Technical Rapid Response Team

Nutrition and WASH Social Behaviour Change Strategy Bentiu, South Sudan

SBC Strategy Bentiu

For Concern Worldwide

May 2016

TABLE OF CONTENT

LIST OF TABLES

LIST OF ABBREVIATIONS AND ACRONYMS

BA	Barrier Analysis
BCC	Behaviour Change Communication
COW	Community Outreach Workers
CNV	Community Nutrition Volunteers
CWW	Concern Worldwide
D	Doers
DBC	Design for Behaviour Change Framework
EBF	Exclusive Breast Feeding
EHA	Essential Hygiene Actions
ENA	Essential Nutrition Actions
GFD	General Food Distribution
HEV	Hepatitis E Virus
HH	Household
HP	Hygiene Promoters
HRRS	Hope Restoration South Sudan
IBF	Immediate Breast Feeding
IOM	International Organisation for Migrants
IYCF	Infant and Young Child Feeding
KAP	Knowledge Attitude & Practice
KPC	Knowledge Practice & Coverage
MBA	Mother and Baby Area
MBC	Mother and Baby Corner
MOH	Ministry of Health
MoU	Memorandum of Understanding
NIWG	Nutrition Information Working Group
ND	Non-Doers
OTP	Out-patient Therapeutic Program
POC	Protection of Civilians
PSA	Public Service Announcement
RGA	Revenue Generating Activities
RUSF	Ready to Use Supplementary Food
RUTF	Ready to Use Therapeutic Food
SBC	Social Behaviour Change
Tech-RRT	Technical Rapid Response Team
TSFP	Targeted Supplementary Food Program
U5	Under 5 Years
UNMISS	United Nations Mission in South Sudan
WASH	Water Sanitation & Health
WHO	World Health Organisation
WFP	World Food Program

EXECUTIVE SUMMARY

A barrier analysis formative research study was conducted in Bentiu PoC (with a population currently estimated at above 100,000 people) located in Rubkona County, Unity State, South Sudan between March 21st and April 29th 2016. The survey was done by the Technical Rapid Response (Tech-RRT) SBC Advisor under the request and hosted by Concern Worldwide with support from OFDA and the validation of the Nutrition Information Working Group (NIWG) of the Nutrition Cluster. The main objective of the survey was to identify the health determinants acting as barriers for seven identified priority behaviours in order to design an SBC strategy that includes populations from the Bentiu POC and surrounding communities:

1- Mothers of infants U6 months feed them only breast milk.
2- Mothers put the new-born to the breast within one hour of delivery.
3- Mothers/care givers of OTP/TSFP enrolled children provide the RUTF/RUSF ration only to their enlisted children.
4- Mothers/care givers of children 6-59 months seek attention from a nutrition specialist within 24 hours of noticing the under nutrition symptoms (wasting, oedema, hair discoloration).
5- Mothers/care givers of children U5 years wash their hands with soap/ash at the five critical times each day
6- Mothers/care givers of children U5 years defecate in a latrine at all times.
7- Mothers/care givers of children 6-59 months years wash the water storage container with soap before fetching water in the morning.

With the barrier analysis formative research we are able to compare subjective standpoints – perceptions – from individuals who practice a behaviour (Doers), and those who don't (Non-Doers). Their particular answers are coded and then tabulated so difference in opinions are highlighted and used to design BCC activities and the overall SBC strategy.
Data was collected using written questionnaires where enumerators directly wrote the respondents' answers on the paper questionnaire. 15 enumerators (9 males & 6 females) were trained over a period of 3 days, and collected data during 8 days. Data was coded and tabulated during 4 days once the data had been collected. With 7 behaviours to survey, and 90 questionnaires distributed per behaviour (45 Doers/45 Non-Doers), this brings the sample size for this study to 630 individuals from both Bentiu POC and the nearby Bentiu and Rubkona towns.

Once finalized, the barrier analysis results were used to design and write a SBC strategy that Concern and the humanitarian community in Bentiu will be able to integrate into their on-going nutrition and WASH programmes. The strategy highlights key activities for each of the barriers to undertake both in Bentiu POC and surrounding communities.

INTRODUCTION

Concern Worldwide first became operational in South Sudan in 1985, when it was still part of Sudan, providing emergency relief to Ethiopian refugees in Upper Nile State. In 1994 Concern started responding to those affected by the civil war with emergency and early recovery interventions, initially in Yei, Eastern Equatoria and then to other areas of the country including counties in Lakes, Northern Bahr el Ghazal (NBeG) and Unity States as well as Nuba Mountains . Currently, Concern operates in Rubkona, Guit and Leer counties in Unity, Aweil West, North and Centre counties of NBeG, and Central Equatorial State in both the UN House PoC and in Juba's peri-urban areas, with its country office in Juba. The violence that erupted in South Sudan in mid-December 2013 led to a humanitarian crisis involving massive displacement of 1.5 million people nationwide. On-going conflict has resulted in the displaced seeking refuge in Protection of Civilian (PoC) sites, host communities and neighbouring countries.

As of February 2016, there were 559,009[1] people estimated to be displaced in Unity State alone, with 120, 278 living in Bentiu PoC[2]. The displacement has generated significant need for emergency services. Despite the presence of humanitarian agencies, living conditions in the PoC sites remain substandard. Widespread food insecurity, high acute malnutrition rates, insufficient water and sanitation services and inadequate child feeding practices have led to increased needs for nutrition interventions. The conflict and associated displacement has had a significant impact on food security and consequently, the prevalence of malnutrition. The most recent Integrated Food Security Phase Classification (IPC) analysis conducted in December 2015 indicated that around 2.8 million people were expected to face food insecurity between January and March 2016[3]. Compared to most previous years, the onset of the 2015 lean season in May is two months earlier and is due to diminished household food stocks, high food prices and long-term effects of the conflict.

BACKGROUND

Bentiu Protection of Civilians (POC) site in Unity State is currently the largest IDP camp in South Sudan. It was established in early 2014 in response to the large influx of displaced people as a result of fighting in the wider area of Unity State commencing in late 2013. Several partners are currently working in the camp, coordinated by the cluster system. Overall camp management is the responsibility of IOM. Concern, CARE and World Relief are currently supporting outpatient therapeutic care and supplementary feeding at sites

[1] OCHA, South Sudan Humanitarian Snapshot, February 2016.
[2] Update DTM, Feb – 12 – 14 2016
[3] Integrated Food Security Classification South Sudan. December 2015 Update

throughout the camp as well as messaging and counselling on IYCF and key health and nutrition practices. MSF supports broader inpatient and out-patient services via a hospital and health centres. WASH is supported by Concern, IOM, Mercy Corps, UNICEF and MSF with clear mandate of each organization to avoid overlapping.

The influx of IDPs into the camp has exceeded its original capacity by more than double. The original site was established somewhat spontaneously as IDPs began to aggregate. Unfortunately, the original site was also vulnerable to flooding and related hygiene risks. Due to the speed of arrivals, services to accommodate the growing population of IDPs initially evolved in a somewhat ad-hoc manner. In mid-2015, a new purpose-built camp was established on an organised grid with better drainage and planning. Due to the ongoing influx of new arrivals however, even this new site remains extremely cramped and the risk of illness and malnutrition is high. A SMART survey undertaken in August 2015 revealed an extremely high level of GAM 34.1 % C.I (31.1 - 37.2) according to WHZ <-2 and/or oedema) and SAM 10.5% C.I (8.5 - 12.9) according to WHZ <-3 and/or oedema).
Both are clearly above international thresholds for a serious emergency and were also significantly higher than a SMART survey carried out the previous year at that same time (August 2014 by CARE). The same surveys revealed low levels of diet diversity and exclusive breastfeeding[4] and a KAP and WASH[5] survey conducted in April suggests open defecation is still widely practiced while hygiene knowledge and practice remain suboptimal.

Partners are considering conducting a more thorough investigation of the causes of under nutrition in Bentiu PoC (potentially a Link-Nutrition Causal Analysis). In the meantime, there is an immediate need to better understand the barriers and potential boosters for key health, hygiene and nutrition behaviours and to develop and lead a coordinated, camp-wide social and behaviour change strategy to efficiently promote improved practices critical for child and maternal health and nutrition. The need for and importance of a more coordinated approach to SBC has been discussed by with the Nutrition Cluster in Bentiu and was a key recommendation from the August 2015 SMART Survey in the camp.

A range of activities by different agencies and across the sectors of nutrition, health and WASH, is underway in the POC to promote positive behaviours and a diversity of agents and

[4] According to the survey, the prevalence of exclusive breastfeeding is very low at 8.7% (95% CI: 3.3%-18.0%).
[5] While 67.32% of respondents would use a nearby latrine in that event, 14.25% (± 3.27%) indicated that they would defecate somewhere around their compound: *WASH and Nutrition in the Bentiu Protection of Civilian Sites: Knowledge, Attitudes and Practices Baseline Survey Report*, Rubkona County, Unity State, South Sudan, May 2015.

volunteers have been recruited to take on this work. These include Kids Clubs, household visits and mass campaigns and are conducted by a range of community members, from hygiene promoters to community nutrition volunteers and home health promoters – all with a slightly different remit, often a slightly different set of messages and behaviour change communication materials and variously incentivized. It is recognized that these efforts could be more effective at improving health and nutrition in the camp if approaches and targets were better harmonized and brought together under a coherent social and behaviour change strategy for the camp. Similarly, as populations begin to move out of the camp (and realistically are likely to move between the camp and the town for some time), the humanitarian community would like to have a sound assessment of the situation outside of the camp, so a more coordinated and coherent social and behaviour change strategy can be adopted by all partners at the outset – to be regularly reviewed as the situation evolves.

PURPOSE OF BENTIU BARRIER ANALYSIS

The purpose of the barrier analysis is to develop an evidence-based behaviour change strategy and action plan for promoting priority hygiene, and nutrition practices that will have the quickest positive impact on the prevention and treatment of malnutrition and illness in children and pregnant women who live in the POC and the evolving settlements in Bentiu and Rubkona towns.

The focus of the BA was to identify social and health determinants that act as barriers towards practicing the recommended behaviours in Nutrition (4) and WASH (3) as stated in the table below. These behaviours were identified using secondary data from the Concern SMART survey (August 2015) and KAP survey (May 2015), and from consulting with Concern's nutrition and WASH teams, as well as wtih WASH and Nutrition sub-cluster partners at the start of the mission.

Table 1: Nutrition behaviours & statements

N1-Exclusive Breastfeeding	**Mothers of infants U6 months feed them only breast milk.**
N2-Immediate Breastfeeding	**Mothers put the new-born to the breast within one hour of delivery.**
N3-Feeding ration to enrolled children	**Mothers/care givers of OTP/TSFP enrolled children provide the RUTF/RUSF ration only to their enlisted children.**
N4-Nutrition seeking support within 24hrs	**Mothers/care givers of children 6-59 months seek attention from a nutrition specialist within 24 hours of noticing the under nutrition symptoms (wasting, oedema, hair discoloration).**

Table 2: WASH behaviours & statements

W1-Hand washing at the 5 critical times	**Mothers/care givers of children U5 years wash their hands with soap/ash at the five critical times each day**
W2- Defecate in a latrine	**Mothers/care givers of children U5 years defecate in a latrine at all times.**
W3- Washing drinking water storage containers	**Mothers/care givers of children 6-59 months years wash the water storage container with soap before fetching water in the morning.**

OBJECTIVE OF THE BARRIER ANALYSIS

Design an evidence-based, context-specific SBC strategy and action plan that covers both the camp and the settlement of Bentiu town, in consultation with key stakeholders, by elaborating a set of context-adapted key behaviour change activities for all partners, a tailored communication strategy and any other actions that need to be taken to enable good behaviours[6].

METHODOLOGY

WHAT IS A BARRIER ANALYSIS?

A Barrier Analysis is a survey that focuses on identifying what is preventing and enabling the Priority Group to adopt a given behaviour. The results of the questions are compared amongst groups of people who already have adopted the new behaviour (called "Doers"); and people who haven't yet adopted the ideal behaviour (called "Non-Doers"). Comparing these two groups allows the researcher to better understand which behavioural determinants are the barriers and enablers of the behaviour change.

Barrier Analysis is both qualitative and quantitative. The questionnaire (annex 2) collects information by posing both open-ended and closed questions elements helping us to explore and describe how the two groups think, but it also has quantitative elements which allow us to say which differences are significant. (e.g. the statistical comparison of Doers and Non-Doers). Barrier Analysis does not measure prevalence of a particular belief; however, quantitative information is being collected and analysed (e.g., which group gave a particular response more often). The standard sample size for BA of 45 interviews of Doers and 45 with Non-Doers gives the most valid results.[7]

Bentiu Barrier Analysis training & preparation

Enumerators responsible for collecting data during the BA where provided by Care, Concern Worldwide, HRSS, IOM, Mercy Corps, and World Relief from both Nutrition and WASH programmes. Training took place between March 30th and April 1st at the UNMISS conference meeting room between 9h00am and 5h00pm. The original list of enumerators consisted of 21 individual (12 women and 9 men).

[6] Key partners likely to benefit from this strategy include CARE, IRC, MercyCorps, WHH, MSF and UNICEF as well as the MoH in Bentiu Town.
[7] *Design for Behaviour Change Curriculum*, Core Group, May 13.

The final number of enumerators[8] selected for the BA exercise was 15 with 6 female and 9 male. The reason for requesting as much as possible female enumerators is based on the sensitive and cultural nature of behaviours such as exclusive breastfeeding, immediate breastfeeding and usage of latrines.
It took longer than expected for the enumerators to understand screening questions in Section A of the questionnaire. This is the part of the BA questionnaire that allows the enumerators to identify if the respondent is a Doer or a Non-Doer, or if a respondent cannot be interviewed. This was somewhat misinterpreted or misunderstood, which led to about 100 questionnaires being cancelled during data collection after noticing that some interviews went on when they were not supposed to. These questionnaires where redone amongst different mothers in different sites.

CONDUCTING BARRIER ANALYSIS IN POC AND BENTIU COMMUNITIES

Data collection

Data was collected in the POC and Bentiu town over an 8-day period (April 2 to 9).
The table shown below indicates the number of questionnaires of each type (Doers/Non-Doer) for each location (POC and Bentiu town).
The intention of collecting perceptions in both these locations is in part due to the ambition of the humanitarian community in South Sudan to intervene outside the POC as the security situation stabilises and where there are a large number of families who have access to limited services. By having respondents from outside the POC give their opinions about behaviours that are perhaps alien to them provides possible avenues to explore for future BCC activities in these areas.

Table 3: Nutrition behaviours questionnaire distribution

N1-Exclusive breastfeeding				N3-Providing rations to enrolled children			
Doers		Non-Doers		Doers		Non-Doers	
POC	Bentiu Town	POC	Bentiu Town	POC	Bentiu Town	POC	Bentiu Town
22	**23**	**20**	**25**	**38**	**6**	**34**	**12**
N2-Immediate breastfeeding				**N4-Seeking nutrition support within 24hrs**			
Doers		Non-Doers		Doers		Non-Doers	
POC	Bentiu Town	POC	Bentiu Town	POC	Bentiu Town	POC	Bentiu Town
23	**22**	**20**	**22**	**29**	**16**	**28**	**17**

[8] See list annex 1.

Table 4: WASH behaviours questionnaire distribution

W1-Hand washing at the 5 critical times				W2- Defecate in a latrine				W3- Washing Drinking Water Storage Containers			
Doers		Non-Doers		Doers		Non-Doers		Doers		Non-Doers	
POC	Bentiu Town	POC	Bentiu Town	POC	Bentiu Town	POC	Bentiu Town	POC	Bentiu Town	POC	Bentiu Town
41	**4**	**34**	**11**	**41**	**4**	**22**	**22**	**45**	**0**	**43**	**2**

Amongst the 15 surveyors, as many as 5 were not able to collect data in Bentiu town based of potential risk linked to local tensions. The alternative was for these surveyors to focus on sectors within the POC. Bentiu town is about 20-30 mins car drive from the POC and its total population is very small. The POC on the other side welcomes a population close to a 100,000 individuals. It is divided in 5 sectors. These sectors are again divided into blocks.

Because the enumerators worked and lived in the POC, rules were set for how to conduct the interviews within the POC in order to minimize research bias:

- Interviewing mothers within the sector where an enumerator resides is forbidden.
- Interviewing mothers within the sector where an enumerator works is forbidden.
- Interviewing mothers within the sectors with new arrivals is highly recommended.

The latter was suggested so that enumerators working only in the POC could interview mothers who like the mothers in Bentiu town had not previously been beneficiaries of the services provided in other sectors by the humanitarian community.

Data coding and tabulation

Once the data for 90 questionnaires (with 45 Doers and 45 Non-Doers) had been collected, the team of enumerators and the BA Coordinator needed to code and tabulate the data. Simply put, this is the time where enumerators share what they have collected and documented from each mother they interviewed. Answers and responses are coded on a flip chart for each question in order to compare what Doers and Non-Doers have answered to these questions. This step took place in the POC from April 11 to 14, with the male enumerators working Monday 11, Wednesday 13 and half day on the 14, and female on Tuesday 12 and half day on the 14.

Methodology limits and challenges

Contrary to the recommended protocol for conducting BA, the coding and tabulation of the data could not be done simultaneously with the data collection due to the availability of meeting rooms/office space; the data collection calendar and availability of the enumerators (two weeks); and to the absence of supervisors and assistants who can update and follow-up

on the numbers of questionnaires completed. To compensate for this limit, we decided that data collection and coding/tabulating would happen once all questionnaires are completed.

Another limit was not being able to fulfil the request of the national Nutrition Information Working Group (NIWG)[9] to conduct the Nutrition BA fully in both Bentiu communities and the PoC, meaning surveying 4 behaviours twice (360 questionnaires in POC and 360 questionnaires in Bentiu town). Technically this would have been very interesting to compare how mothers from both areas feel in regards to all behaviours. However, logistically it turned out to be too taxing for the enumerators (as not all were allowed to travel to Bentiu town); and methodologically, the difference level between the two areas was found to be not enough to justify mobilizing these resources as time was also not on our side. Still, as seen in above tables, behaviours N1 and N2 are the ones that have the most respondents from outside the PoC.

Below are more challenges that impacted the process and content of the BA.

Table 5: Challenges conducting BA in Bentiu POC and outside

Challenges	Description
Not translating the BA questionnaires into Nuer.	- It was decided between the SBC advisor and the enumerators not to translate the questionnaires into Nuer due to the lack of capacity of enumerators to read Nuer, but also to translate it from English. We are not sure that the decision of agreeing on common translation for specific and technical terminology related to each behaviour is the best way forward, but in the context we were in, it was deemed to be the best option.
Data collection.	- No assistant and/or supervisors were allocated for data collection and coding. Their role would have been to support the SBC advisor in coordinating the exercise. They would have also contributed to stimulating and encouraging enumerators in increasing or maintaining the level of concentration and quality required for BA. They would have also been better at managing enumerators where the SBC advisor did not have any "manager to staff" *per se* relationship authority. - The enumerators did not probe as much as they should have and it is possible to think that some interviewed mothers too close to each other hence influencing their response.

[9] Quote from Tracy Dube, CWW Emergency Nutritionist, after presenting the BA protocol to the NIWG in Juba: "If the survey is going to be conducted both in the POC and Host community, it would be good to separate the samples from these areas, as the house felt that these two areas are not as homogeneous and influencers to behaviours might be distinct hence need of separating the samples".

Coding data.	- Considering how important this phase is – that we were able to find a place to compile the data, and achieve this task with relative success – this could also be label as a success instead of a limitation since enclosed meeting rooms are scarce in Bentiu. The feeling here is more in regards to the external conditions such as the heat, rain and wind, ambient noise (generator, school, music), not having tea/biscuit break planned as factors that perhaps influenced the level on concentration of some of the surveyors, and therefore leading to the next limitation. - Surveyors showed and expressed (some more than others) some resistance having to work full days in the conditions previously mentioned. From both the female and male enumerator groups, some staff decided for themselves that they would not show up, hence increasing the burden on their team members.

Methodology Recommendations and Lessons Learnt

Partner organizations in Bentiu that are able to provide enumerators in the future need consider the minimum requirements for them of being able to communicate (understand, read and speak) in English for the main purpose of 1) understand the nature of the questions including their verb tense and technicalities link to the behaviour. Here are other lessons learnt:

- Supervisors and assistants to the technical advisor during BA preparation, collection of data, and coding/tabulating sessions are an essential resource from each organisation. They also would act as mediators when tasks and objectives need to be reinforced and represent the authority of the organisation that provided surveyors.
- Without the support and contribution of supervisors and assistants – who we anticipated to be decision making staff of partner organisations – cluster partners will not be able to conduct barrier analysis. Providing community based staff only is not enough as it limits organisations' capacities to replicate and lead such exercise.

RESULTS & FINDINGS

Within this section we look at all Nutrition and WASH DBC and the barriers that influence the practices of the expected behaviours. A DBC is a tool that allow us to design an SBC strategy based on 1) social profile description of mothers with children under 5 years; 2) the determinants that acts as barriers; 3) Behaviour Change Communications (BCC) objectives designed to address the barriers; 4) suggested messages and tailored BCC activities designed to reach out and influence the priority groups, i-e, mothers with children U5. Strategy wise, the DBC allows us to decide on what BCC activities need priority focus in order to promote the desired change right now and further down the line.

NUTRITION RESULTS

Table 6: Barrier findings for nutrition behaviours

Determinants of Behaviour Change	Nutrition Behaviours			
	N1-Exclusive Breastfeeding (EBF)	N2-Immediate Breastfeeding (IBF)	N3-Providing rations to enrolled children	N4-Seeking nutrition support within 24hrs
Perceived Self-Efficacy	X	X	X	X
Perceived Positive Consequences	X		X	X
Perceived Negative Consequences	X		X	
Perceived Social Norms	X	X	X	X
Perceived Access	X	X	X	X
Perceived Cues for Actions/Reminders	X	X	X	X
Perceived Susceptibility/Risk	X	X	X	X
Perceived Severity	X	X	X	
Perceived Action Efficacy	X	X	X	X
Perceived Divine Will	X	X		
Policy				
Culture	X	X		

WASH RESULTS

Table 7: Barrier findings for WASH behaviours

Determinants of Behaviour Change	WASH Behaviours		
	W1-Hand washing at the 5 critical times	W2- Defecate in a latrine	W3- Washing Drinking Water Storage Containers
Perceived Self-Efficacy	X	X	X
Perceived Positive Consequences	X	X	X
Perceived Negative Consequences		X	
Perceived Social Norms	X	X	X
Perceived Access	X	X	X
Perceived Cues for Actions/Reminders	X	X	X
Perceived Susceptibility/Risk	X	X	X
Perceived Severity		X	
Perceived Action Efficacy	X	X	X
Perceived Divine Will	X	X	
Policy			
Culture		X	

DESIGN FOR BEHAVIOUR CHANGE FRAMEWORKS – NUTRITION

DBC N1-Exclusive Breastfeeding

Mothers of infants 0–6 months feed them only breast milk.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Message and Activities**
Priority group Mother of infant 0-6 months. Influencing Groups Dr, mother, IYCF mother's groups, grand-mothers (elder women), family members/relatives. 1- Demographic Features **Age**: 18-45 years **Income**: 40-100 SSP/day. Families not owning the land they are currently living on. **Residence**: Bentiu PoC+town, Rubkona. **Education level:** Primary School. The populations in Bentiu town and Rubkona are less well educated than those in the POC and believe more strongly in divinity of different sorts which influences their uptake of new behaviours. Most of the educated people in the area came into the POC to get jobs when the crisis started. 2- Things that mothers do; spend their days doing. In the morning, mothers go to the forest to collect firewood, leaving	Access **Doers feel it's hard to get the support they need.** Social norms **Doers = most people approve.**	Increase access to the support needed to only give breast milk to infants 0 – 6 months. Increase the perception that most of the people.	Tentative message Mother! Support is there for you to EBF. Activities - **Training and teaching** the science behind EBF and IBF to health workers and volunteers; increase the number of midwives and their special skills to focus on IYCF practice; create a « squadron » of IYCF specialists whose job will be to teach and mass teach the skills and science of EBF and IBF amongst mothers. - **Media and IEC materials** will help bringing the family members, and elders to get on board with the necessary requirements for EBF and IBF; "Where is my favourite midwife" maps where mothers can see on a calendar or poster where services are available (link with IBF).

Mothers of infants 0–6 months feed them only breast milk.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Message and Activities**
their children with the elder children. (This is common of mothers in Bentiu and Rubkona towns because selling of collected firewood is usually the only way women in the towns can get an income. It is not like the POC where many women are employed. Gaining an income from selling of firewood is a must as the oil and lentils supplied in the food ration by WFP are not enough to last for a whole month). They usual return from mid-day onwards, when they prepare food for the children. Therefore, they don't really have time to clean the babies and children – the elder children are responsible for caring for the children and babies, including washing them etc. Not many mothers have tea shops so they go straight to work at their tea shops in the morning, leaving the babies and young children under the responsibility of the elder daughter. Sometimes the mum might leave instructions with the older daughter, for her to wash the children and prepare the lunch. Sometimes mothers leave children under the responsibility of the grandmother. When there is a grandmother or grandfather, the mother will also be responsible for finding food for these grandparents, who are viewed as a priority since they are elderly. In a case where the mum has a husband living with her who has work, the mum will take care of the children at home. In this case, the mum will take charge of all household activities including food preparation etc.	<u>Self-efficacy</u> - **Doers = can do it.** - **Doers = *it is easier because I have enough milk*.** - **Non-Doers = *it would be more difficult if I don't have enough milk [because food is not enough].***	- Improve the ability of new moms to practice EBF. - Increase the perception that all mothers produce enough breast milk for their babies during the first 6 months even when food is short - Increase the perception that it is ok for mom to eat more than other family members when she is breastfeeding (and even when she is pregnant).	<u>Tentative messages</u> Mother! Learn and find out how EBF can be easy. Mother! It's ok to eat more. You need more food because your baby needs your milk. Family members! Mother is EBFing. Let her eat more. <u>Activities</u> **One on one demonstrations** with mothers within the mother and baby corners. Consider improving them or building news ones to allow the privacy needed.

