Guide for Developing an SBC Strategy

USAID
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Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

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Acronyms

ANC	Antenatal care
ASBCs	Community health workers (Agents de santé basé au communauté)
CAC	Community Action Cycle
CAGs	Community Action Groups
CHNL	Community Health and Nutrition Liaisons
CLTS	Community-led total sanitation
DFSA	Development food security assistance
DHS	Demographic Health Service
FGD	Focus group discussion
FMNR	Farmer-managed natural regeneration groups
GASPA	Care group with maman leaders
HC3	Health Communication Capacity Collaborative
HH	Household
IGA	Income Generating Activities
IPTT	Indicator performance tracking table
IYCF	Infant and young child feeding
M&E	Monitoring and Evaluation
MLA	Mother leader animator
LAHIA	Livelihoods, Agriculture and Health Interventions in Action project
MERL	Monitoring, evaluation, research and learning
MIYCN	Maternal, infant, and young child nutrition
MMD	Mata Masu Dubara
MMF	Matasa Masu Fusaha
NGOs	Non-governmental organizations
OSV	Observatoire de surveillance de la vulnérabilité
PDQ	Program development quality
PLW	Pregnant and lactating women
PNH	Project Nutrition and Hygiene
QIT	Quality improvement team
SBC	Social and behavior change
SBCC	Social and behavior change communication
SCAP/RU	Système communautaire d'alerte précoce et de réponses en urgences
SDA	Small doable actions
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
SMS	Short message service
ToC	Theory of change

TIPs	Trials of improved practices	**VDC**	Village development committee
UNICEF	United Nations Children's Emergency Fund	**WASH**	Water, sanitation and hygiene
USAID	United States Agency for International Development	**WHO**	World Health Organization
USG	United States Government	**YiA**	Youth in Action

Guidance to Assist in Developing a

Social and Behavior Change Strategy

The United States Agency for International Development (USAID) developed the Resilience in the Sahel Enhanced II (RISE II) Intervention to help the populations in Burkina Faso and Niger, supported by resilient systems, effectively manage shocks and stresses and seek durable, sustainable solutions to overcome poverty. RISE II is a group of projects that work together to help achieve this outcome. Most projects are USAID-funded, but some, such as the World Food Program, are part of the enabling environment that supports government technical services to become robust systems that can effectively manage shocks and stresses – both climatic as well as social (terrorism, displacement, etc.).

West Africa is an area that, to date has seen very little focused attention on comprehensive social and behavior change (SBC). Ministries of health acknowledge that their previous activities have encompassed information, education, and communication or behavior change communication. Now they are working towards going beyond improving knowledge and focusing more deeply on analyzing social and cultural norms to address barriers to improving health practices, supporting the enabling environment with updated policies that encourage improved practices and assisting individuals and families to gain the self-efficacy to change individual behaviors.

Purpose of this Document

This umbrella guidance document equips the governments of Burkina Faso and Niger and RISE II programs and implementers involved in SBC activities with access to tools and approaches to help them create and implement a robust SBC program. It does not proscribe how each partner develops its strategy, but provides guidance to help develop an effective SBC strategy. It offers suggestions and opportunities for RISE II projects to coordinate and create linkages related to SBC with one another, but more importantly, engages the national ministries of health to help assure that SBC systems that are activated are synchronized with the national objectives.

This document builds from the FOCUS tool developed by Save the Children under the Gates-funded Saving Newborn Lives project to create an easy-to-use reference document available in print and electronic versions with clear short chapters. Each chapter will include a short introduction, some information tailored to USAID partners, and how-to tips with references to existing SBC modules, tools, and materials for further information and study.

Each particular geographic area will have its challenges and social and cultural peculiarities; SBC strategies, therefore, need to be context aware and unique. In Burkina Faso, RISE II is implemented in Centre Nord region that is currently threatened by insecurity and intermittent terrorist activity. At the same time, an influx of internally displaced persons are flooding the region, creating new challenges and shocks to this fragile environment. In Niger, the Zinder region has been plagued by floods during the 2020 growing season destroying health centers, homes and other key structures needed for

agricultural activities. In Maradi, which is heavily reliant on market hubs in northern Nigeria for commerce, closed borders due to COVID-19 that have left many people jobless. The COVID-19 pandemic has only heightened tribal and political tensions across the Sahel as well as discouraged community members from accessing key health services due to fear of contracting the virus. Implementers will need to consider this ever-evolving social environment and periodically update their SBC Strategy to take into account any changes.

Breakthrough ACTION staff created this document following a series of workshops and coaching efforts with ministries of health and Development Food Security Assistance (DFSA) partners in Burkina Faso and Niger to guide implementers in the design of their SBC strategies.

Overview of SBC

As defined by USAID, **Social and Behavior Change (SBC)** is comprised of, "activities or interventions that seek to change health-seeking behaviors and the social norms that enable them. Such interventions may be grounded in a number of different disciplines, including social and behavior change communication (SBCC), marketing, advocacy, behavioral economics, or human-centered design." Breakthrough ACTION project SBC encompasses a broad spectrum of activities or interventions, which may be grounded in several different disciplines, including the crosscutting use of strategic communication, marketing, advocacy, behavioral economics, or human-centered design and community mobilization or community capacity strengthening. (USAID Breakthrough ACTION proposal)

Save the Children developed an integrated theory based SBC framework (Figure 1) to determine the relative weight of specific social and behavioral determinants that make healthy practices difficult or impossible. This allows identifying tailored and suitable SBC strategies combing both behavior change with community engagement. The framework is based on a socio-ecological model 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 different types of determinants (the colored tags).

When designing an SBC strategy, it is crucial to know what determinants strongly influence and affect behavior in both a positive way (as facilitators) and in a negative way (as barriers). The set of **social and behavioral determinants** in yellow is based on theories of behavioral change. They identify what prompts individuals to perform (or not perform) a health related behavior. This set of determinants includes social and gender norms, which have the capacity to affect, reinforce or hold behaviors in place. The **community capacity strengthening determinants** in blue can be used if the problem is related more to the capacity or leadership of communities to mobilize for collective action, creating demand at the community level, or strengthening the linkage between facility and community. If the program focuses on provider behavior change or on increasing community health workers performance, the **quality service determinants** in gray may better describe issues with quality service delivery (e.g., is their information dissemination based on medical protocols, is their communication with clients respectful, are the services and products they are promoting accessible and are their referrals effective? Also, is there a linkage with communities, such as a community facility committee, to hold services accountable?)

Lastly, the program may be measuring community **resilience determinants** as shown in the multi-colored tag in the SBC integrated framework. Resilience is the "the ability of people, households, communities, countries, and systems to mitigate, adapt to, and recover from shocks and stresses in a manner that reduces chronic vulnerability and facilitates inclusive growth." So for instance, are information systems in place so that individuals/families and the community can address vulnerabilities? Do individuals have access to services to help mitigate food and nutrition insecurity? At the local level, is there coordination of services to help mitigate food and nutrition insecurity? Are there social networks, local community engagement activities or self-help groups that can help mitigate food and nutrition insecurity?

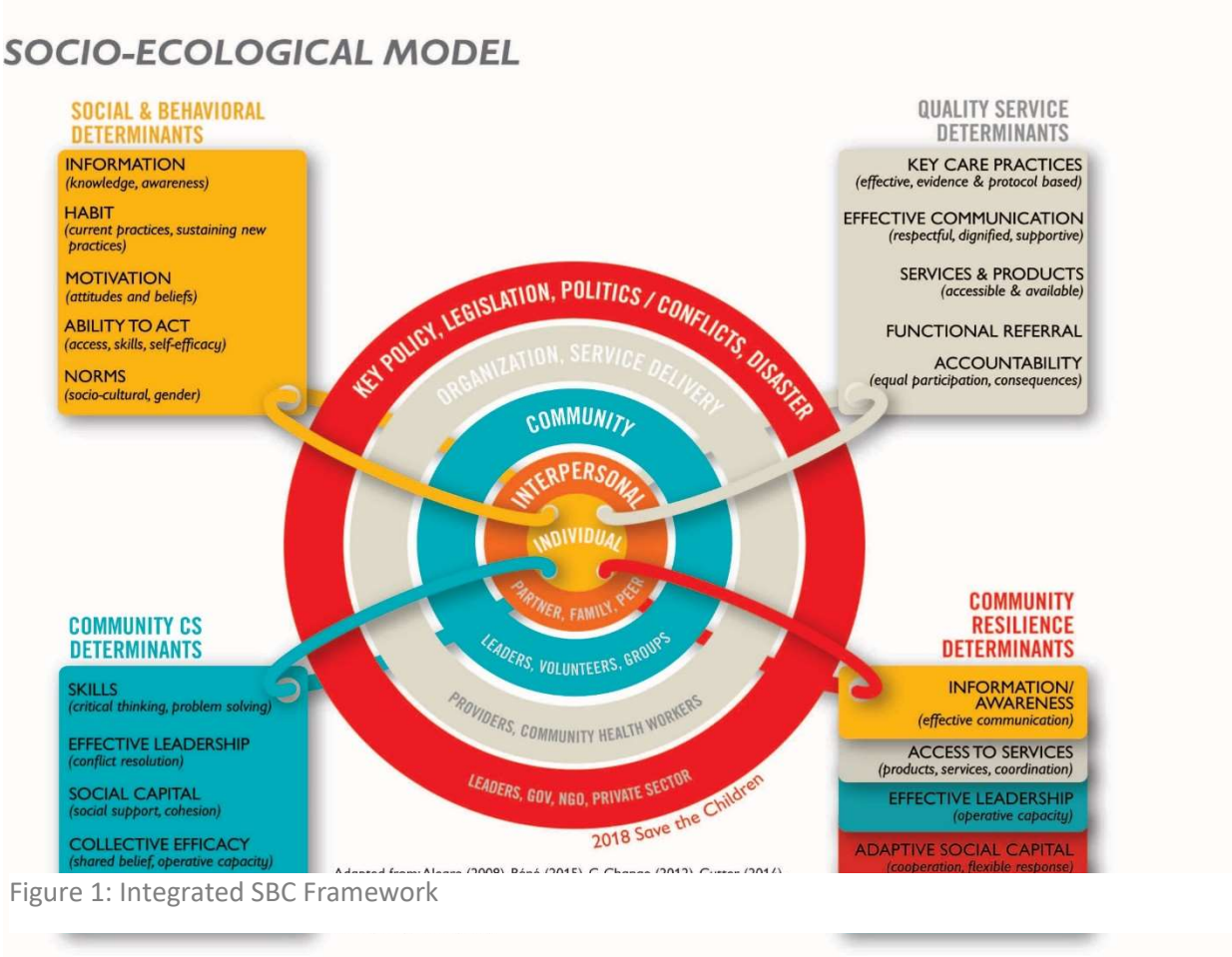
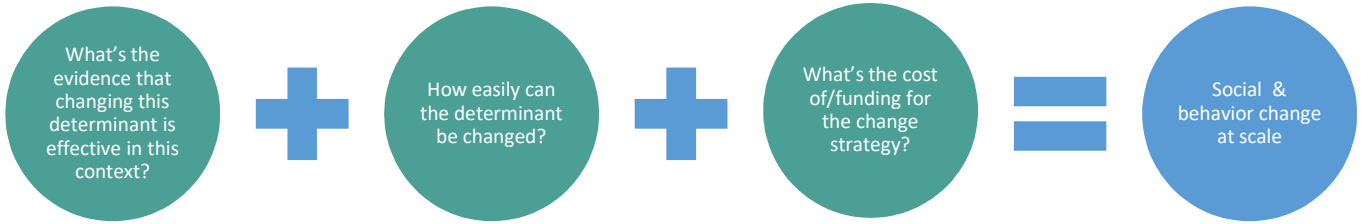


Figure 1: Integrated SBC Framework

The key to any well-written strategy is to figure out which determinants (from the four tags shown in Figure 1) are most important for the program to target to reach the audiences, to move them and motivate them to maintain change. A "one size fits all" approach should never be taken when developing an SBC strategy. To help choose determinant tags we ask the following questions highlighted in Figure 2: What is the evidence? How much time do we have in the program to change determinants? And how much intensity of programming can we afford?

Figure 2: How to choose determinant tags



Other factors to consider when choosing determinants include:

- What other projects and existing activities (e.g., structural or policy advocacy) can you link to make the program more comprehensive?
- Both social change and behavior change can take a long time to occur. How long is the project? (see above "how easily can the determinant be changed?"
- Is there a structural change the program can make that will influence how people think, decide, and act or that can simplify complex choices for them (e.g., automatically enrolling women during their first antenatal care visit in short message service (SMS) to receive more information on healthy pregnancy)?

SBC strategies serve as a project's road map to guide interventions and communications around behavior change; using existing knowledge from secondary data and project formative research, SBC strategies highlight effective "tipping points" (something that pushes an individual/community into action) to trigger or maintain social and behavior change with a variety of audiences. SBC strategies detail specific platforms and activities that can affect the most significant level of behavior change for different audiences and priority behaviors, when to launch certain activities, who to involve and how to measure change. Program implementers can refer back and refine this document throughout the life of the project to ensure the activities implemented

are spurring behavior change, and their indicators are effectively measuring change. This guidance shares the outline for developing an SBC strategy. In addition, several tools described below can also help teams refine their SBC strategy.

