNLs), so can pass on trainings to IYCF groups/Mamans Lumieres on handwashing -Start CLTS in villages with nearby access to water or water facility planned at short term (water used for hand washing and latrine cleaning) -Importance to sustain village efforts to maintain ODF status (6 months to one year after certification); otherwise, high risk to come back to OD -Assess the status of village hygiene and sanitation management committees in all intervention areas and revitalize / set up new ones to support hygiene and sanitation efforts. Assess the possibility to put AUSPE in charge of that role in some villages
Targeted families of children 0 to 5 years old drink	*Ability to Act* -access to water main challenge: most hand pumps are broken or in poor	-water used by households comes mostly from an improved drinking	*Messages* -Treat drinking water with "Aqua Tab" or *eau de javel* -Store water in clean, covered receptacles until drunk -Collect and transport potable water with clean and well-sealed receptacles

potable water in the home. *Waterborne disease is the cause of 14 percent of all childhood deaths in Niger (USAID).* *Only ⅓ people interviewed in SBC Study treat water at home*	conditions; -water availability is seasonal *Resource Mobilization* -water points are poorly managed and tariffs barely collected *Collective efficacy* -lack of confidence and collective efficacy on community's part play a factor in the poor management of PMH and the refusal of some community members to pay fees *Motivation* -households have water container but a third of people only treat water at home	water source, less than 30 minutes distance -most households have access to water container ' -Source of info on WASH: Radio (community, regional, national channels) (more than 50%), then word of mouth as a second source and local health agents as a third source. -67% of HH respondents cite two priority motives to have a potable water facility: to reduce the time and effort required to fetch water and to improve quality of potable water close-by; capacity to pay for a water facility: below and above 2,000 F per household contribution;	*Actions* -Establish triad approach to support WASH practices ● Skills building of Community Health and Nutrition Liaisons (CHNLs), so can pass on trainings to IYCF groups/Mamans Lumieres on treating water ● Water treatment demonstrations during group discussions ● Conduct household visits to see how caregivers are treating water ● Implicate younger caregivers (ie girls who take care of children when mothers away) in triad activities as they are sometimes the main caregivers - Village exchange visits where WPMCs can share best practices -friendly competitions among villages to see who has the "cleanest" village -Waste management (animal feces) in connection with Purpose 2 in supporting communities to compost - Involving users in the design of water and sanitation facilities (adopting the Human Centered Design approach) (WASH Study) -demand generation activities for sanitation should be coordinated with the supply side activities managed by WPMCs as part of the market based sanitation activities -WPMCs fix and maintain pumps, collect fees for maintenance from community members and hold monthly meetings to discuss progress.

AGRICULTURE AND LIVELIHOODS			
Priority Behavior	Barriers	Facilitating Factors	Message and Actions
Directly Affected : Community Men and Women			
Husbands and their wife/ wives jointly plan, organize, direct and control household finances.	*Normes* -Men are considered head of the household unless they are away or incapacitated. -Men have material and financial obligation to their wife/ wives. -Married women cannot open a bank account without her husband being notified. -In some villages the experience and voice of older women was valued, but in others it was dismissed due to their sex.	-Husbands typically ask their wives what they need to buy in terms of food for the family. Sometimes the wife will accompany the husband to the market. -Under LAHIA, husband schools have helped increase dialogue among couples and potentially contributed to increases in use of health services	*Messages* -Make an action plan on the best way to use household resources and finances as a couple and check-in regularly on progress *Actions* -Husband Schools focus on gender equality and negotiation skills ● Hold sessions on how to make an action plan with your wife. Test out approach at home. -Community groups including triad, husband schools, MMDs, MMFs trained in how to create household action plan -create radio programs/radio theater that encourages couples to discuss family dynamics regularly.

Targeted women, who are not already members, join village savings and loans groups	*Information* -Absence of MFIs at the community level. Lack of financial education. *Collective Efficacy* -The concept of "community volunteerism" did not register with SBC formative research participants. Ability to Act -women often don't have time to participate in gatherings -access to credit done outside formal circuit Norms -women need permissions from husbands and/or fathers to speak in public gatherings	-women expressed the desire to be involved in community groups -Fadda's (men's tea groups that meet on a daily basis) sometimes raise small amounts of money	*Messages* -Work together to gradually save money to help supplement household finances -take nutrition into account when making decisions about their savings and credit -use revenues towards products, services, and foods that will improve nutritional status *Actions* -MMD and MMF groups (Village Savings and Loans Groups) for women's groups and youth groups -Encourage other community groups including triad, husband schools to raise money for community activities -work with faddah's (tea groups) to encourage VSL -establishment of warrantage, the establishment of liaison officers at the community level to help community members raise money
Targeted men and women plant nutrition sensitive crops on irrigated community land provided to them by community leaders every year during planting season.	*Information* -Lack of training and awareness on the use of certified seed. *Ability to Act* -81% of the groups of people surveyed do not have land rights for their land according to crop and livestock study -The service of the seed distribution is limited at the level of the departments only. Inaccessibility to fertilizers in villages. -lack of water irrigation systems *Norm*		*Messages* -Plant nutritious crops for household consumption to keep everyone in the household healthy *Actions* -Farmer-managed natural regeneration (FMNR) groups established ● Skills building of members on planting and irrigation of nutrient rich crops ● FMNR groups teach other community groups such as triads and Husband Schools to grow community gardens -negotiate with community on the renting of their land for community gardening activities -crops from community gardens can be used for community nutrition demonstrations

	-SBC formative research suggests that women are often given the least productive community land to plant crops on.		

RESILIENCE			
Priority Behavior	Barriers	Facilitating Factors	Message and Actions
Directly Affected : Community Men and Women			
Targeted farmers adopt 2 or more climate-smart agricultural practices within one year after being introduced to them.	*Information* -research suggests that there may not be knowledge on which crops are climate-smart and/or how to grow them *Ability to Act* -no access to certain tools for climate smart agricultural practices -lack of water irrigation systems *Habit* Reluctance to change, which does not facilitate acceptance of introducing new agricultural technologies	Each household has cultivated land In each commune there is a supervisory agent who reports to the state (agricultural agent)	*Messages* Add messages on benefits to these practices and why farmers should use them *Actions* -Create Farmer-managed natural regeneration (FMNR) groups to increase access to critical information and empower citizens to adopt climate-smart practices -FMNR groups lead discussions on climate smart agriculture and conduct demonstrations of FMNR on farmer's fields at the village level. -FMNR groups can also work with triad and MMD groups on planting other nutrition-sensitive crops that have proven to be low-cost and nutrient-rich in home gardens and community group fields.

Use of health, hygiene and nutrition services			
Priority Behavior	Barriers	Facilitating Factors	Message and Actions
Directly Affected : Girls under 18			
Targeted females who are under the age of 18, or their partners, who do not want to become pregnant, use a modern contraceptive method **See data at** *Adolescents and Youth Dashboard - Niger*	*Information* Women have an assortment of concerns about various family planning methods, some based on real experience, some on hearsay, and some on misinformation or Misinterpretation (i.e. modern contraception will make them sterile) *Norms* -girls must seek permission from partner on FP use -pressure to have large families in Zinder to show "prosperity" -The norm is to have large families. It is not until the second or third child, when parents begin to feel the burden of parenthood that a conversation about procreation typically happens. Men are the main decision makers on contraceptive use and females must have the permission of her husband in order to use contraception.	-There seems to be a lot of trust in the health of the facility staff. Participants seem to respect their opinion. -ASC at health huts can provide contraception in Zinder -adolescent girls have knowledge of many FP options -community consultations show that men see economic benefits to FP use while women see health benefits Birth spacing generally understood to be permitted and even encouraged by Islam -birth spacing allows women to take a rest in between pregnancies and breastfeed longer -Being pregnant with a baby in your lap is really	*Messages* -consult with an ASC and decide on what family planning method to use if you do not want to get pregnant to ensure a healthy pregnancy and/or healthy lifestyle for the woman *Actions* -CHNLs lead conversations to women's groups about how birth spacing will give women time to rest and recuperate while giving families time to prepare financially for a growing family. -CHNLs in collaboration with ASCs lead sessions on FP myths and misconceptions -Target adolescent girls (10-14) before they are sexually active with information about puberty, fertility awareness, nutrition, contraception, relationships, gender dynamics, and opportunities to develop communication, decision-making, and negotiation skills. -Invite grandmothers/mothers in-law to discussion on family planning use during triad meetings -Traditional and religious leaders hold community dialogues about girls' rights, child marriage, maternal mortality and family planning -ASCs hold group discussion with youth (separated by sex and age) on the benefits of FP and how to access services. ASCs could also hold these discussions with MMF which are already youth groups. -Encourage girls to join MMFs, so they have alternatives to building economic security (outside of children), such as vocational skills, farming knowledge,

	-Local authorities, religious leaders, husbands and mother-in-laws influence how many children a girl under 18 may have. -Fetishism and prayer were seen as legitimate solutions by both girls and boys for preventing pregnancies and sexually transmitted diseases. -marriage is preferred to being single, and is praised as being: 1. mandated by Islam, 2. a clear improvement in living conditions, and 3. better than being in your parents' house. One "feels mature, like a woman" and "can eat whatever you want" and "have a family of your own" and "be more useful than just hanging around at home helping with chores." -concept that "Allah decides" how many children I have and not me *Ability to Act* -physical and/or financial barriers to accessing health facilities	bad." "You don't want them to look like twins."	and financial literacy if we expect to see norms change.