Mothers of infants 0–6 months feed them only breast milk.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Message and Activities**
In Rubkona and Bentiu towns some mothers are irresponsible. They like to go to the market in the morning to take shisha and coffee with their friends, or they move around their friends' houses taking coffee in the morning, for socializing, leaving the children at home. 3- Things that mothers want (common desires or interest) Schools for education of their children are the first priority of mothers. The 2nd priority of mothers may be to become employed. Mothers want employment so that they can buy things for their children. The things that they want to buy their children include food (In the food ration given by WFP, mothers feel that the oil and cowpeas is not sufficient for their children to be healthy. Sometimes, the monthly food ration is finished after just 7 days, since relatives come from the rural areas to share the food rations they receive since not everyone has been registered. Therefore, they seek work so that they can buy the necessary items in the market). Mothers want soap for their children. Lactating mothers desire milk. This could support them while they have to go to the forest to collect firewood, as they could leave the milk with the caregiver at home. Mothers desire health services nearby so that clinics are easily accessible. Currently there are only 2 doctors in Rubkona and many people come from the rural areas to get medicine and treatment for their children so it is difficult to see a doctor because of the high demand.	Divine will **Non- Doers = God doesn't approve.**	Increase the perception that God approves of only giving breast milk to infants 0-6 months.	Tentative message Mother! God likes it when you baby is healthy. Activities **Praying sessions** using passages of the holy book where EBF or healthy of infants are approved. Include religious leaders in IEC materials designed to promote approval.
	Susceptibility/risk **Doers feel diarrhoea and malnutrition are risks.**	Increase the perception that infant 0-6 are at risk to suffer from diarrhoea and malnutrition.	Tentative message Mother! The more you EBF, the less your baby will be at risk of diarrhoea/malnutrition. Mother! Diarrhoea/malnutrition is serious and bad illness. EBF and help your baby from being ill. Mother! Diarrhoea and malnutrition is the enemy. Your breast milk is the best weapon for this fight. The more the baby is breastfed the more the milk is produced Activities **Mothers support groups** (care groups like approach) where mothers can speak to and learn from other mothers. Include discussion
	Action efficacy - **Non-Doers = is not that efficient to prevent malnutrition.** - **Doers = it's efficient to prevent diarrhoea.**	Increase the perception that EBF is the best way to prevention malnutrition and diarrhoea and to keep your child healthy.	

Mothers of infants 0–6 months feed them only breast milk.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Message and Activities**
4- <u>Things that prevent mother from practicing the behaviour (common barriers)</u> Lack of enough breast milk as perceived by majority of them due to inadequate food and hot climate thus they introduce complementary foods and water earlier. Having intercourse with a man when the child is still young is perceived to cause disease especially vomiting and diarrhoea. Mothers opt to stop breastfeeding earlier to meet the man sexual demands. Lack of knowledge on importance of EBF and risks of not practising it, pressure from significant others e.g. mother in law, peers to early introduction of complementary foods. Inadequate support family like carrying out house chores, looking for food to feed other family members. Less concentration by health workers on importance of EBF at both health facilities and at the community level. This has led most of the mothers don't much attention to ensure that children are exclusively breastfed. Lack of supportive structure that will encourage EBF like mother support groups, role models, policies that are baby friendly. 5- <u>What mothers know, feel, and practice regarding the behaviour</u> Mothers generally know about EBF, the expected duration but have not been sensitized well on importance of EBF and risk factors of not practising EBF this has negative impact of knowledge to	<u>Severity</u> **Doers perceive malnutrition and diarrhoea are both very serious.**	Increase the perception that malnutrition and diarrhoea are very serious conditions/illnesses, especially in infants.	on benefits and risks. Revamping and building news MBAs and MBCs will allows the space and argue for more time for mother to come and visits the midwives and nurses newly trained. One on one or mothers' group session will allow discussing and educating them on the risk and severity of not practicing EBF and IBF. (Quick link with WASH diseases (cholera and HEV) can be made during these sessions.)
	<u>Cues for actions/reminders</u> **Non-Doers feel it's hard to remember.**	Increase the ability to remember to only give breast milk to your infant from 0 – 6 months (remember to tell others Not to give anything else)	<u>Tentative messages</u> Mother! Listen to your baby. When it cries (and other hungry signs) it needs only your breast milk. Sexual intercourse is not linked to baby's illness. Proper hygiene is critical. <u>Activities</u> **PSA** using *boda boda talk talk*/radio like media.
	<u>Negative consequences</u> **Doers = the child will get diarrhoea.**	Decrease the perception that EBF causes diarrhoea.	<u>Tentative messages</u> Mother! EBF makes your baby healthy, not sick. EBF and it will never be sick. Mother! Culture is dynamic and moving. We say ok to EBF.

Mothers of infants 0–6 months feed them only breast milk.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Message and Activities**
practice part is influenced by household characteristics such as lack of adequate food for the mother, influence from peers/mother in-law, husband not providing full support hence women go to work leaving the infant behind to be fed by a caretaker who gives porridge, cow milk etc. Since EBF is less emphasized, mothers/caregivers pay less attention on it. They think more priority should be given on treatment matters like when child start diarrhoea they take to hospital other than preventives measures like EBF. Majority of the mothers introduce complementary foods to children as young as at one month to meet perceived nutritional needs[10] and thirst because of hot climate. 6- Stages of Change (*pre-awareness, awareness, preparation, action, maintenance)* Awareness.. They do know about EBF but have insufficient knowledge on importance of EBF and risks of not breastfeeding. More information needs to be tailor made to ensure that mothers/caregivers understand well the risks associated with non-exclusively breastfed child.	Perceived culture[11] **Doers = cultural rules against EBF.**	Increase the perception that all cultures are dynamic and change when they learn something new, such as that EBF prevents malnutrition and diarrhoea.	Mother! EBF is the best way to stay away from diseases (diarrhoea/malnutrition). Mother! EBF is the only food your baby needs to be healthy and strong. Activities **Role play, artistic expression** allowing these types of quotes to be represented through powerful and emotionally strong messages. Cultural subtleties need to be integrated and give context to quotes. The messages will allow bending cultural rules in order to make then accessible. Recruiting local artist, professionals will give more impact in terms of credibility. Come up with message on best performing children in class who had EBF
	Positive consequences - **Doers = it prevents from diseases.** - **Doers = it makes the child strong and healthy.**	Increase the perception that EBF is the best way to prevention malnutrition and diarrhoea and to keep your child healthy.	
Universal motivators: good/better husband, children&family, Money/shop/business, school&education, farming/cattle (property), peace/good environment.			
Outcome indicators # and % of infants 0-<6 months of age who are exclusively breastfed.			

[10] Perhaps from culture influence too.
[11] Need to explore what are these rules.

DBC N2-Immediate Breast feeding (putting the baby on the breast within one hour of the birth)

Mothers put the new-born to the breast within one hour of delivery			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Priority group Mothers (when they are expecting). Influencing Groups Midwives have more influence. My mother, grand-mother (elder women), family members/relatives. 1- Demographic Features **Age**: 18-45 years **Income**: 40-100 SSP/day. Families not owning the land they are currently living on. **Residence**: Bentiu PoC+town, Rubkona. **Education level:** Primary School. The populations in Bentiu town and Rubkona are less well educated than those in the POC and believe more strongly in divinity of different sorts which influences their uptake of new behaviours. Most of the educated people in the area came into the POC to get jobs when the crisis started. 2- Things that mothers do; spend their days doing. In the morning, mothers go to the forest to collect firewood, leaving their children with the elder children. (This is common of mothers in Bentiu and Rubkona towns because selling of collected firewood is usually the only way women in the towns can get an income. It is not like the POC where many women are employed. Gaining an income from selling of firewood is a must as the oil and lentils supplied in the food ration by WFP are not enough to last for a whole month).	Cues for actions/reminders **Non-Doers = not that easy to remember.** Culture[12] **Doers = there are cultural taboos.**	Increase the ability of new mothers to put the new-born to the breast within an hour of delivery. Increase the perception that it is culturally acceptable to breastfeeding within an hour of delivery.	Tentative messages Mother! Remember, once the baby is out, put it on your breast. Mother! Your culture is strong and dynamic. It moves as you move. The first milk produced by mother is very important to protect the baby against diseases Activities - **Antenatal visit sessions** on the benefit of IBF, simply the science behind the link between the new-born sulking and the positive influence it has on the mother's body. - **Skill based trainings** on the "key steps" to delivery: from preparation to post-delivery (physical and psychological). Bring the health provider to understand cultural taboos and subtleties so they can to reassure and work around or with them. Convincing health professionals as important as the mother. They both need to be on the same page in that regards. - **Group sessions** by Health workers and midwifes on how EBF and IBF are lives saving practices even more so in the context

[12] The implementers role of this strategy will be to explore into details and get more insight on what are these taboos.

Mothers put the new-born to the breast within one hour of delivery			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
They usual return from mid-day onwards, when they prepare food for the children. Therefore, they don't really have time to clean the babies and children – the elder children are responsible for caring for the children and babies, including washing them etc. Not many mothers have tea shops so they go straight to work at their tea shops in the morning, leaving the babies and young children under the responsibility of the elder daughter. Sometimes the mum might leave instructions with the older daughter, for her to wash the children and prepare the lunch. Sometimes mothers leave children under the responsibility of the grandmother. When there is a grandmother or grandfather, the mother will also be responsible for finding food for these grandparents, who are viewed as a priority since they are elderly. In a case where the mum has a husband living with her who has work, the mum will take care of the children at home. In this case, the mum will take charge of all household activities including food preparation etc. In Rubkona and Bentiu towns some mothers are irresponsible. They like to go to the market in the morning to take shisha and coffee with their friends, or they move around their friends' houses taking coffee in the morning, for socializing, leaving the children at home.			of an emergency bring more credibility.
	Divine will **God approves.**	Increase the perception that God/religion approves of immediate breastfeeding.	Tentative message Mother! God likes it when you baby is healthy. Activities **Praying sessions** using passages of the holy book where EBF or healthy of infants are approved. Include religious leaders in IEC materials designed to promote approval.
	Susceptibility/risk **Non-Doers still not sure excessive bleeding is a risk.**	Reinforce the perception that post-delivery excessive bleeding is a risk.	Tentative messages Mother! Bleeding after delivery is normal. Be aware when it don't stop. Mother! Regain your strength and get better, put your new born on the breast within the first hour.

Mothers put the new-born to the breast within one hour of delivery			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
3- <u>Things that mothers want (common desires or interest)</u> Schools for education of their children are the first priority of mothers. The 2nd priority of mothers may be to become employed. Mothers want employment so that they can buy things for their children. The things that they want to buy their children include food (In the food ration given by WFP, mothers feel that the oil and cowpeas is not sufficient for their children to be healthy. Sometimes, the monthly food ration is finished after just 7 days, since relatives come from the rural areas to share the food rations they receive since not everyone has been registered. Therefore, they seek work so that they can buy the necessary items in the market). Mothers want soap for their children. Lactating mothers desire milk. This could support them while they have to go to the forest to collect firewood, as they could leave the milk with the caregiver at home. Mothers desire health services nearby so that clinics are easily accessible. Currently there are only 2 doctors in Rubkona and many people come from the rural areas to get medicine and treatment for their children so it is difficult to see a doctor because of the high demand. 4- <u>Things that prevent mother from practicing the behaviour (common barriers)</u> 5- <u>What mothers know, feel, and practice regarding the behaviour</u>	<u>Action efficacy</u> **Non-Doers are not sure if it is effective.** <u>Severity</u> - **Non-Doers don't think it is serious enough.**	Increase the perception that putting the new-born to the breast within an hour of delivery will prevent excessive bleeding/help the placenta to come out. - Increase the perception that it's easy to breastfeeding even before the placenta has delivered. - Increase the capacity of health professionals to deliver babies (taking placenta out).	When new born baby is put on breast immediately, it helps to control bleeding <u>Activities</u> - **At home visits** to demystify the fear and increase confidence by engaging "at term" mother to be visited by mother Doers who recently delivered without complications because they did IBF. Let's try to find mothers who did IBF and now will continue EBF until the six to bring even more sense by having them explain the benefits for the other and the new-born. - **Success stories and short documentary films (real life)**, when group sessions are too taxing, that can be showed in hospitals, health centres, of by midwives when conducting antenatal and post natal home visits. High impact potential activities since mothers will see others mothers from own community/neighbourhood testifying of the benefits and successes of these practices.

Mothers put the new-born to the breast within one hour of delivery			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
6- <u>Stages of Change</u> (which one between *pre-awareness, awareness, preparation, action, maintenance)* Awareness.	<u>Self-efficacy</u> - **Doers = can be practiced.** - **Non-Doers = *would be easier if I feel the joy of giving birth.*** - **Non-Doers = *would be more difficult if the placenta is not out.***	- Increase the perception that everyone approves of putting the new-born to the breast within an hour of delivery. - Reinforce the perception that midwives approve of putting the new-born to the breast within an hour of delivery.	<u>Tentative messages</u> Mother! IBF is simple and healthy for your new-born. Mother! It's easy and essential to your new-born. Mother! Ride the love wave and feel the joy of giving new life. Breastfeed now. Health professionals! Help mother stop the bleeding and breastfeed. <u>Activities</u> - **Antenatal practice** sessions (with community nurse and midwives or female family members who were successful doing it). Procuring baby and breast dummies for teaching during these sessions and home visits. - **Academic and professional trainings** of future midwifes (recycling of experiences ones) - **Video tutorials** are often very catchy as they can be captivating and very educational based on the facilitator's skills. IBF can be easy and doesn't require much skill. The hard part is to remember. A lot lies on the shoulder of the professionals who support the mothers who are giving birth. They are the difference between a good and safe delivery *versus* a life threatening/tragic one.
	<u>Social norms</u> - **Doers = most people approve.** - **Doers = midwives approve.**	Increase the perception that post-delivery excessive bleeding is very serious/a mother could die.	

Mothers put the new-born to the breast within one hour of delivery			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
	Access **Non-Doers feel they can't get the necessary support from health professional (institution and HR wise).**	Increase the availability of support for immediate breastfeeding.	Tentative messages Health professional! Mothers need your support. Deliver baby better saves more lives. Mother! Good health professionals are there. Trust them and make your new baby feel good. IBF. Activities - **PSA**: INGOs and service providers experts to "get on the" air and promote on-going services and activities through (increasing awareness of already existing services). - **Develop MoU with MOH** about increasing the number of students in health care support services at university levels (Unity state University); design, implement and lead the "SFSF[13]" program to train an army of knowledgeable and capable midwifes.
Universal motivators: children&family, $/shop/business, school&education, farming/cattle (property), peace/good environment, food, mothers support group.			
Outcome indicators % of children born in the last 24 months who were put to the breast within one hour of birth.			

[13] Sage Femme Sans Frontière, in the same trend of MSF – Médecins Sans Frontière

DBC N3- Providing Rations to RUSF/RUTF program enrolled children only

Mothers/care givers of OTP/TSFP enrolled children provide the RUTF/RUSF rations only to their enrolled children			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Priority group Mothers/care givers of OTP/TSFP enrolled children. Influencing Groups IYCF assistant, nutrition assistant nurses and Community Nutrition worker have more influence. CNV, Parents/relatives. "Other women" have negative influence. 1- Demographic Features **Age**: 18-45 years **Income**: 40-100 SSP/day. Families not owning the land they are currently living on. **Residence**: Bentiu PoC+town, Rubkona. **Education level:** Primary School. The populations in Bentiu town and Rubkona are less well educated than those in the POC and believe more strongly in divinity of different sorts which influences their uptake of new behaviours. Most of the educated people in the area came into the POC to get jobs when the crisis started. 2- Things that mothers do; spend their days doing. In the morning, mothers go to the forest to collect firewood, leaving their children with the elder children. (This is common of	Cues for actions/reminders **Doers = easy to remember.**	Increase the ability to remember to give the ration only to the enrolled child.	Tentative messages Mother! Remember, rations are for your undernourished children. Mother! The rations are for your enrolled kids. Give it and solve it. Mother! Rations are like medicine. Mother! Be the boss. Rations are for undernourished kids only. Parents! Help mother enforce the rule that ration is for under nutrition. Mother! We can help you do it. Be strong and follow our lead. Mother! Saying no will save your children's life. Ratio is medicine and can't be shared Activities - **Moring ritual**: associate the consumption of rations to a morning ritual for sick kids. The notion or ritual is often accepted and creates boundaries between the ones who are allowed to participate in this ritual *versus* the
	Action efficacy **Non-Doers feel it is efficient.**[14]	Increase the perception that giving the ration only to the enrolled child it prevents from malnutrition.	
	Access: **Non-Doers = very hard to limit access to rations.**	Increase the perception that only enrolled children can access rations.	
	Self-efficacy	- Increase the	

[1414] Very interesting here as ND thinks it is very likely, but still are not able to manage to provide it. How strong are the other influences? On the other side, D also think that even if they do the behavior, it will not prevent from under nutrition; some as saying they don't believe in the rations as to be an effective product. Further investigation on how they perceive Plumpynut and Plumpysup would provide better light. Very powerful barrier.

Mothers/care givers of OTP/TSFP enrolled children provide the RUTF/RUSF rations only to their enrolled children			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
mothers in Bentiu and Rubkona towns because selling of collected firewood is usually the only way women in the towns can get an income. It is not like the POC where many women are employed. Gaining an income from selling of firewood is a must as the oil and lentils supplied in the food ration by WFP are not enough to last for a whole month). They usual return from mid-day onwards, when they prepare food for the children. Therefore, they don't really have time to clean the babies and children – the elder children are responsible for caring for the children and babies, including washing them etc. Not many mothers have tea shops so they go straight to work at their tea shops in the morning, leaving the babies and young children under the responsibility of the elder daughter. Sometimes the mum might leave instructions with the older daughter, for her to wash the children and prepare the lunch. Sometimes mothers leave children under the responsibility of the grandmother. When there is a grandmother or grandfather, the mother will also be responsible for finding food for these grandparents, who are viewed as a priority since they are elderly. In a case where the mum has a husband living with her who has work, the mum will take care of the children at home. In this case, the mum will take charge of all household activities including food preparation etc. In Rubkona and Bentiu towns some mothers are irresponsible.	**Non-Doers feel like they cannot do it.**	perception that the enrolled child will grow/recover quicker if the ration is only given to him/her. - Increase the perception that there are ways to give the ration only to the enrolled child so that the other children won't cry.	ones who don't. This has the potential to discourage other kids to access it if they see that they will be punishes of disciplined if they do. - **Hospital and health centre visits**: have women who refuse and encourage sharing of rations (or selling them) to participate accompanied by with CNV and COW in visiting hospital centres where kids are dying of severe malnutrition. This can be harsh we agree, but the outcome is misunderstood or taken too lightly. Activities here need to be strong in meaning in order to dissuade, deter and keep back family members from consuming the "medicine" designed to save the life of their own future generation as the ultimate outcome. (Link with Social Norms) - **Advocate/lobby to manufacturing companies** for making packages unattractive and as neutral as possible; and the product as "disgusting" as possible. It looks and taste good, just like candy, but its medicine!? That's a double sense message that needs rethinking.

Mothers/care givers of OTP/TSFP enrolled children provide the RUTF/RUSF rations only to their enrolled children			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
They like to go to the market in the morning to take shisha and coffee with their friends, or they move around their friends' houses taking coffee in the morning, for socializing, leaving the children at home. 3- <u>Things that mothers want (common desires or interest)</u> Schools for education of their children are the first priority of mothers. The 2nd priority of mothers may be to become employed. Mothers want employment so that they can buy things for their children. The things that they want to buy their children include food (In the food ration given by WFP, mothers feel that the oil and cowpeas is not sufficient for their children to be healthy. Sometimes, the monthly food ration is finished after just 7 days, since relatives come from the rural areas to share the food rations they receive since not everyone has been registered. Therefore, they seek work so that they can buy the necessary items in the market). Mothers want soap for their children. Lactating mothers desire milk. This could support them while they have to go to the forest to collect firewood, as they could leave the milk with the caregiver at home. Mothers desire health services nearby so that clinics are easily accessible. Currently there are only 2 doctors in Rubkona and many people come from the rural areas to get medicine and treatment for their children so it is difficult to see a doctor because of the high demand. 4- <u>Things that prevent mother from practicing the behaviour (common barriers)</u>	<u>Negative consequences</u> **Non-Doers = *it makes the other children cry and fight for it.*** <u>Positive consequences</u> - **Doers = *it makes the child fat/bigger*.** - **Doers = *it makes the child grow better/healthier*.** <u>Susceptibility/risk</u> **Non-Doers = under nutrition a risk.** <u>Severity</u> **Non-Doers = under nutrition is a serious problem.**	Decrease the perception that rations can be shared (it is not candy). - Increase the perception that the rations are there to make the enrolled children healthier, nobody else. - Decrease the perception that rations make the children fat. Reinforce the perception that malnutrition is a risk for children U5. Reinforce the perception that under nutrition is a serious problem for children U5.	<u>Tentative messages</u> Mother! Rations are medicine, not candy. Mother! Rations make healthier, not fatter. Mother! A healthy kid is a well-nourished kid, not a fat kid. <u>Activities</u> **Programme graduate merits**: have mothers present their graduated child/children from a nutrition programme to speak how they did it: on air, in schools, during mothers' group sessions. Develop/identify incentives for "non-enrollers" children. Reward kids who don't consume rations of their siblings. Perhaps same for parents and adults to do so. <u>Tentative messages</u> Mother! Undernutrition is a risk just like any other illness. Beware of the symptoms. Mother! Undernutrition is a serious illness. Keep the rations only for your sick kids. Mothers! Together you can do it. Keep providing the rations to your undernourished children only and save their future. <u>Activities</u>

Mothers/care givers of OTP/TSFP enrolled children provide the RUTF/RUSF rations only to their enrolled children			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
5- What mothers know, feel, and practice regarding the behaviour 6- Stages of Change (which one between *pre-awareness, awareness, preparation, action, maintenance)* Between Pre-awareness and Awareness.	Social norms - **Doers = most people approve (but sometimes other women don't agree or can have a bad influence).**[15] - **Doers = nutrition (IYCF) assistants/CNW approves.**	Increase the perception that everyone approves of giving the ration only to the enrolled child.	- **Songs** addressed to children that their sibling's need the full rations so they can be healthy too; design/develop incentives for not going to the nutrition centre to receive ration because one was able to complete the programme. - **Story telling** of two families: one who shares and one who doesn't.
Universal motivators: health, life, children&family, job/business, education, cattle (property), peace, rule of law, praying, going back to my community.			
Outcome indicators - Number of people treated for SAM/MAM, disaggregated by sex and (6-59 months) Rates of default, death, cure, relapse, nonresponse-transfer, and length of stay.			

[15] This makes a lot of sense since the majority of women don't practice the behaviour, hence making them feel bad about not being able to respect "the rules" that goes with the programs. Another reason could be that the ones who do the behaviour are perceived as not respecting African culture where goods often are shared amongst everyone in the household.

DBC N4-Seeking Nutrition Support Within 24hrs Of Detecting Under Nutrition Symptoms

Mothers/caregivers of children 6-59 months seek attention from a nutrition specialist within 24 hours of noticing the under nutrition symptoms (wasting, oedema, hair discoloration)			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Priority group Mothers/care givers of children 6-59 months. Influencing Groups Community nutrition volunteers (CNV), nutrition specialist, family members/relatives, community outreach workers (COW). 1- Demographic Features **Age**: 18-45 years **Income**: 40-100 SSP/day. Families not owning the land they are currently living on. **Residence**: Bentiu PoC+town, Rubkona. **Education level:** Primary School. The populations in Bentiu town and Rubkona are less well educated than those in the POC and believe more strongly in divinity of different sorts which influences their uptake of new behaviours. Most of the educated people in the area came into the POC to get jobs when the crisis started. 2- Things that mothers do; spend their days doing. In the morning, mothers go to the forest to collect firewood, leaving their children with the elder children. (This is common of mothers in Bentiu and Rubkona towns because selling of collected firewood is usually the only way women in the towns can get an income. It is not	Cues for actions/reminders **Doers = not hard to remember.**	- Increase the ability to remember to seek care when a child is undernourished - Increase the ability to recognize the signs of under nutrition.	Tentative messages Mother! Remember to use the coloured measuring tape and keep your child safe from under nutrition. Mother! Remember: green is keen, yellow is mellow and red is dead. Activities **Cue cards/memory aids** board in the household helping mother monitor, check and inspect the nutrition status of their kid; link with N3, i-e, adding a section to assess the progress of rations consumption of the enrolled children *VS* the rest of family members.