Contents of an SBC Strategy

What to include in a strategy and what comes before developing a strategy

Assessment Reviews

Before starting to write an SBC strategy, it is helpful to thoroughly review already existing research and analyze secondary data such as the Demographic Health Service (DHS). It may be more useful to implement situational research to understand the internal and external factors preventing or encouraging desired behaviors**.** Determinants are factors that strongly influence and affect behavior in both a positive way (as facilitators) and in a negative way (as barriers). The data can help a team formulate a problem statement; prioritize audiences and behaviors that will focus the project's program design.

To understand the context of a problem, examine the following documents:

- National SBC Strategies related to the project's theme
- Current DHS and baseline survey reports
- Reports from programs that exist(ed) in the project intervention area
- Existing SBC communication materials (print, mass and social media)
- Success stories/vignettes from community work
- Studies/reports that provide evidence on barriers and facilitators to behavior change.

SBC STRATEGY RESOURCES

The FOCUS tool, developed by Save the Children under the Gates-funded SNL project, allows a team to develop an SBC strategy step by step. This tool applies tried and tested approaches and measurements to help a project design, implement, monitor, and evaluate activities. By using FOCUS, practitioners can expect to increase the quality of their SBC programming.

Think BIG behavior integration guidance highlights how to design and implement programs that define outcomes as specific behaviors to achieve the development goal, ensuring that strategy, project and activity design are **behavior-led, not intervention-driven.** The website provides tools to help teams focus on identifying and analyzing key behaviors that impact the desired goal and delineate the pathways for change and tools to track progress on behavioral outcomes and assess and adapt programs over time. https://acceleratorbehaviors.org/index

The C-Change project — C-Modules are a six-module learning package for facilitated, face-to-face workshops on SBC communication. C-Modules are also available in French, Portuguese and Spanish. https://www.fhi360.org/resource/c-modules-learning-package-social-and-behavior-change-communication

Health Communication Capacity Collaborative (HC3) - HC3 has developed several products to help social and behavior change communication practitioners design, implement and measure SBCC programs. This SBCC strategy guidance requires following a systematic process to analyze the problem, define key barriers and motivators to change, and design effective messages and interventions. (www.sbccimplementationkits.org) (https://www.thecompassforsbc.org/how-to-guides/how-develop-communication-strategy)

Once the secondary analysis has been examined, the team will have a better idea of the gaps in research and knowledge that exist and need to be addressed in a project's SBC formative research. More specifically, formative research can help a project:

- Narrow and describe target audiences;

- Identify the drivers and determinants that influence the target audience's behavior;
- Decide how to segment the audience; and,
- Outline the types of desired behaviors and the barriers and facilitators to change. The focus should be on which behaviors and norms to address, the audience segment, and understanding the segment's context.

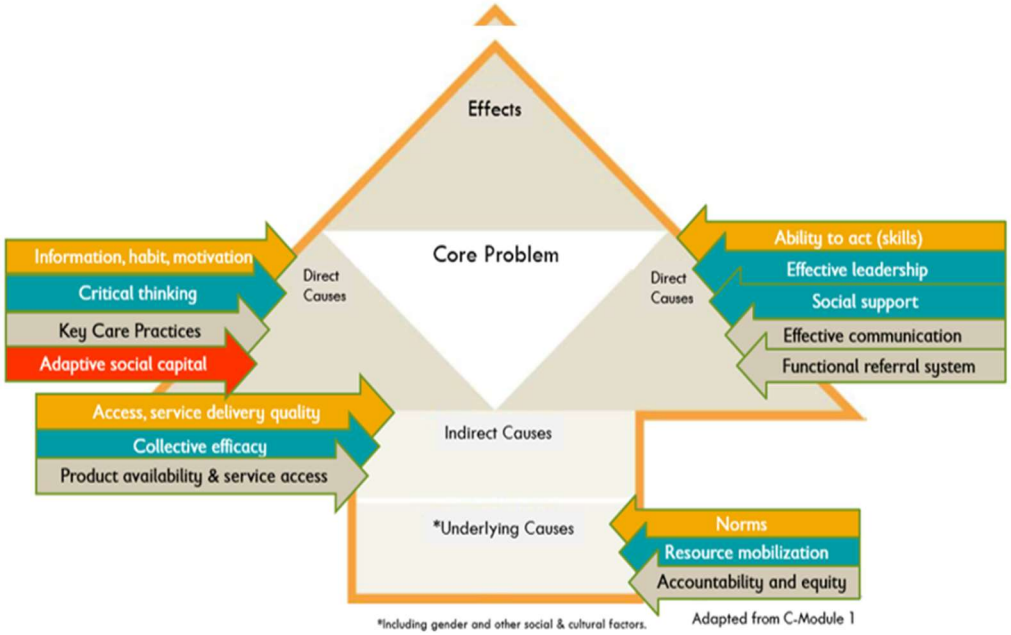


Figure 3: Problem Tree

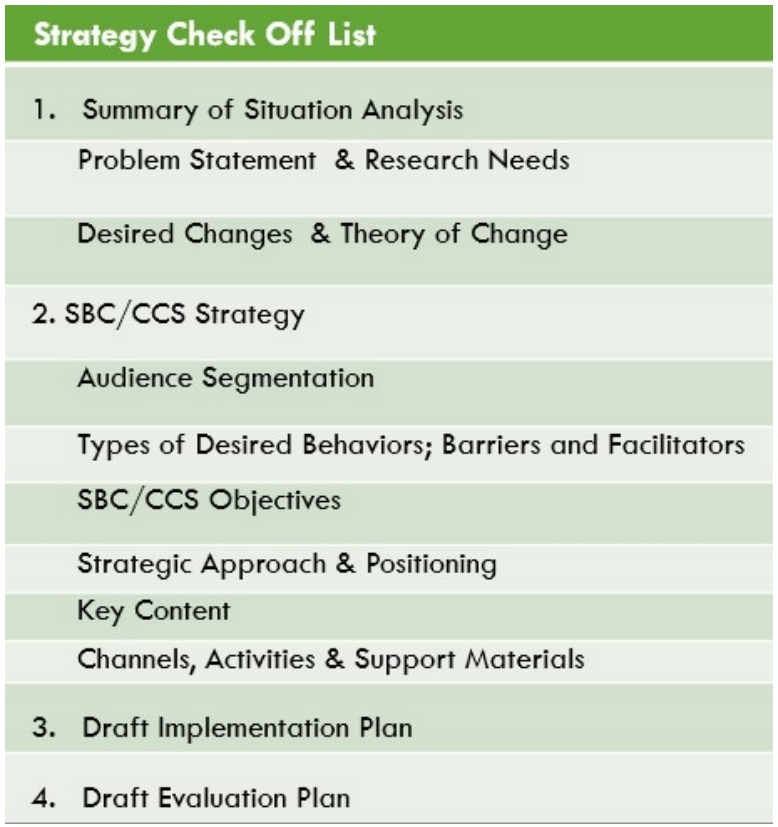
The next step in completing a situational analysis is to work through a problem tree. A problem tree is a planning tool used to analyze a situation including the direct, indirect, and underlying causes of problems in a given context. Some projects develop problem tree graphics that are actual trees with the core problem being in the center of the trunk, the indirect and underlying causes being the roots and the effects being the branches. A problem tree helps to provide a more comprehensive view of the causes, possible effects, and ways to address the problem or situation most effectively based on data. The problem tree in Figure 3 uses the determinants included in the SBC Integrated Framework (Figure 1). Comprehensive strategies combine determinants from the four sets of determinants onto one problem tree. When filling out your problem tree, be sure to use data to base your decisions on rather than assumptions.

This guidance document does not explain how to conduct formative research. However, a variety of formative research methodologies exist, including key informant interviews and focus group discussions on specific topics and participatory activities that can be tipped into interviews and focus groups. Additionally, Barrier Analysis, and Trials for Improved Practices can be part of the formative research to capture specific data. For more information on formative research methodologies, please consult Annex 1.

Elements of an SBC Strategy

The following section provides a working outline for organizations to use to develop a social and behavior change strategy. There is no right way to create a strategy; Breakthrough ACTION recommends considering the key elements in the headings below when developing a strategy. Figure 4 is an easy template programs can follow to guide the SBC strategy writing process:

Figure 4: Key Elements of an SBC Strategy



Introduction with a brief program description

A brief program description will help frame the SBC strategy and orient the reader about what the project is trying to accomplish. The program description can be one or two paragraphs that include the goals and objectives of the project, the funder, and duration of the project. This section can also include one or two sentences describing the objectives of the strategy.

Background

The background section shares key findings from the secondary and/or formative research that inform the content of the SBC strategy. It will include research the project has undertaken, and short paragraphs on key technical areas that the project will address. In addition to the research findings, the background section should describe the context in which the program is working. Understanding the geographic, social, and economic environment helps to identify the elements that could reinforce or hinder progress related to changing particular behaviors.

Problem Statement

The next step is to develop a problem statement—a brief summary of the social and behavioral problems the program wants to address. The problem statement should briefly summarize results from the situational assessment. Then use the situational assessment to consider the actions needed to address the issues.

Problem Statement Formula

1. What is happening? (Take from "core problem" part of the problem tree.)
2. Where and to whom? (Take from the situational analysis.)
3. With what effects? (Take from the "effects" part of problem tree)
4. Who and what is influencing the situation? (Be sure to list who is directly and indirectly influencing. Take from the situational analysis.)
5. And as a result of what cause? (Take from the "direct," "indirect," and "underlying causes" sections of the problem tree.)

Answering the guiding questions in the text box will help the team write **a problem statement**:

The paragraph below is a sample problem statement from the ViMPlus DFSA in Burkina Faso:

According to the formative research and problem tree analysis, despite strong motivation and knowledge of recommended behaviors in health, nutrition, WASH, resilience, and governance, producers, traders, pregnant and lactating women, caregivers of children under 2, and young people (boys and girls) suffer from malnutrition (for themselves and their children under 2) and lack livelihood opportunities. These audiences face many obstacles due to their low status in society. Low self-efficacy, the ability to determine key life outcomes, and lack of access and control over productive assets and households limit economic opportunities for women and youth. The consequences on the short and long-term health of children, on the economy, productivity and household resilience justify a mobilization and commitment in favor of equitable governance, opportunities for vulnerable groups and health and nutrition for the first 1,000 days of a child's life. In today's society, mothers are responsible for feeding and caring for children under two and all household chores. Family members (especially husbands and mothers-in-law) as well as traditional leaders influence their decisions about how to feed their babies and when to seek care. These direct influencers positively and/or negatively influence mothers' behavior depending on the family. Additionally, ASBCs (community health workers) have been found to be mainly positive influencers.

Theory of Change for SBC

The theory of change shows the pathways of change by clearly stating how program activities and outputs will help reach desired outcomes. In other words, a theory of change is an idea of how you will effect change (based on your problem statement). It should highlight assumptions that the project thinks will create change and link these to program activities that, in turn, will transform the assumptions into results. Designing a theory of change can be a creative process! **It helps to work backwards from the final anticipated impact and to the desired results, and lastly detail the activities (inputs) could affect behavior change.** It is important to label the target groups, and at what level of the socio-ecological model (individual, household, community, commune, institutional) change is predicted. Another way to think about it is an upside-down triangle; you start thinking big and gradually think about specific activities and groups that will trigger change. Creating different box shapes, colors, and shading, as well as arrows for each level of your theory of change helps better distinguish the pathway.

TOP TIP: It is important to make sure the assumptions identified can be backed up by evidence. Often program planners focus on individual behavior change and increasing people's knowledge about the benefits of a behavior or the consequences of not taking action. Yet lack of knowledge is usually not the biggest barrier, so focusing your intervention solely on increasing knowledge will do little to change behavior.

The sample template below (Figure 5) uses an ecological model of SBC. The project's ToC considers changes that are needed at individual, intrapersonal and community levels, and at the organizational/ service delivery levels. This 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 will result in opportunities.

Below is a simple theory of change based on the template above for a maternal and child health project that includes health providers and community leaders. This Theory of Change is based on the assumption that the combination of building/strengthening health system service delivery, community capacity and increased social capital will result in opportunities for change including increased practice of recommended maternal and child health behaviors at the household level and increased in care seeking. In the end, these changes will lead to reduced maternal and newborn morbidity and mortality.