Directly Affected : Pregnant women 18-35 years old			
Targeted pregnant women attend four antenatal care consultations	*Ability to Act* -The high cost of services at the healthcare facilities and unavailability of effective means of transportation are major barriers--self medicate and/or pray because of this. -women need permission from husbands to leave the home -long distances to health centers	ANC for pregnant women is free	Messages -to keep you and your baby safe before giving birth, visit the doctor for your 4 ANC visits Actions -CHNLs identify pregnant women in the community and direct them to IYCF support groups for personalized care and support (part of triad approach) -CHNLs accompany pregnant women to health center for ANC
Targeted pregnant women give birth in a health center.	*Ability to Act* -The high cost of services at the healthcare facilities and unavailability of effective means of transportation are major barriers--self medicate and/or pray because of this. -women need permission from husbands to leave the home -long distances to health centers		Messages -for a safe pregnancy and to provide the best care to your baby, give birth at the health center Actions -CHNLs identify pregnant women in the community and direct them to IYCF support groups for personalized care and support (part of triad approach) -CHNLs accompany pregnant women to health center when they are giving birth -COGES and/or VHCs raise money to pay for emergency transport services for women in labor
Directly Influencing: Husbands			
Husbands/partners support their wives/partners in their	*Norms* -girls must seek permission from partner on FP use	-there is prestige and respect if you can take care of your family well	*Messages* -Smaller family sizes allow you to save money for other expenses such as health visits, nutritious foods and other economic opportunities

decisions to use/not use family planning	-pressure to have large families in Zinder to show "prosperity" -Local authorities, religious leaders, husbands and mother-in-laws influence how many children a girl under 18 may have. -concept that "allah decides" how many children I have and not me *Motivation* -any children is considered a blessing from heaven, and a reason for a future blessing in heaven, as the number of people one takes care of in life is a mark of honor for Muslims. "Men are like herders. In heaven, we will be asked how many people we took care of." *Ability to Act* -physical and/or financial barriers to accessing health facilities	-Birth spacing generally understood to be permitted and even encouraged by Islam -Being pregnant with a baby in your lap is really bad." "You don't want them to look like twins." -birth spacing allows gives husband time to acquire the resources to have the next child.	-Allah believes family harmony is paramount; smaller family sizes encourages stronger bonds, better relationships and healthier habits among members *Actions* -Husband Schools hold discussions with ASCs and District Health Officer about options of FP available in the community -Traditional and religious leaders hold sermons on the health and economic benefits of birth spacing using religious texts -Work with migrating young men – either pre- or post-migration – to delay marriage courtship and formation upon returning from labor migration, using this demographic transition to catalyze changes in attitudes and normative expectations around age at marriage, fertility, and family size. -encourage young men to practice modern family planning method if sexually active

Husbands support their wives in seeking health and hygiene services particularly (ANC, PNC, assisted birth and family planning)	*Norms* -Discriminatory social norms limit people's access to certain things (e.g., wagons are in high demand and it is the men and boys that get to use them) *Ability to Act* -The high cost of services at the healthcare facilities and unavailability of effective means of transportation are major barriers--self medicate and/or pray because of this.	ASCs in community seemed to be trusted by community members Women in peak health is associated with a modern, urban, elite lifestyle, suggesting possibilities for narrative evolution, insofar as health is a priority.	*Messages* -To support the health of your wife and child, encourage her to go to the health center for routine visits *Actions* -Husband Schools hold discussions around the health services and health needs of women and children and finds ways to support this -VDCs, Husband Schools, COGES work together to raise money to support transport costs for women to travel to health centers

YOUTH AND ADOLESCENTS			
Priority Behavior	Barriers	Facilitating Factors	Message and Actions
Directly Affected : Mothers 18-35			
Targeted mothers delay the birth of their second or subsequent pregnancies for at least two years after the birth of their last child.	*Norms* -Stigma around infertility and contraceptive use -belief that childbirth is "God's will" Habit -ability to envision alternative to early motherhood	Participants favor adolescents' pursuit of increased economic opportunities or education Husband Schools under LAHIA program have shown that	*Messages* By delaying the birth of your second child, you are creating a brighter future for yourself and your firstborn child. *Actions* -mitigating barriers to reproductive health care through triad activities, MMFs and support from Husband Schools

	Ability to Act -Lack of autonomy to make decisions about childbirth (control of husband)	fathers/husbands are in favor of family planning and reproductive health	-ASCs hold group discussion with youth (separated by sex and age) on the benefits of delaying marriage. ASCs could also hold these discussions with MMF that are already youth groups. -training adolescent girls on viable economic activities
Directly Affected: Girls under 18			
Targeted girls under 18 years old delay marriage until they are at least 18. *Women aged 20 to 24 years who were married before their 18th birthday in Zinder= 87% (DHS, 2012)* *The average age of marriage of daughters across all households represented by the 12 communities that participated in the SBC formative research= 15.5. However, the average age of the oldest daughter still living at home is 12.4 across all households represented by the 12 communities. This indicates that girls may be getting married off younger than stated.*	*Habit* -Parents tell them they are of age to marry and ask them to "produce a husband," which they choose and who may or may not be accepted by the parents. -Girls are highly influenced by their peers and seek to be married when their friends are getting married. -Marriage is a necessary step to adulthood and for women is a way to increase their value and voice in the community -Married girls enjoy a certain level of respect within society that cannot not be achieved if unmarried, regardless of how successful she may become professionally. *Ability to Act* -girls cannot make the final decision about if and when they marry	Girls can choose their partner, but the choice needs to be approved by parents The data indicate that religious beliefs do not play a large role in child marriage. Rather, it has more to do with family economics and to protect a girl's dignity and preserve her virginity. Girls will primarily seek advice from an intimate but wide circle of female family members Some participants said that there has been sensitization at the community level against child marriage and the perception that norms are starting to change.	*Messages* By delaying marriage until 18 you have a better chance of staying healthy and having a healthy baby in the future. *Actions* -Recruit and train local mothers to serve as mentors to the girls. -Weekly mentoring sessions held in 'safe spaces', where participants feel comfortable sharing stories and challenges from their daily lives (Gender and Youth analysis found that most young female leaders identified were between the ages of 30 and 39) -ASCs hold group discussion with youth (separated by sex and age) on the benefits of delaying marriage. ASCs could also hold these discussions with MMF which are already youth groups.