Mothers/caregivers of children 6-59 months seek attention from a nutrition specialist within 24 hours of noticing the under nutrition symptoms (wasting, oedema, hair discoloration)			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
like the POC where many women are employed. Gaining an income from selling of firewood is a must as the oil and lentils supplied in the food ration by WFP are not enough to last for a whole month). They usual return from mid-day onwards, when they prepare food for the children. Therefore, they don't really have time to clean the babies and children – the elder children are responsible for caring for the children and babies, including washing them etc. Not many mothers have tea shops so they go straight to work at their tea shops in the morning, leaving the babies and young children under the responsibility of the elder daughter. Sometimes the mum might leave instructions with the older daughter, for her to wash the children and prepare the lunch. Sometimes mothers leave children under the responsibility of the grandmother. When there is a grandmother or grandfather, the mother will also be responsible for finding food for these grandparents, who are viewed as a priority since they are elderly. In a case where the mum has a husband living with her who has work, the mum will take care of the children at home. In this case, the mum will take charge of all household activities including food preparation etc. In Rubkona and Bentiu towns some mothers are irresponsible. They like to go to the market in the morning to take shisha and coffee with their friends, or they move around their friends' houses taking coffee in the morning, for socializing, leaving the children at home. 3- <u>Things that mothers want (common desires or interest)</u>	<u>Action efficacy</u> **Non-Doers = don't know if seeking support is effective.**	Increase the perception that seeking support is the first step in treating under nutrition.	<u>Tentative messages</u> Mother! Help us help you. Examine your kid every month and let us know how healthy your children are. Mother! Take the tape and change their faith. Mother! Under nutrition is a risk. Check your kid and break the cycle. <u>Activities</u> - **Morning ritual**: associate the consumption of rations to a morning ritual for sick kids. The notion or ritual is often accepted and creates boundaries between the ones who are allowed to participate in this ritual *versus* the ones who don't. This has the potential to discourage other kids to access it if they see that they will be punishes of disciplined if they do. - **Songs** addressed to children that their sibling's needs the full rations so they can be healthy too; design/develop incentives for not going to the nutrition centre to receive ration because one was able to complete the program. - **Story telling** of two families: one who shares and one who doesn't. - **Teaching sessions**: have Doer mothers become available to take part in teaching
	<u>Self-efficacy</u> **Doers = can do it.**	Increase the ability to recognize the signs of under nutrition.	

Mothers/caregivers of children 6-59 months seek attention from a nutrition specialist within 24 hours of noticing the under nutrition symptoms (wasting, oedema, hair discoloration)			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Schools for education of their children are the first priority of mothers. The 2nd priority of mothers may be to become employed. Mothers want employment so that they can buy things for their children. The things that they want to buy their children include food (In the food ration given by WFP, mothers feel that the oil and cowpeas is not sufficient for their children to be healthy. Sometimes, the monthly food ration is finished after just 7 days, since relatives come from the rural areas to share the food rations they receive since not everyone has been registered. Therefore, they seek work so that they can buy the necessary items in the market). Mothers want soap for their children. Lactating mothers desire milk. This could support them while they have to go to the forest to collect firewood, as they could leave the milk with the caregiver at home. Mothers desire health services nearby so that clinics are easily accessible. Currently there are only 2 doctors in Rubkona and many people come from the rural areas to get medicine and treatment for their children so it is difficult to see a doctor because of the high demand.	Susceptibility/risk **Doers = severe malnutrition is not a risk.**	Decrease the perception that severe malnutrition is not a risk among U5 children.	sessions within their neighbourhood and within their blocks in POC. - **Film tutorials**: produce short tutorials with CNV and COW that they will use during training sessions on how to use the measuring tape; tapes can loan with the incentives of respective the rules when committing to become an agent of change, being able to identifying, teach how to identify symptoms; while promoting the positive outcomes of under nutrition programs graduates. Huge opportunity to link with N3.
	Access **Doers = health centre easy to access.**	Increase the perception that services for malnourished children are easily available.	Tentative messages Mother! Look around, the support you need is everywhere. Use it. Mother! Looking after your sick child's good health is something that we all agree with. Mother! When in doubt, don't pout. We all

Mothers/caregivers of children 6-59 months seek attention from a nutrition specialist within 24 hours of noticing the under nutrition symptoms (wasting, oedema, hair discoloration)			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
4- Things that prevent mother from practicing the behaviour (common barriers) 5- What mothers know, feel, and practice regarding the behaviour 6- Stages of Change (which one between *pre-awareness, awareness, preparation, action, maintenance)* Awareness.	Social norms **Doers = most people approve.**	Increase the perception that everyone approves of prompt care seeking for an undernourished child.	want our children free from under nutrition. Mother! Help your children get strong again, check them every month for signs of under nutrition. Mother! A strong child is a well-nourished child. Activities - **Calendars** (IEC) showing every 12 nearest health centres with community members acting as guides through the 12 months. - **PSA/billboards** where family members express the message that "we are thanking you mother for making your children strong. A family with strong children is a strong family".
	Positive consequences **Doers = *my child will become strong again*.**	Reinforce the perception that prompt care seeking for a child who is undernourished helps the child become strong again more quickly.	
Universal motivators: cooking, my country, children&family/relatives, job/business, school&education, farming&cropping, peace/reconciliation, being alive, God, going back to my community, good health, good husband.			

Mothers/caregivers of children 6-59 months seek attention from a nutrition specialist within 24 hours of noticing the under nutrition symptoms (wasting, oedema, hair discoloration)			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Outcome indicators			

DESIGN FOR BEHAVIOUR CHANGE FRAMEWORKS – WASH

DBC W1-Hand washing at the 5 critical times

Mothers/care givers of children 0–59 months wash their hands with soap/ash at the five critical times each day			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Priority group Mother/care givers of children 0-59 months. Influencing Groups Hygiene promoters (HP) have more influence. Health promoters/CNV, community/block leaders, family members/relatives, neighbours. 1- Demographic Features **Age**: 18-45 years **Income**: 40-100 SSP/day. Families not owning the land they are currently living on. **Residence**: Bentiu PoC+town, Rubkona. **Education level:** Primary School. The populations in Bentiu town and Rubkona are less well educated than those in the POC and believe more strongly in divinity of different sorts which influences their uptake of new behaviours. Most of the educated people in the area came into the POC to get jobs when the crisis started. 2- Things that mothers do; spend their days doing.	Access **Doers = it's easy to access soap/ash and water.**	Increase the availability of soap/ash and water.	Tentative messages Mother! Keep the soap for washing hands. It's ok to use ash too. Mother! Spending water and soap to wash hands is worth the price. Mother! Remember, 3 *befores* and 2 *afters*. Mother! Count with me:1…; 2…; 3…; 4… and 5… Activities - **Transcripts** (IEC) using Ants and Bees: stickers, packages and soap prints. - **IGA**: organise for mothers or fathers or elders to organise into COOP like association where they produce soap. - **Cue cards** near the water containers with visuals of the 5 times (link with W3). - **Hygiene billboards** with indicating hot spots for where to buy soaps within the community.
	Cue for actions/reminders **Doers = not hard to remember.**	Increase the ability to remember to wash hands with soap at the critical times each day.	

Mothers/care givers of children 0–59 months wash their hands with soap/ash at the five critical times each day			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
In the morning, mothers go to the forest to collect firewood, leaving their children with the elder children. (This is common of mothers in Bentiu and Rubkona towns because selling of collected firewood is usually the only way women in the towns can get an income. It is not like the POC where many women are employed. Gaining an income from selling of firewood is a must as the oil and lentils supplied in the food ration by WFP are not enough to last for a whole month). They usual return from mid-day onwards, when they prepare food for the children. Therefore, they don't really have time to clean the babies and children – the elder children are responsible for caring for the children and babies, including washing them etc. Not many mothers have tea shops so they go straight to work at their tea shops in the morning, leaving the babies and young children under the responsibility of the elder daughter. Sometimes the mum might leave instructions with the older daughter, for her to wash the children and prepare the lunch. Sometimes mothers leave children under the responsibility of the grandmother. When there is a grandmother or grandfather, the mother will also be responsible for finding food for these grandparents, who are viewed as a priority since they are elderly. In a case where the mum has a husband living with her who has work, the mum will take care of the children at home. In this case, the mum	<u>Susceptibility/risk</u> **Non-Doers = HEV and cholera are risks.**	Reinforce the perception that Cholera and HEV are a risk amongst U5 children.	<u>Tentative messages</u> Mother! Listen to the HP, they know how much of a risk is Cholera and HEV. You can trust them. Mother! Keep your family safe from HEV/Cholera. Clean your hands after … and before…. Mother! Washing hands kills HEV/Cholera. <u>Activity</u> **School play**: "The invisible army"; catchy title of the new school play where kids replicate the contamination cycles of cholera and HEV. At the end, kids recite about the nature of the diseases as well as how much they want their mother to prevent themselves and family member from catching it. (Link with all WASH behaviours, as well as N3 and N4 as these diseases are high risk of causing under nutrition). Mandatory audiences are mothers – have them sit in from of the men. Men are not allowed to sit in the front.

Mothers/care givers of children 0–59 months wash their hands with soap/ash at the five critical times each day			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
will take charge of all household activities including food preparation etc. In Rubkona and Bentiu towns some mothers are irresponsible. They like to go to the market in the morning to take shisha and coffee with their friends, or they move around their friends' houses taking coffee in the morning, for socializing, leaving the children at home. 3- <u>Things that mothers want (common desires or interest)</u> Schools for education of their children are the first priority of mothers. The 2nd priority of mothers may be to become employed. Mothers want employment so that they can buy things for their children. The things that they want to buy their children include food (In the food ration given by WFP, mothers feel that the oil and cowpeas is not sufficient for their children to be healthy. Sometimes, the monthly food ration is finished after just 7 days, since relatives come from the rural areas to share the food rations they receive since not everyone	<u>Social norms</u> - **Doers = most people approve.** - **Doers = hygiene promoters.**	Increase the perception that everyone approves of frequent hand washing with soap/ash; especially HPs.	<u>Tentative messages</u> Mother! Look around, everyone is happy when you remember to wash your hands before… and after… Mother! Washing hands is also like praying God. He too wants you and your family to be healthy. Mother! We can't practice God when we are sick. <u>Activity</u> **Praying sessions**: team up with God for hygiene SSP – Super Sunday Preaching – with preachers and HPs. Using this concept could be catchy linking SSP (preaching) and SSP (the money).
	<u>Divine will</u> **Non-Doers = don't know if God approves.**	Reinforce the perception that God approves.	

Mothers/care givers of children 0–59 months wash their hands with soap/ash at the five critical times each day			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
has been registered. Therefore, they seek work so that they can buy the necessary items in the market). Mothers want soap for their children. Lactating mothers desire milk. This could support them while they have to go to the forest to collect firewood, as they could leave the milk with the caregiver at home. Mothers desire health services nearby so that clinics are easily accessible. Currently there are only 2 doctors in Rubkona and many people come from the rural areas to get medicine and treatment for their children so it is difficult to see a doctor because of the high demand. 4- <u>Things that prevent mother from practicing the behaviour (common barriers)</u> **Lack of soap**: when the HP do their house-to-house visits and advise mothers to wash their hands with soap or ash, the mothers always ask them, "Where is the soap that you want me to use for this?"). The soap provided at GFD (8 bars per 20 people) is not sufficient for washing hands. Soap is prioritized for washing clothes and bed sheets first. **Lack of jerry cans**: in Rubkona, when HP are talking to mothers about hand washing, the mothers usually say that they can't wash their hands at all 5 key times because the water source is too far away. Likely, they only have 1 jerrycan, and by the time they get home from the water source, they do not have time to go back again. They have to prioritise the water they have brought for cooking and drinking. **Mothers are too busy**: they go straight to the forest in the morning so that they can collect firewood and sell it to get "money for food for their children.	<u>Self-efficacy</u> - **Doers = can do it.** - **Doers = *it's easier when ash/soap and water are there/when I have it (access).***	- Increase the perception that it's doable to wash hands at the five critical times. - Increase the perception that soap/ash and water are available	<u>Tentative messages</u> Mother! Buying soap and water is a good use of your money. Mother! Remember, by washing your hands, you wash the diseases away. Mother! Washing your hands reduces the risk of your child to be sick. Mother! More washing means less dying from HEV/Cholera. <u>Activities</u> **Demonstration sessions**, perhaps during SSP sessions where soap and ash are compare in giving the same results: killing germs – the same germs that gives HEV and cholera (keeping the family healthy!) *See positive consequences below.*
	<u>Action efficacy</u> - **Non-Doers = confident it prevents from cholera.** - **Doers = not confident it prevents from HEV.**	Increase the perception that hand washing with soap/ash at the five critical times each day is the best way to prevent HEV and cholera	

Mothers/care givers of children 0–59 months wash their hands with soap/ash at the five critical times each day			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Ignorance – Most mothers in Rubkona and Bentiu towns are from the rural areas before the crisis and have only moved into Bentiu and Rubkona recently (most of the people who lived in the towns before the crisis now live in the POC). The mothers from the rural areas are not well educated. They listen to the messages on hand washing given by the HP, but by the next day they will have forgotten them because they are uneducated and usually illiterate. Lack of knowledge that ash should be used for hand washing – the majority of mothers are not aware that ash will have a similar effect as soap if used for hand washing. Culturally, there are 3 kinds of food: paper food (kisra etc), dry food, and water food. Dry and water food are eaten using a ladle (large spoon used here). Only paper food is eaten with the hands. Most mothers (and everyone) believe that it is not necessary to wash your hands if you are eating dry food or water food. They believe it is only necessary to wash your hands if you are about to eat paper food. In reality, currently most mothers wash their hands with water at the 5 key times. Especially, they wash their hands before preparing food and eating food, and after cleaning the baby's bottom. However they only use water for hand washing as they use the little soap they receive for washing clothes, bed sheets, etc. 5- <u>What mothers know, feel, and practice regarding the behaviour</u> Mothers do not tend to know about good hygiene practices (i.e. the critical times to wash hands 5 times a day but they do know that at some point they should probably wash their hands). We think they feel like good hygiene is necessary, but they are unlikely to mention to know how it is associated to health and nutrition. Inside the POC, at	<u>Positive consequences</u> **Doers = *keeps family healthy.***	Increase the perception that it keeps the family healthy.	<u>Tentative messages</u> Mother! Hands that are clean mean children with dreams. Mother! Keep your family healthy, wash your hands. <u>Activity</u> **Song**: theme song; link this quote with the school play one could argue that this quote can be applied to reinforce all of the 3 WASH behaviours. Why not design a song, sang by all members of the influential groups (here above) in a "we are the world" kind of song. We could go as far as making this quote the slogan of the hygiene campaign: the "Healthy Family Hygiene" campaign (HFH). Using bees and ants as campaign mascots is even catchier. Have them repeat hygiene messages and find ways to get mothers attentions; perhaps by them replicating mothers' work around the house that involves focus on the 3Bs and 2As. (link with W3 where washing the container <u>b</u>efore fetching water – another "B")

Mothers/care givers of children 0–59 months wash their hands with soap/ash at the five critical times each day			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
least half of mothers would now know at least some of the key times for hand washing, because of the concerted hygiene promoters (HP) and nutrition efforts. Outside of the POC knowledge of the key times for hand washing is lower, but a lot of mothers have moved out of the POC into the 2 towns so we do come across mothers who know the key times and tell you that it's because they were living in the POC. Washing hands before eating is widely practised, but washing hands after using the latrine is not widely practised. The majority of mothers are not practicing hand washing at the 5 critical times with soap or ash, but the majority of mothers are practicing hand washing at the 5 critical times with water only. The majority of mothers are willing to start washing their hands with soap or ash because of messages received from the Hygiene Promoters. 6- Stages of Change (which one between *pre-awareness, awareness, preparation, action, maintenance)* "Awareness" stage of change – they are seriously thinking about taking up the behaviour of washing their hands with soap or ash at the 5 critical times.			
Universal motivators: being social, good governance, children&family/relatives, $/shop/business, school&education, farming&cropping, peace/good environment, being alive, religion/church, house (property), good health, good husband.			
Outcome indicators - # of respondents who know 3 of 5 critical times to wash hands - % population who know and can recall the two critical moments of hand washing - % of population who know the two critical times for hand washing - % of the population who wash their hands with soap or ash			

DBC W2- Defecate in a Latrine

Mothers/care givers of children 0–59 months of age defecate in a latrine at all times.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Priority group Mother/care givers of children 0-59 months. Influencing Groups Hygiene promoters (HP), community leader/members, neighbours, relatives/parents, myself. 1- Demographic Features **Age**: 18-45 years **Income**: 40-100 SSP/day. Families not owning the land they are currently living on. **Residence**: Bentiu PoC+town, Rubkona. **Education level:** Primary School. The populations in Bentiu town and Rubkona are less well educated than those in the POC and believe more strongly in divinity of different sorts which influences their uptake of new behaviours. Most of the educated people in the area came into the POC to get jobs when the crisis started. 2- Things that mothers do; spend their days doing.	Self-efficacy - **Non-Doers are no sure about being able to do it.** - **Doers = *it's difficult when there is no latrine around the house (access)*.**	- Increase access to latrines around the house. - Increase the confidence of mothers to use latrines made for them.	Tentative messages Mother! Feel good about using the latrines built for you. It is strong and safe (says the men). Activity **Build latrine** (competition): once the men have built the latrines, have the women "test" them, their solidity, etc., while the hole is still plugged before being operational. Or having them test the solidity of the platform before the walls are installed. They could be the judge if building latrines is done as part of a competition. (*see below Access)*
	Susceptibility/risk **Doers feel cholera and HEV are risks.**	Increase the perception that everyone is at risk of getting cholera.	Tentative messages Mother! Beware of HEV/cholera, your children are at risk. Mother! cholera/HEV is a risk for your kids. Latrines are there, use them.

Mothers/care givers of children 0–59 months of age defecate in a latrine at all times.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
In the morning, mothers go to the forest to collect firewood, leaving their children with the elder children. (This is common of mothers in Bentiu and Rubkona towns because selling of collected firewood is usually the only way women in the towns can get an income. It is not like the POC where many women are employed. Gaining an income from selling of firewood is a must as the oil and lentils supplied in the food ration by WFP are not enough to last for a whole month). They usual return from mid-day onwards, when they prepare food for the children. Therefore, they don't really have time to clean the babies and children – the elder children are responsible for caring for the children and babies, including washing them etc. Not many mothers have tea shops so they go straight to work at their tea shops in the morning, leaving the babies and young children under the responsibility of the elder daughter. Sometimes the mum might leave instructions with the older daughter, for her to wash the children and prepare the lunch. Sometimes mothers leave children under the responsibility of the grandmother. When there is a grandmother or grandfather, the mother will also be responsible for finding food for these grandparents, who	<u>Action efficacy</u> - **Doers = confident it prevents from cholera.** - **Non-Doers = little confident it prevents from HEV.**	Increase the perception that defecating in a latrine is an effective way of prevention cholera.	Mother! By using the latrine, you reduce the risk of spreading fatal diseases like cholera/HEV. Use it. Mother! Keep your helps us fight cholera/HEV, use the latrine. Mother! HEV/cholera is serious. Use the latrines. <u>Activity</u> **School play**: "The invisible army"; catchy title of the new school play where kids replicate the contamination cycles of cholera and HEV. At the end, kids recite about the nature of the diseases as well as how much they want their mother to prevent themselves and family member from catching it. (Link with all WASH behaviours, as well as N3 and N4 as these diseases are high risk of causing under nutrition). Mandatory audiences are mothers – have them sit in from of the men/men are not allowed to sit in the front.
	<u>Severity</u> **Doers = cholera and HEV are serious.**	Increase the perception that cholera is a very serious disease – many people die from cholera, especially children.	

Mothers/care givers of children 0–59 months of age defecate in a latrine at all times.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
are viewed as a priority since they are elderly. In a case where the mum has a husband living with her who has work, the mum will take care of the children at home. In this case, the mum will take charge of all household activities including food preparation etc. In Rubkona and Bentiu towns some mothers are irresponsible. They like to go to the market in the morning to take shisha and coffee with their friends, or they move around their friends' houses taking coffee in the morning, for socializing, leaving the children at home. 3- <u>Things that mothers want (common desires or interest)</u> Schools for education of their children are the first priority of mothers. The 2nd priority of mothers may be to become employed. Mothers want employment so that they can buy things for their children. The things that they want to buy their children include food (In the food ration given by WFP, mothers feel that the oil and cowpeas is not sufficient for their children to be healthy. Sometimes, the monthly food ration is finished after just 7 days, since relatives come from the rural areas to share the food rations they receive since not everyone has been registered. Therefore, they seek work so that they can buy the necessary items in the market). Mothers want soap for their children. Lactating mothers desire milk. This could support them while they have to go to the forest to collect firewood, as they could	<u>Cues for actions/reminders</u> **Non-Doers = it's not always easy to remember.**	Increase the ability to remember to defecate in a latrine.	<u>Tentative message</u> Mother! When you need to go, look for the latrine with the female logo. <u>Activity</u> **Art paint decoration/stickers (IEC)**: identify female's latrine with female logos, and visuals: before making the latrine operational have kids decorate them with themes they can express through art and their own imagination. (Can backfire if latrines attract too much attention. That's one thing mothers don't want.)
	<u>Divine will</u> **God approves.**	Increase the perception that God approves of defecating in a latrine.	<u>Tentative messages</u> Mother! It's ok to use the latrines; God/religious community approves and likes it. Mother! A community with latrines is a blessed community. <u>Activity</u> **Praying sessions**: team up with God for hygiene SSP – Super Sunday Preaching – with preachers and HPs. Using this concept could be catchy linking SSP (preaching) and SSP (the money).

Mothers/care givers of children 0–59 months of age defecate in a latrine at all times.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
leave the milk with the caregiver at home. Mothers desire health services nearby so that clinics are easily accessible. Currently there are only 2 doctors in Rubkona and many people come from the rural areas to get medicine and treatment for their children so it is difficult to see a doctor because of the high demand. 4- <u>Things that prevent mother from practicing the behaviour (common barriers)</u> The majority of mothers in Bentiu and Rubkona towns are not used to latrines, as they are from the rural areas and only moved to the urban areas recently. Many mothers therefore do not have experience using latrines and fear them slightly. For example, some mothers advise their children not to use latrines, telling them that they could fall into the hole. Even they sometimes feel that they would not be able to stabilize themselves over the hole without falling into the hole. (However, during the upcoming rainy season, it will not be possible to walk to some of the areas common for open defecation in Bentiu and Rubkona towns, because of flooding. At this time, mothers without experience of using latrines may be more likely to use latrines, if latrines are constructed by that time.) Some mothers fear using a latrine because they feel that they would come out of the latrine smelling, and that this smell would be indicative that they have been infected with diseases. If male and female latrines are very close, mothers would not want to use the latrine. They would feel shy (embarrassed) because they would not like a man to see them leave the latrine.	<u>Positive consequences</u> **Doers = *keeps children and community clean*.**	Increase the perception that defecating in a latrine keeps children and the community looking clean.	<u>Tentative messages</u> Mother! Look, the kids can play where it's not dirty. Use the latrine. Mother! A community with latrines is a clean community. Mother! Be reassure, other women also like to use the latrines. Mother! Be confident, your community leaders think it's a good thing for everyone to use the latrines, even more for women. <u>Activity</u> **Mother's group sessions**: if most people approve it perhaps means that cultural taboos can be demystified. Have D and ND from various background and generations meet and talk about the reality of today. The same D here can work on teaching ND from different backgrounds and generations talk about the positive quote (from positive consequences); perhaps elaborating on the reasons why it is much more important in crisis contexts than when there is no crisis. Uses these sessions to demystify again against the perception that it bring flies (perhaps the symbol of the Demon). It doesn't when it is in good shape and maintained.
	<u>Social norms</u> **Doers = most people approve.**	Increase the perception that everyone approves of defecating in a latrine.	
	<u>Culture</u>[16] **Doers = cultural taboos exist.**	Decrease the perception that there are cultural rules against women using latrines.	

[16] Need to explore what are and work around and with them.

Mothers/care givers of children 0–59 months of age defecate in a latrine at all times.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
For older caregivers (grandmothers for example), they will say that in the past, people did not use latrines and they didn't die because of this, so why should they start to use a latrine now? Culturally, there is a saying that when many people defecate in one hole, someone might die (If you use the latrine, you could be the one to die). In Rubkona and Bentiu there are hardly any functional latrines at all. 5- <u>What mothers know, feel, and practice regarding the behaviour</u> Many of the mothers would like their family to construct a latrine when they leave the POC, but they would probably tell you that this is	<u>Access</u> **Non-Doers = finding latrine is a bit difficult.**	Increase the perception that latrines are accessible.	<u>Tentative messages</u> Mother! Latrines are there, use them. Men! Build latrines for your wives and save community children's lives. Leaders! Make you community cleaner and healthier, build latrines. <u>Activity</u> **Build latrines**: find ways to use all the "man power" already available within the POC to build latrine in Bentiu town.

Mothers/care givers of children 0–59 months of age defecate in a latrine at all times.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
unlikely to mention for quite some time due to lack of resources. Part of this is related to the fact that they will think that a latrine has to be constructed to the same standard as the latrines constructed within the POC). Regarding latrine construction outside the POC, some mothers are interested in constructing a latrine if supported with the necessary materials. It seems that these mothers are mothers who are living on land that belongs to them. Many people in Bentiu and Rubkona towns had latrines prior to the crisis so constructing a latrine would be on their list of things to do, but other activities such as home construction likely to mention will take priority. The majority of mothers in Bentiu and Rubkona towns have and are continuing to receive messages about latrine use (from HP and other sources) as a result of them now living in the urban setting. Mothers regularly ask the HP when Concern or other agencies are going to construct latrines. Therefore, there is a demand amongst mothers for latrines. This demand is coming ahead of the rainy season, when mothers realise that some current open defecation areas will become inaccessible due to flooding 6- Stages of Change (*pre-awareness, awareness, preparation, action, maintenance)* "Awareness" stage of change - most mothers are willing to start using latrines in the urban setting.	Negative consequences **Doers = *Brings flies*.**	Increase the perception that good usage (and maintenance) of latrines keeps flies away.	Tentative messages Mother! Tell us when the latrine is dirty, we will clean it. Mother! More latrines, less flies. Use them. Activity **Mother's group sessions**: if most people approve it perhaps means that cultural taboos can be demystified. Have D and ND from various background and generations meet and talk about the reality of today. The same D here can work on teaching ND from different backgrounds and generations talk about the positive quote (from positive consequences); perhaps elaborating on the reasons why it is much more important in crisis contexts than when there is no crisis. Uses these sessions to demystify again against the perception that it bring flies (perhaps the symbol of the Demon). It doesn't when it is in good shape and maintained.
Universal motivators: children&family, $/shop/business, school&education, farming&cropping, peace/good environment, life, religion/church/God, more food, good health facility, water, good husband.			