Figure 5: Sample Theory of Change Template

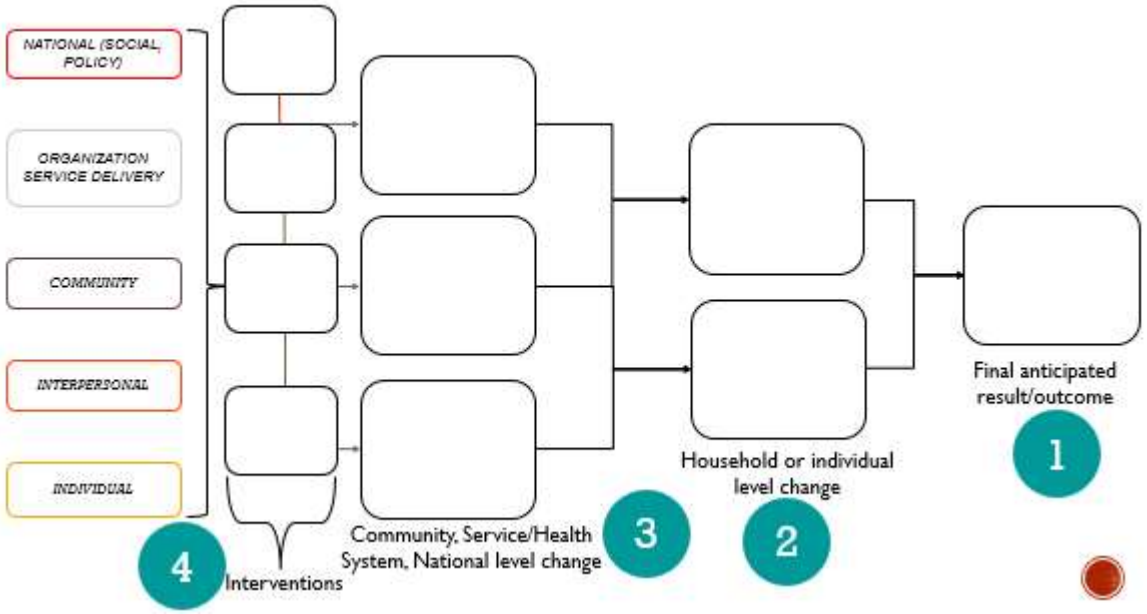
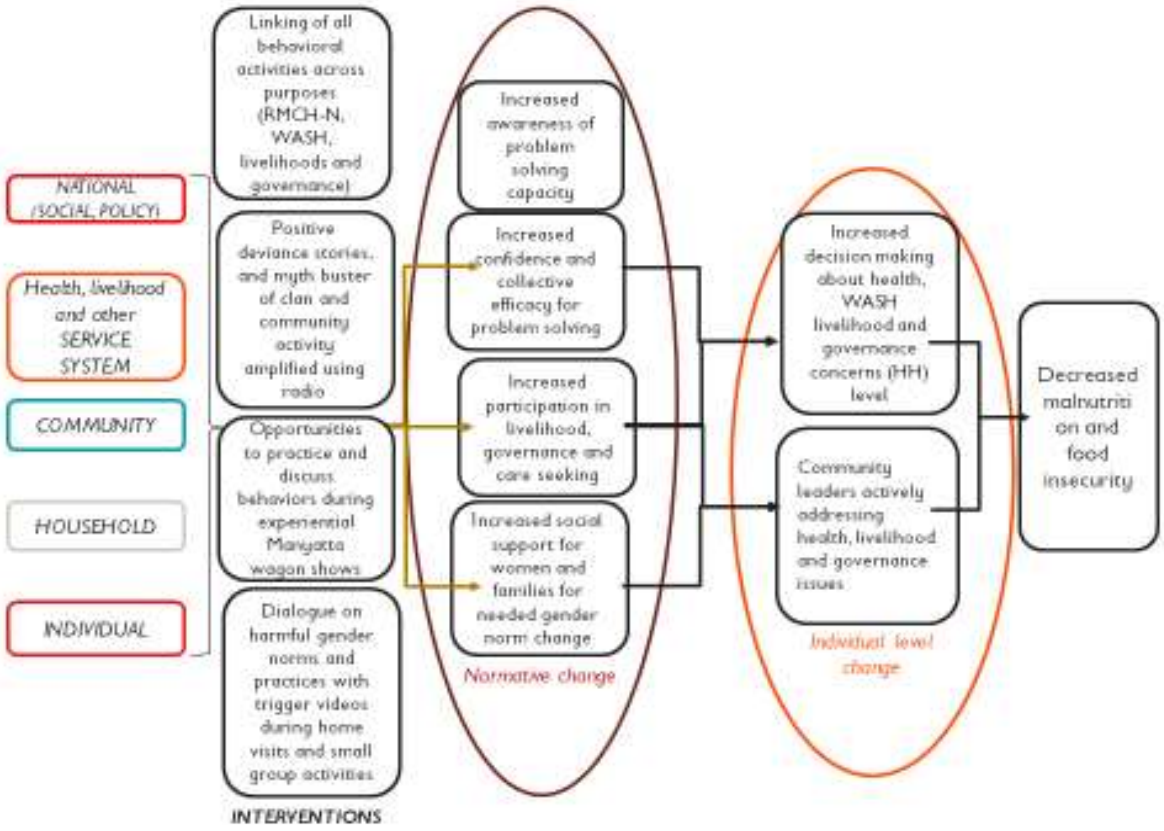


Figure 6: Example Theory of Change from the Uganda Apolou Project



Audiences Segmentation

Audience segmentation is a key activity that divides a large audience into groups of people, or segments, with similar needs, values or characteristics. Segmentation recognizes that different groups will respond differently to social and behavior change activities and support materials. Segmenting enables a program to focus on those audience members who are most critical to reach and to design the most effective and efficient strategy for helping each audience adopt new behaviors.

There are three main types of audiences.

1. **Primary audience** are individuals or groups who are **directly affected** and required to change behavior
2. **Secondary Audience**, also known as the **direct influencers**, are individuals or groups who play key roles in influencing the primary audience positively or negatively. This group can be very important in the change process, as the primary audience may not have agency to change themselves.
3. **Tertiary Audience** known as Indirect Influencers, are individuals or groups that indirectly influence the primary audience by shaping social and cultural 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).

There is no magic number as to how many audiences a strategy can have; however, limiting the number of primary audiences, direct key influencers, and indirect key influencers to no more than 2 – 3 will help focus an effective SBC strategy and also be more realistic with regard to time frame and available budget. Often, when the strategy is developed further, SBC objectives and activities may be similar among key influencers, and they can be combined a bit more.

Mapping audiences directly affected and those that are influencing the behavior change targeted audience per purpose will show overlap among most audiences, and you may realize that it will be important to coordinate among purposes. **In fact, your SBC strategy can help with such coordination because it can align activities with the same audiences with each other and combined packages of messages and activities per audience, based on their needs, instead of competing for their attention, each vertical purpose at a time. Audiences do not think in the same way as health or development programmers do.** Most program descriptions include a section on behaviors that programmers and donors intend to change to improve overall health outcomes. The role of the SBC strategy is to understand why people are not yet performing or accepting these behaviors and to find ways and motivators to work with people to increase uptake of these behaviors for the overall good of public health. In integrated programming, it is challenging to address all behaviors that could contribute to health and wellness. Experience has shown that changing all behaviors at once is not feasible. Therefore, it is critical to identify the behaviors that need to change most urgently or to choose behaviors that may have the most impact and lead to further change. These are called **gateway behaviors**.

Top TIP: When designing interventions, remember that behaviors do not exist without people. Behaviors also do not change without respect for the people and communities who either prioritize them or not. The SBC strategy and subsequent programming should be **people-centered** before being **behavior-centered**; this is why in this SBC guide starts with audience segmentation rather than behavioral prioritization.

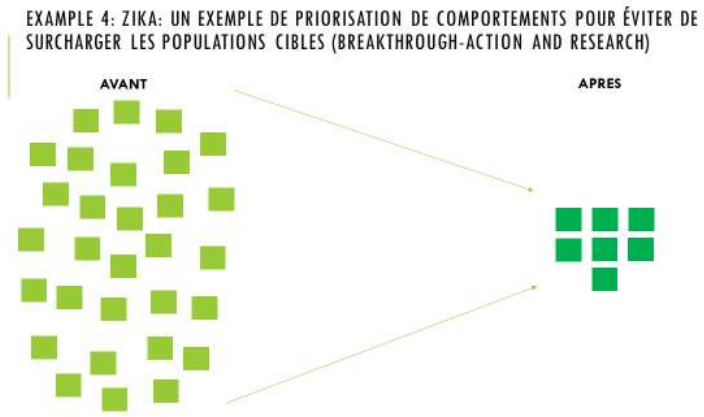
Sometimes the desired change is at the individual level (in the middle of the socio-ecological model), and other times the change desired is health provider behavior or community norms about a practice. Deciding which behaviors are most critical to focus on should take place after the program has completed and analyzed any formative research to understand the people whose behavior is supposed to change. Understanding the results from the

formative research will help programs determine the audiences more likely to change what kind of behaviors in a given period and which audiences and behaviors are prioritized. In addition, the information from this research will help the program identify barriers and facilitating factors for people to changing such behaviors. For example, Wadata found that couples' communication does not exist in most areas with the exception of discussions on what to feed the family—husband ask their wives what to buy at the market for the family and they provide the essentials. Fathers also believe malnutrition of children under two, is a real problem in their villages, so they sometimes provide special snacks for children to "keep them happy". The project is using couples' communication around food as a gateway to encourage discussion around other health and nutrition topics and working with fathers through husband schools to give them the tools needed to support diversified nutrition in their homes, especially for children under age two.

Many different tools exist that can be used to help prioritize audiences and behaviors or to phase them over time. Key models including the Life Stage Model, the Gateway Behaviors Model and a hybrid model based on formative research, are described in Annex 2 along with a link to the different tools.

During the December 2019 Refine and Implement workshop in Niamey Niger, Breakthrough ACTION introduced one approach to help teams prioritize the behaviors on which to focus. We are sharing this tool below.

Figure 7: Example of minimizing number of behaviors



To do this, the program needs to assess each potential behavior using these criteria. To determine whether to choose a particular behavior, teams need to evaluate each behavior using a set of criteria as described below. Before diving into behavioral prioritization discussions and filling out the table, it is also important to research if the behavior is widely practiced or not. For example, if secondary data show that 80% of women practice exclusive breastfeeding for the first six months in the Project zone, it may not be worth prioritizing this behavior compared to others that are not practiced as widely.

Table 1: Behavioral Prioritization Table

Behavior:
Target Audience:

Criteria	Analysis
Effectiveness of preventive behavior (e.g., exclusive breastfeeding for nutrition)	
Potential to affect the goal of the project (e.g., transmission of malaria)	
Practicability for audiences to perform in terms of	
• Frequency (how often do they need to perform it?)	
• Feasibility for audiences (easy or hard?)	
• Access (to services or products needed for the behavior)?	

As mentioned, a big challenge that large, integrated programs face is that each different technical area (nutrition, health, water and sanitation, livelihoods, governance etc.) has different behaviors that need changing and the list can become long. **People have a limited attention span, and sometimes, change takes time, motivation, and a lot of intensity or repetition. Thus, programs need to prioritize audiences and their behaviors, group them and sequence them over time.** Understanding the nature of the behavior that needs to change can help the project team brainstorm about different activities that can encourage behavioral adoption. For instance, for a habitual behavior, a project may need to create activities that are repetitive, hands-on, and simple and fun that make them easier to practice daily.

SBC Objectives

SBC objectives specify the kind and amount of change you expect to achieve for a specific population within a given period for each intervention. Be sure to base objectives on the barriers the Project needs to decrease and the facilitators need to increase and make sure the objectives are "SMART" (i.e. Specific, Measurable, Achievable, Relevant, Time-specific). For example, the program objective, "Increase demand for and use of agricultural services by women" is not the same as an SBC objective, as it has not considered barriers to change and selected a specific determinant for change that can be measured and formulated as a SMART objective. And SBC objective could be "Increase self-efficacy in women to access and use agricultural services, or increase trust in agricultural services, or increase uptake of improved and tailored services for women. A SMART SBC objective is specific, measurable or time-specific. An improved SMART objective could be "By the end of Year 4 of the Project, rural women aged 18-45 increase their use of compost in community fields by 20 percent." It is important to orient the change in behaviors to previously established baseline data. Otherwise such targets may not be realistic.

Strategic Approach

The last step highlighted how to determine who to work with through audience segmentation, priority behaviors and what the projects wants to achieve through writing objectives. In this step, implementers can tailor their approach and determine which activities or interventions will be used for each audience to achieve the SBC objectives as well as which channels and materials will support the activities and reach the audience. In this step, implementers also decide the overall strategic approach, which holds together the different channels, activities and messages, so that they can be recognized as being from one program strategy.

Rather than impose predetermined behavior change activities and support materials onto communities, now is the time in the strategy development process to start to collaborate closely with your partners (including communities) to identify activities that will address problems or goals, mobilize resources, and develop support materials that will help to achieve the goals. Additionally, it is efficient to align SBC efforts with ongoing efforts of the Ministry of Health, as well as organizations like UNICEF, WHO, or other implementers.

A **strategic approach** is at the heart of each SBC strategy. It ties together the different interventions, channels, and support materials and packages them into a synergistic program. For instance, Wadata's overarching goal is to increase economic productivity, strengthen governance, and improve health and wellbeing for families in implementation areas of Zinder, Niger. **Wadata's strategic approach** outlines how the project's approaches and interventions will be used to achieve the project's objectives. It combines several approaches under the umbrella of a comprehensive community outreach and engagement focus to allow the project to address multiple audiences across the various social-ecological levels. Each approach and intervention is then 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.