Directly Influencing : Parents of unmarried girls			
Parents of unmarried adolescent girls support delaying marriage until their daughter is at least 18 years old	*Norms* -Parents support early marriage in order to prevent pregnancy out of wedlock, and because marriage and number of children confers social status on women. *Motivation* -Unmarried girls are seen as a problem and an expense to the family. -It is perceived as serious if a girl is not married before 18. People gossip and there is fear of her becoming pregnant outside of wedlock. Additionally, it results in a lack of peace of mind for the parents and is considered bad luck. *Ability to Act* -Some families marry off their daughters to men of wealth as a survival tactic, and in the hope of increasing their economic and social prosperity	The data indicate that religious beliefs do not play a large role in child marriage. Rather, it has more to do with family economics and to protect a girl's dignity and preserve her virginity.	*Messages* -Support the health and wellbeing of your daughter by discouraging marriage until she is at least 18 years old *Actions* -Community dialogues led by parents about girls' rights, child marriage, maternal mortality and other key issues. -Recruit and train local mothers to serve as mentors to the girls. Weekly mentoring sessions are held in 'safe spaces', where participants would feel comfortable sharing stories and challenges from their daily lives. Please note that the Gender and Youth analysis found that most young female leaders identified were between the ages of 30 and 39. -husband schools hold discussions with fathers on the health implications on their daughters regarding early marriage -ASC can talk about the negative health effects of early marriage

GENDER EQUALITY/SOCIAL INCLUSION			
Priority Behavior	Barriers	Facilitating Factors	Message and Actions
Directly Affected : Husband and wife/wives			
Husbands and their wife/ wives jointly plan, organize, direct and control household finances	*Normes* -Men are considered head of the household unless they are away or incapacitated. -Men have material and financial obligation to their wife/ wives. -Married women cannot open a bank account without her husband being notified. -In some villages the experience and voice of older women was valued, but in others it was dismissed due to their sex.	-Husbands typically ask their wives what they need to buy in terms of food for the family. Sometimes the wife will accompany the husband to the market. -Under LAHIA, husband schools have helped increase dialogue among couples and potentially contributed to increases in use of health services	*Messages* -To encourage family harmony, make an action plan on the best way to use household resources and finances as a couple and check-in regularly on progress *Actions* -Husband Schools focus on gender equality and negotiation skills ● Hold sessions on how to make action plan with wife. Test out approach at home -Community groups including triad, husband schools, MMDs, MMFs trained in how to create household action plan -create radio programs/radio theater that encourages couples to discuss family dynamics regularly.
Husbands and wife/wives hold open dialogue about the health and nutrition of their family at least once per week (Topics: 1) what crops to grow; 2) how to store crops; 3) what crops to sell; 4) and what food should be	*Norms* -women/girls must seek permission from partner on going to health center -pressure to have large families in Zinder to show "prosperity" -Islam establishes that "the house is a man's" and there is no need to discuss details with wife if this means seeking agreement rather than finding obedience	Both male and female caregivers decide fairly equally on the nutrition of their young children. Men are primarily responsible for purchasing food and bringing it home for women to prepare the meal and feed the children.	*Messages* -Keep open dialogue with your wife/wives about household agriculture and food consumption *Actions* -Husband Schools activities ● Group meetings about the benefits (economic and relationships) of sharing household chores ● Listening sessions with husbands who attempted the sharing of chores

purchased for household consumption; and 5) what food should be purchased for children 6-24 months of age).	-enjoying "leisure" time talking to one's wife is considered taboo, uncultured, unmanly, frivolous *Habit* -men and women have their daily routines already set -young men and women are entering marriage as strangers and have not had previous conversations on how the household will be run	-concept that dictatorial husband may find himself alone -Husbands want, and Islam emphasizes, peace and harmony, including in the family	• Follow-up visits from husband leaders to other husbands in the community to find out the barriers of not sharing chores
Directly Affected : Husbands			
Husbands participate in household chores and childcare on a daily basis.	*Habit* -This is not part of their daily routine *Norms* -Household chores are seen as women's work -women must seek approval from their husbands for everything -negotiating with wives about chores makes men seem "weak" and "frivolous"	Husbands typically ask their wives what they need to buy in terms of food for the family. Sometimes the wife will accompany the husband to the market. -Husbands want, and Islam emphasizes, peace and harmony, including in the family	*Messages* -Be a leader and do your share of household chores -Support your family by regularly sharing in child care *Actions* -Husband Schools activities • Group meetings about the benefits (economic and relationships) of sharing household chores • Listening sessions with husbands who attempted the sharing of chores • Follow-up visits from husband leaders to other husbands in the community to find out the barriers of not sharing chores • Community conversations about the benefits of more equal distribution of household chores – especially WASH related and especially when women are pregnant and lactating

Directly Affected : Women 18-35 years old, adolescent girls and boys 15-17 (unmarried), adolescent girls 15-17 (married)			
Targeted women and adolescents (boys and girls) participate and speak without permission in sector specific groups and community wide meetings	*Norms* -Married women often need the permission from their husband to speak at public gatherings. -Women, girls and boys do not have agency to speak in public gatherings.	-76% of community consultation interviewees believe that the involvement of all social strata especially women and youth (men and women) can improve the functioning of VDCs -the existence of several village chiefs in several villages	*Messages* -Feel confident that your opinions matter enough to share your ideas during community meetings *Actions* -Community platform leaders such as triads and MMDs hold participatory discussions about different health and livelihood topics, encouraging all women in group to speak -encourage participants in community-wide demonstrations (such as cooking, or farmer field schools) to explain their technique to other participants. -all members of groups practice leading the discussion on a rotating basis.
Directly Influencing: Traditional and Religious Leaders			
Traditional and religious leaders support the participation of women and adolescents in community wide meetings	*Norms* -Married women often need the permission from their husband to speak at public gatherings. -Women, girls and boys do not have agency to speak in public gatherings.	-76% of community consultation interviewees believe that the involvement of all social strata especially women and youth (men and women) can improve the functioning of VDCs -the existence of several village chiefs in several villages	*Messages* -For more efficient and integrated community-led development, encourage communities to allow women and adolescents to participate in community groups and/or community-wide events. *Actions* -Community influencers discuss women's participation during community gathering -community influencers participate in Husband Schools and community-wide events N.B, Triads and MMDs are venues that can help women learn to speak up and share their opinions in a safe space. As they get confident in those situations, they will be more able to speak up in public forums.

[1] Excerpted from Murphy, Emmet; Oot, Lesley; Sethuraman, Kavita. 2017. USAID Office of Food for Peace Food Security Desk Review for Burkina Faso. Washington, DC: FHI 360/FANTA.

GOVERNANCE			
Priority Behavior	Barriers	Facilitating Factors	Message and Actions
Indirect Influencer : VDCs			
Targeted VDCs set up social accountability measures to help manage community goods and infrastructure within one year of working with the Wadata project. *Less than 50% of villages in Zinder have functional VDCs* *(Refine Year Community Consultation and CBO Census)*	*Information* -60% of the community consultation interviewees say that they do not know what a VDC is. -lack of awareness/ acknowledgement of the importance of the roles that youth can play in community development *Skills* Community consultation interviewees do not believe that VDCs work *Collective Efficacy* -no collaboration maintained between community health structures	COGES are government-mandated health management committees that could be leveraged for funding/support VDCs are government-mandated that could be leveraged for support Fadas (informal tea groups) meet regularly and could be leverage for community-led development and household follow-u	*Messages* -Support the establishment, management and supervision of VDCs *Actions* -Use Community Action Cycle methodology to train VDCs how to prioritize, plan for, implement and evaluate development activities and advocate for government funding -recruit diverse group of members from community to be part of VDC including marginalized groups such as women, adolescents, and people with disabilities -ensure that government stakeholders preside over certain action planning meetings -link VDCs to COGES and harmonize work plans

Indirect Influencer : Communities			
Communities register their land transactions in the rural file at the Cofos level within six months of the transaction taking place.	Existence of basic land commissions (COFOB) in some villages For each department there is a permanent secretariat of the departmental land commission which regulates land transactions, donations, pledges and loans.	- By the end of 2021, all villages are covered by COFOs - By the end of the project, all land transactions are recorded at COFOB level	Registering land transactions with COFOs reduces the risk of conflicts within the community Secure land holdings through deeds drawn up with Cofo

Delivery

Implementation Plan

The implementation plan describes the process that will be undertaken to actualize the SBC/C strategy. The key to the success of the implementation of SBC activities will be a well-coordinated approach. Activity implementation will be informed by data and respect of the situation with Covid-19, local traditions, and seasonality. Below are the interventions that are critical to the implementation of this strategy:

Table 10. Wadata Implementation Plan

Intervention	What it will take to start the activity (e.g., training, resources, etc.)	Who will be implementing this? Lead staff, consultants, volunteers, and/or partners	Position in sequence and what phase	Frequency of intervention	How many community people on average will participate?
Mata Masu Dubara (MMD) (Women's Savings and Loans Groups)	There currently aren't any MMD's in any of the 4 communes, but there are some VSLAs and IGAs to build off of Wadata led field staff orientation missions on the MMD approach and after that, there were sensitization sessions with women to understand what MMD is and how it works.	Wadata staffs and state agents Private partners (microfinance institution) Village facilitator (specifically to supervise MMDs)	Setting up Capacity Building Regulatory framework (drafting of texts for operation such as internal regulations) Action plan for each MMD	Monthly follow-up by staff Weekly follow-up by village animators Regular monitoring by MFI in case of granting credit	16,500
Farmer Managed Natural Regeneration (FMNR) Groups	Wadata completed the Combined Natural Resource Management and Conservation Agriculture training 'Purpose 1 & 2)	Wadata staff, state agents (agriculture, environment)	Activities to be done by village chosen on cultivated fields particularly Identified sites (proposed by the farmers themselves and validated by the	Continuous activity (more intense in the rainy season)	424 people planned for 2020 as pilots From 2021, each farmer makes the extension with the support of