Mothers/care givers of children 0–59 months of age defecate in a latrine at all times.			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Outcome indicators # of people who report using a latrine the last time they defecated # of people with access to improved sanitation facilities # of FGDs carried out on latrine design and location prior to latrine construction. # of new latrines constructed # of semi-permanent gender-segregated communal latrines cleaned at least 4 times daily. # of communities participating in sanitation triggering activities. # of shared-family latrines constructed by community members following sanitation triggering activities and construction of demonstration latrines. # of all available usable latrines # of people per usable latrine # of communal latrine stances that have been constructed # communal latrine stances that are in service # of nutrition centre latrine stances that have been constructed # of gender segregated toilets constructed at the nutrition centres % of latrines found clean during weekly spot checks.			

DBC W3- Washing Drinking Water Storage Containers

Mothers/care givers of children U5 years wash the water storage container with soap before fetching water in the morning			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
Priority group Mother/care givers of children U5 years. Influencing Groups Hygiene promoters (HP) have more influence. Water point attendant, neighbours, and children. 1- Demographic Features **Age**: 18-45 years **Income**: 40-100 SSP/day. Families not owning the land they are currently living on. **Residence**: Bentiu PoC+town, Rubkona. **Education level:** Primary School. The populations in Bentiu town and Rubkona are less well educated than those in the POC and believe more strongly in divinity of different sorts which influences their	Access **Doers = easy to find soap and water.**	Increase the perception that everyone has access to soap and water to wash drinking water containers.	Tentative message Mother! Look near; soap and water are already there and everywhere. Activities - **Transcripts** (IEC) using Ants and Bees: stickers, packages and soap prints. - **IRA**: organise for mothers or fathers or elders to organise into COOP like association where they produce soap. - **Cue cards** near the water containers with visuals of the 5 times (link with W3). - **Hygiene billboards** with indicating hot spots for where to buy soaps within the community.

Mothers/care givers of children U5 years wash the water storage container with soap before fetching water in the morning			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
uptake of new behaviours. Most of the educated people in the area came into the POC to get jobs when the crisis started. 2- <u>Things that mothers do; spend their days doing.</u> In the morning, mothers go to the forest to collect firewood, leaving their children with the elder children. (This is common of mothers in Bentiu and Rubkona towns because selling of collected firewood is usually the only way women in the towns can get an income. It is not like the POC where many women are employed. Gaining an income from selling of firewood is a must as the oil and lentils supplied in the food ration by WFP are not enough to last for a whole month). They usual return from mid-day onwards, when they prepare food for the children. Therefore, they don't really have time to clean the babies and children – the elder children are responsible for caring for the children and babies, including washing them etc. Not many mothers have tea shops so they go straight to work at their tea shops in the morning, leaving the babies and young children under	<u>Self-efficacy</u> - **Non-Doers = *it would be difficult because soap is/can be costly (access)*.** - **Doers feel they can do it.**	- Increase the perception that it's worth spending for soap. - Increase the perception that every mother has the ability do it.	<u>Tentative messages</u> Mother! A clean water container is worth the health of your family. Mother! Keeping your water container clean is easy. You can do it. Mother! Good budgeting of money helps for good life and good health. <u>Activity</u> **Counselling session** on budgeting by HP for wives and husbands together and the same time: can be done when handing out cue cards/memory aids on when and how money was spent on what is considered priority spending within the household. This could help budget holders to let go of some "unnecessary" expense that have less impact on the health of the family.

Mothers/care givers of children U5 years wash the water storage container with soap before fetching water in the morning			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
the responsibility of the elder daughter. Sometimes the mum might leave instructions with the older daughter, for her to wash the children and prepare the lunch. Sometimes mothers leave children under the responsibility of the grandmother. When there is a grandmother or grandfather, the mother will also be responsible for finding food for these grandparents, who are viewed as a priority since they are elderly. In a case where the mum has a husband living with her who has work, the mum will take care of the children at home. In this case, the mum will take charge of all household activities including food preparation etc. In Rubkona and Bentiu towns some mothers are irresponsible. They like to go to the market in the morning to take shisha and coffee with their friends, or they move around their friends' houses taking coffee in the morning, for socializing, leaving the children at home. 3- <u>Things that mothers want (common desires or interest)</u> Schools for education of their children are the first priority of mothers. The 2nd priority of mothers may be to become employed. Mothers	<u>Susceptibility/risk</u> **Doers feel HEV and cholera are not risks.**	Increase the perception that cholera and HEV are a risk.	<u>Tentative messages</u> Mother! Keep your family safe from HEV/cholera. Clean the water containers every time before fetching water. Mother! When you wash your water container with soap it kills HEV/cholera. <u>Activity</u> **School play**: "The invisible army"; catchy title of the new school play where kids replicate the contamination cycles of cholera and HEV. At the end, kids recite about the nature of the diseases as well as how much they want their mother to prevent themselves and family member from catching it. (Link with all WASH behaviours, as well as N3 and N4 as these diseases are high risk of causing under nutrition). Mandatory audiences are mothers – have them sit in from of the men/men are not allowed to sit in the front.

Mothers/care givers of children U5 years wash the water storage container with soap before fetching water in the morning			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
want employment so that they can buy things for their children. The things that they want to buy their children include food (In the food ration given by WFP, mothers feel that the oil and cowpeas is not sufficient for their children to be healthy. Sometimes, the monthly food ration is finished after just 7 days, since relatives come from the rural areas to share the food rations they receive since not everyone has been registered. Therefore, they seek work so that they can buy the necessary items in the market). Mothers want soap for their children. Lactating mothers desire milk. This could support them while they have to go to the forest to collect firewood, as they could leave the milk with the caregiver at home. Mothers desire health services nearby so that clinics are easily accessible. Currently there are only 2 doctors in Rubkona and many people come from the rural areas to get medicine and treatment for their children so it is difficult	Social norms - **Doers = most people approve.** - **Doers = hygiene promoters.**	Increase the perceptions that most the community approves; especially hygiene promoters.	Tentative messages Mother! You are not alone. Your community/neighbours also approves of you keeping your containers clean. Mothers! Your children and I feel better when you wash the container before fetching water. (From water attendant and kids) Activity **Sticker (IEC)**: find the best HP face (or any of those among the influential groups who are most accepted for each context; could be a team of them including water point attendant) and create some sort of "HP-2001" validation sticker.

Mothers/care givers of children U5 years wash the water storage container with soap before fetching water in the morning			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
to see a doctor because of the high demand. 4- <u>Things that prevent mother from practicing the behaviour (common barriers)</u> The problem is this scarcity of water. This is due to both the shortage of jerry cans (usually each household has only 1 jerrycan) and the distance to the water source, which is often far away, particularly in Rubkona where there are very few functional boreholes (water can be bought from donkey carts but it costs 5SSP per jerrycan which is not affordable for most people). Since the household usually only has 1 water container, at night the water becomes finished. Therefore, first thing in the morning, the mum usually has to rush to fetch water and when she returns home, because of competing demands on time, she must hurry to cook breakfast and give drinking water to the children. Ignorance – some mothers do not know the importance of washing water containers with soap before collecting water. However, the	<u>Cues for actions/reminders</u> **Doers = easy to remember.**	Reinforce the perception that it is easy to remember.	<u>Tentative message</u> Mother! Remember to wash you container before fetching water. <u>Activities</u> - **Cue card/memory aid** next to the containers so mothers can keep track of when it's washed; same goes for hand washing (link with W1). - **PSA** with Internews. - **Transcripts** (IEC) using <u>A</u>nts and <u>B</u>ees: stickers, packages and soap prints. - **IRA**: organise for mothers or fathers or elders to organise into COOP like association where they produce soap. - **Hygiene billboards** with indicating hot spots for where to buy soaps within the community.

Mothers/care givers of children U5 years wash the water storage container with soap before fetching water in the morning			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
majority of mothers to know the importance of cleaning jerry cans. Some mothers even use gravel instead when they do not have soap, because they understand the importance. Laziness – some mothers know the importance of washing water containers with soap before collecting water but they just don't bother. Lack of soap – soap obtained from the soap distribution at GFD (8 bars per 20 people) is not sufficient to meet all domestic needs. It is usually prioritized for washing clothes and is often finished within 2 days of receipt. 5- <u>What mothers know, feel, and practice regarding the behaviour</u> Most mothers are willing to wash their water containers with soap every morning but only after certain conditions are met. These conditions include their need for more water containers per household,	<u>Action efficacy</u> **Doers are not confident that it prevents from cholera and HEV.**	Increase the perception that washing drinking water containers is a good way to prevent the water from getting contaminated with germs/bacteria that cause cholera and HEV.	<u>Tentative messages</u> Mother! Cleaning the water container will reduce the risk of you and family becoming ill with HEV/Cholera. Mother! Every time you clean the water container, you make us feel better. Mother! A clean bucket means no maggot. Mother! When you clean the bucket, it also kills the germs and bacteria that transmit diseases. Mother! Fetching water with a clean container prevents from contamination. <u>Activities</u> - **School play**: "The invisible army"; catchy title

Mothers/care givers of children U5 years wash the water storage container with soap before fetching water in the morning			
Priority Group & Influence Groups	**Determinants**	**Bridges to Activities**	**BCC Activities and Messages**
and a closer water supply. The mothers feel that with the current conditions, they cannot do this behaviour. 6- Stages of Change (*pre-awareness, awareness, preparation, action, maintenance)* "Pre-awareness" stage of change as, right now, they are not seriously thinking of adopting this behaviour.	Positive consequences **Doers = *water does not get contaminated; it protects from germs/bacteria.***	Increase the perception that washing drinking water containers is a good way to prevent the water from getting contaminated with germs/bacteria that cause cholera and HEV.	of the new school play where kids replicate the contamination cycles of cholera and HEV. At the end, kids recite about the nature of the diseases as well as how much they want their mother to prevent themselves and family member from catching it. (Link with all WASH behaviours, as well as N3 and N4 as these diseases are high risk of causing under nutrition). Mandatory audiences are mothers – have them sit in from of the men/men are not allowed to sit in the front. - **Demonstration sessions**, perhaps during SSP sessions where soap and ash are compare in giving the same results: killing germs – the same germs that gives HEV and cholera (keeping the family healthy!)
Universal motivators: children&family, good job/business, school&education, farming&cropping, peace/good environment, leadership, religion/church/God, history, good health facility, my country, good husband.			
Outcome indicators - # of people enabled to practice safe water storage and handling at the household level - # of jerry cans cleaned per month. - # of households who store their drinking water safely in clean containers			

UNIVERSAL MOTIVATORS

Universal Motivators are those factors that can be used to encourage people to change behaviours irrespective of culture, ethnicity, nationality and religion or the behaviour[17]. As part of the barrier analysis, we ask respondents what they might want the most in life in order to further capacitate the strategy to use these motivators in favour of promoting the desired behaviours. In the context of Bentiu, capital of Unity Sate of South Sudan, most women we talked to were most interested, or desire most in life: good governance, children & family/relatives, money/owning shop/having a business, school & education for themselves and their children, being able to go back to farming & cropping, peace/good environment to live in, being alive, religion/church, owing a house (property), good health, and counting on a good husband.

MONITORING AND EVALUATION

What we suggested is that in time HP and CNV will be able to develop tools and quick ways check list in order to effectively monitor and compile information in regard to process indicators such as # of mothers, materials, airing and sessions conducted. In the stages of getting more familiar with how BCC campaign will be designed and take shape, we suggest that organisations lean towards:

- Using the LQAS to monitor the progress of practices (every 6-9 months).[18]
- KPC (or KAP) surveys will also allow getting more information on the attitudes of mothers towards the behaviours, their degree of practice and the coverage (every 18-24 months).[19]

For the first stages of getting feedback on the progression (or not) of this SBCC strategy we suggest conducting focus groups discussion that will allow us to get a better feeling of how community workers and mothers interact together. They can be done randomly, very quickly and without cost to measure variables linked to the channels of communication (independent) and the influence they have on mothers' perceptions (dependent). These 10 variables needs to be formulated into the shape of a question such as: "do you know who designed the PSA on XYZ?"; "did the PSA made sense to you? Why?"; "do you like to follow these PSA knowing they are designed by ZYZ? Why?"; "did the messages in the PSA made sense to you? WHY?"; "are there other PSA or activities (or organisations) in your community talking about the same topics?"; "are these topics talk about in the same way? Do they say the same thing?", etc.

Table 8: M&E BCC variables to measure during focus groups

Independent Variables	Dependent Variables
A: Communication source - Identification of the source.	A: Beliefs Modifications, trends of change and

[17] Bonnie Kittle, April 2014.
[18] CORE Group, September 2008. Protocol for Parallel Sampling: Using Lot Quality Assurance Sampling to Collect Rapid CATCH Information. (summary report available at http://www.coregroup.org/working_groups/monitoring.cfm)
[19] http://www.coregroup.org/resources/core-tools/242-knowledge-practice-coverage-kpc-survey-training-curriculum-

Independent Variables	Dependent Variables
- Is it cohesive, makes sense (cohesion). - Attractive (interest). - Credibility.	perceptions in regard to the problems.
B: Individual (interpretation) - Capacity of listeners (information receivers) to adjust and adapt to the source.	B: Values Identification of values link to the problems.
C: Message - Logic (does it makes sense) - Comprehension - Attractive/captivating (interest) - Acceptable (Doxa)	C: Attitudes Modifications, trends of change and perceptions in regard to the problems.
D: Communication Channel - Double sense in meaning - Interference - Retroaction - Adapted to context	D: Abilities Increment in showing abilities to do the behaviour. Increment in showing abilities to prevent against the problem.
E: Context *VS* adaption - Saturation of information	E: Behaviour modification Capacity to advise others.

OVERALL RECOMMENDATIONS

I. WASH & Nutrition: setup Care Groups[20] to address the specific bridges to activities for all 7 behaviours studied[21]. [22]

II. WASH & Nutrition: praying sessions can start immediately. Like in the case for Culture we need to understand the specific topics that are preventing audiences from perceiving that God approves of practicing the behaviours (EBF, IBF, hand washing, latrine usage). We need to coordinate and commonly organised praying sessions with religious authorities that includes discussions around the sections in the respective Holy books that promote these behaviours.

III. WASH: Using other means than written communication here would be a huge improvement on the traditional ways to communicate negatives messages about life threatening diseases. We need to take into account the capacity of our audience to process and retain the information that we want them to acquire. Since the confidence level is already low towards practicing the 3 behaviours, let's use channels and ways to communicate that will increase their capacity to learn and acquire knowledge in ways where they can feel good about themselves. One could argue that helping mothers and fathers to become better at managing their revenues could increase their perception about having enough income to purchase more soap than they initially thought of; parallel to that, we could have men use their time better in participating in cooperative like organisation where their effort contribute to producing soap locally. This could have the triple impact of engaging them to be more active, creating a new revenue source, and assuring the health of their family and community.

[20] Medair/S. Sudan is also doing Care Groups so it's possible that they already have materials that these partners could use and save time and $$.
[21] See annex 6 for the bridges to activities to address with the Care Groups.
[22] *Care Groups in Emergencies: Evidence on the Use of Care Groups and Peer Support Groups in Emergency Settings*, April 2015.

IV. WASH: coordinate and develop with schools within the POC and outside a play for mothers (with high school level children) to attend only (because men will also come and be there, have mothers sit in front. For every "public event" activities organize this way). There are a lot of efforts and activities in hygiene already on going and that are original (IOM-hand washing champions league with school kids), but don't necessarily target mothers. A 30-40 minutes school play taking about the danger of HEV, Cholera, and how it is link with everything else that happens health wise in Bentiu is a great, innovative, original, low cost way to address perceived Susceptibility/Risk, Severity and Action Efficacy. An overlap and links need to be made with the same barriers but for nutrition and how good hygiene (or the lack of it) contributes to eradicating malnutrition.

V. Media: a complete exercise of designing and testing messages using the concepts identified with the barrier analysis before disseminating them is the first step into promoting tailored made BCC messages.

VI. Media: the content, themes and concepts used to designed the PSA need to be in sync with the rest of the media activities such as films, short documentary and all visual media and *vice versa*. All activities designed to address perception based barriers (opposite to skills and knowledge) need to focus on these same thematic and concepts. Hence, we need to spend the time and effort designing and testing concepts amongst the audiences.

BCC Activities Recommendations

N1-Exclusive Breastfeeding

1) Improving/creating MBAs and MBCs where health professionals can conduct one on one counselling is one of two eminent needs. The other is to scale up the capacities of IYCF professional to teach and help mothers becoming more confident on how to technically practice EBF. This logistic transformation includes improving and stamping IEC materials usually utilised to teach and educate mothers on the recommended practice.
2) These two activities will allow organisations to facilitate one on one visit with mothers and IYCF professionals; and organise mothers group sessions (similar to the care group approach) where mothers can share common learning and teach each other's techniques, and discuss the benefits, risks, and negative impact of EBF (or not). This will help increase the confidence and ability of mothers to EBF (Self-Efficacy), as well as promoting the fact that EBF is something that everyone approves of (Social Norms).
3) Because a lot of mothers are susceptible to feel it would be difficult to EBF because they don't have enough milk (Self-Efficacy), the media campaign will use influencing groups such as mothers, grandmothers, adult family members and relatives, telling

mothers who are EBF that it is acceptable for them to consume more food while they are EBF. Include as part as activities with the media. Working with Internews to develop PSA in the form of short sketches where members of the influential groups discuss Access, Social Norms, Culture, Positive (*it makes the child strong and healthy*) and Negative (*it gives diarrhoea*) Consequences. The latter quotes are needed to build concept for films and PSA outreach.

N2-Immediate Breastfeeding (within one hour after the delivery)

1) Media attention can be done very simply and successfully by documenting live IBF and the preparations and coordination it needs: short tutorial film of a baby delivery on how efficient IBF is to help the mom recuperate after birth, while discussing the benefits, and incorporate a sequence on how to put the baby for the first time, etc. IBF and EBF are intrinsically inked, so having these short films presented and discussed during IYCF mother groups would have an immediate impact on both behaviours. Being able to link both and sequence them during a 6 months period will help mothers see the big picture.
2) Increase the capacity of those who have a supportive responsibility towards delivering mothers to help them putting the baby to the breast before and after giving birth. "Before" can be done during antenatal visits and within the enhanced MBA/MBC, or at home where most mothers prefer giving birth.[23] Having better equipped supporting staff (both technically and knowledge wise) will also increase the confidence of delivering mothers to "do the right thing" because they *feel that it would be easier if they are able to enjoy the feeling of giving birth.* Increasing the capacities of midwives or health professional is an urgent task, but also one that needs time and coordination.
3) Culture is very strong barrier. We need to explore what are the under laying factors that leads Non-Doer to throw away colostrum and provide cow or goat milk instead. This can be done easily in the shape of focus group discussions in and out of the POC, with mothers and men only groups. The content of this discussion needs to inspire and feed the media and PSA activities. Again here influential groups members stands (midwives, mothers, grand-mothers) will need to be included (original voices would be best so community members can identify to the person speaking).
4) Suggesting the creation or scaling up mother and child health university department is not far stretch. What can be done in the mean and most immediate time is to progressively scale-up the capacities of these health workers by conducting mass training and recycling of skills and technics.

N3-Providing rations to RUSF/RUTF program enrolled children only

1) Immediate attention on the way mothers are receiving the rations. Suggesting to review the distribution protocol and procedures in order dissociate the notion of "food distribution" with "ration distribution".
2) Encourage mothers to have their child complete the program within three months (and discourage relapses) by establishing a system of points, following rules, where an external support (health workers) monitor and validate the passage and graduation of the child base on merits. Implementing and encouraging the concept of ritual around

[23] It was mentioned during the nutrition sub-cluster presentation in Bentiu that mothers prefer giving birth at home, apparently due to the lack of trust and confidence, or lack of available services at health centers/hospitals.

the consumption the ration to only enrolled children has the potential to create a boundary between those enrolled and not.

3) Using negative connotation like messages such as "eating and selling rations is not caring for your child" need to be included in songs sung by kids to their parents. This is one creative activity that needs to accompany a short story telling of families where children complete the program and succeeds at recovering from under nutrition *versus* a family where children unfortunately become more malnourished because mothers are not able to provide the rations only to them.

N4-Seeking attention from a nutritionist with 24hrs of noticing under nutrition symptoms

1) It is strategic here to promote this behaviour in a way where mothers can improve their ability to find the time and remember to conduct monthly checks of their children (Reminders), using cue cards or calendars with visual representations of benefits and community members. Deconstructing the complexity of the science behind how under nutrition can be detected is something that need focus to help mothers feel more empowered (ownership) *vis-à-vis* their role in the fight against under nutrition.
2) Using revamps MBA/MBC, or during at home visits, provide and teach mothers to use cue cards with symbols and simple visual telling her when and how to inspect and monitor their under 5 children health status. Very low cost and easy to do considering the number of staff already working in the POC.
3) Film tutorials can be produced in the POC, or outside to use some community figures in order to influence mothers of the positive impact of being able to prevent malnutrition *versus* having to rely on an external support. The whole idea here is to empower mothers to feel responsible and involved in fighting malnutrition.
4) Low cost production of calendar, billboards promoting the perception that most people approve (Social Norms), that it is easy to access the health centre (Access), and that it *makes the child strong again* (Positive Consequences) when mothers seek nutritional support.

W1-Hand washing at the five critical times

1) Use the quote from Doers: *…it keeps the family healthy* (Positive Consequence), as the main theme/title of the WASH campaign: the "keep the family healthy" BCC campaign. The other WASH behaviours fit into this theme where "using latrines" and "washing the water container" are also what is need to *keep the family healthy*. Develop and produce a theme song – sang by the youth (primary and high school kids[24]) – around this concept/notion to stamp and link with all activities suggested in this WASH section.

[24] A lot of activities in WASH are targeting school kids.

2) Helping mothers to remind (Cues for Actions) themselves of the 5 critical times is priority. Cue cards and other IEC materials with HPs and CNV, accompanied by community and block leaders, reminding mothers of the 5 times. The cue cards needs to be kept in the house next to water storage. The same cue cards need to include message from W3-washing the water container before fetching water.
3) Testing out the concept of Bees and Ants to see if it fits with the audiences of mothers. If so, use it as a main theme for the campaign, i-e mascots, cartoons sketches, etc. as the main visual/brand for the whole wash campaign.
4) Invest in designing areas in the POC and in Bentiu town to address the barrier of Access and have members of the influential groups remind mothers where soap can be accessed; as well as using these members to convince whoever is in charge of the finance within the HH that it is acceptable to invest in buying soap so that family members and kids stay healthy.
5) Praying sessions needs to start being coordinated an included in the same way as suggested in the nutrition section. The fun aspect of this is that it does not need to be so technical and needs to be presented in an attractive/interactive ways. Look at the possibility of organisation "Super Sunday Preaching" (SSP) with interactive games, or sessions, where mothers and members of the influential groups (Social Norms) do the preaching themselves.

W2-Defecate in a latrine

1) Outside the POC: organise a "build a latrine for my wife" type competition where men, applying engineering standards, design and build latrines for their wife(s) within the HH(s) to increase their confidence and ability to use them (Self-Efficacy and Access). Mothers and wives are the ones who judge the competition. At the end of the competition, the objective is to have latrines mothers feel comfortable using since they know it is for their use and that it is not shared with men. Perhaps adding some visibility or symbols confirming that they are only for women to use (Culture).
2) Facilitated by female HPs, organise mothers group session (perhaps after the SSP, or during Care Group sessions), and discuss the taboos linked to using latrines where Doers and Non-Doers debate what is acceptable, and how in the end latrines need to be used despite cultural rules (Negative Consequences, Culture). A consensus on using latrines needs to be reached in the end. Part of the messaging we will need to reinforce is that the reality of today is different because social contexts and environments have change (for the reason we all know), and that surely tradition ways (defeating in open areas) have become obsolete in the sense where they are not safe anymore

W3- Washing drinking water storage containers

1) As part of the HPs' HH visits and counselling responsibilities, conduct sessions with husband and wives on how to plan and make budget decision on WASH management within the HH, i-e, proportion of budget being invested in health and hygiene. Help the couple make better financials decision that includes investing for health practices: buying soap.

2) Introduce a "rewarding system" where mothers who are Doers receive a validation like "HP-2001" sticker given by the HPs (Social Norms).
3) Design IEC materials as done previously for W1 and W2 with specific W3 messages (Cues for Actions). Building program messages around the concept that family members approve of being healthy, hence it is possible and permitted to focus perhaps more money toward buying soap in order to keep everyone in the family healthy.