Apolou' Uganda's strategic approach matches its Theory of Change and is focusing on a positive deviance approach at community level as a motivational platform for the overall Apolou intervention. This approach aims to promote reflections on the pros and cons of existing norms and practices as well as dialogue on small doable key actions to increase acceptance and uptake. The approach counters far reaching disempowerment and lack of confidence among nomadic audiences facing significant challenges in their lives. Media, branding and communication will focus on possibilities, opportunities and learning, true to the project name of Apolou (Growth). This will help to generate social support at community level and help individuals to address slowly changing harmful social and gender norms more easily which appear as one of the biggest barriers for change across all program areas.

Social and Behavior Change Charts

The chart below put together by the Hamzari DFSA forms the core of the behavior change strategy. This chart is elaborated further by audience and priority behavior in the Hamzari DFSA SBC Strategy. It identifies the audiences affected by the situation and influencing behaviors, and the prioritized behaviors to change. The next column identifies barriers that may hinder or the determinants that may facilitate the audience achieving this change. The SBC objectives column helps the project determines how to address the barriers (e.g., people do not see a reason to change may appear in the barrier section, and the SBC objective picks it up as increase in risk perception). The objective needs to be SMART: specific, measurable, achievable, realistic and time-bound. Finally, the last column helps projects determine what approaches and activities to use to help reach the people involved in the best way, and are able to achieve the SBC objectives (for example, radio often reaches more males and cannot build skills, if your objective increases skills building

for women, another channel or activity needs to be used). If there are key messages these can also be included in this column, though it may require a more focused review to determine the most effective messages to use. The table below is a sample chart shows how to fill in this information.

Table 2: Hamzari DFSA Social Behavior Change Sample Chart

Primary Audience	**Priority Behaviors by Purpose**	**Barriers**	**Facilitators**	**SMART Objectives (by the end of the project there will be an increase in (audiences) with (key determinant)**	**Approaches/ Channels Activities**	**Support Materials**
Mothers of children 5 years old or younger	Wash hands with soap during 5 critical moments (before cooking, before eating, before breastfeeding, after using the latrine, after cleaning baby's bottom)	Barriers: ✓ Lack of motivation ✓ Lack of means to obtain soap ✓ Do not know the importance and benefits of washing hands with soap and water or ash ✓ Insufficient time because they are overloaded with household chores ✓ Believe that hand washing is an imported practice ✓ Insufficient drinking water points in the intervention area	✓ Think hand washing is important; ✓ Partially wash hands, often without soap, sometimes the steps are not followed—people wash hands five times/day during ablutions	By year 3, mother of children under 5 believe that washing hands with soap at critical times protects the community, especially children, against malnutrition and diarrheal disease, increased by at least 40%; By year 3, 50% of mothers of children under 5 wash their hands systematically at the 5 critical times and with soap and water By year 3, mothers of children under 5 will have access to washing devices is increased in at least 50% of the concessions	MMD (female IGA groups) launch soap making initiatives Reinforce the capacity of water management committees to construct tippy taps and advocate for soap at community-level shops Reinforce youth groups and primary school groups to lead handwashing sessions and construct tippy-taps for public places in community Work with community positive deviants to facilitate handwashing sessions at the community level	Handwashing not only protects you from disease, but also your children! Soap and water can stop the spread of disease Handwashing with soap takes 30 seconds. It is worth your time to keep you and baby healthy. Be a role model; wash your hands with soap! *Support materials:* Materials for soap

Primary Audience	Priority Behaviors by Purpose	Barriers	Facilitators	SMART Objectives (by the end of the project there will be an increase in (audiences) with (key determinant)	Approaches/ Channels Activities	Support Materials
						Materials for handwashing devices Flip charts

Interventions and Activities

This section of the strategy should provide details on the specific SBC activities and community platforms proposed in the SBC strategy. The purpose is to describe the interventions, which audiences will participate in the approach, and which priority behaviors this activity will support. It is not necessary here to determine how many targets to reach.

In many cases, activities are inter-linked, so it helps to detail how each platform and/or activity will work together at the same time (synchronously) and with other project actors. For example, if the activities is trying to reach pregnant women and women with children under six months, in order to increase the consumption of nutrient-rich foods, the approach could include interactive cooking demonstrations, working through community nutrition groups and farmer field schools.

The table in Annex 2 highlights different platforms that have been successful at supporting behavior change for other community-level programs in the Sahel through every program has approaches tailored to its context. As programs develop new approaches, these may also be considered as effective platforms to use to stimulate behavior change. Before finalizing any activities, work with community members to develop those activities they think are best suited for their needs.

How different platforms address the integration of behaviors targeted for change

It is always helpful to diagram which approaches, interventions and platforms target which audiences and behaviors behaviors. Developing a table that shows which behaviors will be addressed by which platforms can be a useful way to see how the project is addressing behavior change. Table 4 provides an abridged 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 10 on how Wadata's SBC/C overall approach is integrated.

Table 3: Approaches, Interventions and related objectives for Wadata

Approach and Priority Audiences	Related Wadata SBC and Program Objectives	Focus Area	Interventions
Building/ strengthening community infrastructure •Women of reproductive age (18 – 24 and 25 – 35) •Men 18+	• 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	Ag & Livelihoods Gender Equality and Social Inclusion Governance Resilience	Farmer Managed Natural Regeneration (FMNR) Groups Mata Masu Dubara (MMD) (Women's Savings and Loans Groups)
Community service delivery •Women of reproductive age (18 – 24 and 25 – 35) •Men 18+	• 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 equitable access to, control over and benefit from community systems, structures and resources for girls and women	Gender Equality & Social Inclusion Governance Resilience WASH	Système Communautaire d'Alerte Précoce et de Réponses en Urgences (SCAP/RU) Water Point Committees
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	• 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	Gender Equality & Social Inclusion Nutrition Use of health, hygiene and nutrition services	Community Influencers Husband Schools Matasa Masu Fusaha (MMF) Young People Groups and MMD Triad volunteers (community health and

15 – 17 (unmarried) • Adolescent girls 15 – 17 married)		Youth and Adolescents WASH	nutrition liaisons, IYCF groups, Mamans Lumieres) includes growth monitoring
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)	● 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	Gender Equality and Social Inclusion Governance Resilience Youth & Adolescents	CAC MMF Village Development Committees

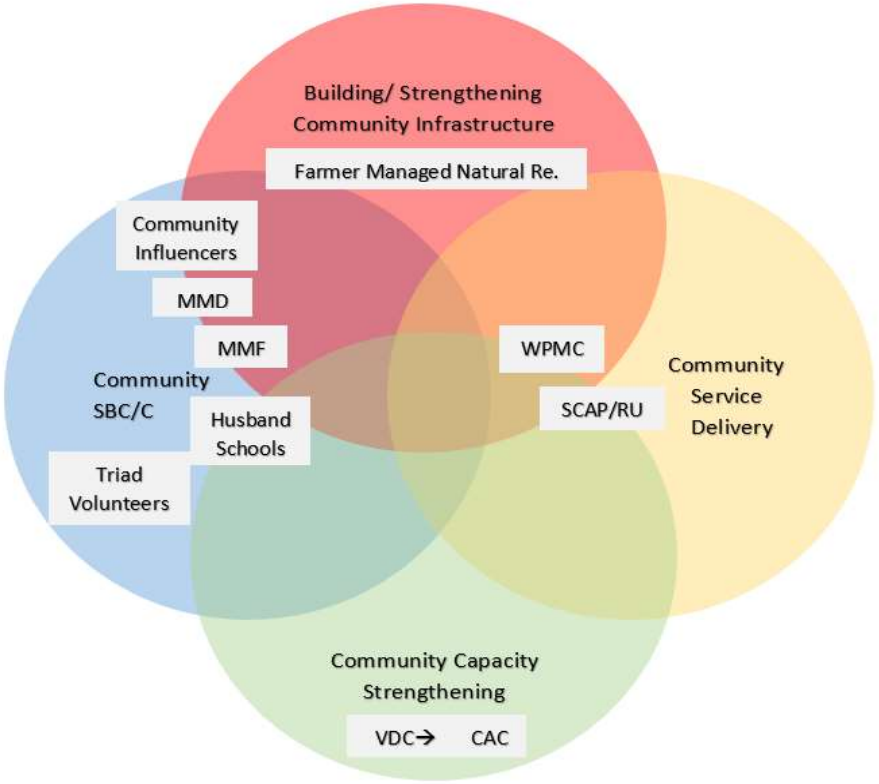


Figure 8: How Wadata's SBC/C integrated approach fits together

Figure 8 outlines how Wadata's SBC integrated approach fits together, highlighting the four overall strategic approaches (circles) and interventions (square boxes). As shown in Figure 10, several of the interventions are a mixture of approaches (i.e., community influencers, husband schools, MMD, MMF, SCAP/RU, and WPMC). The village development committees (VDCs) will be trained and coached on the CAC.

Implementation Plan

Now that the Project has identified key activities, channels, messages and integrated approaches, it is time to create an implementation plan that details partner roles and responsibilities, activities, timeline, budget, and management considerations. Here are questions that can help you develop your implementation plan:

- What are the activities that need to be implemented?
- What are the intermediate steps for each activity?
- What is the necessary sequence?
- Who will be responsible for the implementation of each activity?
- What role will your community partners play? Community capacity, efficacy, and empowerment are keys to communities being able to adopt and sustain new behaviors.
- How will coordination for implementation be handled?

Other aspects of implementation that are critical to plan for is timing the program activities against other events, making activities mutually supportive, and integrating with complementary programs.

Table 4: Example implementation plan

Audience and Activity	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 will be reached and how many on average will participate?

Monitoring and Evaluation

This last step involves putting together the monitoring and evaluation (M&E) plan to help the project compare the effects of SBC/intervention with program objectives and identify factors that helped or limited the project's success.

A good place to start with the M&E plan is thinking about what you will measure. Indicators are used to track the way in which a program evolves and to show changes in relevant program areas, including SBC/C components. Measuring indicators can alert managers to any program changes or problems. At the end of the program, indicators are also measured to validate the success and achievements of the intervention. Process indicators and outcome indicators are used to measure social and behavior change.

Process: What has been done? What materials developed and used? How many radio spots have aired? How many community mobilisers have been trained?

Output: Who has been reached? Are you reaching your target audience, (in the number you wanted at the right time?

Outcome: What does the target audience think about the SBC approach? Do they understand and trust your messages?

Outcome: How has behavior changed? How has SBC contributed to behavior change (risk perception, knowledge, self-efficacy, action triggered, maintained)

Process indicators – Are used to provide information about the scope and quality of activities implemented (these are considered monitoring indicators). Project should include indicators that measure your **inputs** (e.g., resources, contributions, and investments that go into a program).

- Number of community dialogues held
- Number of job aids distributed
- Number of supportive supervision visits conducted
- Number of peer group sessions conducted

And your **outputs** (e.g., activities, services, events, and products)

- Number and percent of respondents who report having seen and/or heard messages or participated in activities
- Number or percentage of vulnerable family members participating in any community organization activities

Output indicators generally measure the number of times a certain activity takes place, the number of meetings held, the number of people participating in a certain services, or the number of distributions made. Behavioral indicators may be affected if certain output indicators are not met. For example, if the number of cooking demonstrations led by community nutrition groups are not meeting targets, the priority complementary feeding behaviors may not be met and the nutritional status of children may not improve. The monitoring and evaluation team and technical teams can then work with community actors to modify program activities so certain targets are met. These output indicators also have an impact on the project's theory of change and may require modifying certain hypotheses about actors, groups, or activities on the pathway to change.

This table shows the different types of indicators and the type of data and frequency of measurement.

Outcome indicators – Measure changes towards progress of results or changes for the different levels of audiences; these are considered evaluation indicators.

- Percent of women in union and earning cash who report participation in decisions about the use of spouse/partner's self-earned cash
- Percentage of farmers who used at least three sustainable agriculture practices and/or technologies (i.e., crop, livestock, and/or natural resources management) in the past 12 months
- Percentage of community influencers who are favorable in involving women and youth in decision-making process at community level

The first step to creating program indicators for monitoring and evaluation is to determine which characteristics of the program are most important to track. Refer back to the **theory of change** and **SBC Objectives** to help determine what these indicators may be.