Intervention	What it will take to start the activity (e.g., training, resources, etc.)	Who will be implementing this? Lead staff, consultants, volunteers, and/or partners	Position in sequence and what phase	Frequency of intervention	How many community people on average will participate?
			technicians (project staff and state agents)		staff and agents of the state
Community System for Early Warning and Emergency Response (SCAPRU)	Constitute clusters of villages before setting up Training of members on incident, risk and disaster reporting tools and information feedback system	Sub-regional committee for the prevention and management of crises and disasters (department level) Vulnerability Monitoring Observatory (common level) Wadata staff for local support) Community orientation on the SCAP / RU approach	Constitution of clusters of villages Establishment of SCAP / RU Capacity Building Action plan Collection and feedback of information on a weekly basis 36 SCAP / RU to be set up in the intervention area	Collection and feedback of information on a weekly basis 36 SCAP / RU to be set up in the intervention area	Collection and feedback of information on a weekly basis 36 SCAP / RU to be set up in the intervention area
Water Point Committees	State of play of existing committees Restructuring of committees monitoring the implementation of new	Wadata Hydraulics and Wash Supervisors Versatile agent for local support	Management of the water service based on the operating account Maintenance and upkeep of water and	Monthly	Not defined (the number will be equal to that of modern water points made and / or rehabilitated

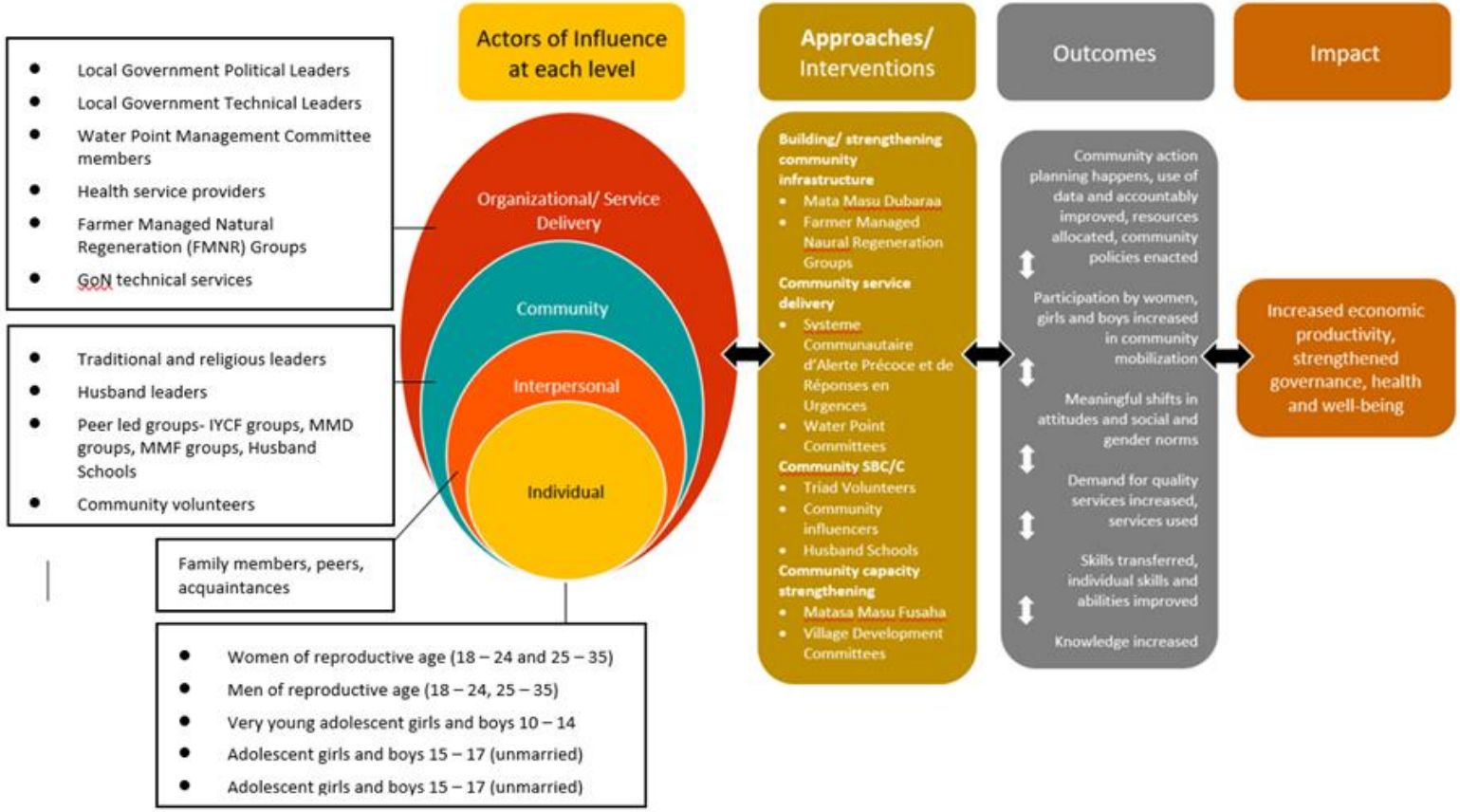
Intervention	What it will take to start the activity (e.g., training, resources, etc.)	Who will be implementing this? Lead staff, consultants, volunteers, and/or partners	Position in sequence and what phase	Frequency of intervention	How many community people on average will participate?
	Training of members on the management of the water service	Municipal water and hydropower service	sanitation infrastructure		by all intervening in the area
Triad volunteers	Some relays exist in certain villages and Wadata takes them as CNHL	Wadata staff and health workers for training (1000 days, PFE, ANJE) Orientation on behavior change through thematic sessions	Setting up Training Equipment (activity supports) Reporting	Bi-weekly, monthly	
Community influencers	Identification in each village of influential people and development of a nominal directory as well as the area in which they exert their influence	Wadata Cross-cutting team	During rounds with health workers	Weekly for religious leaders	636 influencers to support awareness-raising on various themes
Husband Schools	Orientation of staff on the Husband Schools approach Sensitization of men in the villages Establishment of schools	Field staff Cross-cutting team Network of communicators Multisectoral community mobilization team from Gouré and DTK		Monthly	212 husband schools for the Wadata zone (2,500 members)
Matasa Masu Fusaha (MMF) Young	In some communities, there are some youth groups that the MMF can be built upon.	Field agents		Monthly	212 MMF in the Wadata zone

Intervention	What it will take to start the activity (e.g., training, resources, etc.)	Who will be implementing this? Lead staff, consultants, volunteers, and/or partners	Position in sequence and what phase	Frequency of intervention	How many community people on average will participate?
People Groups		Technical service for the promotion of young people			
Village Development Committees	Mobilize MMD / MMFs via new VDCs to solidify economic development coordination Coordinates development actions at the village level Umbrella structure of all community platforms	Field agents Community Development Department Administration of municipalities		Monthly	212 CVD for all the villages and hamlets in the area

Monitoring and Evaluation

The following lists of indictors (Table 11 and Table 12) are taken from Wadata's existing Log Frame and align with Wadata's SBC/C theory of change (see the outcomes column in the image below) and the Wadata SBC/C objectives. The theory of change specifically addresses determinants to social and behavior change based on Wadata's formative research. See Wadata's Log Frame for the full list of indicators. See Wadata's monitoring and evaluation plan for details on how and when the data will be collected.

Wadata SBC/C Theory of Change



Overall Objectives of the SBC/C Strategy

- Strengthen the **empowerment** of women and girls, **social networks and participation** to support **informed decision-making**
- Decrease discriminatory **gender norms, attitudes and behaviors** towards girls and women
- Improve informed **decision-making by females and couples**
- Increase equitable **access to, control over and benefit from community systems**, structures and resources for girls and women
- Increase **engagement** of women, girls and boys in meaningful **participation** in community life
- Increase **demand for and use of quality health, nutrition, WASH and agricultural services** by girls, boys, women and men based on a voluntary, non-coercive approach
- Improve **governance and accountability** for community infrastructure
- Increase girls, boys, and women's leadership development, confidence, conflict management and negotiation **skills**
- Improve **knowledge, motivation and ability** of girls, boys, women and men to **adopt and practice appropriate health, nutrition, agriculture, resilience and livelihoods behaviors**

Refer back to **Table 8** to see how Wadata's SBC/C objectives are related to each of the interventions.