NUTRITION & WASH ACTION PLANS

Both the nutrition and WASH action plan tables give us an overview of the activities that are recommended in the DBCs as when in time they would be best implemented to have maximum impact. They are spread-out on 12 months until May 2017 but can easily be foreseen to go until 2-3 years from now. For the most part, our recommendations focus on activities that are to be implemented within the next 6 months in order to set the tone with activities that are low cost, engaging from an audience perspective, and relatively easy to monitor and follow up. Our recommendations take into account and are a summary of what is already suggested in each DBC in the previous sections.
Some of the activities to start later in the calendar is to have a reinforcing meaning and a more validating role. The overall idea here is to start to implement activities that increase confidence, capacities, knowledge and skills since most of our audience is at the stage of awareness, leaning towards preparation to change.

Technical Rapid Response Team

Table 9: BCC nutrition action plan

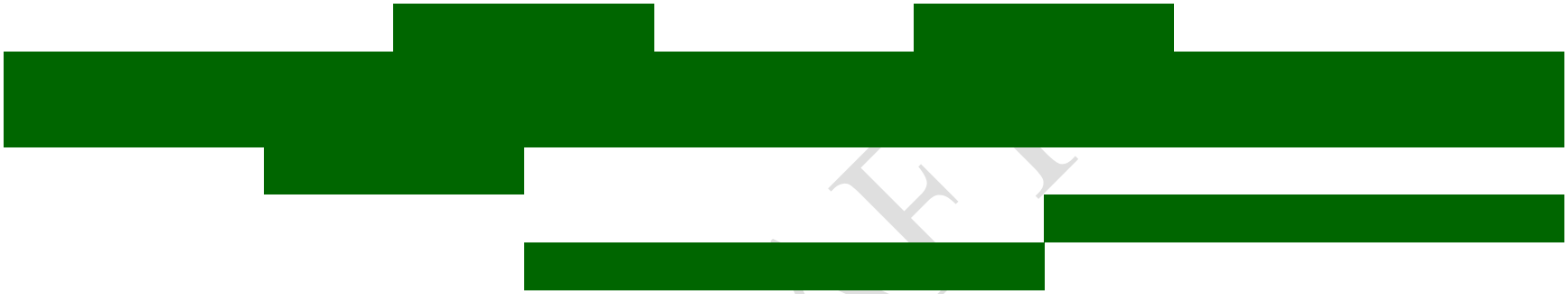
	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
N1-EBF												
Training and teaching												
Media and IEC material												
One on one demonstrations												
Praying sessions												
Mothers support groups												
PSA												
Role play, artistic expression												
N2-IBF												
Antenatal visit sessions												
Skill based trainings												
At home visits												
Short documentary films (SS)												
Antenatal practice												
Academic and professional trainings												
Video tutorials												
PSA												
Develop MoU with MOH												
Praying sessions												


N3-Feeding rations to enrolled children
Story film of D and ND families
Song(s)
Programme graduate merits
Advocate/lobby to companies
Hospital and health centre visits
Morning ritual
N4-Seeking nutrition support within 24hrs of noticing under nutrition symptom
PSA/billboards
Calendars
Film tutorials
Teaching sessions
Cue cards/memory aids
Hospital and health centre visits
Story film of D and ND families

Technical Rapid Response Team

Table 10: WASH action plan

Activities	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17
W1-Hand washing 5 critical times												
Song												
Demonstration sessions												
Praying sessions												
School play												
Transcripts (IEC) Bs&As												
IRA												
Cue card/memory aid												
Hygiene billboards (IEC)												
W2-Defecate in a Latrine												
Build latrines												
Mother's group sessions												
Praying sessions												
Art paint/stickers (IEC)												
School play												
W3-Washing water storage containers												
PSA												
Cue card/memory aid												


School play
Counselling session
Sticker (IEC)
Transcripts (IEC) Bs&As
IRA
Hygiene billboards (IEC)

ANNEXES

ANNEX 1 – BARRIER ANALYSIS ENUMERATORS LIST

Table 11: List of enumerators

NAME[25]	GENDER	TITLE	ORGANIZATION
1. Simon Gatdiet Gai	Male	Nutrition assistant	Care Sect1: b7
2. Anthony Ruot Yiey	Male	Nutrition assistant	Care Sect5: b7
3. Anna Nyadhiel Joseph	Female	IYCF Assistant	Concern Worldwide Sect3: b7
4. Monica Nyaliah Mayaual	Female	Hygiene promoter	Concern Worldwide Sect5: b6
5. Bateah Kuol Wiech	Male	Assistant nutrition project officer	Concern Worldwide Sect4: b11
6. John Puok Chuol	Male	nutrition project Assistant	Concern Worldwide Sect4: b11
7. Nyaruai John James	Female	Hygiene promoter	Concern Worldwide Sect5: b2
8. Nyaluak William Tim (Viola)	Female	Nutrition and health volunteer	Hope Restoration South Sudan Sect5: b7
9. David Chuong Giel	Male	Health hygiene promoter	IOM Sect 2: b5-7-8-17
10. Pouk John Ruei	Male	Health hygiene promoter supervisor	IOM Sect 3: b3-4-7-8-12
11. Teresa Nyakhan Diew	Female	Health hygiene promoter supervisor	IOM Sect 3: b9-10-11-13-14
12. Machar Mai Koyom	Male	Hygiene promoter	Mercy Corps Sect1: b3
13. Michael Guong Puot	Male	Hygiene promoter	Mercy Corps Sect4: b7
14. Angelina Nyaluak Bhap	Female	Nutrition assistant	World Relief Sect5: b15
15. Stephen Nyak Riak	Male	Nutrition assistant	World Relief Sect2: b15

[25] Simon Gatdiet Gai, Anthony Ruot Yiey, Bateah Kuol Wiech, John Puok Chuol, Stephen Nyak Riak were not able to go to Bentiu Town due to security reasons.

Technical Rapid Response Team

ANNEX 2 – BARRIER ANALYSIS QUESTIONNAIRES BENTIU

Exclusive Breastfeeding

N1 – BARRIER ANALYSIS QUESTIONNAIRE

MOTHERS OF INFANTS 0–6 MONTHS FEED THEM ONLY BREAST MILK.

Demographic data

Interviewer's Name: _____ Questionnaire No.: _____

Date: ____/____/____Community: _____

Scripted Introduction:
Hi, my name is_____; and I am part of a study team looking into infant and young child feeding habits. The study includes a discussion of this issue and will take about 20 minutes. I would like to hear your views on this topic. You are not obliged to participate in the study and no services will be withheld if you decide not to. If you decide to talk with me you will not be remunerated or receive any gifts or services. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Would you like to participate in the study? [If not, thank them for their time.]

Section A - Screening questions

1. How old is your youngest child? (write the age in months) _____
   - ❑ A. 5-12 months
   - ❑ B. 0- 4 month → *end the interview and look for another respondent*
   - ❑ C. 13 month or older → *end the interview and look for another respondent*
   - ❑ D. Don't know/won't say → *End interview and look for another respondent*

2. Have you ever breast fed this child?
   - ❑ A. Yes
   - ❑ B. No → *End the interview and look for another respondent*
   - ❑ C. Do not remember/no response → *End interview and look for another respondent*

3. Now I would like you to remember back when your baby was very young – even when s/he was a newborn. Please tell me how old the baby was when you first gave him/her any liquids other than breast milk – like water, juice, cow's milk or goat milk.
   - ❑ A. 5 months or older
   - ❑ B. 0-4 months → *Mark as Non-doer*
   - ❑ C. Do not remember / no response → *End interview and look for another respondent*

4. Please tell me how old the baby was when you first gave him/her semi solid foods – like soup, porridge, etc.
   - ❑ A. 5 months or older
   - ❑ B. 0-4 months → *Mark as Non-doer*
   - ❑ C. Do not remember/no response → *End interview and look for another respondent*

DOER (all of the following)	**NON-DOER** (any of the following)	**DO NOT INTERVIEW** (any of the following)
Question 1 = A		Question 1 = B or C or D
Question 2 = A		Question 2 = B or C
Question 3 = A	Question 3 = B	Question 3 = C

Question 4 = A	Question 4 =B	Question 4 = C

Section B. Research Questions

(Perceived Self Efficacy/Skills) **1. Doer and Non-Doer:** With your present knowledge, resources, and skills, do you think that you could give only breast milk to your baby for the first 6 months?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know
(Perceived Self-efficacy) **2a. Doer**: What makes it **easier** for you to give only breast milk to your baby for the first 6 months? **2b. Non-Doer**: What would make it **easier** for you to give only breast milk to your baby for the first 6 months? ***(Probe with "What else?")***	
3a. Doer: What makes it **more difficult** for you to give only breast milk to your baby for the first 6 months? **3b. Non-Doer**: What would make it **more difficult** for you to give only breast milk to your baby for the first 6 months? ***(Probe with "What else?")***	
(Perceived Positive Consequences) **4a. Doer:** What are the **advantages** of only giving breast milk to your baby for the first 6 months? **4b. Non-Doer:** What would be the **advantages** of only giving breast milk to your baby for the first 6 months? ***(Probe with "What else?")***	
(Perceived Negative Consequences) **5a. Doer:** What are the **disadvantages** of only giving breast milk to your baby for the first 6 months? **5b. Non-Doer:** What would be the **disadvantages** of only giving breast milk to your baby for the first 6 months? ***(Probe with "What else?")***	
(Perceived Social Norms – Who Approves) **6a. Doer:** Do most of the people that you know approve of you only giving breast milk to your baby for the first 6 months? **6b. Non-Doer**: Would most of the people that you know approve of you only giving breast milk to your baby for the first 6 months?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know/won't say
7a. Doer: Who are the people that **approve** of you only giving breast milk to your baby for the first 6 months? **7b. Non-Doer:** Who are the people that **would approve** of you only giving breast milk to your baby for the first 6 months? ***(Probe with "Who else?")***	
8a. Doer: Who are the people that **disapprove** of you feeding your 0-6 month infant only breast milk? **8b. Non-Doer:** Who are the people that **would disapprove** of you feeding your 0-6 month infant only breast milk? ***(Probe with "Who else?")***	

(Perceived Access) **9a. Doer:** How difficult is it to get the support you need to give only breast milk to your baby for the first 6 months? **9b. Non-Doer:** How difficult would it be to give only breast milk to your baby for the first 6 months?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Cues for Action/Reminders) **10a. Doer:** How difficult is it to remember to give only breast milk to your baby for the first 6 months? **10b. Non-Doer:** How difficult would it be to give only breast milk to your baby for the first 6 months?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Susceptibility/Risk) **11. Doer/Non-Doer:** How likely is it that your baby will become malnourished?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
12. Doer/Non-Doer: How likely is it that your baby will get diarrhoea?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perceived Severity) **13. Doer/Non-Doer:** How serious would it be if your baby became malnourished?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
14. Doer/Non-Doer: How serious would it be if your baby got diarrhoea?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
(Action Efficacy) **15. Doer/Non-Doer:** How likely is it that your baby will become malnourished if you only breast feed for the first 6 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
16. Doer/Non-Doer: How likely is it that your baby will get diarrhoea if you only breast feed for the first 6 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perception of Divine Will) **17a. Doer:** Do you think that **God approves** of you only breastfeeding for the first 6 months? **17b. Non-Doer:** Do you think that **God would approve** of you breastfeeding for the first 6 months?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Culture) **18. Doer/Non-Doer:** Are there any cultural rules or taboos against only breastfeeding your baby for 6 months?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say

Now I am going to ask you a question totally unrelated to breastfeeding.

(Universal Motivators)

19. Doer/Non-Doer: What is the <u>one</u> thing that you desire most in life?

THANK THE RESPONDENT FOR HIS/ HER TIME!

Immediate Breastfeeding

N2 – BARRIER ANALYSIS QUESTIONNAIRE

MOTHERS PUT THE NEW-BORN TO THE BREAST WITHIN ONE HOUR OF DELIVERY

Demographic Data

Interviewer's Name: _____ Questionnaire No.: _____ Date: ____/____/____ Community: _____

<u>Scripted Introduction</u>:

Hi, my name is_____; and I am part of a study team looking into new-born feeding practices. The study includes a discussion of this topic and will take about 20 minutes. I would like to hear your views on this topic. Would you be willing to talk with me? You are not obliged to participate in the study and no services will be withheld if you decide not to. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Would you like to participate in the study? [If not, thank them for their time.]

Section A - Screening questions

1. Did you give birth within the last 6 months?
   - ❑ A. Yes
   - ❑ B. No → *End interview and look for another mother*
   - ❑ C. Won't say → *End interview and look for another mother*

2. After your baby was delivered how long it took before you put it to the breast?
   - ❑ A. Within 1 hour
   - ❑ B. After 1 hour
   - ❑ C. Never breastfed at all → *End interview and look for another mother*
   - ❑ D. Can't recall / no response → *End interview and look for another mother*

DOER	NON-DOER	DO NOT INTERVIEW
Question 1 = A		Question 1 = B or C
Question 2 = A	Question 2 = B	Question 2 = C or D

Section B – Research Questions

(Perceived Self Efficacy/Skills)

1. Doer and Non-Doer: With your present knowledge and skills do you think that you could put your next baby to the breast within one hour of delivery?

- ❑ a. Yes
- ❑ b. Possibly
- ❑ c. No
- ❑ d. Don't know

(Perceived Self-efficacy)

2a. Doer: What makes it **easier** for you to put your new-born to the breast within one hour of delivery?

2b. Non-Doer: What would make it **easier** for you to put your new-born to the breast within one hour of delivery?

(Probe with "What else?")

3a. Doer: What makes it **difficult** for you to put your new-born to the breast within one hour of delivery? **3b. Non-Doer:** What would make it **difficult** for you to put your new-born to the breast within one hour of delivery? ***(Probe with "What else?")***	
(Perceived Positive Consequences) **4a. Doer:** What are the **advantages** of putting your new-born to the breast within one hour of delivery? **4b. Non-Doer:** What would be the **advantages** of putting your new-born to the breast within one hour of delivery? ***(Probe with "What else?")***	
(Perceived Negative Consequences) **5a. *Doer:*** What are the **disadvantages** of putting your new-born to the breast within one hour of delivery? **5b. *Non-Doer:*** What would be the **disadvantages** of putting your new-born to the breast within one hour of delivery? ***(Probe with "What else?")***	
(Perceived Social Norms – Who Approves) **6a. Doer:** Do most of the people that you know **approve** of you putting your new-born to the breast within one hour of delivery? **6b. Non-Doer**: Would most of the people that you know **approve** of you putting your new-born to the breast within one hour of delivery?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know/won't say
(Perceived Social Norms) **7a. Doer:** Who are the people that ***approve*** of you putting your new-born to the breast within one hour of delivery? **7b. Non-Doer:** Who are the people that ***would approve*** of you putting your new-born to the breast within one hour of delivery? ***(Probe with "Who else?")***	
(Perceived Social Norms) **8a. Doer:** Who are the people that ***disapprove*** of you putting your new-born to the breast within one hour of delivery? **8b. Non-Doer:** Who are the people that ***would disapprove*** of you putting your new-born to the breast within one hour of delivery? ***(Probe with "Who else?")***	
(Perceived Access) **9a. Doer:** How difficult was it to get the support you needed to put your new-born to the breast within one hour of delivery? **9b. Non-Doer:** How difficult would it be to get the support you need to put your new-born to the breast within one hour of delivery?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say

(Perceived Cues for Action/Reminders) **10a. Doer:** How difficult is it to remember to put your new-born to the breast within one hour of delivery? **10b. Non-Doer:** How difficult do you think it would be to remember to put your new-born to the breast within one hour of delivery?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Susceptibility/Risk) **11. Doer and Non-Doer:** How likely is it that you will bleed excessively after the delivery?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say

(Perceived Severity) **12. Doer and Non-Doer:** How serious would it be to bleed excessively after the delivery?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
(Perceived Action Efficacy) **13. Doer and Non-Doer:** How likely is it that you bleed excessively after the delivery if you put your new-born to the breast within one hour of delivery?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't Know/won't say
(Perception of Divine Will) **14a. Doer:** Do you think that **God approves** of you putting your new-born to the breast within one hour of delivery? **14b. Non-Doer:** Do you think that **God would approve** of you putting your new-born to the breast within one hour of delivery?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Policy) **15a. Doer:** Are there any community laws or rules in place that helped you put your new-born to the breast within one hour of delivery? **15b. Non-Doer:** Are there any community laws or rules in place that would help you put your new-born to the breast within one hour of delivery?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Culture) **16. Doer and Non-Doer:** Are there any cultural rules or taboos that you know of for or against putting your new-born to the breast within one hour of delivery?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say

Now I am going to ask you a question unrelated to immediate breastfeeding.

(Universal Motivators) **17. Doer/Non-Doer:** What is the <u>one</u> thing that you desire most in life?

THANK THE RESPONDENT FOR HER TIME!

Feeding rations to enrolled children

N3 – BARRIER ANALYSIS QUESTIONNAIRE

MOTHERS/CARE GIVERS OF OTP/TSFP ENROLLED CHILDREN PROVIDE THE RUTF/RUSF RATIONS ONLY TO THEIR ENROLLED CHILDREN

Demographic Data

Interviewer's Name: _____ Questionnaire No.: _____

Date: ____/____/____ Community: _____ Gender of interviewee: ❑ Male ❑ Female

Scripted Introduction:
Hi, my name is_____; and I am part of a study team looking into management of malnutrition habits. The study includes a discussion of this issue and will take about 20 minutes. I would like to hear your views on this topic. You are not obliged to participate in the study and no services will be withheld if you decide not to. Likewise, should you decide to talk with me, you won't receive any gifts, services or remuneration. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Would you like to participate in the study? [If not, thank them for their time.]

Section A. Screening Questions

1. Do you have any children currently receiving food supplement rations (Plumpy'Nut or Plumpy'Sup or CSB+/++)?
   ❑ A. Yes
   ❑ B. No → *End interview and look for another respondent*

2. If I am to tell you that – despite us talking the truth about how are theses rations are handled once you got them from the NGO – none of your enrolled kids will be taking out of that program [because they can't and they won't], are you willing to tell me precisely how rations are managed within your household?
   ❑ A. Yes
   ❑ B. No → *End interview and look for another respondent.*

3. Now, thinking about the past two weeks, how did you notice the rations being used? (Let the respondent say what she thinks. DO NOT SUGGEST ANSWER!)
   ❑A. Given as prescribed by the programs: once a day for one enrolled child
   ❑B. Shared among my 6-59 months children ONLY
   ❑C. Shared within the household (siblings, parents, relatives young and old)
   ❑D. Used to prepare food
   ❑E. Used for selling at the market
   ❑F. Doesn't know/won't say → *End interview and look for another respondent*

DOER (all of the following)	**NON-DOER** (any ONE of the following)	**DO NOT INTERVIEW** (any ONE of the following)
Question 1 = A		Question 1 = B
Question 2 = A		Question 2 = B
Question 3 = A, B	Question 3 = C, D, E	Question 3 = F

Section B – Research Questions

(Perceived Self Efficacy/Skills) **1. Doer and Non-Doer:** With your current knowledge, skills and resources do you think you can provide the rations only to your enrolled children?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know
(Perceived Self-efficacy) **2a. Doer**: What makes it **easier** for you to provide the rations only to your enrolled children? **2b. Non-Doer**: What would make it **easier** for you to provide the rations only to your enrolled children? ***(Probe with "What else?")***	
3a. Doer: What makes it **difficult** for you to provide the rations only to your enrolled children? **3b. Non-Doer**: What would make it **difficult** for you to provide the rations only to your enrolled children? ***(Probe with "What else?")***	
(Perceived Positive Consequences) **4a. Doer:** What are the **advantages** of providing the rations only to your enrolled children? **4b. Non-Doer:** What would be the **advantages** of providing the rations only to your enrolled children? ***(Probe with "What else?")***	

(Perceived Negative Consequences) **5a. Doer:** What are the **disadvantages** of providing the rations only to your enrolled children? **5b. Non-Doer:** What would be the **disadvantages** of providing the rations only to your enrolled children? ***(Probe with "What else?")***	
(Perceived Social Norms) **6a. Doer:** Do most of the people that you know **approve** of you providing the rations only to your enrolled children? **6b. Non-Doer**: Would most of the people that you know **approve** of you providing the rations only to your enrolled children?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't Know/won't say
7a. Doer: Who are the people that **approve** of you providing the rations only to your enrolled children? **7b. Non-Doer:** Who are the people that **would approve** of you providing the rations only to your enrolled children? ***(Probe with "What else?")***	
8a. Doer: Who are the people that **disapprove** of you providing the rations only to your enrolled children? **8b. Non-Doer:** Who are the people that **would disapprove** of providing the rations only to your enrolled children? ***(Probe with "What else?")***	
(Perceived Access) **9a. Doer:** How difficult is it to limit the access of the rations only to enrolled children? **9b. Non-Doer:** How difficult would it be to limit the access of the rations only to enrolled children?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Cues for Action/Reminders) **10a. Doer:** How difficult is it to remember to provide the rations only to your enrolled children? **10b. Non-Doer:** How difficult it would be to remember to provide the rations only to your enrolled children?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't Know/won't say
(Perceived Susceptibility/Risk) **11. Doer and Non-Doer:** How likely is it that your children will be undernourished?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perceived Severity) **12. Doer and Non-Doer:** How serious would it be if your children become undernourished in the next 3 months?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
(Action Efficacy) **13. Doer and Non-Doer:** How likely is it that your children become undernourished if you provide the rations only to the ones who are enrolled?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perception of Divine Will) **14a. Doer:** Do you think that **God approves** of you providing the rations only to your enrolled children? **14b. Non-Doer:** Do you think that **God would approve** of you providing the rations only to your enrolled children?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Culture) **15. Doer and Non-Doer:** Are there any cultural rules or taboos against providing the rations only to your enrolled children?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say

(Policy)

16 Doer and Non-Doer: Are there any community laws or rules in place that make it more likely that you provide the rations only to your enrolled children?

❑ a. Yes
❑ b. No
❑ c. Don't know/won't say

Now I am going to ask you a question unrelated to sharing rations.

(Universal Motivators)

17. Doer and Non-Doer: What is the <u>one</u> thing that you desire most in life?

THANK THE RESPONDENT FOR HIS OR HER TIME!

Seeking nutrition support within 24hrs of finding under nutrition symptoms

N4 – BARRIER ANALYSIS QUESTIONNAIRE

MOTHERS/CAREGIVERS OF CHILDREN 6-59 MONTHS SEEK ATTENTION FROM A NUTRITION SPECIALIST WITHIN 24 HOURS OF NOTICING THE UNDER NUTRITION SYMPTOMS (WASTING, OEDEMA, HAIR DISCOLORATION)

Demographic Data

Interviewer's Name: _____ Questionnaire No.: _____ Date: ____/____/____ Community: _____ Gender of interviewee: ❑ Male ❑ Female

Scripted Introduction:
Hi, my name is_____; and I am part of a study team looking into management of malnutrition habits. The study includes a discussion of this issue and will take about 20 minutes. I would like to hear your views on this topic. You are not obliged to participate in the study and no services will be withheld if you decide not to. If you decide to talk with me you will not be remunerated or receive any gifts or services. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Would you like to participate in the study? [If not, thank them for their time.]

Section A - Screening Questions

1. How old is your youngest child? (write the age in months here) _____
   ❑A. 6-59 months or less
   ❑B. 59 months or older → *end interview and find another respondent*
   ❑C. Not sure/no reply→ *end interview and find another respondent*

2. Now, thinking about this child, in the past year did you notice the child to be too thin for height; or to have swelling feet and face; or to have hair discoloration?
   ❑A. Yes → *check as **Doer** if can mention at least one of these 3 symptoms.*
   ❑B. No→ *mark as **Non-Doer** and continue with Section B.*
   ❑C. Can't remember/No reply→ *end interview and find another respondent.*

3. Did you seek nutrition care/treatment when you noticed the symptoms?
   ❑A. Yes
   ❑B. No → *mark as **Non-Doer** and continue with Section B.*
   ❑C. Can't recall → *end interview.*

4. Where did you seek health care/treatment?

❑A. Government nutritionist; or a private nutritionist; or POC nutritionist
❑B. A traditional healer/a spiritual healer/bought meds herself→ *mark as* ***Non-Doer*** *and continue with Section B*
❑C. Can't recall/won't say → *end interview and look for another respondent*

5. From the time you noticed the symptoms, how long did it take for you to see a health care provider at a health facility?
❑A. Within 24 hours (less than 2 days)
❑B. Over 24 hours (more than 2 days) → mark as Non-Doer
❑C. Don't remember → *end interview and look for another respondent*

DOER (all of the following)	**NON-DOER** (any of the following)	**DON'T INTERVIEW** (any of the following)
Question 1= A		Question 1 = B or C
Question 2= A	Question 2= B	Question 2 = C
Question 3= A	Question 3 = B	Question 3 = C
Question 4= A	Question 4 = B	Question 4 = C
Question 5= A	Question 5 = B	Question 5 = C

Explanation: When I say "undernourished" child, I am talking about a child who shows symptoms of under nutrition: swelling feet and face, being too thin for his height and showing hair discoloration.
(Note: consider having a picture showing infants with these symptoms as a reminder to the mother.)