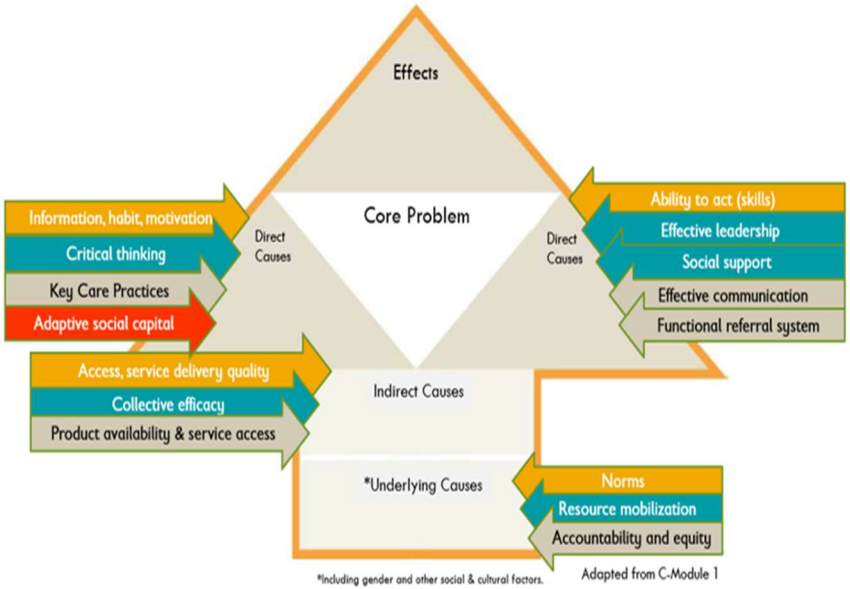
Another option is to look back at **the Problem Tree** of the project created in Step 1. For instance all the determinants listed on Save the Children's Integrated SBC Framework can be turned into an indicator.

EXAMPLE INDICATORS:

- Social norms around these priority behaviors
- Level of community social cohesion and capacity to absorb SBC project activities
- # 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)
- 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 community leader consensus that most people in their community support the priority behavior X
- Number of women reporting perceived social support from community leaders and members for x behavior change at household level

Figure 9: Problem Tree



Sometimes projects may already have set indicators that they have to measure. Instead of reinventing the wheel and creating new indicators to measure improvements in priority behaviors, it helps to start by looking at what indicators are included in the project's Indicator Performance Tracking Table (IPTT). The IPTT lists the project's information into a short concise table. It shows the original and revised indicators and progress achieved toward reaching the indicator targets. Because projects must submit IPTTs to USAID, project teams are more accountable to measuring these indicators regularly and analyzing progress. This analysis can in turn help show behavior change over time. For example, the SBC team may have identified a priority behavior related to mothers exclusively breastfeed their baby for the first six months. It helps to look back at the IPTT table to see if an indicator around exclusive breastfeeding already exists; this indicator could then be listed as a way to monitor the priority behavior and a reference could be made back to the IPTT.

In some cases, priority behaviors are very specific and the project does not have a set indicator to measure change, or the IPTT indicator does not fully measure the priority behavior. It may help to include several indicators related to the above determinants to show change over time.

The table below from Girma is a good way to organize indicators to measure behavior change. The table also shows how SBC priority behaviors and indicators fit into the project's overall theory of change.

Table 4: Sample of Girma Indicator Table

Domain/Audience	Sub-purpose/Outcome	Priority Behavior	Indicators from IPTT and/or custom indicators
Nutrition **PLW,** **adolescent girls** **Pregnant and lactating women** **Children under 5**	SP 1.1 Vulnerable individuals, especially PLW, adolescent girls, and children under age 2, consume an adequate, safe, and stable diet	All members of the household (HH), especially pregnant and lactating women and children under 5, consume safe, nutritious and diversified food	IPTT Indicator • Number of children under five (0-59 months) reached with nutrition-specific interventions through USG-supported programs (AM 2) Custom Indicators • Percentage of women practicing exclusive breastfeeding (denominator: women having children aged 0-6 months) • Percentage of HH who produce/purchase nutritious foods and crops through USG-supported programs (AM-C 1.1) • Household Dietary Diversity Score (HDDS) (AM-C 5.1) • Proportion of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk). (DHS) (AM-C 8.1)

If you have additional SBC objectives that can measure the change in the key determinants you have seen as barriers to change, those should also be added and measured to show the pathway to behavior change you have outlined in your SBC Theory of Change.

This table shows the different types of indicators and the type of data and frequency of measurement.

Table 5: Breakthrough ACTION example SBC indicator table

Audience	SBC Objective	Activity	Indicator	Indicator Type	Data Source	Frequency of Measurement	Frequency of Reporting	Responsible for Measurement
Pregnant women	**Increase women's motivation to access ANC**	**Care groups promote for women to go to all eight ANC**	# care group sessions conducted # of women reached in care group sessions.	Output	Internal Project Documentation	Baseline, then every 6 months	Once per year Once per year	M&E Officer

Audience	SBC Objective	Activity	Indicator	Indicator Type	Data Source	Frequency of Measurement	Frequency of Reporting	Responsible for Measurement
		visits at the health center	% of care groups established that have regular meetings	Process	Internal Project Documentation	Baseline, then every 3 months	Once every 6 months	M&E Officer
			% of women in community who report believing that ANC visits will help women have a healthy baby	Intermediate Outcome	Knowledge Attitudes Practice Survey	Baseline, then annually	Once per year	Research Firm
			% of women in communitywho report attending at least 3 ANC visits	Behavioral Outcome		Baseline; Midline; Endline		

Managing SBC Programs

One of the most important determining factors for the success of SBC programming is adequate management, which includes budgeting and staffing. SBC as is the case for all programs need to be managed carefully. Resource allocation is a critical component of SBC program management. These include staffing resources, stakeholders and financial resources.

Budgeting for SBC

Resources are necessary for implementing SBC activities. Thus planning for resource needs is important. Costs vary over time and in different contexts, but practical planning will help programs ensure that resources are available.

A critical element in proper budgeting is having the right staff available to lead SBC programming who are adequately compensated for their specialized expertise. Depending on the size of the program having one focal person dedicated to SBC may not be sufficient, especially when implementing an integrated SBC program. Good SBC programming requires numerous, diverse functions that include coordination within and across sectors, strategy development (including formative research, prioritization of behaviors, audience segmentation, selection of appropriate interventions, development of monitoring evaluation research and learning (MERL plans), overseeing implementation, and rolling out MERL activities. Having a designated SBC staff

person on board also ensures the inclusion of SBC outcomes, sub-outcomes and outputs in the Project theory of change, which in turn holds all team members accountable to creating tailored behavior change programs.

There are three main categories to consider when budgeting

1. Resources for research to identify the SBC approaches needed
2. Resources for implementing activities
    a. SBC staffing
    b. Training for SBC
    c. Conducting community-based activities
    d. Developing and disseminating communication materials
3. Resources for monitoring and evaluating the SBC activities used

Several tools exist to help programs budget for SBC and are found in the box.

Resources for budgeting

A Learning Package for Social and Behavior Change: https://www.fhi360.org/sites/default/files/media/documents/Module4-Practitioner.pdf

Global Health Communications Course https://www.globalhealthlearning.org/course/health-communication-managers/page/typical-cost-categories-health-communication-programs

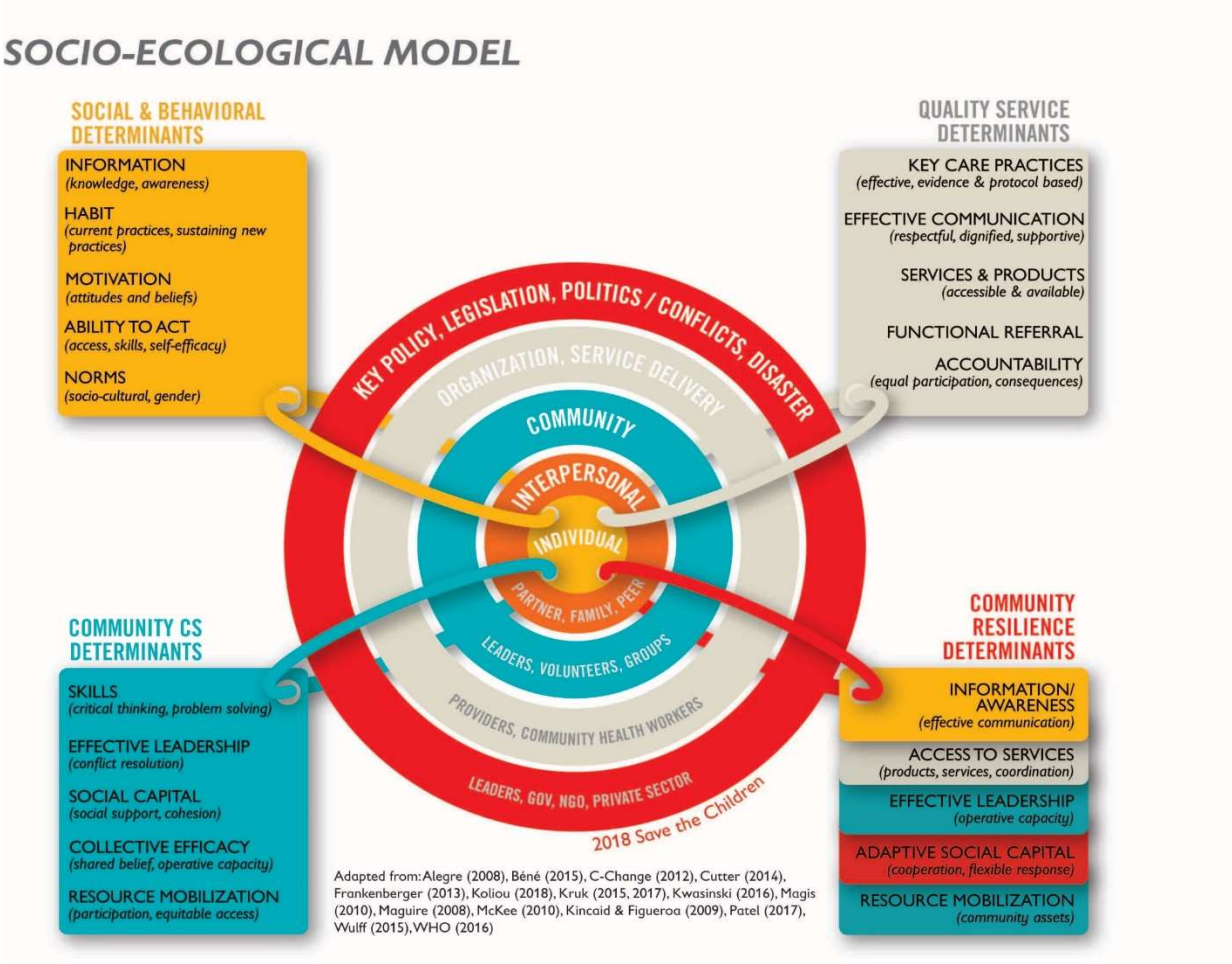
Staffing SBC Programs

Staffing is as critical as properly synchronizing and budgeting for activities. Determining the skills and expertise required in staff and consultants before implementing activities and matching the requirements with the people hired will help programs achieve results.

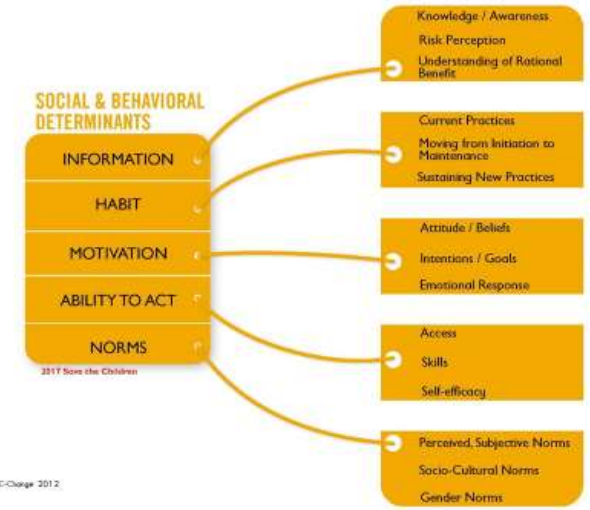
In addition to an adequate number of SBC staff, their technical capacity is crucial to be able to design, implement, and monitor programming. Skills and experience in SBC are not always easy to find, so consider including a budget for SBC capacity building after onboarding, in case candidates do not have sufficient experience or expertise. Social and behavior change goes beyond communication-based approaches and SBC expertise must include an understanding of when and how non-communication interventions should be used or integrated.

Understanding who else is working in the same space and building relationships with partners is also a key management concern. It is also important to engage all stakeholders in the SBC efforts. These partners can either help or hinder SBC programs.