Table 11. Indicators by Wadata focus area/ priority behavior

Focus area and intervention	Priority behavior	Sub-purpose/ outcome	Existing indicators on Wadata's log frame
Nutrition	Targeted mothers only give breastmilk to their infants from birth to 6 months of age.	Intermediate Outcome 3.2.2 : Improved adolescent, maternal, infant and young child nutrition practices	Prevalence of exclusive breastfeeding of children under six months of age (indicator BL13)
	Targeted caregivers of children ages 6-23 months feed them at least three cooked meals a day that contain (proteins), vitamins (fruits and veggies) at the	Intermediate Outcome 3.2.3 : Increased consumption of adequate and diverse foods by PLWs, CU5 and adolescent girls	Percent of children 6–23 months receiving a minimum acceptable diet (MAD) (indicator BL12)

Focus area and intervention	Priority behavior	Sub-purpose/ outcome	Existing indicators on Wadata's log frame
	recommended quantity and frequency		
		Sub-Intermediate Outcome 3.2.3.1. Improved knowledge of adequate and diverse diets, especially for children and adolescents	Percent of mothers/caregivers and adolescents girls who can cite at least 4 criteria required of diverse dietary, particularly for CU5 and adolescents (indicator C 63)
	Pregnant and lactating women consume additional nutritious food and liquids during pregnancy and lactation (i.e., one extra meal or snack during pregnancy and two extra meals or snacks during lactation).	Sub intermediate outcome 32.31 : Improved knowledge of adequate and diverse diets, especially for children and adolescents	Percent of mothers/caregivers and adolescentes girls who can cite at least 4 critereas required of diverse dietary, particularly for CU5 and adolescents (indicator C 63)
WASH	Targeted families wash their hands with soap and water at critical moments on a daily basis.	Intermediate Outcome 3.3.1 Increased application of improved hygiene and sanitation behaviors	Percentage of community members who practice at least 2 key WASH behaviors (indicator C 64)
		Sub-Intermediate Outcome 3.3.1.1. Increased household knowledge of improved hygiene and sanitation practices	Percent of respondents who know three of five critical moments for handwashing (indicator C 65)
		Sub intermediate 1.2.2.2 Community water resource management improved	Number of WPMG in the target area utillizing at least 4 of the 5 sustainable water management practices (indicator C15)
		Sub-Intermediate Outcome 3.3.2.2 Improved norms and	Percentage of adults who consider handwashing to be linked to family health (indicator C 71)

Focus area and intervention	Priority behavior	Sub-purpose/ outcome	Existing indicators on Wadata's log frame
		attitudes towards handwashing	
	Targeted families drink potable water daily	Intermediate Outcome 3.3.1 Increased application of improved hygiene and sanitation behaviors	Percentage of community members who practice at least 2 among key WASH behaviors (indicator C 64)
AG & Livelihoods	Husbands and their wife/ wives jointly plan, organize, direct and control household finances.	Sub purpose 3.2 Increased adoption of optimal nutrition and health practices	Percent of women in union and earning cash who report participation in decisions about the use of self-earned cash (Indicator M 5)
		Sub intermediate outcome 2.1.1.3 Increased equitable control over time and productive resources	Percent of women in union and earning cash who report participation in decisions about the use of spouse/partner's self-earned cash (indicator BL 34)
	Targeted women, who are not already members, join village savings and loans groups	Sub-Intermediate Outcome 2.1.1.2 Increased women's skills for income generating activities	Number of women who use at least one IGA strategy (indicator C 25)
	Targeted men and women plant nutrition-sensitive crops on irrigated community land provided to them by community leaders every year during planting season.	Purpose 2 Increased capacities, assets and agency to access adequate and diverse foods at all times	Percent of female direct beneficiaries of USG nutrition-sensitive agriculture activities consuming a diet of minimum diversity (indicator M6)
Resilience	Targeted farmers adopt 2 or more climate-smart agricultural practices within one year after being introduced to them.	Sub-purpose 2.2 Increased profitability of livestock and irrigated crop production	Percentage of farmers who used at least three sustainable agriculture (crop, livestock, and/or NRM) practices and/or technologies in the past 12 months (indicator C 29)

Focus area and intervention	Priority behavior	Sub-purpose/ outcome	Existing indicators on Wadata's log frame
Use of health, hygiene and nutrition services	Targeted women, or their partners, who are under the age of 18 who do not want to become pregnant, use a modern contraceptive method.	Intermediate outcome 3.1.2 Norms, attitudes, and behaviors on pregnancy timing and spacing improved	Percent of women in union who have knowledge of modern family planning methods that can be used to delay or avoid pregnancy (indicator BL 36)
	Targeted pregnant women attend four antenatal care consultations	Sub-Intermediate Outcome 3.1.2.1 Increased decision-making power of women and girls over their own health and that of their children	Percentage of PLW and adolescents girls who report being able to seek healthcare of their own will (indicator C 54)
		Sub-Intermediate Outcome 3.2.1.1 Increased male support for women's and children's health and nutrition actions	Number of live births receiving at least four antenatal care (ANC) visits during pregnancy (indicator M 24) Percentage of women who report increased health and nutrition support actions from their male partners (indicator C 60)
		Sub-Intermediate Outcome 3.2.1.2 Increased knowledge of health seeking requirements by women of reproductive age, pregnant women and caregivers of young	Percentage of adult females that can give at least two reasons why access to health services is important to children under five and for women of child bearing age, including adolescent girls (indicator C 61)
	Targeted pregnant women give birth in a health center.	Sub-Intermediate Outcome 3.1.2.1 Increased decision-making power of women and girls over their own health and that of their children	Percentage of PLW and adolescents girls who report being able to seek healthcare of their own will (indicator C 54)
		Sub-Intermediate Outcome 3.2.1.1 Increased male support for women's and children's health and nutrition actions	Percentage of women who report increased health and nutrition support actions from their male partners (indicator C 60)

Focus area and intervention	Priority behavior	Sub-purpose/ outcome	Existing indicators on Wadata's log frame
Youth and adolescents	Targeted girls under 18 years old delay marriage until they are at least 18.	Sub-Intermediate Outcome 3.1.1.2 Adolescent attitudes towards early marriage improved	Percentage of respondents who state ideal age of marriage is 18+ (indicator C 51)
	Targeted mothers delay the birth of their second or subsequent pregnancies for at least two years after the birth of their last child.	Intermediate Outcome 3.1.2 Norms, attitudes, and behaviors on pregnancy timing and spacing improved	Percentage of adolescent girls and women of reproductive age who state ideal age at first birth is 18 or over (indicator C 52) Percentage of adolescent girls and women of reproductive age who state that the ideal timing between birth and next pregnancy is 2 years (indicator C 53)
Gender Equality and social inclusion	Targeted women and adolescents (boys and girls) participate and speak without permission in sector-specific groups and community-wide meetings	Sub-Intermediate Outcome 1.1.2.1 Increased knowledge of social and ecological challenges to food, nutrition and water security	Percentage of CBO members that are women and/or youth (indicator C 2)
		Intermediate Outcome 1.1.3 Community influencers support gender-equitable, youth-inclusive development	Percentage of community influencers who are favorable in involving women and youth in decision-making process at community level (indicator C 7)
	Husbands participate in household chores and childcare on a daily basis.	Sub-Intermediate Outcome 3.2.1.1 Increased male support for women's and children's health and nutrition actions	Percentage of women who report increased health and nutrition support actions from their male partners (indicator C 60)
	Husbands hold an open dialogue with their wives about the nutrition of their family at least once per week (Topics: 1) what crops to grow; 2) how to store crops; 3) what crops to sell; 4) and what food should be	Sub purpose 3.2 : Increased adoption of optimal nutrition and health practices	Percentage of men/women in union with children under two who make maternal health and nutrition decisions (indicator C56) Percentage of men/women in union with children under two who make child health and nutrition decisions (indicator C58)