Section B – Research Questions

(Perceived Self Efficacy/Skills) **1. Doer and Non-Doer:** With your current knowledge, skills and resources do you think you can seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms.	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know
(Perceived Self-efficacy) **2a. Doer**: What makes it **easier** for you to seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **2b. Non-Doer**: What would make it **easier** for you to seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? ***(Probe with "What else?")***	
3a. Doer: What makes it **difficult** for you to seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **3b. Non-Doer**: What would make it **difficult** for you to seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? ***(Probe with "What else?")***	

(Perceived Positive Consequences) **4a. Doer:** What are the **advantages** of seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **4b. Non-Doer:** What would be the **advantages** of seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? ***(Probe with "What else?")***	
(Perceived Negative Consequences) **5a. Doer:** What are the **disadvantages** of seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **5b. Non-Doer:** What would be the **disadvantages** of seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? ***(Probe with "What else?")***	
(Perceived Social Norms) **6a. Doer:** Do most of the people that you know **approve** of you seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **6b. Non-Doer**: Would most of the people that you know **approve** of you seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know/won't say
7a. Doer: Who are the people that **approve** of you seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **7b. Non-Doer:** Who are the people that **would approve** of you seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? ***(Probe with "What else?")***	
8a. Doer: Who are the people that **disapprove** of you seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **8b. Non-Doer:** Who are the people that **would disapprove** of seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? ***(Probe with "What else?")***	
(Perceived Access) **9a. Doer:** How difficult is it to get to the health centre within 24 hours of noticing under nutrition symptoms? **9b. Non-Doer:** How difficult would it to get to the health centre within 24 hours of noticing under nutrition symptoms?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say

(Perceived Cues for Action / Reminders) **10a. Doer:** How difficult is it to remember to seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **10b. Non-Doer:** How difficult do you think it would be to seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Susceptibility/Risk) **11. Doer and Non-Doer:** How likely is it that your child will become severely malnourished (last stage before death) within the next 3 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perceived Severity) **12. Doer and Non-Doer:** How serious would it be if your child suffers from severe malnutrition (last stage before death)?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
(Action Efficacy) **13. Doer and Non-Doer:** How likely is it that your child will suffer from severe malnutrition (last stage before death) if you seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perception of Divine Will) **14a. Doer:** Do you think that **God approves** of you seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms? **14b. Non-Doer:** Do you think that **God would approve** of you seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Culture) **15. Doer and Non-Doer:** Are there any cultural rules or taboos against seeking attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Policy) **16 Doer and Non-Doer**: Are there any community laws or rules in place that make it more likely that you seek attention from a nutrition specialist within 24 hours of noticing under nutrition symptoms?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say

Now I am going to ask you a question unrelated to seeking nutrition services.

(Universal Motivators) **17. Doer and Non-Doer:** What is the <u>one</u> thing that you desire most in life?

THANK THE RESPONDENT FOR HIS OR HER TIME!

Hand Washing at 5 critical times

W1 – BARRIER ANALYSIS QUESTIONNAIRE

MOTHERS/CARE GIVERS OF CHILDREN 0–59 MONTHS WASH THEIR HANDS WITH SOAP/ASH AT THE

Demographic Data

Interviewer's Name: _____ Questionnaire No.: _____ Date: ____/____/____ Community: _____ Gender of interviewee: ❑ Male ❑ Female

Scripted Introduction:
Hi, my name is_____; and I am part of a study team looking into personal hygiene habits. The study includes a discussion of this issue and will take about 20 minutes. I would like to hear your views on this topic. You are not obliged to participate in the study and no services will be withheld if you decide not to. If you decide to talk with me you will not be remunerated or receive any gifts or services. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Would you like to participate in the study? [If not, thank them for their time.]

Section A. Screening Questions

6. How old is your youngest child? _____ months ← *write the age in months*
   ❑A. 0-59 months
   ❑B. Over 59 months → *End interview and look for another respondent*
   ❑C. Don't know→ *End interview and look for another respondent*

7. Yesterday, did you wash your hands?
   ❑A. Yes
   ❑B. No → *Mark as* ***Non-Doer*** *and go straight to Section B*
   ❑C. Don't remember → *End interview and look for another respondent*

8. I would like you to think about yesterday and tell me how many times you washed your hands yesterday. _____ *(this is just to help with memory)*

9. Yesterday, what are all the moments that you washed your hands? (DO NOT READ THE LIST – Mark all that are mentioned)
   ❑A. After defecation
   ❑B. After cleaning a child's diaper/nappy
   ❑C. Before cooking/preparing food
   ❑D. Before eating
   ❑E. Before feeding a child
   ❑F. Don't know or won't say→ *End interview and look for another respondent*

10. In addition to water, did you use anything else to wash your hands yesterday?
   ❑A. Yes
   ❑B. No → *Mark as* ***Non-Doer*** *and continue to Section B*
   ❑C. Don't remember → *End interview and look for another respondent*

11. In addition to water, what else did you use to wash your hands?
   ❑A. Soap/ash
   ❑B. Anything else → *Mark as* ***Non-Doer*** *and continue to Section B*
   ❑C. Don't know/refused to answer → *End interview and look for another respondent*

12. May I see the soap/ash that you use?
    - ❑A. Soap/ash is available and looks used
    - ❑B. Soap/ash is available but does not look used → *Mark as **Non-Doer** and continue to Section B.*
    - ❑C. No soap/ash available→ *Mark as **Non-Doer** and continue to Section B.*

DOER (all of the following)	**NON-DOER** (any one of the following)	**DO NOT INTERVIEW** (any one of the following)
Question 1 = A		Question 1 = C
Question 2 = A	Question 2 = B	Question 2 = C
Question 4 = **A plus** any **two** from B, C, D, E[26]	Question 4 = No A; or A and **only one** other response between B, C, D, E	Question 4 = C
Question 5 = A	Question 5 = B	Question 5 = C
Question 6 = A	Question 6 = B	Question 6 = C
Question 7 = A	Question 7 = B or C	

Section B – Research Questions

(Perceived Self Efficacy/Skills)

1. Doer and Non-Doer: With your current knowledge, skills and resources do you think you can wash your hands with soap/ash at the five critical times?

- ❑ a. Yes
- ❑ b. Possibly
- ❑ c. No
- ❑ d. Don't know

(Perceived Self-efficacy)

2a. Doer: What makes it **easier** for you to wash your hands with soap/ash/ at the five critical times each day?

2b. Non-Doer: What would make it **easier** for you to wash your hands with soap/ash at the five critical times each day?

(Probe with "What else?")

3a. Doer: What makes it **difficult** for you to wash your hands with soap/ash at the five critical times each day?

3b. Non-Doer: What would make it **difficult** for you to wash your hands with soap/ash at the five critical times each day?

(Probe with "What else?")

(Perceived Positive Consequences)

4a. Doer: What are the **advantages** of washing your hands with soap/ash at the five critical times each day?

4b. Non-Doer: What would be the **advantages** of washing your hands with soap/ash at the five critical times each day?

(Probe with "What else?")

(Perceived Negative Consequences)

5a. Doer: What are the **disadvantages** of washing your hands with soap/ash at the five critical times each day?

5b. Non-Doer: What would be the **disadvantages** of washing your hands with soap/ash at the five critical times each day?

[26] This is an example of how to relax a behavior when you don't think you'll be able to find enough Doers.

(Probe with "What else?")	
(Perceived Social Norms) **6a. Doer:** Do most of the people that you know **approve** of you washing your hands with soap/ash at the five critical times each day? **6b. Non-Doer**: Would most of the people that you know **approve** of you washing your hands with soap/ash at the five critical times each day?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know/won't say
7a. Doer: Who are the people that **approve** of you washing your hands with soap/ash at the five critical times each day? **7b. Non-Doer:** Who are the people that **would approve** of you washing your hands with soap/ash at the five critical times each day? ***(Probe with "What else?")***	
8a. Doer: Who are the people that **disapprove** of you washing your hands with soap/ash at the five critical times each day? **8b. Non-Doer:** Who are the people that **would disapprove** of washing your hands with soap/ash at the five critical times each day? ***(Probe with "What else?")***	
(Perceived Access) **9a. Doer:** How difficult is it to get the soap/ash you need to wash your hands at the five critical times each day? **9b. Non-Doer:** How difficult would it be to get the soap/ash needed to wash your hands at the five critical times each day?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Cues for Action/Reminders) **10a. Doer:** How difficult is it to remember to wash your hands with soap/ash at the five critical times each day? **10b. Non-Doer:** How difficult do you think it would be to remember to wash your hands with soap/ash at the five critical times each day?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Susceptibility/Risk) **11. Doer and Non-Doer:** How likely is it that your child will get Hepatitis E in the coming 3 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
12. Doer and Non-Doer: How likely is it that your child will get Cholera in the coming 3 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perceived Severity) **13. Doer and Non-Doer:** How serious would it be if your child got Hepatitis E?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
14. Doer and Non-Doer: How serious would it be if your child got Cholera?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say

(Action Efficacy) **15. Doer and Non-Doer:** How likely is it that your child will suffer from Hepatitis E if you wash your hands with soap/ash at the five critical times each day?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
16. Doer and Non-Doer: How likely is it that your child will suffer from Cholera if you wash your hands with soap/ash at the five critical times each day?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perception of Divine Will) **17a. Doer:** Do you think that **God approves** of you washing your hands with soap/ash at the five critical times each day? **17b. Non-Doer:** Do you think that **God would approve** of you washing your hands with soap/ash at the five critical times each day?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Culture) **18. Doer and Non-Doer:** Are there any cultural rules or taboos against washing your hands with soap/ash at the five critical times each day?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Policy) **19 Doer and Non-Doer**: Are there any community laws or rules in place that make it more likely that you wash your hands with soap/ash at the five critical times each day?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say

Now I am going to ask you a question unrelated to washing hands.

(Universal Motivators) **20. Doer and Non-Doer:** What is the <u>one</u> thing that you desire most in life?

THANK THE RESPONDENT FOR HIS OR HER TIME!

Defecate in a latrine

W2 – BARRIER ANALYSIS QUESTIONNAIRE

MOTHERS/CARE GIVERS OF CHILDREN 0–59 MONTHS OF AGE DEFECATE IN A LATRINE AT ALL TIMES

Demographic Data

Interviewer's Name: _____ Questionnaire No.: _____

Date: ____/____/____ Community: _____ Gender of interviewee: ❑ Male ❑ Female

Scripted Introduction:

Hi, my name is_____; and I am part of a study team looking into defecation habits. The study includes a discussion of this issue and will take about 20 minutes. I would like to hear your views on this topic. You are not obliged to participate in the study and no services will be withheld if you decide not to. If you decide to talk with me you will not receive any remuneration, gifts or services. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Would you like to participate in the study? [If not, thank them for their time.]

Technical Rapid Response Team

Section A – Screening Questions

1. How old is your youngest child? _____<-- write the age in months
   - ❑A. 59 months or younger
   - ❑B. 60 months or older→ *End interview and look for another interviewee.*
   - ❑C. Don't know/won't say → *End interview and look for another interviewee.*

2. In the last 4 days, how many times did you defecate?
   - ❑A. 2 or more times
   - ❑B. 1 or fewer times→ *End interview and look for another interviewee.*
   - ❑C. Do not remember / no response → *End interview and look for another interviewee.*

3. Thinking back over the last 4 days, what are <u>all</u> the places that you defecated? *(read all the responses)*
   - ❑A. My own latrine/neighbour's latrine/community latrine/any latrine→ *ask question 4.*
   - ❑B. Bush → *if <u>bush</u> is the ONLY response, mark as <u>Non-Doer</u> & continue with Section B.*
   - ❑C. Do not remember/no response → *End interview and look for another interviewee.*

4. Thinking back over the last 4 days, how many times did you defecate in a latrine?
   - ❑A. 2 or more times
   - ❑B. 1 or fewer times
   - ❑C. Do not remember/no response → *End interview and look for another interviewee*

DOER (all of the following)	**NON-DOER** (any of the following)	**DO NOT INTERVIEW** (and of the following)
Question 1 = A		Question 1 = B or C
Question 2 = A		Question 2 = B or C
Question 3 = A	Question 3 = B	Question 3 = C
Question 4 = A	Question 4 = B	Question 4 = C

Section B – Research Questions

(Perceived Self Efficacy/Skills) **1. Doer and Non-Doer:** With your present knowledge, resources, and skills, do you think that you could use a latrine every time you needed to defecate?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know
(Perceived Self-efficacy) **2a. Doer**: What makes it **easier** for you to use a latrine every time you need to defecate? **2b. Non-Doer**: What would make it **easier** for you to use a latrine every time you need to defecate? ***(Probe with "What else?")***	
3a. Doer: What makes it **difficult** for you to use a latrine every time you need to defecate? **3b. Non-Doer**: What would make it **difficult** for you to use a latrine every time you need to defecate? ***(Probe with "What else?")***	

(Perceived Positive Consequences) **4a. Doer:** What are the **advantages** of using a latrine every time you need to defecate? **4b. Non-Doer:** What would be the **advantages** of using a latrine every time you need to defecate? ***(Probe with "What else?")***	
(Perceived Negative Consequences) **5a. Doer:** What are the **disadvantages** of using a latrine every time you need to defecate? **5b. Non-Doer:** What would be the **disadvantages** of using a latrine every time you need to defecate? ***(Probe with "What else?")***	
(Perceived Social Norms) **6a. Doer:** Do most of the people that you know **approve** of you using a latrine every time you need to defecate? **6b. Non-Doer**: Would most of the people that you know **approve** of you using a latrine every time you need to defecate?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know/won't say
7a. Doer: Who are the people that **approve** of you using a latrine every time you need to defecate? **7b. Non-Doer:** Who are the people that **would approve** of you using a latrine every time you need to defecate? ***(Probe with "What else?")***	
8a. Doer: Who are the people that **disapprove** of you using a latrine every time you need to defecate? **8b. Non-Doer:** Who are the people that **would disapprove** of using a latrine every time you need to defecate? ***(Probe with "What else?")***	
(Perceived Access) **9a. Doer:** How difficult is it to access a latrine each time you need to defecate? **9b. Non-Doer:** How difficult would it be to to access a latrine each time you need to defecate?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Cues for Action/Reminders) **10a. Doer:** How difficult is it to remember to use a latrine every time you need to defecate? **10b. Non-Doer:** How difficult do you think it would be to remember to use a latrine every time you need to defecate?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Susceptibility/Risk) **11. Doer and Non-Doer:** How likely is it that you will get Hepatitis E in the next 3 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
12. Doer and Non-Doer: How likely is it that you will get Cholera in the next 3 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say

(Perceived Severity) **13. Doer and Non-Doer:** How serious would it be if you got Hepatitis E?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
14. Doer and Non-Doer: How serious would it be if you got Cholera?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
(Action Efficacy) **15. Doer and Non-Doer:** How likely is it that you will get Hepatitis E if you used a latrine every time you need to defecate?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
16. Doer and Non-Doer: How likely is it that you will get Cholera if you used a latrine every time you need to defecate?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perception of Divine Will) **17a. Doer:** Do you think that **God approves** of you using a latrine every time you need to defecate? **17b. Non-Doer:** Do you think that **God would approve** of you using a latrine every time you need to defecate?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Culture) **18. Doer and Non-Doer:** Are there any cultural rules or taboos that you know of against using a latrine every time you need to defecate?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Policy) **19 Doer and Non-Doer**: Are there any community laws or rules in place that make it more likely that you use a latrine every time you need to defecate?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say

Now I am going to ask you a question unrelated to using latrines.

(Universal Motivators) **20. Doer and Non-Doer:** What is the <u>one</u> thing that you desire most in life?

THANK THE RESPONDENT FOR HIS OR HER TIME!

Washing drinking water storage containers

W3 – BARRIER ANALYSIS QUESTIONNAIRE

MOTHERS/CARE GIVERS OF CHILDREN U5 WASH THE WATER STORAGE CONTAINER WITH SOAP BEFORE FETCHING WATER IN THE MORNING

Interviewer's Name: _____ Questionnaire No.: _____

Date: ____/____/____ Community: _____ Gender of interviewee: ❑ Male ❑ Female

Scripted Introduction:

Hi, my name is_____; and I am part of a study team looking into diarrhoea prevention practices. The study includes a discussion of this issue and will take about 20 minutes. I would like to hear your

views on this topic. You are not obliged to participate in the study and no services will be withheld if you decide not to. Likewise, should you decide to talk with me, you won't receive any gifts, services or remuneration. Everything we discuss will be held in strict confidence and will not be shared with anyone else. Would you like to participate in the study? [If not, thank them for their time.]

Section A. Screening Questions

1. How old is your youngest child? _____ ← *write age in months*
   - ❑ A. Child is 5 yrs. or younger
   - ❑ B. Child is older than 5 yrs. of age → *End interview and look for another respondent*
   - ❑ C. Doesn't know/won't say → *End interview and look for another respondent*

2. Do you have a water storage container at home for drinking water?
   - ❑ A. Yes
   - ❑ B. No → *End interview and look for another respondent*
   - ❑ C. Doesn't know/won't say → *End interview and look for another respondent*

3. Yesterday, did you wash the container?
   - ❑A. Yes
   - ❑B. No → *Mark as **Non-Doer** and go straight to Section B*
   - ❑C. Don't remember → *End interview and look for another respondent*

4. At what time of the day did you wash the storage container?
   - ❑A. In the morning before fetching the water
   - ❑B. Any time before fetching water
   - ❑C. In the evening when empty (before sleeping) → *Mark as **Non-Doer**, go straight to Section B*

5. In addition to water, what else did you use to wash the container?
   - ❑ A. Soap
   - ❑ B Other disinfectant product
   - ❑ C. Water only → *Mark as **Non-Doer** and go straight to Section B*
   - ❑ D. Sand only → *Mark as **Non-Doer** and go straight to Section B*

DOER (all of the following)	**NON-DOER** (any ONE of the following)	**DO NOT INTERVIEW** (any ONE of the following)
Question 1 = A		Question 1 = B or C
Question 2 = A		Question 2 = B or C
Question 3 = A	Question 3 = B	
Question 4 = A, B	Question 4 = C	
Question 5 = A, B	Question 5 = C, D	

Section B – Research Questions

(Perceived Self Efficacy/Skills)

1. Doer and Non-Doer: With your current knowledge, skills and resources do you think you can wash the water storage container with soap before fetching water in the morning?

- ❑ a. Yes
- ❑ b. Possibly
- ❑ c. No
- ❑ d. Don't know

(Perceived Self-efficacy)

2a. Doer: What makes it **easier** for you to wash the water storage container with soap before fetching water in the morning?

2b. Non-Doer: What would make it **easier** for you to wash the water storage container with soap before fetching water in the morning?

(Probe with "What else?")

3a. Doer: What makes it **difficult** for you to wash the water storage container with soap before fetching water in the morning? **3b. Non-Doer**: What would make it **difficult** for you to wash the water storage container with soap before fetching water in the morning? ***(Probe with "What else?")***	
(Perceived Positive Consequences) **4a. Doer:** What are the **advantages** of washing the water storage container with soap before fetching water in the morning? **4b. Non-Doer:** What would be the **advantages** of washing the water storage container with soap before fetching water in the morning? ***(Probe with "What else?")***	
(Perceived Negative Consequences) **5a. Doer:** What are the **disadvantages** of washing the water storage container with soap before fetching water in the morning? **5b. Non-Doer:** What would be the **disadvantages** of washing the water storage container with soap before fetching water in the morning? ***(Probe with "What else?")***	
(Perceived Social Norms) **6a. Doer:** Do most of the people that you know **approve** of you washing the water storage container with soap before fetching water in the morning? **6b. Non-Doer**: Would most of the people that you know **approve** of you washing the water storage container with soap before fetching water in the morning?	❑ a. Yes ❑ b. Possibly ❑ c. No ❑ d. Don't know/won't say
7a. Doer: Who are the people that **approve** of you washing the water storage container with soap before fetching water in the morning? **7b. Non-Doer:** Who are the people that **would approve** of you washing the water storage container with soap before fetching water in the morning? ***(Probe with "What else?")***	
8a. Doer: Who are the people that **disapprove** of you washing the water storage container with soap before fetching water in the morning? **8b. Non-Doer:** Who are the people that **would disapprove** of washing the water storage container with soap before fetching water in the morning? ***(Probe with "What else?")***	
(Perceived Access) **9a. Doer:** How difficult is it to get the soap you need to wash the water storage container with soap before fetching water in the morning? **9b. Non-Doer:** How difficult would it be to the water soap needed to wash the water storage container with soap before fetching water in the morning?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say
(Perceived Cues for Action/Reminders) **10a. Doer:** How difficult is it to remember to wash the water storage container with soap before fetching water in the morning? **10b. Non-Doer:** How difficult do you think it would be to remember to wash the water storage container with soap before fetching water in the morning?	❑ a. Very difficult ❑ b. Somewhat difficult ❑ c. Not difficult at all ❑ d. Don't know/won't say

(Perceived Susceptibility/Risk) **11. Doer and Non-Doer:** How likely is it that your family members will get Hepatitis E in the coming 3 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
12. Doer and Non-Doer: How likely is it that your family members will get Cholera in the coming 3 months?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perceived Severity) **13. Doer and Non-Doer:** How serious would it be if your family members got Hepatitis E?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
14. Doer and Non-Doer: How serious would it be if your family members got Cholera?	❑ a. Very serious ❑ b. Somewhat serious ❑ c. Not serious at all ❑ d. Don't know/won't say
(Action Efficacy) **15. Doer and Non-Doer:** How likely is it that your family get Hepatitis E if you wash the water storage container with soap before fetching water in the morning?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
16. Doer and Non-Doer: How likely is it that your family get Cholera if you wash the water storage container with soap before fetching water in the morning?	❑ a. Very likely ❑ b. Somewhat likely ❑ c. Not likely at all ❑ d. Don't know/won't say
(Perception of Divine Will) **17a. Doer:** Do you think that **God approves** of you washing the water storage container with soap before fetching water in the morning? **17b. Non-Doer:** Do you think that **God would approve** of you washing the water storage container with soap before fetching water in the morning?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Culture) **18. Doer and Non-Doer:** Are there any cultural rules or taboos against washing the water storage container with soap before fetching water in the morning?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say
(Policy) **19. Doer and Non-Doer**: Are there any community laws or rules in place that make it more likely that you wash the water storage container with soap before fetching water in the morning?	❑ a. Yes ❑ b. No ❑ c. Don't know/won't say

Now I am going to ask you a question unrelated washing the water container.

(Universal Motivators) **20. Doer and Non-Doer:** What is the <u>one</u> thing that you desire most in life?

ANNEX 3 – PROFILING MOTHERS/CAREGIVERS OF CHILDREN U5

Bentiu POC

22/04/16

2. Things that mothers do; spend the day doing

The first priority of mums who don't work for an NGO is usually collecting firewood in the forest. Mums usually wake up at 5am and rush to the forest to collect firewood. They usually leave their children sleeping and return back around 2pm. (Sometimes the mum might leave instructions with the eldest child to take care of the other children while she is gone). When they get back, they next have to rush to collect water (there is not water in the taps constantly throughout the day) and then prepare food for the family.

After cooking, the mum will usually take the rest of the firewood she has brought back to the market and sell it. After she sells the firewood, she will buy a little fish or meat soup for the family, but even that soup is not enough. Mums have to spend much of the day collecting firewood because the WFP food ration is not enough and they need to supplement this food ration. Due to this, most of the small babies are left in the charge of children. It is common for the child left in charge to be as young as 8 years old.[27]

When the mum returns home from the forest she will often find the baby with flies on his or her mouths as the baby has not been taken care of well, and the baby often later gets diarrhoea. For mums who work in an NGO, the situation is similar as working mums usually report to work at 8am, and don't get home for lunch until 1pm. At 1pm, they have to rush to prepare food for lunch. This is not easy as it usually requires them to collect water and also to grind. After preparing the food, she has to rush back to work, leaving the small children once again.

Because the mums are focusing all their efforts on survival, the small children are usually not eating until the afternoon, and similarly, many babies are not breastfed until lunch time. **As a result, the babies and small children become malnourished.**

The mums spend their day trying to obtain enough money to buy the additional food needed for their family's survival. They stated that if they were given more food, they wouldn't be as occupied by trying to survive and would be able to focus on the messages they are given by NGO workers. Previously, before the crisis, mums didn't have to spend the whole day fighting for survival. Most grew vegetables nearby the home and had free time in the mornings when they could even do sewing etc, before the time came to prepare lunch. Most also had cows, so their babies had plenty of milk.

The mums can spend so long searching for firewood that they return to the camp late, and this sometimes leads to rape.

3. Things that mothers want (common desires or interests)

- Mums want milk for their babies, so that when the mum is not around (like when she is searching for firewood) to breastfeed, the baby will still have milk. Mums will then be happy that their kids are healthy.
- Mums want enough food for the family.
- Mums want enough water and charcoal or firewood, more soap, shoews, underwear, sanitary towels, hygiene kits, jerrycans and buckets. Mums want clothes for their children (enough clothes so that each child has a change of clothes). If mums had all

[27] Note that this means that the "Care giver" is often a child themselves and as a result nutrition and hygiene messaging needs to be targeted specifically at children.

these things, they would not have to run up and down each day, the way they are doing now.

- Mums want schools for the children and healthcare for mums and children.
- Mums would like adult education. This would help relieve their stress and trauma.
- Mums want employment and equality. Mums want women to be able to make decisions at home – not just the men. (Men can often be suspicious of working wives, and suspect that they are taking a little of the money.) Some husbands forcefully confiscate the money from the wife. The women talked about one Hygiene Promoter whose husband always confiscates her incentives and puts them in his pocket. He does the same with his 2nd wife, who also works for an NGO. As a result, their children are malnourished because they are only surviving on food rations. When the mums take the children to the nutrition centre, afterwards, the husband confiscates the plumpy nut and sells it in the market.
- Mums want clothes. Clothes are priority, because when you don't have clothes you are ashamed to be seen.