Annex 1: Integrated SBC Framework: Set of Determinants

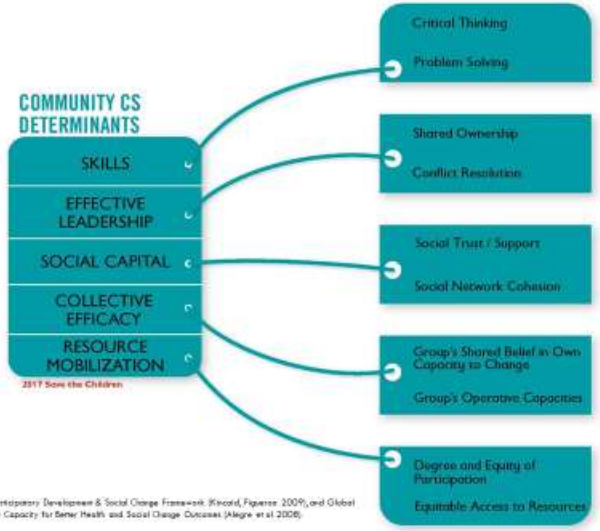


SOCIAL & BEHAVIORAL DETERMINANTS



Adapted from McKee 2010, C-Change 2012

COMMUNITY CAPACITY STRENGTHENING DETERMINANTS

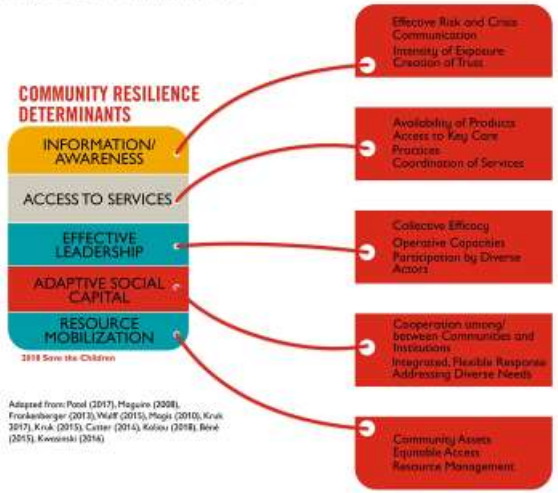


Adapted from Communication for Participatory Development & Social Change Framework (Kincaid, Figueroa 2009), and Global Case Study on Measuring Community Capacity for Better Health and Social Change Outcomes (Alegre et al 2008)

QUALITY SERVICES DETERMINANTS

Adapted from WHO Quality of Care Framework 2016

RESILIENCE DETERMINANTS



Adapted from: Patel (2017), Maguire (2008), Frankenberger (2013), Wolff (2015), Magis (2010), Kruk 2017), Kruk (2015), Cutter (2014), Kotiou (2018), Béné (2015), Kwasinski (2016)

Annex 2: Suggested resources to help with SBC formative research design

Excellent websites!

- Breakthrough ACTION SBC resource site: www.thecompassforsbc.org
- Institute of Development Studies Participatory Methods: http://www.participatorymethods.org
- International Institute for Environment and Development Participatory Learning in Action Guide: http://www.iied.org/participatory-learning-action
- ANH Academy webinar on How to Understand Barriers and Motivators to Behavior Change https://www.anh-academy.org/sbc-webinar-2

Free Online Toolkits for Participatory Learning and Action

- Tools Together Now! 100 Participatory Tools to Mobilize Communities for HIV/AIDS. (2006). International HIV/AIDS Alliance. This document can be downloaded for free at: http://www.aidsalliance.org/assets/000/000/370/229-Tools-together-now_original.pdf?1405520036
- Ideas and Action: Addressing the Social Factors that Influence Sexual and Reproductive Health. (2007). Cooperative for Assistance and Relief Everywhere, Inc. (CARE). This document can be downloaded free at: http://www.care.org/sites/default/files/documents/social_analysis_manual.pdf
- Participatory Analysis for Community Action (PACA) Training Manual. (2007). Peace Corps. This document can be downloaded for free at: http://multimedia.peacecorps.gov/multimedia/pdf/library/PACA-2007.pdf
- A Guide to Participatory Monitoring of Behavior Change Communication for HIV/AIDS. (2005). PATH, FHI, USAID. This document can be downloaded free of charge at: http://www.stoptb.org/assets/documents/countries/acsm/HIV-AIDS_BCC_partic%20monit_guide%20(PATH).pdf
- Participatory learning and action: with 100 field methods. (2002) by Neela Mukherjee. This book can be viewed but not downloaded at: http://books.google.com/books?hl=en&lr=&id=CPDylQ5_RKAC&oi=fnd&pg=PA7&dq=particpatory+learning+and+action&ots=r4ASYuhlYi&sig=PjWOSjWdshD8qMkPxwRawjBe6NE#v=onepage&q&f=false
- Empowering Communities: Participatory Techniques for Community-Based Program Development. Volume 1: Trainer's Manual and Volume II: Participant's Handbook. FHI 360.This document can be downloaded free of charge at: http://www.globalhealthcommunication.org/tools/36
- 100 Ways to Energise Groups: Games to use in workshops, meetings and the community. (2002). International HIV/AIDS Alliance. http://www.impactalliance.org/ev_en.php?ID=3782_203&ID2=DO_TOPIC
- Embracing Participation in Development: Wisdom from the Field. (1999). CARE. http://pqdl.care.org/CuttingEdge/Embracing%20Participation%20in%20Development-Wisdom%20from%20the%20Field.pdf

- Participatory monitoring, evaluation, reflection and learning for community-based adaptation: PMERL manual–a manual for local practitioners. (2012). CARE & the International Institute for Environment and Development (IIED) http://www.care.org/sites/default/files/documents/CC-2012-CARE_PMERL_Manual_2012.pdf
- Insights into Participatory Video: A Handbook for the Field. (2006). InsightShare. http://www.insightshare.org/resources/pv-handbook
- Community Screenings for Participatory Video - A Guide. (2014). InsightShare. http://www.insightshare.org/sites/insightshare.org/files/Community%20Screenings%20for%20Participatory%20Video%20-%20A%20Guide.pdf
- Participatory action research in health systems: A methods reader. (2014). TARSC, AHPSR, WHO, IDRC Canada, EQUNET, Harare. http://www.equinetafrica.org/bibl/docs/PAR%20Methods%20Reader2014%20for%20web.pdf
- Rapid Rural Appraisal (RRA) and Participatory Rural Appraisal (PRA) (1999). Catholic Relief Services. https://www.spring-nutrition.org/publications/tool-summaries/rapid-rural-appraisal-rra-and-participatory-rural-appraisal-pra

Training of Trainers Guides

- All Together Now! Community Mobilization for HIV/AIDS. (2006). International HIV/AIDS Alliance. https://frontlineaids.org/resources/all-together-now-community-mobilisation-for-hiv-aids/
- A Facilitator's Guide to Participatory Workshops with NGOs/CBOs Responding to HIV/AIDS. (2001). International HIV/AIDS Alliance. http://www.aidsalliance.org/assets/000/001/045/fge1101_Facilitators_guide_eng_original.pdf?1413458577
- Participatory Processes Towards Co-Management of Natural Resources in Pastoral Areas of the Middle East. A Training of Trainers Source Book
  Based on the Principles of Participatory Methods and Approaches. 2003 Dawn Chatty, Stephan Baas, Anja Fleig for FAO. ftp://ftp.fao.org/docrep/fao/006/ad424e/ad424e00.pdf

A combination of methods using formative research can help prioritize behaviors:

Trials of Improved Practices (TIPs) is a formative research technique developed by the Manoff Group. Using TIPs, program planners pretest the actual **practices** that a program will promote. The procedure consists of a series of visits in which the interviewer and the participant analyze current practices, discuss what could be improved, and together reach an agreement on one or a few solutions to try over a trial period; and then assess the trial experience together at the end of the trial period. The results are moved directly into program design. TIPs has been applied to nutrition as well as other public health issues including HIV/AIDS, school health , infectious disease control, maternal health and family planning. https://www.manoffgroup.com/wp-content/uploads/summarytips.pdf

Negotiating small doable actions (SDA) is a behavior that, when practiced consistently and correctly, will lead to personal and public health improvement. It is considered feasible by the householder, from HIS/HER point of view, considering the current practice, the available resources,

and the particular social context. Although the behavior may not be an "ideal practice," more households likely will adopt it because it is considered feasible within the local context. To encourage the target audience to practice a small doable action, the community agent can assess current practice, validate the householder's current good practice, identify one or a few behaviors for improvement, and actively problem solve to overcome barriers or resistance to make the selected SDA easier to do. The negotiation ends with a commitment to try the improved practice(s), and requires follow-up (perhaps with another round of negotiation and/or commitment to the current or an advanced SDA) to ensure sustained practice. (https://www.fhi360.org/sites/default/files/media/documents/resource-washplus-learning-brief-sda.pdf)

Annex 3: List of Different Social and Behavior Change Approaches

Table 6: List of Different Social and Behavior Change Approaches

<table>
<tr><td colspan="2">Husband Schools are drivers of behavior change in targeted villages. A group of 12 men meet twice a month with the head nurse of the health center to discuss the importance of antenatal and postnatal health visits for women, assisted births and family planning and how to sensitize and encourage community members to support these health practices effectively. They collaborate with female triad volunteers during community-wide nutrition events such as nutrition demonstrations. Husband Schools create their own community action plans, mobilize resources and choose their own leaders. They get refresher trainings on health topics and communication techniques to drive behavior change at the community and household level. Health Center staff attend husband school meetings and offering additional training around maternal, infant, and young child feeding and family planning. Some schools raise money and resources for community projects to improve village health status, e.g. constructing health center latrines, guard housing, and examination and delivery rooms. Model Husband Schools have established savings and credit groups to help with medical evacuation, delivery costs, and cleaning campaigns.</td></tr>
<tr><td>Why is it Innovative?</td><td>Results</td></tr>
<tr><td>The strengthening of inter-family discussion has allowed for more regular and participatory exchanges within households. Members/Model Husbands are more inclined to discuss sensitive topics (e.g., family planning, household feeding, reducing women's burden, and health center attendance by women and children) with their family and include their wives in decision-making. There are many examples of husbands who assist their wives during pregnancy these days. Additionally, the generational mix of members in the Husbands' Schools provides a platform where exchange and sharing of information can happen. For instance, older members have adopted innovations that have been proposed by the youngest members.</td><td>The project analyzed the strengths and weakness of each husband group to maximize the effectiveness of this approach. As an illustration, men are proud to accompany not only their wives to health facilities to choose a method of contraception and for prenatal care, but also for deliveries and post-natal consultations. In addition, male doctors/heads of health facilities are no longer an impediment to the use of health services by women. For example, health centers recorded an increase in the utilization rate of health services, from 63.37% in 2015 to 67.92% in 2016. The contraceptive prevalence rate data from health center records show increases from 30.05% in 2015 to 33.55% in 2016.</td></tr>
<tr><td colspan="2">Père Burkinabila is a group of 10-15 fathers of adolescent boys and girls who meet two times per month as a group with a facilitator. The fathers also learn interpersonal and negotiation skills to better communicate with their children about more sensitive health topics. The goal of the innovation is to</td></tr>
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<tr><td colspan="2">change adolescents' behaviors to reduce teenage pregnancy and unwanted pregnancy in three villages of the Barsalogho municipality. The approach began after discovering that adolescents cannot talk to their fathers about issues of sexuality. Adolescents do not receive sufficient information or guidance to better manage their puberty-related urges. Further, fathers who talk to their children about sexuality are not taken seriously. This approach aimed to motivate fathers, strengthen their knowledge and negotiation skills on adolescent sexuality and family planning, establish, and strengthen frank and uncomplicated communication between fathers and adolescents on issues of sexuality and family planning.</td></tr>
<tr><td>Why is it Innovative?</td><td>Results</td></tr>
<tr><td>This community-based approach was developed while search for innovative evidence-based strategies. The human centered design workshop led by TRANSFORM / PHARE program in Burkina Faso selected and financed the pilot project entitled "Burkinbila fathers accompany adolescents to responsibly manage their sexuality."

This approach was tested in three villages (Basma, Saaba and Tamassogo) with a budget of USD 70,000, from February to July 2018.</td><td>These communities are familiar with "human-centered design" activities such as husbands' schools and care groups (GASPA), which facilitated the acceptance of the approach. The project team involved all stakeholders from the start and communities accepted this intervention without subsidies.

The flipchart job aid broke the ice and provided a playful atmosphere of learning. Fathers used this job aid to engage in the discussions. They were then more comfortable with approaching difficult questions from adolescents because they had pictures to guide them.

Involving leaders in selecting fathers and validated the selection with the general village assembly caused no major complaint. It also helped in selecting the right people to participate in Burkinbila fathers' clubs.</td></tr>
<tr><td colspan="2">Triads work through Community Health and Nutrition Liaisons (CHNLs), IYCF groups, and Mamans Lumieres to improve HH-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 children under age 2, 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 graphic below for specific breakdown of tasks.</td></tr>
<tr><td>Why is it Innovative?</td><td>Results</td></tr>
<tr><td>Triads build absorptive capacity by improving the health of women and children most at risk of undernutrition, which enhances the ability to withstand unplanned shocks. To some extent, these activities also build transformative capacity in that the CHNLs, IYCF groups and Mamans Lumieres, linked to community health worker, can contribute to a safety net that can identify/treat or refer at-risk cases.

Triads build self-efficacy among members who are newly able to detect, screen for and refer malnutrition cases; cook nutritious recipes</td><td>Triad model may have contributed to statistically significant final evaluation health improvements:

• Increased exclusive breastfeeding among infants under age 6 months: 44.1% (baseline) to 56.8% (endline)
• Decrease in underweight children under 5: 46.8% (baseline) to 37.1% (endline)
• Decrease in stunted children under 5: 46% (baseline) to 35.7% (endline)
• Decrease of wasted children under 5: 16.7 (baseline) to 11.6 (endline)</td></tr>
</table>

for families; negotiate behavior changes among community members; identify when to visit health center. Further, these groups are able to provide social support during group-wide activities.