Focus area and intervention	Priority behavior	Sub-purpose/ outcome	Existing indicators on Wadata's log frame
	purchased for household consumption; and 5) what food should be purchased for children 6-24 months of age).		
Governance	Targeted VDCs set up social accountability measures to help manage community goods and infrastructure within one year of working with the Wadata project.	Sub-Intermediate Outcome 1.1.1.1 Existence and effectiveness of VDCs increased	Number of VCDs who have completed their coordination of village action plan (indicator C 4)
		Sub-Intermediate Outcome 1.1.1.3 VDC understanding of commune-level development planning enhanced	Number of VDCs linked/introduced to Commune-level counterparts for better understanding of planning and budget cycle (indicator C 83)
		Sub-purpose 1.3 Effective responses to community- level shocks and stresses	Number of cluster with disaster early warning and response systems working effectively (indicator C 16)
	Communities register their land transactions in the rural file at the Cofos level within six months of the transaction taking place	Intermediate outcome 1.2.1 : Conflicts related to land and water use are reduced	Number of conflict prevention systems, conflict assessment, or response mechanisms supported by USG (indicator C11)

Table 12. Indicators by Intervention

Intervention	Indicators relevant to SBC from Wadata Log Frame
Community influencers	• Percentage of community influencers who are favorable in involving women and youth in decision-making process at community level (indicator C 7) • Number of religious and traditional leaders trained in peer mentorship (indicator C 84) • Number of community influencers recognized as contributors to SBC messaging by their community (indicator C 81)

	• Percentage of women married at early age (indicator C 48) • Percentage of respondents who state ideal age of marriage is 18+ (indicator C 49) • Number of early marriage cancelled and/or suspended as a result of the activities of community influencers (indicator C 50)
Farmer Managed Natural Regeneration Groups	• Percent of community members participating in collective action (indicator M 37) • Number of people who received basic training on social and ecological challenges to food, nutrition and water security (indicator C 1) • Percentage of community influencers who are favorable in involving women and youth in decision-making process at community level (indicator C 7) • Number of farmers who used at least [a project-defined minimum number of] sustainable NRM practices and/or technologies (indicator C 10) • Percentage of farmers who used at least three sustainable agriculture (crop, livestock, and/or NRM) practices and/or technologies in the past 12 months (indicator C 29) • Number of people using climate information or implementing risk-reducing actions to improve resilience to climate change as supported by USG assistance (indicator M 11) • Percentage of livestock-rearing MMD and FMNR members who have applied improved animal production practices (indicator C 36) • Number of people trained in improved breeding technology (indicator C 37) • Number of individuals in the agriculture system who have applied improved management practices or technologies with USG assistance (indicator M 16)
Husband Schools	• Prevalence of underweight (BMI <18.5) women of reproductive age (indicator BL 7) • Contraceptive prevalence rate (CPR) (indicator BL 20) • Percentage of men/women in union with children under two who make maternal health and nutrition decisions (indicator C 56) • Percent of men in union and earning cash who report spouse/partner participation in decisions about the use of self-earned cash (indicator BL 35) • Percent of births receiving at least 4 antenatal care (ANC) visits during pregnancy (indicator BL 26) • Percentage of women who report increased health and nutrition support actions from their male partners (indicator C 60)
Matasa Masu Fusaha (MMF) Young People Groups	• Number of MMF groups that are functional (indicator C 27 • Percentage of MMF members employed (indicator C 28) • Percentage of women and youth in union who earned cash in the past 12 months (indicator C 23) • Percent of participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment) who are female (indicator M 34) • Number of women who use at least one IGA strategy (indicator C 25)

	• Percent of women in union and earning cash who report participation in decisions about the use of spouse/partner's self-earned cash (indicator BL 34) • Percent of participants in USG-assisted programs designed to increase access to productive economic resources who are youth (15-29) (indicator M 35) • Number of MMF members trained (indicator C 26) • Number of full-time equivalent off-farm jobs created with USG assistance (indicator M 17) • Contraceptive prevalence rate (CPR) (indicator BL 20) • Percentage of MMF members who state ideal age of marriage is 18+ (indicator C 51) • Percent of women in union and earning cash who report participation in decisions about the use of self-earned cash (indicator BL 33)
Mata Masu Dubara (MMD) Women's Savings and Loans Groups	• Number of MMD groups that are functional (indicator M 24) • Proportion of households participating in group-based savings, micro-finance or lending programs (indicator B 31) • Percentage of women and youth in union who earned cash in the past 12 months (indicator C 23) • Percent of participants in USG-assisted programs designed to increase access to productive economic resources (assets, credit, income or employment) who are female (indicator M 34) • Number of individuals participating in USG assisted group-based savings, micro-finance or lending programs (indicator M32) • Number of women who use at least one IGA strategy (indicator C 25) • Percent of women in union and earning cash who report participation in decisions about the use of spouse/partner's self-earned cash (indicator BL 34) • Percent of participants in USG-assisted programs designed to increase access to productive economic resources who are youth (15-29) (indicator M 35) • Number of MMD members trained (indicator C 26) • Percentage of livestock-rearing MMD and FMNR members who have applied improved animal production practices (indicator C 36) • Percent of women in union and earning cash who report participation in decisions about the use of self-earned cash (indicator BL 33)
Triad volunteers	• Prevalence of underweight (BMI <18.5) women of reproductive age (indicator BL 7) • Contraceptive prevalence rate (CPR) (indicator BL 20) • Number of children under 2 (0-23 months old) participating in growth monitoring and promotion (indicator M 5) • Percentage of adult females that can give at least two reasons why access to health services is important to children under five and for women of childbearing age, including adolescent girls (indicator C 61) • Percent of women of reproductive age consuming a diet of minimum diversity (indicator BL 11) • Prevalence of exclusive breastfeeding of children under six months of age (indicator BL 13) • Number of individuals receiving nutrition-related professional training through USG-supported programs (indicator M 26)

	• Percent of children 6–23 months receiving a minimum acceptable diet (MAD) (indicator BL 12) • Percent of mothers/caregivers and adolescents girls who can cite at least 4 criteria required of diverse dietary, particularly for CU5 and adolescents (indicator C 63) • Number of pregnant women reached with nutrition-specific interventions through USG-supported programs (indicator M3)
Systeme Communautaire d'Alerte Précoce et de Réponses en Urgences	• Percent of community members participating in collective action (indicator M 37) • Number of people who received basic training on social and ecological challenges to food, nutrition and water security (indicator C 1) • Percentage of community influencers who are favorable in involving women and youth in decision-making process at community level (indicator C 7) • Number of host government or community-derived risk management plans formally proposed, adopted, implemented or institutionalized with USG assistance (indicator M28) • Number of people trained in disaster preparedness as a result of USG assistance (indicator M 10)
Village development Committees	• Percent of community members participating in collective action (indicator M 37) • Percentage of VDC members by sex and age (indicator C 5) • Number of people who received basic training on social and ecological challenges to food, nutrition and water security (indicator C 1) • Percentage of community influencers who are favorable in involving women and youth in decision-making process at community level (indicator C 7) • Number of host government or community-derived risk management plans formally proposed, adopted, implemented or institutionalized with USG assistance (indicator M28) • Number of VDCs who report receiving information from SCAPRU at least once per quarter (indicator C 17) • Number of people trained in disaster preparedness as a result of USG assistance (indicator M 10) • Number of VDCs who report holding a joint planning meeting with SCAP RU members in their villages (indicator C 19)
Water Point Committees	• Percent of community members participating in collective action (indicator M 37) • Number of people who received basic training on social and ecological challenges to food, nutrition and water security (indicator C 1) • Percentage of community influencers who are favorable in involving women and youth in decision-making process at community level (indicator C 7) • Number of people gaining access to basic drinking water services as a result of USG assistance (indicator M 21) • Number of WPMG linked with private sector of Water Point Management Groups following at least three recommended practices (indicator C 78)

	• Number of infrastructures build and/or rehabilitated for basic drinking water services due to USG assistance (indicator C 77)

List of indicators related to SBC that are in the Log Frame but not being addressed through SBC interventions