4.A. Things that prevent mothers from washing their hands with soap or ash at the 5 critical times each day

- Busyness – mums are so busy all day. Mums can wash their hands if you ask them too, but straight after washing they will have to dry their hands on their clothes and rush to do a task like collecting water or collecting firewood. Mums are always competing for time. For example, water is only in the taps for a short time each day, so as soon as there is water, mums are racing for water.
- Lack of awareness – Some mums, especially those in block 15 where the new arrivals are, are from the deep village and weren't aware previously about washing hands. For these mums, accepting the messages about handwashing and remembering them is difficult. For example, one Hygiene Promoter said she often sees mums coming straight from defecation, and then picking their baby up straight away and breastfeeding without handwashing. When the Hygiene Promoters talk to these mums about handwashing, the mums say, "We have never done this and our parents and their parents have not done it. There is no problem." However, these mums are slowly getting the ideas due to the fact that they are living closely with other mums who understand the messages and practice handwashing.
- Lack of soap and water scarcity. When Concern used to give small pieces of soap to children who attended kids' hygiene club, when you went to the homes of those children you always found the mums in the home practicing handwashing with that piece of soap. The kids advised the mums to wash their hands at that time.[28]
- Lack of jerrycans and buckets. Every household received 1 bucket and 1 jerrycan in 2014, but that was 2 years ago and many of these buckets and jerrycans are damaged

[28] Unfortunately they are talking about a time when we had less than 30 kids in kids club. Now we have so many kids clubs and there is a shortage of soap so we can't give out the pieces of soap anymore.

now. Also, 2 containers is not enough to collect enough water for all the needs, such as washing clothes, cooking, drinking, and handwashing.

- Mums don't wash their hands with ash because they fear it. Mums say that ask is like a chemical and it can make a rash on your hands.
- Mums also don't wash their hands with ash because mums do hard tasks every day like collecting firewood and grinding. As a result, their hands are usually cracked and have small cuts in them. If they wash their hands with ash, it will be uncomfortable or painful.

4.B. Things that prevent mothers from defecating in a latrine at all times

- The bad smell. This particularly prevents pregnant mums and lactating mums from using the latrine, as they can't handle the smell.
- The majority of mums weren't familiar with latrine use when they came to the POC.
- Fear of the hole. Mums fear falling in. If they have enough courage to use the latrine, they often sit at the back of the slab and hold on to the timber. If they find the slab is soft, they don't trust that it will not fall into the pit when they stand on it. Sometimes, they remove their shoes because they feel that if they fall in, they will not fall in fully, but they will lose thir shoes.
- There is a cultural belief that when you defecate in the same place as many others, you are doing something that can cause others to die (like bringing a curse).
- Shyness – mums do not want to be seen by men as they leave the latrine. Because the doors of the latrines face the shelters, many men will be watching. It would have been better if the doors had faced the other way.
- If the latrines are full, the mums will not use them.
- The new temporary latrines are not good. They are made from tarpaulin and soon there will be holes in the tarpaulin and people will be able to see you when you are inside the latrine.
- Sometimes men use female latrines, especially men from the deep village. The men don't understand the gender marking.
- Sometimes, due to all the above reason, mums would rather go out the gate of the POC and open defecate outside the POC.

4.C. Things that prevent mothers from washing the water storage containers with soap before fetching water in the morning

- Shortage of water and shortage of jerrycans. Most mums only have 1 jerrycan and the water is used for both cooking and cleaning. By the morning, there is no water remaining and as soon as the water comes on in the taps, the mum has to rush to the taps. This water is then used for cooking and drinking. If you try to clean your jerrycan at the taps, other women will insist that you get out of the way so that they can get water for their children (because water only comes for a short time). If you decide to clean your jerrycan, then you have to go to the back of the line again to queue for water to take home.
- Lack of soap.
- Women are very busy. In the morning, they are rushing to go and collect firewood, so

they just don't have time to wash out the water containers. In the afternoon, when they return to the POC, their priority is to collect water to prepare lunch.

- Lack of basins makes cleaning the water containers difficult. If you try to clean the jerrycan, the ground becomes muddy and the jerrycan becomes dirtier.

5.A.3 What mothers practice (actually do) regarding washing their hands with soap or ash at the 5 critical times

Some mums do wash their hands at the 5 times (especially those women who arrived in the POC early on). **If** soap is available, they will use it to wash their hands. Those who were biometrically registered have soap. Others who don't have soap sometimes use sand for cleaning their hands or, if they have wounds on their hands they just use water. Many mums are willing to wash their hands at all the critical times **but** they don't have the necessary materials (soap, buckets and water).

6.A. Stages of change: pre-awareness, awareness, preparation, action, maintenance: handwashing

Most mums are handwashing at the 5 critical times. They are willing and are doing it as best as possible given the lack of the necessary materials. Most people started handwashing at the relocation, so more than 6 months ago. Even people from the villages have adopted the practice.

Therefore, they agreed to place the mums in the POC at the "maintenance" stage of change. They are doing the practice, but more materials are needed.

6.B. Stages of change: Using a latrine at all times

Most mums are using the latrine. In the old POC, people were usually open defecation, but during relocation, latrines became more accessible. Even the fact that the new latrines are cleaner than in the old POC helped people start to use them.

Therefore, they agreed to place the mums in the POC at the "maintenance" stage of change.

6.C. Stage of change: washing the water container with soap every morning

The majority of mums like washing their water containers. Because of the Hygiene Promotion, most mums are willing to wash their water containers, but they always ask the Hygiene Promoters for more soap. Mums only started washing their water containers more recently when Concern started doing the jerrycan cleaning regularly. Sometimes now, mums come to wash their containers and are disappointed when it is not a day for jerrycan cleaning and there is no soap available for this.

Therefore, they agreed to place the mums at the "action" stage of change, since this practice was most widely taken up within the last 6 months.

Bentiu town and Rubkona

20/04/16

2. Things that mothers do; spend their day doing

- In the morning, mums go to the forest to collect firewood, leaving their children with the elder children. (This is common of mums in Bentiu and Rubkona towns because selling of collected firewood is usually the only way women in the towns can get an income. It is not like the POC where many women are employed. Gaining an income from selling of firewood is a must as the oil and lentils supplied in the food ration by WFP is not enough to last for a whole month). They usual return from mid-day onwards, when they prepare food for the children. Therefore, they don't really have time to clean the babies and children – the elder children are responsible for caring for the children and babies,

including wash them etc.

- Small mums have tea shops so they go straight to work at their tea shops in the morning, leaving the babies and young children under the responsibility of the elder daughter. Sometimes the mum might leave instructions with the older daughter, for her to wash the children and prepare the lunch.
- Sometimes mums leave children under the responsibility of the grandmother. When there is a grandmother or grandfather, the mother will also be responsible for finding food for these grandparents, who are viewed as a priority since they are elderly.
- In a case where the mum has a husband living with her who has work, the mum will take care of the children at home. In this case, the mum will take charge of all household activities including food preparation etc.
- In Rubkona and Bentiu towns some mums are irresponsible. They like to go to the market in the morning to take shisha and coffee with their friends, or they move around their friends' houses taking coffee in the morning, for socializing, leaving the children at home.

3. Things that mothers want (common desires or interests)

- Schools for education of their children is the first priority of mums.
- The 2nd priority of mums may be to become employed. Mums want employment so that they can buy things for their children. The things that they want to buy their children include food (In the food ration given by WFP, mums feel that the oil and cowpeas is not sufficient for their children to be healthy. Sometimes, the monthly food ration is finished after just 7 days, since relatives come from the rural areas to share the food rations they receive since not everyone has been registered. Therefore, they seek work so that they can buy the necessary items in the market).
- Mums want soap for their children.
- Lactating mums desire milk. This could support them while they have to go to the forest to collect firewood, as they could leave the milk with the caregiver at home.
- Mums desire health services nearby so that clinics are easily accessible. Currently there are only 2 doctors in Rubkona and many people come from the rural areas to get medicine and treatment for their children so it is difficult to see a doctor because of the high demand.

4.A. Things that prevent mothers from washing their hands with soap or ash at the 5 critical times each day.

- Lack of soap (When the Hygiene Promoters do their house-to-house visits and advise mums to wash their hands with soap or ash, the mums always ask them, "Where is the soap that you want me to use for this?"). The soap provided at GFD (8 bars per 20 people) is not sufficient for washing hands. Soap is prioritized for washing clothes and bed sheets first.
- Lack of jerrycans.
- In Rubkona, when Hygiene Promoters are talking to mums about handwashing, the mums usually say that they can't wash their hands at all 5 key times because the water source is

too far away. Likely, they only have 1 jerrycan, and by the time they get home from the water source, they do not have time to go back again. They have to prioritise the water they have brought for cooking and drinking.

- Mums are too busy. They go straight to the forest in the morning so that they can collect firewood and sell it to get money for food for their children.
- Ignorance – Most mums in Rubkona and Bentiu towns are from the rural areas before the crisis and have only moved into Bentiu and Rubkona recently (most of the people who lived in the towns before the crisis now live in the POC). The mums from the rural areas are not well educated. They listen to the messages on handwashing given by the Hygiene Promoters, but by the next day they will have forgotten them because they are uneducated and usually illiterate.
- Lack of knowledge that ash should be used for handwashing – the majority of mums are not aware that ash will have a similar effect as soap if used for handwashing.
- Culturally, there are 3 kinds of food: paper food (kisra etc), dry food, and water food. Dry and water food are eaten using a ladle (large spoon used here). Only paper food is eaten with the hands. Most mums (and everyone) believe that it is not necessary to wash your hands if you are eating dry food or water food. They believe it is only necessary to wash your hands if you are about to eat paper food.
- In reality, currently most mums wash their hands with water at the 5 key times. Especially, they wash their hands before preparing food and eating food, and after cleaning the baby's bottom. However they only use water for handwashing as they use the little soap they receive for washing clothes, bedsheets etc.

4.B. Things that prevent mothers from defecating in a latrine at all times.

- The majority of mums in Bentiu and Rubkona towns are not used to latrines, as they are from the rural areas and only moved to the urban areas recently. Many mums therefore do not have experience using latrines and fear them slightly. For example, some mums advise their children not to use latrines, telling them that they could fall into the hole. Even themselves, the mums sometimes feel that they would not be able to stabilize themselves over the hole without falling into the hole. (However, during the upcoming rainy season, it will not be possible to walk to some of the areas common for open defecation in Bentiu and Rubkona towns, because of flooding. At this time, mums without experience of using latrines may be more likely to use latrines, if latrines are constructed by that time.)
- Some mums fear using a latrine because they feel that they would come out of the latrine smelling, and that this smell would be indicative that they have been infected with diseases.
- If male and female latrines are very close, mums would not want to use the latrine. They would feel shy because they would not like a man to see them leaving the latrine.
- For older caregivers (grandmothers for example), they will say that in the past, people did not use latrines and they didn't die because of this, so why should they start to use a latrine now?
- Culturally, there is a saying that when many people defecate in one hole, someone might

die (If you use the latrine, you could be the one to die).

- In Rubkona and Bentiu there are hardly any functional latrines at all.

4.C. Things that prevent mothers from washing their water storage containers with soap before fetching water in the morning.

- The problem is this scarcity of water. This is due to both the shortage of jerrycans (usually each household has only 1 jerrycan) and the distance to the water source, which is often far away, particularly in Rubkona where there are very few functional boreholes (Water can be bought from donkey carts but it costs 5SSP per jerrycan which is not affordable for most people). Since the household usually only has 1 water container, at night the water becomes finished. Therefore, first thing in the morning, the mum usually has to rush to fetch water and when she returns home, because of competing demands on time, she must hurry to cook breakfast and give drinking water to the children.
- Ignorance – Some mums do not know the importance of washing water containers with soap before collecting water. However, the majority of mums to know the importance of cleaning jerrycans. Some mums even use gravel instead when they do not have soap, because they understand the importance.
- Laziness – Some mums know the importance of washing water containers with soap before collecting water but they just don't bother.
- Lack of soap – Soap obtained from the soap distribution at GFD (8 bars per 20 people) is not sufficient to meet all domestic needs. It is usually prioritized for washing clothes and is often finished within 2 days of receipt.

6.A. Stage of change for the Handwashing Behaviour:

The majority of mums are not practicing handwashing at the 5 critical times with soap or ash, but the majority of mums are practicing handwashing at the 5 critical times with water only. The majority of mums are willing to start washing their hands with soap or ash because of messages received from the Hygiene Promoters.

Therefore, we agreed that we would place the mums at the "Awareness" stage of change – they are seriously thinking about taking up the behaviour of washing their hands with soap or ash at the 5 critical times.

6.B. Stage of change for the behaviour of Using a Latrine at all times:

The majority of mums in Bentiu and Rubkona towns have and are continuing to receive messages about latrine use (from Hygiene Promoters and other sources) as a result of them now living in the urban setting. Mums regularly ask the Hygiene Promoters when Concern or other agencies are going to construct latrines. Therefore, there is a demand amongst mums for latrines. This demand is coming ahead of the rainy season, when mums realise that some current open defecation areas will become inaccessible due to flooding.

Therefore, we agreed that we would place the mums at the "Awareness" stage of change - most mums are willing to start using latrines in the urban setting.

6.C. Stage of change for the behaviour of Washing the water container with soap every morning:

Most mums are willing to wash their water containers with soap every morning but only after certain conditions are met. These conditions include their need for more water containers per household, and a closer water supply. The mums feel that with the current conditions, they cannot do this behaviour. Therefore, we agreed to place the mums at the "Pre-awareness" stage of change as, right now, they are not seriously thinking of adopting this behaviour.

ANNEX 4 – SUB-CLUSTERS MEETING NOTES, BENTIU APRIL 2016

Nutrition

NUTRITION SUB-CLUSTER MEETING – BARRIER ANALYSIS RESULTS BENTIU

Date: 04/21
Participants:

- Care
- Concern Worldwide
- UNICEF
- WFP
- World Relief

Agenda meeting:

- Meeting's objectives
- BA methodology summary
- Studied behaviours: stages of changes exercise
- Data presentation: main barriers N1-N2-N3-N4 (see PowerPoint)
- Brainstorm activities/messages exercise

1. Meetings objectives

a. Talk and share the results on the Nutrition BA that was done in both Bentiu POC and town.
b. As « key informants », use some of your inputs that will contribute to the overall SBCC strategy.

2. BA methodology summary

- Qualitative survey finding out what determinants of health (barriers) is preventing the Priority Group from adopting the behaviour.
- Sample of 90 respondents per behaviour.
- The results of the questions are compared between the Doers (45) and Non-Doers (45).
- When comparing results we look for responses with 15% difference and a P-value below 0.05 (if above 0.05 than the answer is due to chance).
- 4 behaviours: EBF, IBF, providing rations, nutrition seeking support.
- 15 interviewers: 9 males, 6 females.
- Surveyed POC and Bentiu community (40%) from 2nd to 9th.
- Data was coded and tabulated from 11th the 14th in POC (CWW Tukul).

3. Studied behaviours: stages of changes exercise

- N1-EBF: *mothers of infants U6 months feed them only breast milk*: preparation, up-side for action.
- N2-IBF: *mothers put the new-born to the breast within one hour of delivery*: awareness.
- N3-Providing rations: *mothers/care givers of OTP/TSFP enrolled children provide the*

RUTF/RUSF ration only to their enlisted children: between pre-awareness and awareness.

– N4-Nutrition seeking: *mothers/care givers of children 6-59 months seek attention from a nutrition specialist within 24 hours of noticing the under nutrition symptoms (wasting, oedema, hair discoloration)*: awareness.

4. Brainstorm messages/activities exercise

Messages

- That Plumpynut/sup is medicine (it tastes bad!); "sharing is not caring".
- Take the angle of negative messages for adults (prevent consumption and selling)
- Plumpynut/sup treatment cures malnutrition; "it is [the same as] breast milk for babies"; it's baby food.
- EBF gives healthy babies; it prevents your baby from getting sick; breast milk is ready and available; EBF can be done anywhere and anytime; the best way to prevent early malnutrition is going EBF; do EBF, avoid hospital; no money, no worry, EBF is free.

Activities

- Graduates of nutrition program to speak how they did it.
- Develop/identify incentives for "non-enrollers" children.
- Changing the package; making it less attractive; better identification for children (as if it was medicine).
- Promote positive reinforcement through "healthy children" campaign.
- Songs addressed to children that their siblings needs the full rations so they can be healthy too!; time as incentive not going to nutrition centre.
- Stories of two families: one who shares and one who doesn't.
- Mothers to mothers' groups; visual messages.
- Public awareness campaign with Internews/community groups.
- Counselling sessions during mother support groups (MSG).
- Group session during ante natal visit.
- Radio jingles; community discussions; breastfeeding weeks; mobile broadcasting with Internews.
- IEC materials (t-shirts, posters, banners).
- Involve religious and community/traditional leaders (as key informants) to pass messages.

WASH

WASH SUB-CLUSTER MEETING – BARRIER ANALYSIS RESULTS BENTIU

Date: 04/20

Participants:

- Concern Worldwide
- IOM
- Mercy Corps
- UNICEF

Agenda meeting:

- Meeting's objectives
- BA methodology summary
- Studied behaviours: stages of changes exercise
- Data presentation: main barriers W1-W2-W3 (see PowerPoint)
- Brainstorm activities/messages exercise

5. Meetings objectives

a. Talk and share the results on the WASH BA that was done in both Bentiu POC and town.
b. As key informants, use some of your inputs that will contribute to the overall SBCC strategy.

6. BA methodology summary

- Qualitative survey finding out what determinants of health (barriers) is preventing the *Priority Group* from adopting the behaviour.
- Sample of 90 respondents per behaviour.
- The results of the questions are compared between the Doers (45) and Non-Doers (45).
- When comparing results we look for responses with 15% difference and a P-value below 0.05 (if above 0.05 than the answer is due to chance).
- 3 behaviours: hand washing 5 critical times, latrine usage, water storage: washing containers.
- 15 interviewers: 9 males, 6 females.
- Surveyed POC and Bentiu community (12%) from 2nd to 9th.
- Data was coded and tabulated from 11th the 14th in POC (CWW Tukul).

7. Studied behaviours: stages of changes exercise

1. W1-Hand washing 5 critical times: *mothers/care givers of children U5 years wash their hands with soap/ash at the five critical times each day*: preparation leaning towards action.
2. W2-Latrine usage: *mothers/care givers of children U5 years defecate in a latrine at all times:* awareness, with too many obstacles preventing preparation.
3. W3-Water storage: *mothers/care givers of children 6-59 months years wash the water storage container with soap before fetching water in the morning*: late pre-awareness leaning towards awareness.

8. Brainstorm messages/activities exercise

Messages

- No poo on my shoe.
- We spend more money when we are sick than when we need soap.
- Ash and water are free.
- Wash hands to keep cholera and HEV away.
- A healthy family is a happy family. Health comes from hand washing.
- You can wash hands with ash too.
- Remember the 2As and 3Bs (transcript using Ants and Bees).

- A family that washes hands is a healthy family which is happy.
- HEV and cholera are dangers for small children. Hand washing keeps them away.
- Mom, everyone else washes their hands, why don't you?
- Cleanness is nearly to God; God loves a healthy family.
- Health comes from washing hands.
- We can't practice God when we are sick.

Activities

- Murals and mirrors.
- Poo cleansing demonstrations.
- Steps of latrines usages sessions, visuals, demonstrations.
- Block competitions; football tournaments (other mothers interest competitions)
- Using PSA and "boda boda talk talk" with Internews.
- Drama, theatre groups.
- School hygiene clubs where moms come to watch.
- IEC materials highlighting pictures and images.
- Community group forums.
- Songs and poems by children reaching out to mothers.
- Global calendar day for WASH.
- Designated days for specific messaging and activities.
- Cholera preventer/maskers.
- Puppets and Muppets; video clips.
- Block leader to talk about importance of hand washing.
- Distribution of E-bricks to households-care to be kept with utensils in cooking area.
- Pictures and cartoons every kind of person (from the community) washing their hands happily.
- Working with church leaders to promote messages.

ANNEX 5 – INTERPRETATION & ANALYSIS OF BARRIERS

Exclusive Breastfeeding

Exclusive breast feeding is one of the behaviour where gaps difference and confidence intervals amongst doer and non-doers are the most significant amongst the seven behaviours that were studied. Despite having almost all of the twelve determinants[29] acting as barrier, Access, Social Norms, Risk and Action Efficacy needs more attention. When looking at access, Doers, despite confirming that are able to do the behaviour, are 21.9 times more likely to mention that it is hard to find the support they need to practice EBF. This could be due to the misreading of the question (or translation) when conducting the survey where respondent or enumerators did little to differentiate EBF from breast feeding in general. This would make sense in the sense where mothers are telling us that despite breastfeeding, the support is missing. In the context of where the question was properly asked and understood, this is still appealing to us in the sense of being able to reinforce and improve on the support that already exists. Perhaps we could think of enhancing facilities where mothers are being taught how to EBF once they are out of the hospital. This could also be done before delivery and as we will see in regards to *immediate breastfeeding*, ante natal session, Post natal, supplementary clinic, routine check-ups, OPD section explaining and teaching the technique of EBF are crucial. They are plenty of occasion and locations where mothers can be accessed one on one, now the challenge remains in improving those environments. When talking about Social Norms, Doers are 48.7 times more likely to mention that most people approve EBF than Non-Doers. No one in particular appears to have more influence in regards of who approves or not to EBF. Working with doctors, mothers of EBF mothers, IYCF mothers' groups, grand-mothers (elder women), and family members/relatives will help channel messages that EBF is a practice commonly accepted. In regards to Susceptibility and Risk, Doers are again 14.8 times more likely to identify diarrhoea as a risk, and 11.5 times more likely to mention malnutrition than Non-Doers. It's a trend amongst nutrition behaviours that the perception of diarrhoea and malnutrition are intrinsically linked. Self-Efficacy wise, Doers feel confident about being able to practice EBF. This will help our intervention if we are able to have able mothers teach and show mothers who are limited in their abilities. While doing so, it will be important to take into account the perception that where Doers feel it is easier because they are already producing the milk. In contrast, Non-Doers feel it would be more difficult because "I don't have enough milk [because food is not enough]". It will be interesting to monitor the reaction of other family members when trying to convince them that the mother with 0-6 months old baby can and should eat more food during the time she needs to EBF. We understand that food can be a scarce resource at times. But again, finding out what arguments are best serves to promote EBF will be interesting considering not many individuals amongst the family disapprove (or would) of the practice. Finally it will be important to be able to bring Non-Doers, who are 18.9 times more likely to express their lack of confidence than Doers, to understand and accept that when practiced, EBF reduced malnutrition for under 6 months children. In regards to reducing diarrhoea, Doers are only 5.5 times more likely to express their confidence in regards to Action Efficacy.

As part of the remaining determinants acting as barriers are Divine Will where Non-Doers are 18 times more likely to mention that God doesn't approve; Severity where Doers are 16.5 and 11.7 times more likely to mention that malnutrition and diarrhoea are serious; Cues for Actions with Non-Doers feeling it is hard to remember to EBF; Culture, where despite Doers being able to practice it, are 7.7 times more likely to mention that cultural taboos exist;

[29] Policy was not part of the questionnaire.

Negative Consequence with Doers feeling that one of the disadvantages is that "it gives diarrhoea; and finally Positive Consequences with Doers stating that "it prevents from diseases, as well as "it makes the child strong and healthy." These are two important notions that are true and accurate, and that we will need to use when building concept around the added values of exclusively breastfeeding infant during their first six month of existences. On the other hand, it will be as important to reduce the negative perception that EBF gives diarrhoea, and perhaps argue the fact that the slightest imbalance caused by the consumption of external food/liquids will lead to diarrhoea even if breastfeeding more than 99% of the time.

Immediate Breastfeeding

Among the 9 barriers for IBF, about half are more significant than the others: Culture, Cues for Action/Reminder, Action-Efficacy and Susceptibility/Risk. Culture should be of more interest here because it might be influential and the reason why so little is made to promote and reinforce this practice (from an individual perspective). Before beginning the barrier analysis, when discussing the importance and behaviours to prioritise, IBF was mentioned specifically because culturally there seemed to be arguments for why mothers would not put the baby to the breast immediately after birth; and instead of providing colostrum to the new-born, cow milk (sometimes mixed with water) would be preferred. Interestingly enough, Culture came on top of the list as a barrier for this behaviour with Doers 14.1 times more likely to express the existence of taboos. Again this makes a lot of sense where despite practicing it, they are aware of the cultural reasons that would prevent it. On the other hand, Non-Doers, perhaps because of these cultural justifications, are not even able to project themselves doing it, and therefore are not able to understand the behaviour as a healthy behaviour. Outside of documenting the reasons behind throwing away colostrum, we will need to investigate the subtleties of culture in order to understand their better roots. This can be done easily in the shape of focus group discussions in and out of the POC, with mothers and men only groups. Another barrier of significance here is Cues for Action/Reminders with Non-Doers 39.5 times more likely to express their incertitude, or not being sure about being able to remember to do it. This brings the interesting point of giving birth, where as a prerequisite to IBF, it is not something that a mother is able to "alone". Giving birth is a process (for the lack of a better term) that involves even more people than the mother and obstetrician. It is easily understood and quite acceptable to assume that after going through the hard labour of bring a child to life, the exhausted mother perhaps does not have the capacity to remember all that she has been thought during the ante natal care sessions in which she took part months previously (again considering that these services or at all available). It is totally fair to think that it could and should not only let to the mother to "remember" by herself to bring the child and put it on her breast within one hour of birth. Because IBF is a subsequent behaviour that involves the people who are taking part in the delivery, by default it also depends on them if the new mother is able to do it or not; and therefore, the same logic applies in the case of her having to remember to do it. For this reason here one of the roles we will have to play when promoting IBF is to involve health professionals and midwifes, and everyone else responsible to take care of mother and her new infant right within one hour of delivery.