The Program Development Quality (PDQ) approach brings together community members and health service providers to identify problems with health service quality, develop action plans to address these problems and monitor key indicators to determine whether positive changes have occurred. The project's health and nutrition coordinator and supervisors hold a series of consultations with the government's regional health office and the targeted district management teams to build, support and strengthen their capacity to facilitate PDQ process. Then district and project staff hold series of focus group discussions in each district with poor and marginalized community members to identify reasons why they do not use the local health center and to understand their perceptions about health centers. Simultaneously district and project staff hold focus group discussions with health center service providers to understand their concerns and challenges. Service providers and community members come together at each health center to discuss the challenges identified and potential solutions. Community members and service providers appoint an equal number of delegates to form a quality improvement team (QIT) that is tasked with developing action plan and identifying community resources to tackle the problems that contributed to low quality. The QIT meets quarterly and updates the action plan annually.

Why is it Innovative?

PQD is helping community members adopt health seeking behaviors that will improve their health and the health of their families by identifying and working with existing structures and pinpointing those most affected by the issues. Establishing support groups comprised of health center staff and community members redefines community structures and roles. This participatory process improves relations among health center staff and community members as they work together to tackle key health issues from multiple angles.

Results

Table 1: Zongo Clinic Data on Key Health-Seeking Indicators, January 2015-August 2017

	2015[3]	2016	2017[4]
Percent of pregnant women who attend all four pre-natal visits at the health clinic	25.40%	31.59%	43.00%
Percent of pregnant women who gave birth with assistance from a skilled provider	28.60%	53.54%	87.44%
Percent of new mothers who attend all three post-natal consultations	17.00%	24.24%	58.00%

The **GASPA** (Care group) approach uses project health promoters to train 10 Mother Leader Animatrices (MLA) from each target village on IYCF and WASH best practices. The GASPA meets once a month. The community health workers supports care group sessions and shares data with health center staff. Over time, the community health workers take more of a leadership role while the project health promoters become supervisors. GASPA learn group facilitation techniques for group discussion and interpersonal communication skills for one on one counseling sessions and how to screen and refer cases of malnutrition to the community health worker or directly to the health center. GASPAs also lead community-wide cooking demonstrations using locally

available, culturally acceptable and nutritious foods at least once a month and take advantage these gatherings to share information about infant and young child feeding and to screen for malnutrition.

Each MLA has her own care group of 10-15 women of reproductive age that meets at least once per month. Each MLA is responsible for training and monitoring health practices her neighborhood group members and sharing the learning she receives from the GASPA. To promote exclusive breastfeeding, MLAs give lessons on how to properly position the baby during breastfeeding, how many times a day the baby should suckle, and how to negotiate these practices with influential family members. MLAs conduct home visits and recommended small doable actions to support gradual adoption of this practice. MLAs used similar SBC techniques to encourage the women to adopt other priority recommended behaviors such as dietary diversity for pregnant and lactating women and children 6-23 months and handwashing during critical times. MLAs follow-up with mothers at community sessions to check if they are preparing nutritious recipes in the home. They provide tailored guidance on recipes and IYCF if necessary to each mother.

Why is it Innovative?	**Results**
This approach builds social support among members and increases group members' capacity to plan activities, facilitate group sessions, and negotiate for behavior change. In some cases, GASPA become self-managed savings groups (tontines) and save money to pay for important health center visits among members. Strengthening the inter-family dialogue has allowed for more regular and participatory exchanges within households and examples of spouses assisting their wives during pregnancy are increasing.	The GASPA model may have contributed to statistically significant health improvements from baseline to endline (2012-2018): • Exclusive breastfeeding among infants under 6 months increased from 39.8% to 69.5% • Immediate breastfeeding increased from 39.8% to 69.5% • Prevalence of underweight children under 5 declined from 31.2% to 25.5% • Prevalence of stunted children under 5 declined from 24.7% to 19.7% • Knowledge about critical handwashing times increased from 1.8% to 41.6% • Households with water and soap present at frequently used handwashing station increased from 1% to 17%.

Youth in Action (YiA) is an approach to engage adolescents to contribute positively to their futures, and that of their families and their communities. The approach, developed under an integrated, holistic project in five African countries with young men and women (12-18), out of school and living in rural areas, mirrors the Positive Youth Development framework and is grounded in three pillars: **Youth Learn**, **Youth Act**, and **Youth Connect**. It supports male and female youth to identify and explore livelihood opportunities through non-formal educational and practical learning experiences, with an intentional focus on gender integration. Most program participants focused on agricultural value chains or agri-business. This approach simultaneously improves youths' perceptions of their environment, improves adults' perceptions of youth, and strengthens relationships and networks that allow youth to enter and thrive in the labor market.

Key Activities:

- Training on foundational skills (literacy, numeracy, financial literacy), transferable life skills (negotiation, communication, planning, etc.), entrepreneurship skills;
- Livelihood pathway choices with a small cash grant, including back-to-school, apprenticeships, small enterprise, vocational training;

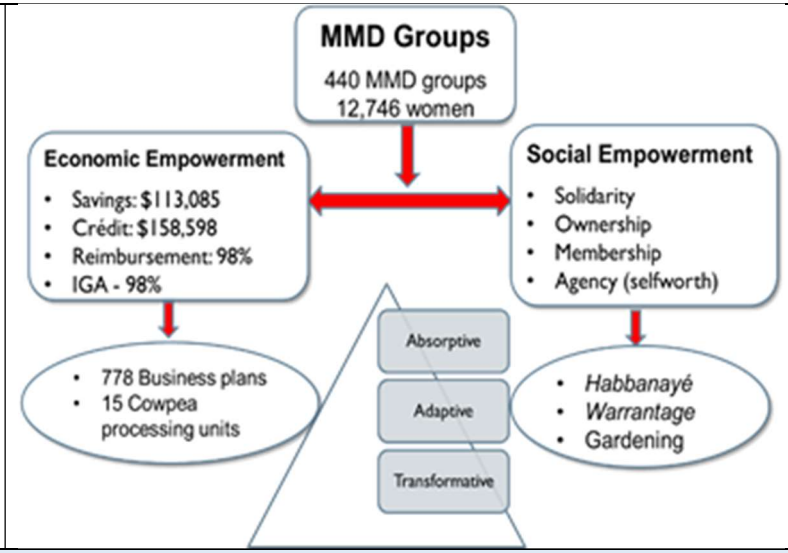
- Post-training mentorship support and links to community services such as reproductive health, business development, financial services, cooperatives, government livelihoods services, etc.;
- Family and community celebrations that support positive youth engagement in social and economic activities, including those focused on gender equality.

Why is it Innovative?	**Results**
Youth in Action intentionally engages young people with their immediate environment. YiA encourages positive shifts in the surrounding enabling environment by: (1) engaging family and community members in program activities; (2) demonstrating youth's capabilities, work and value to family and community members; and (3) reflecting on youth skills, maturation, and how to support livelihood development. This is done while providing youth with opportunities to build skills to take the lead–learning, acting and connecting with their peers and adults in their communities. Grounded in local contexts, the approach can be adapted to include many different topics and linkages for young men and women.	As young men and women developed new knowledge, attitudes and skills, the YiA approach changed community perceptions of youth behaviors, which resulted in increased support for young men and women and their contributions towards socio-economic development in their communities. During the six-year project (2012-2018), the average youth cohort participated in a 6-month project cycle. • Young people were six times more likely to be self-employed nine months after the project ended (73% vs 12%) demonstrating that youth were shifting to more integrated and sustained self-employment through the program. • In Egypt, Ethiopia and Uganda, youth found work that elevated them individually above the international poverty line (USD1.9). • More youth reported regular savings (80% vs 40%) than when the project started and youth savings increased by 384%. • Most youth (80%) had a regular business mentor 9+ months after the project ended. • Youth in Burkina Faso, Egypt, and Ethiopia reported marked increases in their families' contribution of material supports – land, space, tools/ materials, animals. • In Burkina Faso, more YiA graduates owned businesses than before (75% vs 26%). • In Malawi, 64% of youth had high financial literacy skills than before (64% vs 22%). • In Egypt, female working youth increased (85% vs 13% before YiA. • Participation in YiA helped youth to delay marriage and reduced school dropout.

Farmer-Managed Natural Regeneration (FMNR) groups/Farmer Field Schools: FMNR groups work together to bring back trees to the land and encourage farmers to practice climate-smart agriculture. FMNR groups set up 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 the project and the Government Ministry of

Environment. Lead famers practice FMNR in their own fields and encourage other farmers to do the same. Local farmers learn how to switch from traditional cultivation slash-and-burn approaches to selective cutting when preparing for the growing season. FMNR groups lead discussions on climate smart agriculture and demonstrate natural regeneration on fields in the village. The FMNR committee acts as an intermediary between the farmers and the government's environmental technical services.	
Why is it innovative?	**Results**
FMNR makes it possible to restore and protect the environment against deforestation and soil erosion and work with their fellow community members to manage crops and resources planted by community members properly. FMNR groups find innovative solutions to degraded environment such as scaling up grafting improved varieties of Jujube fruit tree (Magaria or Sahel Apple). Fruit trees help diversify agricultural production in the Sahel, contribute to optimal use of land for agriculture and encourage family consumption of nutritious foods. FMNR groups can also work with triad and women's savings and loans groups (Mata Masu Dubara or 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.	FMNR groups are successfully combatting Sida Cordifolia, a noxious weed that is pervasive in the Maradi Region. Through Food-for-Work (FFW) and FMNR group support, local communities cleared over 814 hectares of fields invaded by the weed. This removal process was repeated yearly for a three-year period so that Sida Cordifolia would not return. By restoring pasturelands, the LAHIA project also reduced the time required to move livestock to pasture and increased the availability of quality forage crop biomass. The removal of Sida Cordifolia increased biomass production to 600 to 1000kg/hectare in project zones versus a Sahelian regional average of 500kg/hectare (values are calculated by regional animal health agents based on an illustrative sample). While Sida Cordifolia still exists, native grasses are reemerging in the area. The project reported that three non-project villages embraced removing Sida Cordifolia and cleared 22 hectares of grazing land without outside assistance. FMNR groups spread Eragrotis Tremula seeds over 240 hectares, a plant that ruminants eagerly consume as fodder. This activity benefitted 4,341 vulnerable beneficiaries (1,539 women) and some 1,160 HHs in the five intervention communes.
Women's Savings and Loans Groups: In Niger the LAHIA project'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 these groups have social capital and solidarity. 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 household and communities.	
Why is it Innovative?	**Results**

MMD groups are the primary entry points for building women's economic and social empowerment. This approach uses MMD knowledge on savings and lending to develop business plans and support women's income generating activities that broaden household asset bases and enhance women's agency and leadership. MMD groups take advantage of men's engagement and support through husband schools. Together MMD and husbands schools contribute to positive household and community resilience. The program also created "networks" of MMD groups that allow free flow of information and sharing.



The **Community Action Cycle (CAC)** mobilizes communities to organize for action; explore development issues and set priorities; and plan, act, and evaluate successful programs. The program team supports communities throughout the cycle. Village development committees, village councils, community health groups and other community groups can use CAC methodology to strengthen community members' skills and capacities to address underlying causes and reduce barriers to social and behavior change.

Why is it innovative?	**Results**
CAC instills community member ownership and sustainability by encouraging village development committees to lead the process of community development. Often these groups raise their own money during monthly meetings to pay for transport to meetings, or for implementing activities written in their community action plans. The CAC also fosters equity by inviting vulnerable populations such as women and youth to participate in planning, implementing and monitoring community activities. Dynamic village development committees have the influence and voice to advocate for including priority activities in large commune development plans and potentially secure funding to scale up future activities. Government financial support directed strategically to priority issues identified by village development committees fosters trust between community	The USAID/Services de santé a grand impact (SSGI) project in Mali established 257 community action groups (CAGs) and 95% have a current action plan and carried out activities included in their action plan. Over half of these groups have at least 30% female membership. Balanmassala is a village far from the health center. Roads are poorly maintained, especially during the rainy season and no cars and few motorcycles are available to transport patients to the health center. In June 2016, the CAG created a community action plan to address the biggest health problems, including low care seeking for ANC, low vaccination rates of children under two and the low number of facility-based births. The CAG discovered that many villagers did not understand the importance of ANC visits and the dangers of giving birth at home. Many families were discouraged about the long distance to the health center. "We conducted household visits to share the benefits of health center

and government stakeholders, inspiring community members to continue to improve their own development over time.	care. We contacted all family members including fathers and grandmothers. We included these activities in our community action plan. Each CAG member conducted weekly visits to families to discuss progress." The CAG also analyzed health center attendance from 2016/2017 to create realistic objectives. After one year, the CAG achieved its objectives.
Community Early Warning System and Emergency Response (Système Communautaire d'Alerte Précoce et de Réponses en Urgences or **SCAP/RU**). This approach has the potential to equip communities threatened by disasters with the capacity to disseminate early warning bulletins so communities can prepare and take preventive action in a timely fashion to mitigate shocks and stressors. SCAP/RU members develop a village's emergency preparedness action plan. A project builds the skills of key VDC and SCAP/RU members to regularly collect and analyze data across five key subsectors. The SCAPRU team determines how to collect, process, and analyze rural data. The group then passes this data to Vulnerability Monitoring System (Observatoire de surveillance de la Vulnérabilité or OSV) at the commune (district) level so a higher-level response can be deployed, if needed. A project can assist communities to put in place a SCAP/RU if it is not functional.	
Why is it innovative?	**Results**
SCAP/RUs put response planning in the hands of community members. These groups can come up with innovative community-based solutions for dealing with shocks and stresses. Once they create community level plans, they can be shared with the OSV in the event support from the commune is needed to respond.	Information gathered by SCAP/RUs prompted many village development committees to revamp their overall development approach and include more emergency contingency plans in the past. Communes are collecting and analyzing data and requesting funding to support an early warning system. Saé Saboua Commune in Niger funds the entire cost of its SCAP/RU operations. The LAHIA project mapped all potential technical and financial partners in the communes. Several communes held an "advocacy forum" that engaged key stakeholders who agreed to support emergency response plan elements. Other positive results include: • Tchadoua Commune broadcast SCAP/RU action plans on radio. The sessions are popular and use examples from past and present disasters. This "reality radio" helps villagers embrace the SCAP/RU concept. The commune committed to collect rainfall data. Now several communes have adopted this practice. • Aguie and Gangara Communes provide regular reports about rural food prices via radio. Villagers say this information helps them to know agricultural news. These communes included a campaign to fight the invasive weed Sida Cordifolia in their SCAP/RU action plans. The fight campaign has helped agro-pastoralists gain new grazing areas.
WASH Committees or Water User Associations can encourage adopting recommended behaviors around water collection, management, safe storage and treatment, governance and water quality management. These committees operate at a village or sector level and members reflect the professional	