- Index of social capital at the household level (indicator BL 38)
- Percent of women/men in a union who are members of a community group (indicator BL 41)
- Percentage of CBO members that are women and/or youth (indicator C 2)
- Percentage of adolescent girls and women of reproductive age who state ideal age at first birth is 18 or over (indicator C 52)
- Percent of women in union who make decisions about modern family planning methods in the past 12 months (indicator BL 37)
- Percentage of PLW and adolescent girls who report being able to seek healthcare of their own will (indicator C 54)
- Number of small group and one-to-one contraceptive information sessions held with women and adolescents (indicator C 55)
- Percent of women in union who have knowledge of modern family planning methods that can be used to delay or avoid pregnancy (indicator BL 36)
- Number of live births receiving at least four antenatal care (ANC) visits during pregnancy (indicator M 24)
- Percentage of men and women with children under two who have knowledge of maternal and child health and nutrition (MCHN) practices with USG assistance (indicator C 62)
- Percent of households with soap and water at a handwashing station on premises (indicator B 17)
- Percentage of households in target areas practicing correct use of recommended household water treatment technologies (indicator BL 18)
- Percentage of community members who practice at least 2 key WASH behaviors (indicator C 64)
- Percent of respondents who know three of five critical moments for handwashing (indicator C 65)
- Number of people reached with handwashing/hygiene messaging (indicator COVID 19-1)
- Number of households accessing handwashing/hygiene kits with USAID assistance (indicator COVID 19-2)
- Percentage of adults who consider handwashing to be linked to family health (indicator C 71)

Indicators that might be considered for the monitoring and evaluation plan

- Social norms around these three priority behaviors in particular:
  - Targeted girls under 18 years old delay marriage until they are at least 18.
  - Targeted women and adolescents (boys and girls) participate and speak without permission in sector-specific groups and community-wide meetings

    - Husbands participate in household chores and childcare on a daily basis
- Level of community social cohesion and capacity to absorb SBC project activities (Method: Community Capacity Assessment)
- # of project sites with significant insecurity or instability (during the month, quarter, year)
- Stakeholder consensus on which contextually-driven project adjustments contributed most to achieving the objectives of the project (Method: Most Significant Change)
- Qualitative assessment of unexpected outcomes (Method: Most Significant Change, Outcome Harvesting)
- Agreement of target population on the statement, "I do not see any need to change my current behaviors in the area of X" (Method: Likert scale)
- Number and type of planned project interventions/ activities modified (e.g., rescheduled, added, expanded or canceled) due to unforeseen changes.
- Frequency of activities in which community members and/or frontline workers participate in program progress and contribute to problem-solving or decision making
- Number of participants reporting behavior change who express confidence in sustaining the targeted behavior change over the next year without additional project support.
- Extent of stakeholder consensus that the target population will be able to maintain target behaviors after the project's completion.
- % of triad volunteers who agree that the target behavior X is a priority for them.
- Extent of community leader consensus that most people in their community support the priority behavior X.
- Extent of community leader consensus that people in their community will maintain the priority behavior X.

Capturing important data and information for learning and documentation

Let's think ahead to project documentation. In order to advance our understanding of SBC programming, we should not only measure and report whether Wadata's interventions have successfully changed behavior, and how effective they have been (based on observable behavior change), but also *how* they have achieved their effects.

Table 13. Important information and data we should be sure to capture for project documentation

Recommendation on what to capture	Specific details on what to capture, and why it is essential to capture this data and information
Details about the local context	• Local social norms and the challenges, contradictions and paradoxes • Key barriers and facilitators to program implementation (e.g., available resources, political stability, the state of the health system, emergency vs. development context, social, cultural, and religious drivers, socio-economic and structural drivers, current priorities of key stakeholders) • The relationships between people, groups, and organizations (e.g., who participates and who implements the intervention(s), who holds decision-making power), the nature of the partnerships relevant to the program (e.g., strong, weak, conflicted, collaborative) • How components of the various interventions interact in synergistic or incompatible ways
Characteristics of the participants involved in the intervention(s)	• What are early adopters of the behavior(s) like?
Details about the SBC intervention(s)	The core program components/activities: • what was done (type of activity) • how (methods/processes of implementation/delivery) • when (frequency, intensity, duration of activity) • by whom (implementing personnel, i.e., staff or volunteer providers, including a description of their skills, training, characteristics and responsibilities) and the level of skill required by those delivering the intervention in order to meet the intervention objectives • the relationship between program implementers and participants- Level of engagement by the participants in the program design and implementation and how they participated • efforts used to increase and sustain participation of stakeholders • education/support materials, if used (how they were developed/used where they can be accessed) • Resources required for the SBC interventions (i.e., financial, physical, and human)
Intended, unintended, expected, unexpected, negative and positive change	• Who and what has changed, when and where change occurred, and how the change was influenced including plausible contribution of change agents to outcomes • Social and organizational norms and contextual factors that may have affected the process of change • Non-participation and dropout rates among the participants, reported by key socio-demographic characteristics and reasons given, as well as a description of any actions taken to reach out to these individuals • Resistance or lack of support among stakeholders or program participants

Recommendation on what to capture	Specific details on what to capture, and why it is essential to capture this data and information
Adaptations	• How the intervention(s) worked in reality and any adaptations made and why • How responsive the program is/was to external shocks (e.g., new policies, program funding, new stakeholders, etc.) • How participant and stakeholder feedback was used in making decisions about implementation
Acceptability	• The acceptability of the program among participants and implementers
Contradictory or negative evidence	• Small or lack of adoption of new practices • How implementation of the intervention(s) contributed/ did not contribute to changes
Sustainability	Gains the program made can be difficult to sustain unless specific efforts are made. Be sure to document details about: • What resources are needed to maintain the program activities • What level of engagement is needed by stakeholders and participants • What relationships or partnerships are needed

Summary of the Wadata SBC/C Strategy

Overall Objectives of the SBC/C Strategy

- Strengthen the empowerment of women and girls, social networks and participation to support informed decision-making
- Decrease discriminatory gender norms, attitudes and behaviors towards girls and women
- Improve informed decision-making by females and couples
- Increase equitable access to, control over and benefit from community systems, structures and resources for girls and women
- Increase engagement of women, girls and boys in meaningful participation in community life
- Increase demand for and use of quality health, nutrition, WASH and agricultural services by girls, boys, women and men based on a voluntary, non-coercive approach
- Improve governance and accountability for community infrastructure
- Increase girls, boys, and women's leadership development, confidence, conflict management and negotiation skills
- Improve knowledge, motivation, and ability of girls, boys, women and men to adopt and practice appropriate health, nutrition, agriculture, resilience and livelihoods behaviors

Vision for the Wadata SBC interventions

Wadata will deliver cohesive and logically packaged SBC interventions that unite divergent health and development areas and contribute to long-term social change, beyond the lifetime of the project.