One of the complications sometimes occurring after birth is excessive bleeding, either caused by the delayed exit of the placenta, and/or God forbidding, other complications. One thing that is again documented is that one of the benefits of putting the new-born to the breast within one after the birth is to bring the uterus back to "its original position", or its normal

shape. We will let nutritionist and specialists describe the process better, but one thing that it can prevent from is excessive (or continuous) bleeding, which can be life threatening. About the barrier of Susceptibility/Risk, Non-Doers are 23.3 times more likely than Doers to mention that they are not sure and feel that it is only somewhat of risk. The same goes in regards to Action Efficacy, where they are 18.4 times more likely to express their lack of confidence in making the correlation between putting the new-born to the breast and reducing the risk of bleeding excessively.

Of the many remaining barriers, the ones mentioned are Access to the support and service needed to IBF with Non-Doers 11.5 times more likely to mention that it is hard to access the necessary support from health professional (institution and HR wise); Self-Efficacy where Doers are 16.8 times more likely to mention that they have enough capacity and knowledge to do it, and Non-Doers to mention "that it would be easier if they are able to enjoy the feeling of giving birth", as well as "it would difficult to do if the placenta was not yet out"; Severity where Non-Doers are 15.1 more times more likely to mention that excessive bleeding is not serious; Social Norms with Doers 17.5 times more likely to mention that most of people approve, with props to midwives as having positive influence; and finally Divine Will is still an important barrier with Doers 25.8 times more likely to mention that God approves.

Feeding rations to enrolled children

Providing rations to enrolled children only is a context specific behaviour, opposite to WHO's ENA: EBF and IBF. One of the issues that were discussed when consulting with key informants on the importance of identifying priority behaviours that needed to be studied was the never ending cycle of OTP and TSFP in nutrition programs for children under 5 years of age. Key informants regularly mentioned that the nutrition rations are being sold at the market, that rations would be mixed with other foods such as ugali mix, that other children would eat the two weeks rations within a day, and that other family members (elders most of the time) would also consume them thinking it would make them feel stronger and better.

The most significant barriers for this behaviour are Cues for Action, Access, Self-Efficacy, and Action Efficacy. The latter speaks the louder when looking at the "problem" from a big picture standpoint. Here Non-Doers are 5.9 times more likely to say that doing the action is efficient in regards to curing and solving under nutrition. That tells us that despite being aware of the solution, they still don't have the tools, the capacity, or to an extent the ambition to solve the problem. Perhaps and most likely the influence of the context, let alone other family members or financial resource missing influences, is more important to deal with than having to listen to the "good advice" of nutrition volunteer. Perhaps the perception towards the OTP and FSTP programmes is one of food providing alternative to mass distribution; would it possible that the thinking behind can go as far as saying "We have flour on one side, why not give it taste and supplement on the other side", or "This is valuable on the market because many mothers wants it, let's sell it" kind of thinking. Another perceptive that is very plausible is to look at it from a family perspective. How much pressure is a mother under when she comes back home with perceived food in shiny and attractive packages, in plenty. Is it fair to say that perhaps elders, husband insist that she needs to share among everyone, especially mother in law and the children? Why give only to one child when everyone is hungry anyway? And what about Doer mothers, who "don't share", how are they perceived by the rest of the community? Perhaps negatively, hence the reason for identifying "other women" as potential people who disapprove. Again, considering the fragile state of the social fabric, it is only fair to assume that mothers don't want to be tagged as "Doers", where the impact of being labelled as such is greater that providing rations to only enrolled children.

Again, these are all fair point that could be made although we can't be sure of them, since the BA is intended to captures inputs on the barriers towards doing [or not] a behaviour. For this reason, it will be as essential to document and research the perceptions on rations and the programs they have been designed for in order to complement messaging and action for the promotion of this behaviour. Non-Doers are again 4 times more likely to mention that it is hard to limit access to the rations [within the household]. They also are 3.3 times more likely to mention that they cannot provide rations only to enrolled children. On the other side, Doers are able to remember when to do it as they are 6.4 times more likely to say so than Non-Doers.

Other barriers consist of Susceptibility/Risk with Non-Doers 2.9 times more likely to mention that their U5 children are at risk of malnutrition; Severity with Non-Doer are 2.5 times more likely to mention that under nutrition is a serious problem; Social Norms where Doers are 2.7 times most likely to mention that Most people approve (although sometimes other women don't agree or can have a bad influence); Negative Consequences with Non-Doers stating that what would make it difficult is that "it makes the other children cry and fight for it"; and finally Positive consequences with Doers feeling that "it makes the child fat/bigger", and that "it makes the child grow better/healthier".

Seeking nutrition support within 24 hours of noticing the under nutrition symptoms

Of all the nutrition behaviours we studied, seeking nutrition support within 24hrs of noticing under nutrition symptoms is the one with fewer barriers. Perhaps this is an indication that within the POC (where this behaviour was most surveyed), services and awareness is quite high in regards to fighting under nutrition within the household. We understand that many organisations have deployed great efforts either through nutrition volunteers and community Nutrition workers (CNW) to help mothers identify symptoms and conduct regular check-ups on their children. Nonetheless, the purpose of assessing the barriers for this behaviour is to reinforce the perception that mothers, despite the support they already receive, are at the front line of fighting malnutrition. There will always be external support either giving by international organisation or the national health system, but by encouraging the practice of this behaviour, we hope that mothers will become more able to understand the risks and identify the symptoms of under nutrition affecting their children. The main barriers for this behaviour are Self-Efficacy, Cues for Action/Reminders, and Action Efficacy. The latter somehow validate our initial premise since Non-Doer literally don't know if practicing this behaviour is efficient in preventing under nutrition as they are nearly 4.3 times more likely to day so than Doers. Another thing specific here is that practice is considered to be a "composite behaviour". A composite behaviour is a statement where you have more than one actions needed to be completed in order to achieve the desired behaviour. In the case of this one, before even making the decision of seeking support or not, the mother needs to be able to identify the symptoms when checking her child. That's at least 2 actions needed to be completed before being able to then seek support. There is a possibility that during the BA survey, mothers interpreted that question as being able to identify symptoms only. This barrier would then makes sense since it is not clear cut conclusion that by being able to only identify symptoms reduces the under nutrition in general. It is going to be strategic here to promote this behaviour in a way where mothers can improve their ability to find the time and remember to conduct monthly checks of their children (Reminders). In this regard, Doers are only 1.9 times more likely to mention that remembering is easy. Once this is out of the way, we will need to reinforce the ability of a mother to detect and identify under nutrition

symptoms such as change in hair colour, swelling of the face and so on (Self Efficacy). Here Doers are 2.9 times more likely to say that they can do the behaviour.
The other barriers for this last nutrition behaviour are Susceptibility/Risk, Access, Positive Consequences and social norms. Outside of Action Efficacy, every barrier seems to have Doers feeling more confident in knowledge and practice than Non-Doers. This is important for us to understand since it could mean that mothers are in a very "dependant" state when I comes to taking part in fighting under nutrition. Perhaps it also could mean that they rely too much on external support and help instead of taking the lead in making sure their children are not under nourished. Is it possible that they feel that understanding under nutrition is "too technical" and therefore – considering their education levels – feel they can't learn the science behind it? Deconstructing the complexity of the science behind how under nutrition can be detected is something we could look into and help them feel more empowered (ownership) *vis-à-vis* their role in the fight against under nutrition.

Hand washing at the 5 critical times

Significant barriers for hand washing at the 5 critical times are Access, Cues for Action and Severity/Risk. Looking at Access, Doers – who by definition do the behaviours, and who we assume understand what's needed to do it – are 4.4 times more likely to mention that it is easy to access soap/ash and water when needing to wash their hands. We are going to reinforce the perception that soap is accessible, but that it is also ok to keep soap for hand washing only instead ofdoing laundry. Convincing and using arguments around resource management is going to be crucial. Reminder is one of the most underrated barriers amongst any WASH behaviour. Underrated in the sense where once mothers will have developed the ability to, there is a great chance that we might see great improvement in perceiving that the 3*Bs* and the 2*As* are easy to remember. In that regards, Doers again are 5.6 more times likely to say that they remember them than Non-Doers. Another thing to mention is that information coming from mothers in Bentiu communities tells us that they are aware of their lack of capacity to remember because of their low literature rate. Nothing screams impact louder than knowledge and the confidence of being able to apply it daily. The Severity barrier complements the previous two here when we see Non-Doers already [very] aware that HEV and cholera are constant risks; 5.5 times and 3.2 times more likely to mention than Doers. This suggest that perhaps the reason why Doers don't feel as much threatened by those disease is that they can associate better doing the behaviour prevents from illnesses (Action Efficacy). Another suggestion could also be that Non-Doers simply feel they are not able to act despite the severity of the risks. The latter provides us with a great opportunity to work in convincing and reinforcing the perception that the 5 steps are easy, and that not only resources are available to practice hand washing, but that it is ok to manage them using the argument that health is in the end what counts most (more than clean clothes, or bed sheets; and that it is worth it investing). These last points make again much sense considering the other barriers for this behaviour are Social Norms where most people approve, but especially HPs; Divine Will where Non-Doers are not sure God approves; Self-Efficacy where Doers feel they can do it, and will also comment that "it is easier to do when they have soap/ash and water"; and finally Positive Consequence where Doers are 2.1 times more likely to mention that one of the perceived benefits of hand washing is: "it keeps the family healthy!". Full of emotional power because of the values it is made of, and the conceptual value it provides us with. Let's build on that quote.

Defecate in a latrine

Sections 4 to 6 in the *Priority Group* description section of the DBC is more than eye

opening when looking at the obstacles limiting mothers to use latrines for defecation. From logistic to fear based obstacles, they are not to be taken lightly and needs to consideration as much as what the BA survey tells us. In that regards, it only makes more sense that latrine usage is the WASH behaviour with the most barriers, 11. This is quite significant considering that the information in column 2 was provided before this analysis, and is of cultural nature more than anything else. It is not coincidence then that the main barriers are Action Efficacy, Severity/Risks, Positive Consequences, with the most significant being Culture and Self-Efficacy. Self-Efficacy validates the comment about Non-Doers fearing they (or their child) might slip and fall into the pit when using it. They are 38 times more likely than Doers to express that it is only possible or them to be able to use it, and that what makes it more difficult is "when there is no latrine around the house. We need an action plan to build latrine in masses for communities outside of the POC. Then we will be able to work on the subjective part of making them more attractive for mothers, as well as differentiate them from women and men. This brings us to focus on the barrier of Culture, and understand why even Doers are 12.8 times more likely than Non-Doers to mention the existence of cultural taboos related to latrine usage by women. Although we are limited in commenting on the origins of these taboos now, we will need to understand how we can work around belief such as evil spirits building up in the latrine hole; or to have women not being embarrassed by the sight of men when leaving latrine. Communication implementers will need to pay attention to these beliefs when deciding on which messages to employ to convinced mothers.

The perception that HEV and cholera are high risk again validates the group discussions collected information. The BA tells us that Doers are 15.4 times more likely (cholera) and 14.8 times more likely (HEV) than Non-Doers to mention that both these diseases are risks. Perhaps because times change, and that environments in which communities live in has also evolve, that old habits once safe have become a higher risk of propagating illnesses. It will be interesting to highlight how much the national crisis context has influenced and justified the creation of a POC areas where close to hundreds of thousands individuals live in really close proximity. Although this proximity is one of the ways to protect civilians from the war, it also creates a public health situation that perhaps did not need to be addressed in the same way as before. That said when individuals are forced to live closer together with limited human waste management infrastructures, the risk of infectious diseases such as HEV and cholera increases. Hence making the usage of latrine a life-saving practice for all, care givers being of all ages, elders included, it is important to reinforce the perceptions and reiterate the message that such diseases are at greater risk spreading when people are massed in an enclosed environment.

This leads us to the barrier of Action Efficacy where Doers are 14.3 times more likely than Non-Doers to mention that using latrines is efficient for the prevention of cholera, meaning that they feel confident about reducing the risk of infection by doing the behaviour. In contrast, Non-Doers don't feel as it is as efficient in the case of HEV, with them 7.9 times more likely to mention "somewhat likely" than Doers. The lesson here is that we need to reinforce the perception that the risk is greater because of the situation communities are faced with. Although it can true be that 50 or 100 years back, cholera and HEV were non-existent diseases and did not create any public health issues. Part of the messaging we will need to reinforce is that the reality of today is different because social contexts and environments have changed (for the reason we all know), and that surely traditional ways have become obsolete in the sense where they are not safe anymore

The remaining barriers that impair the practice of this behaviour are Severity, with Doers 20.2 times more likely to mention that cholera is very serious than Non-Doers, and 16.9 times

in the case of HEV; Divine Will, where Doers are 10.4 times more likely to mention that God approves; Cues for Action with Non-Doers 12.1 times more likely to mention it is not that easy to remember to use latrines; Access where Non-Doers are 10 times more likely to mention that is it somewhat difficult to access latrine; Negative Consequences with Non-Doers stating that "latrines bring flies"; Social Norms where Doers feel most people approve; and finally, Positive Consequence where one of the benefits of using latrines, adding to most people approving, is that "it keeps the children and the community clean". This is a great quote from which a concept of how a simple act can save and ensure future generations a healthy lifestyle.

Washing drinking water containers

The reason behind wanting to promote this behaviour is that collecting water with infected containers was high on the top of the list that was generated from the FGDs. It is a context specific behaviour as opposed to the two previous ones as part of WHO's EHA. For this reason, key informants staffs from many organisations and community workers feel that perhaps mother might not be aware of being able to prevent HEV and cholera simply by taking the time to wash their storage containers before fetching water. Although fewer, barriers here are more or less of the same nature as the ones we found when surveyed hand washing practices. The most significant again being Access to soap and water, cholera and HEV not being perceived as Risks, and Self-Efficacy. In regards to the latter, Non-Doers state that it would difficult to do "because soap is or can be costly." From the Doers perspective, they are 9 times more likely to mention that they can do it considering their skills, knowledge and available resources. This supports the Access barrier where again Doers are 9.2 times more likely to mention that finding soap and water is easy. It will be important when talking about soap and water access in general to reassure mothers that it is relatively easy to access soap and water. We agree that managing these resources within the household can be a challenge. Again building program messages around the concept that family members approve of being healthy, hence it is possible and permitted to focus perhaps more money toward buying soap in order to keep everyone in the family healthy. The same way it is ok for pregnant and lactating mothers to eat a bit more, it is ok for soap to be used for actions that ensure generations within the same household to stay healthy.

Once more, a point of emphasis should be made in regards to the risks that are cholera and HEV. It's hard to understand why Doers in WASH previous surveys felt that cholera and HEV where risk to them and their family members, but not in this one. When asked, Doers were 7.2 and 7.3 times more likely to mention that both cholera and HEV are not a risk. In difference to the other WASH behaviours, washing water storage containers doesn't involve being in contact with human faeces (unlike hand washing and using latrines). Is it fair to say that they perceived cholera and HEV as being transmittable only when in touch with human faeces; or that as long as they use latrines and wash their hands, that they are not risks; or that these disease can travel and contaminate water? Perhaps they feel as if since organisations are credible enough and that the water that is being provided with all its treatment is powerful and safe enough that it can never carry diseases? The Action Efficacy barrier seems to validate this line of thought since Doers don't think it is efficient as they are 3.5 and 2.5 times more likely to mention that washing their water container before fetching water will not prevent their family members from getting ill with either both diseases. This is somehow interesting for in the sense of being able to fill in gap in regards to perception towards patterns of diseases (epidemiology).

The other barriers negatively influencing the practices are Social Norms, with Doers saying

most people approves, with a special props to hygiene promoters; Cues for Action where Doers are 5.5 times more likely to mention that it is easy to remember; and Positive Consequences with Doers saying that one of the benefits of washing containers is that "water does not get contaminated; it protects from germs/bacteria". One then could ask: "you mean the same germs that can infect humans with cholera or HEV? Exactly!

ANNEX 6 – BRIDGES TO ACTIVITIES TO BE ADDRESSED WITH CARE GROUPS

Exclusive Breastfeeding

- (Self-efficacy) Increase the perception that all mothers produce enough breast milk for their babies during the first 6 months even when food is short
- (Positive consequences/action efficacy) Increase the perception that EBF is the best way to prevention malnutrition and diarrhoea and to keep your child healthy.
- (Cue for action)Increase the ability to remember to only give breast milk to your infant from 0 – 6 months (remember to tell others Not to give anything else)
- (Access) Increase access to the support needed to only give breast milk to infants 0 – 6 months.
- (Divine will) Increase the perception that God approves of only giving breast milk to infants 0-6 months.
- (Culture) Increase the perception that all cultures are dynamic and change when they learn something new, such as that EBF prevents malnutrition and diarrhoea.
- (Severity) Increase the perception that malnutrition and diarrhoea are very serious conditions/illnesses, especially in infants.

Immediate Breastfeeding (within one hour)

- (Self-efficacy) increase the perception that it's easy to breastfeeding even before the placenta has delivered.
- (Social Norms) increase the perception that everyone approves of putting the newborn to the breast within an hour of delivery.
- (Social Norms) Reinforce the perception that midwives approve of putting the new-born to the breast within an hour of delivery.
- (access) increase the availability of support for immediate breastfeeding
- (Cue) Increase the ability of new mothers to put the newborn to the breast within an hour of delivery.
- (Severity) increase the perception that excessive bleeding/placenta not coming out is very serious/a mother could die.
- (Action efficacy) increase the perception that putting the newborn to the breast within an hour of delivery will prevent excessive bleeding/help the placenta to come out.
- (Divine will) Increase the perception that God/religion approves of immediate breastfeeding.
- (Culture) Increase the perception that it is culturally acceptable to breastfeeding within an hour of delivery.

Feeding Ration only to the enrolled child

- (Self-efficacy) Increase the perception that the enrolled child will grow/recover quicker if the ration is only given to him/her.
- (Self-efficacy) Increase the perception that there are ways to give the ration only to the enrolled child so that the other children won't cry.

- (Social Norms) Increase the perception that everyone approves of giving the ration only to the enrolled child.
- (Access) this is significant but I have no idea what would have been asked related to 'access' since this behaviour doesn't really have an access component.
- (Cue) Increase the ability to remember to give the ration only to the enrolled child.

Care Seeking for undernourished child (6 – 59 month)

- (Positive Consequences/Action Efficacy) Reinforce the perception that prompt care seeking for a child who is undernourished helps the child become strong again more quickly.
- (Social Norms) Increase the perception that everyone approves of prompt care seeking for an undernourished child.
- (Access) Increase the availability of services for malnourished children (increase the perception that services for malnourished children are easily available.)
- (Cue/Self-efficacy) Increase the ability to remember to seek care when a child is undernourished. (Increase the ability to recognize the signs of under nutrition.

Hand washing

- (Positive Consequences/Action Efficacy) Increase the perception that hand washing with soap/ash at the five critical times each day is the best way to prevent HEV and cholera.
- (social Norms) Increase the perception that everyone approves of frequent hand washing with soap/ash.
- (Access) Increase the availability of soap/ash and water
- (Cue) Increase the ability to remember to wash hands with soap at the critical times each day.

Defecate in a latrine

- (Self-efficacy /access) increase access to latrines.
- (Positive Consequences) Increase the perception that defecating in a latrine keeps children and the community looking clean.
- (Social Norms) Increase the perception that everyone approves of defecating in a latrine.
- (Cue) increase the ability to remember to defecate in a latrine.
- (Risk) Increase the perception that everyone is at risk of getting cholera.
- (Severity) increase the perception that cholera is a very serious disease – many people die from cholera, especially children.
- (Action Efficacy) Increase the perception that defecating in a latrine is an effective way of prevention cholera.
- (Divine Will) Increase the perception that God approves of defecating in a latrine.

Washing Drinking Water Storage Containers

- (Positive Consequences/Action Efficacy) Increase the perception that washing drinking water containers is a good way to prevent the water from getting contaminated with germs/bacteria that cause cholera and HEV.
- (Access) Increase the perception that everyone has access to soap you need to wash drinking water containers.

ANNEX 7 – ACTIVITIES MILESTONES AND TARGETS

Nutrition

Table 12: BCC Nutrition Action Plan Milestones & Targets

Activities	Milestones and Targets
N1	
Training and teaching	# of trained (certified) CNV/midwifes; % of midwives in POC and Bentiu town who applied learning on EBF.
Media and IEC material	# of barrier based concepts material; # of material; % of mothers mentioning they have received materials; % of IEC materials using community champions.
One on one demonstrations	# of demonstrations, # of MBC/MBA build or enhanced.
Praying sessions	# of mothers participants; # of religious leaders disseminating messages; # of barrier based messages.
Mothers support groups	# of mothers in groups; # of groups; % of attendance in the group every semester.
PSA	# of barrier based concepts /PSA; # of PSA; % of mothers who can mention hearing at least 4 PSA; # of PSA using community champion.
Role play, artistic expression	# of presentations/semester; % of mothers who can mention at least one theme from the play/artistic expression.
N2	
Antenatal visit sessions/practice	# of visits; # of mothers visited; % of mother who can show skills after visits.
Skill based trainings	# of trained (certified) CNV/midwifes; % of midwives in POC and Bentiu town.
At home visits	# of visits; # of mothers visited; % of mother who can show skills after visits.
Short documentary films (SS)	# of barrier based concepts /video; % of mothers who can mention seeing the at least one film at least once; # of projections.
Academic and professional trainings	# of trained (certified)midwifes/health professionals; % of midwives in POC and Bentiu town who applied learning on EBF.
Video tutorials	# of tutorials; % of mothers who can mention seeing the tutorials at least once; # of projections.
PSA	# of barrier based concepts /PSA; # of PSA; % of mothers who can mention hearing at least 4 PSA; # of PSA using community champion..
Develop MoU with MOH	Signed MoU; # of graduate/year; % of graduates working in POC and Bentiu town; # of students.
Praying sessions	# of mothers participants; # of religious leaders disseminating messages; # of barrier based messages.
N3	

Activities	Milestones and Targets
Story film of D and ND families	# of barrier based concepts /video; % of mothers who can mention seeing the film at least once.
Song(s)	# of songs; # of barriers/song; % of women who can mention at least one song.
Program graduate merits	# of graduates; % of graduates who did not go back to the programs.
Advocate/lobby to companies	# of negotiation/advocacy session; time between change in labels.
Hospital and health centre visits	# of visits; # of mothers taking part in the visits; % of mothers saying they would never take part in a visit again; % of mother whose enrolled children completed the program within 3 months.
Moring ritual	% of mothers practicing the ritual (morning); # of enrolled children graduating from the program.
N4	
PSA/billboards	# of barrier based concepts /PSA/billboards; # of PSA; % of mothers who can mention hearing at least 4 PSA; # of PSA using community champion.
Calendars	# of barrier based calendars; # of calendars distributed; % of mothers owning a calendar; # of calendars showing community champions.
Video tutorials	# of tutorials; % of mothers who can mention seeing the tutorials at least once; # of projections.
Teaching sessions	# of session; % of mothers who attended the sessions.
Cue cards/memory aids	# of distrusted card; % of mothers who uses the cards; # mothers trained on how to use the card.
Hospital and health centre visits	# of visits; # of mothers taking part in the visits; % of mothers saying they would never take part in a visit again; % of mother whose enrolled children completed the program within 3 months.
Story film of D and ND families	# of barrier based concepts /video; % of mothers who can mention seeing the film at least once.

WASH

Table 13: BCC WASH Action Plan Milestones & Targets

Activities	Milestones & targets
W1	
Song	# of songs; # of barriers/song; % of women who can mention at least one song.
Demonstration sessions	# of session; % of mothers who attended the sessions.
Praying sessions	# of mothers participants; # of religious leaders disseminating messages; # of barrier based messages.

Activities	Milestones & targets
School play	# of barrier based concepts in the play(s); # of school participating in producing plays; # of mothers attending; % of women who can mention seeing the play; % of women saying they were moved by the play/that it made a difference to them.
Transcripts (IEC) Bs&As	# of material using Bees and Ants; % of mothers remembering the 5 times; % of mother who mention it help them remember.
GRA	# of mother/fathers registered in the COOP; % of HH using COOP products.
Cue card/memory aid	# of mother with distributed cards; # mothers trained to use the cards, % of mother using the card.
Hygiene billboards (IEC)	# of material using Bees and Ants; % of mothers who can mention seeing/relating to it.
W2	
Build latrines	# of building latrines competition; # of new latrines; # of mothers who validated the latrines; % of hh with latrines; % of mothers using latrines.
Mother's group sessions	# of sessions; # of mothers attending; # of cultural based barriers introduced and discussed; % of mother using latrines.
Praying sessions	# of mothers participants; # of religious leaders disseminating messages; # of barrier based messages.
Art paint/stickers (IEC)	# of latrines designed; % of women who approve; % of women who use latrines.
School play	# of barrier based concepts in the play(s); # of school participating in producing plays; # of mothers attending; % of women who can mention seeing the play; % of women saying they were moved by the play/that it made a difference to them.
W3	
PSA	# of barrier based concepts /PSA; # of PSA; % of mothers who can mention hearing at least 4 PSA; # of PSA using community champions.
Cue card/memory aid	# of mother with distributed cards; # mothers trained to use the cards, % of mother using the card.
School play	# of barrier based concepts in the play(s); # of school participating in producing plays; # of mothers attending; % of women who can mention seeing the play; % of women saying they were moved by the play/that it made a difference to them.
Counselling session	# of sessions; # of mothers who were counselled; % of women showing the skills.
Sticker (IEC)	# of certified mothers; % of certified mothers who practice W3.
Transcripts (IEC) Bs&As	# of material using Bees and Ants; % of mothers remembering the 5 times; % of mother who mention it help them remember.
GRA	# of mother/fathers registered in the COOP; % of HH using COOP products.
Hygiene billboards (IEC)	# of material using Bees and Ants; % of mothers who can mention seeing/relating to it.