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<tr><td colspan="2">and socio-cultural diversity of the neighborhood. A WASH committee has 10 to 12 members and an elected president (who is on the village development committee), vice-president and secretary. They meet once or twice a month to review priority WASH issues and collaborate with other groups to encourage improved WASH behaviors. WASH committee members conduct home visits to monitor progress to good WASH practices and correct behaviors to maintain a clean and healthy village landscape.</td></tr>
<tr><td>Why is it innovative?</td><td>Results</td></tr>
<tr><td>WASH committee members can adapt to the specific WASH needs and requests of their locality. If lack of water is the primary issue, members can mobilize resources to construct a pump, set up systems for operations and maintenance and even create business plans for water user fee collection and use. They can work with other village volunteers such as community nutrition groups to change behaviors around handwashing by creating behavioral nudges near latrines to remind people to wash their hands with soap. If the government promotes Community-led Total Sanitation (CLTS) initiatives, the WASH committee can take the lead and leverage community resources to become open defecation free.</td><td>The USAID/Nutrition and Hygiene Project (PNH) in Mali certified 207 villages as open defecation free helping communities oversee the construction or rehabilitation of 5,011 latrines and 7,799 handwashing stations. The project supported over 137,000 people to gain access to a latrine and over 27,000 people to gain access to an improved water source. Final project evaluation results indicate that improved hand-washing practices and access to clean water at the community level, the project contributed to a 50 percent decline in underweight in children under 0–59 months and a 14 percent decline in wasting. WASH activities were managed by WASH committees. Results from the project supported mid-term evaluation</td></tr>
<tr><td colspan="2">Traditional and mass media includes interactive radio programs, television series, interactive voice radio cellphone messaging, theater, and village-wide discussions. The goal of such media is to reach a large audience with messages about a specific priority issue that affects people in the given community. Sometimes messages target a specific group (such as fathers, fathers to be, adolescent girls, etc.) who have access to radio. In order to decide what type of mass media to use, the Project should conduct a formative research to understand patterns of mass media use by sub-group in a given community and work with community members on which types of mass media would be more appropriate. Sometimes community groups can listen, watch or participate in radio or television programs and then discuss their thoughts and questions together as a group. Formative research can help projects choose which medium to use as it will help teams understand which audiences use different media. Sometimes community groups can listen, watch or participate in radio or television programs and then discuss their impressions and questions as a group.</td></tr>
<tr><td>Why is it innovative?</td><td>Results</td></tr>
<tr><td>Community members can use traditional and mass media while working on other household chores (i.e. listening to the radio while in the home or field). Story telling techniques can also make messages easier to digest and more entertaining for listeners.</td><td>A mass media study in Burkina Faso found that mass media campaigns can lead to changes in some behaviors linked to child survival. The research cautioned this finding does not mean that any and every mass media campaign can change behavior. Key factors in a successful media campaign to change behavior include the “dose” delivered and received by the target audience and the quality of the messages. These findings suggest governments could prioritize saturation based</td></tr>
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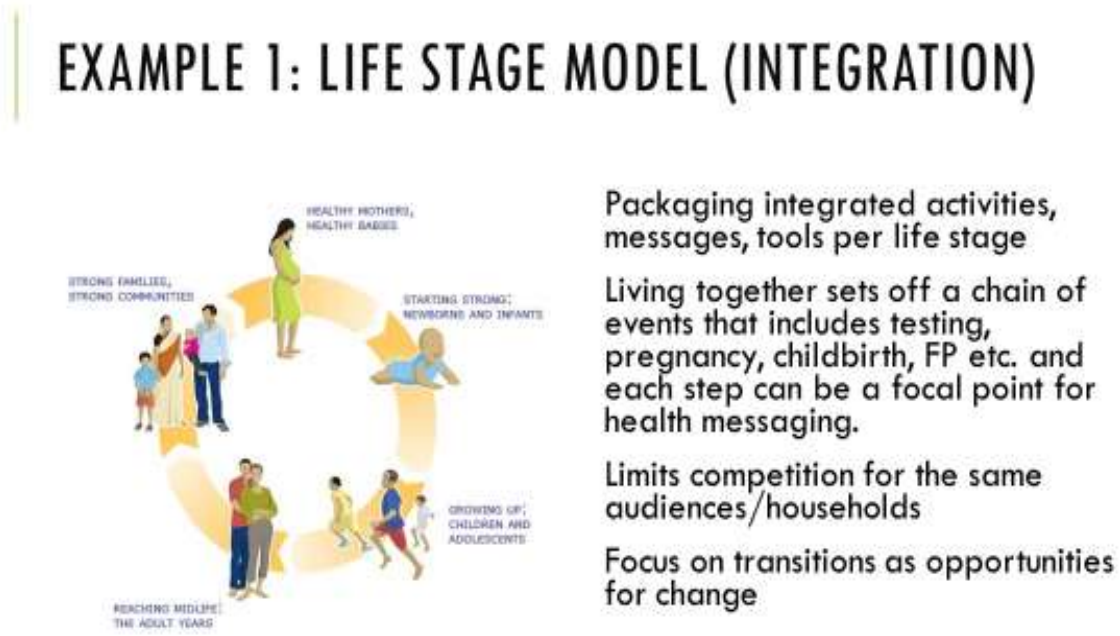
	media campaigns and can help influence public health interventions. [1] [1] : Sarrassat, S., Meda, N., Badolo, H., Ouedraogo, M., Some, H., & Bambara, R. et al. (2018). Effect of a mass radio campaign on family behaviours and child survival in Burkina Faso: a repeated cross-sectional, cluster-randomised trial. The Lancet Global Health, 6(3), e330-e341. doi: 10.1016/s2214-109x(18)30004-4
Video Approach: The SPRING/Digital Green pilot intervention in Niger aimed to decrease childhood illnesses caused by poor handwashing and to improve dietary intake through increasing responsive feeding practices. Rural communities created and shared videos to promote high-impact maternal, infant, and young child nutrition (MIYCN) and hygiene behaviors. Select communities developed and disseminated videos focused on 10 MIYCN and hygiene themes using community actors. Project mediators presented the videos during monthly community meetings and facilitated discussions with existing community groups. In addition to engaging the existing community groups, mediators showed the videos to three influencers groups: mothers-in-law, husbands, and co-wives. Field mediators conducted home visits to address any questions raised by the videos and checked whether the household member understood the behavior and whether they promoted the practice with others in their family or community.	
Why is it innovative?	**Results**
The use of video for social and behavior change offers several advantages when working in rural communities: information is standardized and not dependent on the quality of educators and low-literacy populations respond well to such a medium. Behavior change approaches that incorporate videos coupled with guided discussions at the community level have shown promise in public health (Desta et al. 2014; Khoury et al. 2002; Roye and Hudson, 2003; Tuong, Larsen, and Armstrong 2014).	Program beneficiaries noted in the final evaluation that the timing and duration of the video shows were appropriate but attracted many people. Women connected with the stories shared and felt that the visual helped them understand the messages more deeply than a verbal presentation. Findings from the FGDs also indicated that the videos had generated excitement that was helping to change social norms. Women and mediators found that participating in the activities helped elevate their social status. Other community members consulting them about the messages shared through the videos and home visits. Survey findings indicate that the community video approach significantly increased the presence of a handwashing station at home (as demonstrated in the videos) from 14 percent at baseline to 59 percent one to two months after the video was shown. In addition, the percentage of households with a handwashing station with soap and water, indicating regular use, increased significantly from 73.8 percent to 96.2 percent. Findings for the second priority behavior studied, responsive feeding of children 6–24 months and feeding from a separate plate, also indicate very promising results. After watching the video, the percentage of children within arm's reach of a responsible person at the last meal increased significantly

	from 65 percent to 80 percent. The percentage of women who fed their child from a separate plate increased significantly from 70 percent to 97 percent (https://www.spring-nutrition.org/publications/reports/seeing-believing)

Annex 4 – Different Behavior Prioritization Models

The Lifestage Model focuses on transitions in a person's life that makes it easier to change a practice. This model makes a lot of sense intuitively; however, funders and implementers need to program activities for all audiences and cannot wait until the first phase (e.g. pregnancy) is over to address caretakers or adolescents.

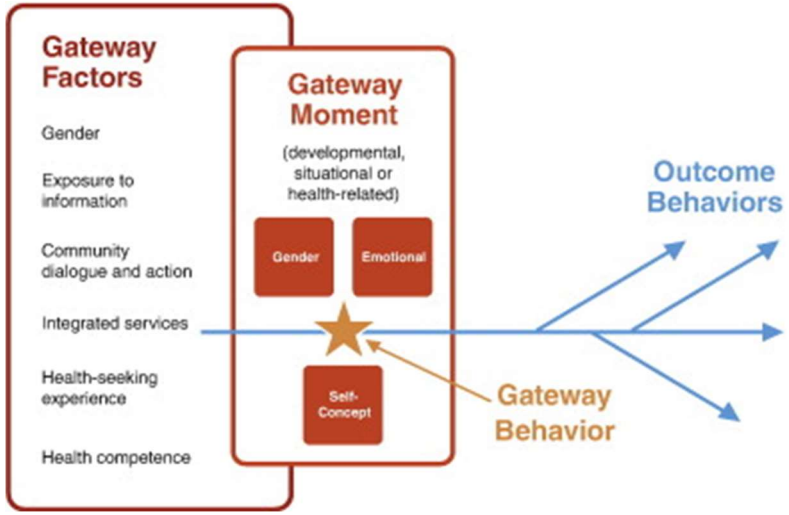
Figure 10: Life stage model



Gateway behaviors identify and prioritize those behaviors that have a domino effect on other behaviors. By focusing on a gateway behavior, other related behaviors follow more easily. In the model in Figure 12, three gateway concepts—**behaviors, moments**, and **factors**—are presented as a set of interrelated components.[1] The **gateway behavior** is an action initiated by the individual, which takes place within a **gateway moment**, which refers to key transitional points in life (e.g. menarche, marriage, pregnancy, or first child) when individuals or families could be particularly receptive to make positive health changes. These gateway moments might be developmental (becoming an adolescent), situational (such as pregnancy or marriage), health-related, or illness-related (such as learning COVID-19 status). During this time, one or more **gateway factors** operate to influence the gateway behavior. A gateway factor refers to the context, attributes, or conditions that facilitate behavior change and might have a positive or negative influence on downstream behaviors.

For example, the large Alive and Thrive project's nutrition program in Vietnam, funded by the Bill and Melinda Gates Foundation and implemented by FHI 360, found that encouraging mothers to NOT give water for the baby's first six months had a huge positive impact on exclusive breastfeeding. In this case, the gateway behavior is not giving water, the gateway moment is first child and gateway factors that may influence the behavior include "health seeking experience, cultural/social norms, family influencers and health competence.

Figure 11: Factors and Moment to promote a Gateway Behavior



[1] Chwandt, H. M., Skinner, J., Takruri, A., & Storey, D. (2015). The Integrated Gateway Model: A catalytic approach to behavior change. International Journal of Gynecology & Obstetrics, 130, E62-E68

Annex 5 – SBC Chart

The chart below is a summary table that presents the priority behaviors for each priority and secondary audience, the key barriers 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 in the table can be normal. All the actions here only give a general picture of what can be done to anchor the recommended behaviors. Please refer to the Project's operational plan for more details on specific activities to address behavior change.

Table 7: Template for overall SBC chart

Desired Behavioral Outcome:						
Primary Audience	**Priority Behaviors**	**Barriers / Facilitators**	**SMART Objectives**	**Channels/Activities/Approaches**	**Support materials Key messages**	**Indicators**
Secondary Audiences						