Audience Segmentation

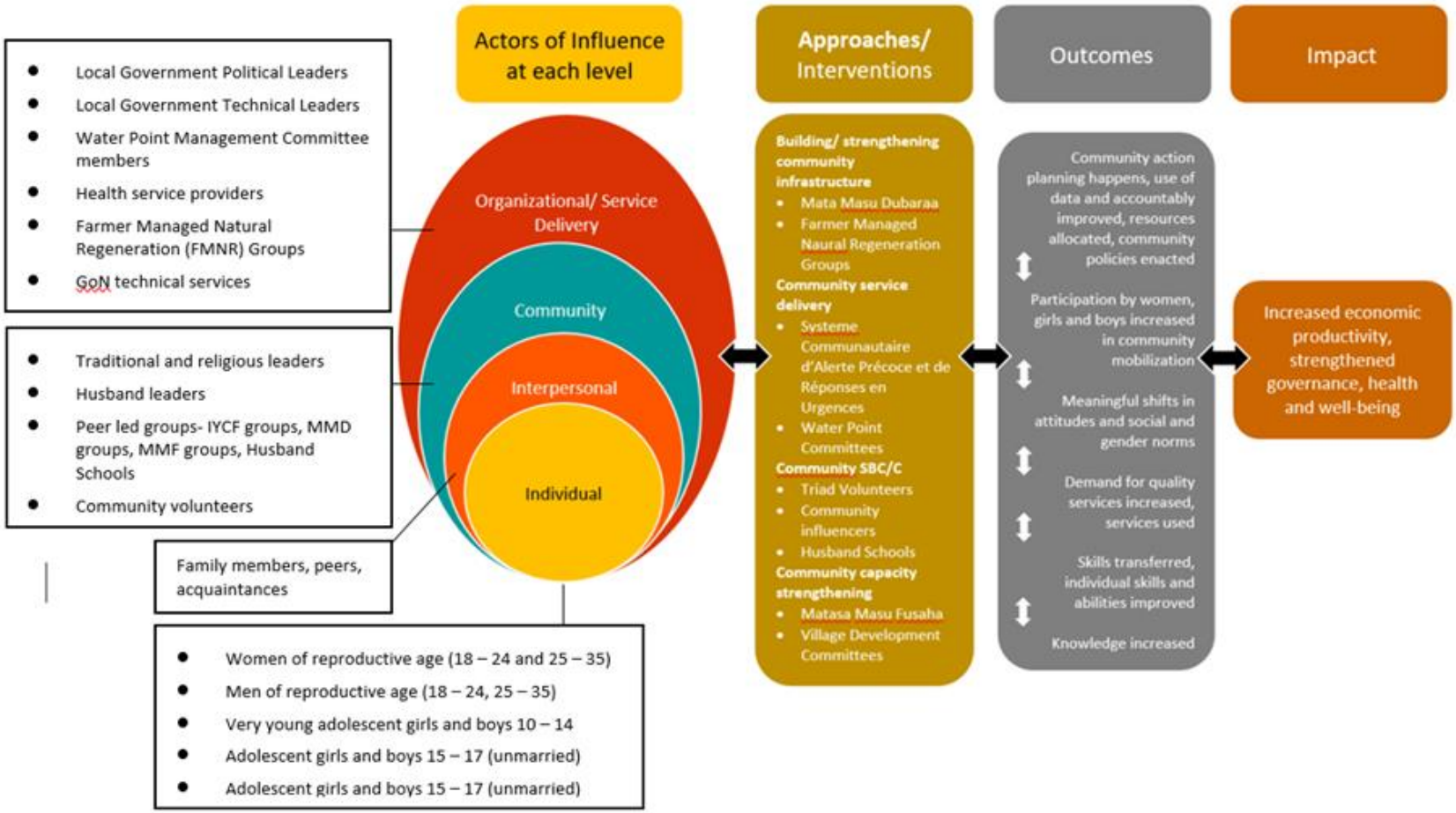
Directly affected	Direct influencers	Indirect influencers
• Women of reproductive age (18 – 24 and 25+) • Couples (18-35) • Men (18 -24 and 25+ • Very young adolescent girls and boys 10 – 14 • Adolescent girls and boys 15 – 17 (unmarried) • Adolescent girls 15 – 17 (married)	• Family members (especially grandmothers, husbands for nutrition and parents for unmarried girls under 18) • Traditional and religious leaders • Husband leaders • Peer led groups- IYCF groups, MMD groups, MMF groups, Husband Schools • Community volunteers: Triad volunteers (Community Health and Nutrition Liaisons (CHNLs), Mamans Lumieres (MLs) and IYCF group leaders)	• Local Government Political Leaders: village chief, VDCs, commune administrators • Local Government Technical Leaders: VDCs, SCAPRU • Water Point Management Committee members • Health service providers • Farmer Managed Natural Regeneration (FMNR) Groups • GoN technical services • Regional Directorates • Private sector actors

Problem statement

Poverty and gender inequality appear to be the major driving forces affecting all aspects of health, nutrition, WASH, food security, livelihoods, use of health, hygiene and nutrition services, and resilience in the Zinder Region. According to the World Bank (2019), over 40% of the country's 22.4 million people live in extreme poverty. Additionally, there is an inadequate availability of sufficient, high-quality, and diverse foods due to shocks, climate change, challenging agro-ecological conditions, population growth, and underdeveloped food systems. Families often have insufficient purchasing power to access sufficient, high-quality, and diverse food, which is exacerbated by ongoing cycles of shocks and crises. Poverty limits access to formal health care, while hierarchy and power limit access to community resources.

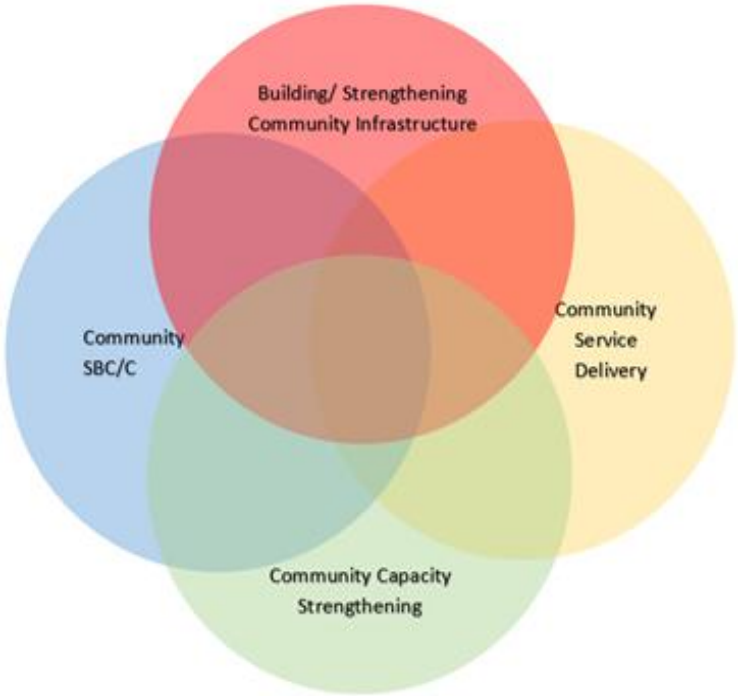
In terms of gender, pre-existing gender inequalities resulting from unequal access to opportunities contribute to the limited access to resources and skills among women and girls, which in turn increases their vulnerability. Women do not necessarily have the knowledge and agency to provide for their well-being, nor the well-being of their children. The extremely disadvantaged position of women, including inadequate care of mothers and young children, coupled with high levels of early marriage and pregnancy, leads to an intergenerational cycle of poverty, malnutrition, and poor health. In addition, cultural and social norms prevent the uptake of practices that could lead to improved health, nutrition, WASH. Imbalances in power and lack of resources also lead to more significant problems such as maternal, adolescent and infant malnutrition, water-borne diseases, adolescent pregnancies, poor agricultural yields, lack of opportunities for youth livelihoods, and inability to prepare appropriately for shocks and stresses. Husbands/fathers have tremendous potential to be either a positive or a negative presence within the family ecosystem as well as other influencers such as religious leaders, traditional leaders, community health agents, and other family members.

Theory of Change


Actors of Influence at each level
Approaches/ Interventions
Outcomes
Impact
Local Government Political Leaders
Local Government Technical Leaders
Water Point Management Committee members
Health service providers
Farmer Managed Natural Regeneration (FMNR) Groups
GoN technical services
Traditional and religious leaders
Husband leaders
Peer led groups- IYCF groups, MMD groups, MMF groups, Husband Schools
Community volunteers
Family members, peers, acquaintances
Organizational/ Service Delivery
Community
Interpersonal
Individual
Women of reproductive age (18 – 24 and 25 – 35)
Men of reproductive age (18 – 24, 25 – 35)
Very young adolescent girls and boys 10 – 14
Adolescent girls and boys 15 – 17 (unmarried)
Adolescent girls and boys 15 – 17 (unmarried)
Building/ strengthening community infrastructure
Mata Masu Dubaraa
Farmer Managed Naural Regeneration Groups
Community service delivery
Systeme Communautaire d'Alerte Précoce et de Réponses en Urgences
Water Point Committees
Community SBC/C
Triad Volunteers
Community influencers
Husband Schools
Community capacity strengthening
Matasa Masu Fusaha
Village Development Committees
Community action planning happens, use of data and accountably improved, resources allocated, community policies enacted
Participation by women, girls and boys increased in community mobilization
Meaningful shifts in attitudes and social and gender norms
Demand for quality services increased, services used
Skills transferred, individual skills and abilities improved
Knowledge increased
Increased economic productivity, strengthened governance, health and well-being

Approaches

Wadata's strategic approach is a combination of building/strengthening community infrastructure, community service delivery, community social and behavioral change and community capacity strengthening that aims to improve gender equality and social inclusion, increase economic productivity for females and males, strengthen governance and resilience in communities and improve health and well-being for individuals and families.



1. Building/strengthening community infrastructure
2. Community Service Delivery
3. Community Social and Behavior Change/Communication
4. Community Capacity Strengthening

Interventions

- Community influencers
- Farmer Managed Natural Regeneration Groups
- Husband Schools
- Matasa Masu Fusaha (MMF) Young People Groups
- Mata Masu Dubara (MMD) Women's Savings and Loans Groups
- Triad volunteers
- Systeme Communautaire d'Alerte Précoce et de Réponses en Urgences
- Village development Committees Water Point Committees