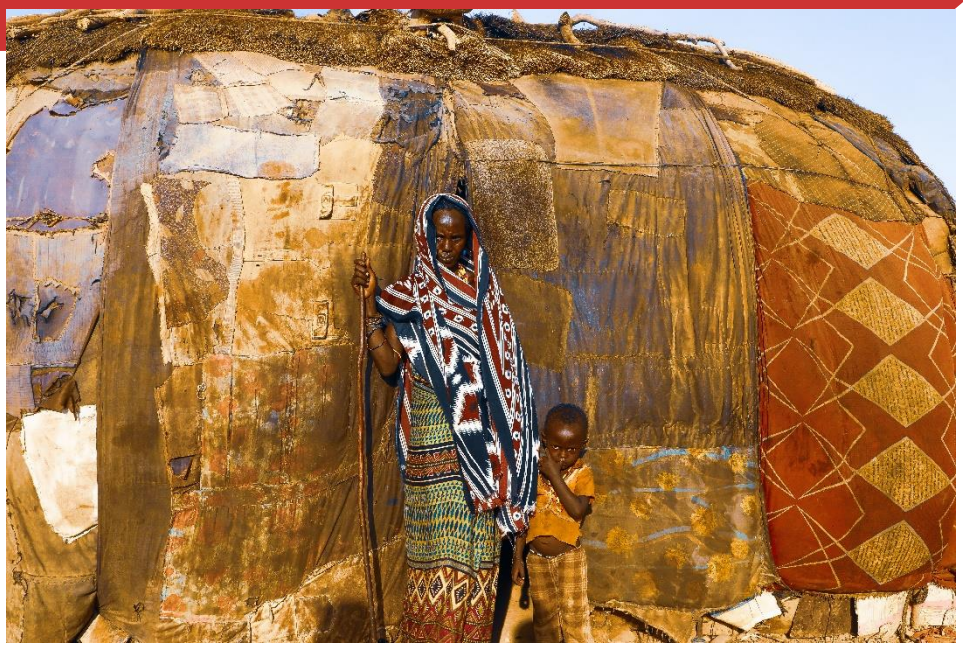


Photo: CRS USAID Nawiri /Anthony Nyandiek

USAID Nawiri Learning Brief: Social and Behavior Change

Background

Social and Behavior Change (SBC) is a critical element cross-cutting Nawiri activities. SBC entails, fundamentally, creating enabling environments for positive change and ensuring that basic systems and desirable behaviors are in place, through working closely with individuals, communities, local partners and administrations to achieve this in context appropriate ways. To understand how to align the SBC work across Nawiri, including where to direct our focus and how best to achieve desired change, Nawiri undertook a robust, two-part assessment to:

Part 1:

1.Identify the most critical behaviors to change at different levels, in order to address persistent acute malnutrition in Isiolo and Marsabit Counties.

2.Identify key actors, their roles and opportunities to change the critical behaviors of target groups (different level, including service providers), in Isiolo and Marsabit Counties.

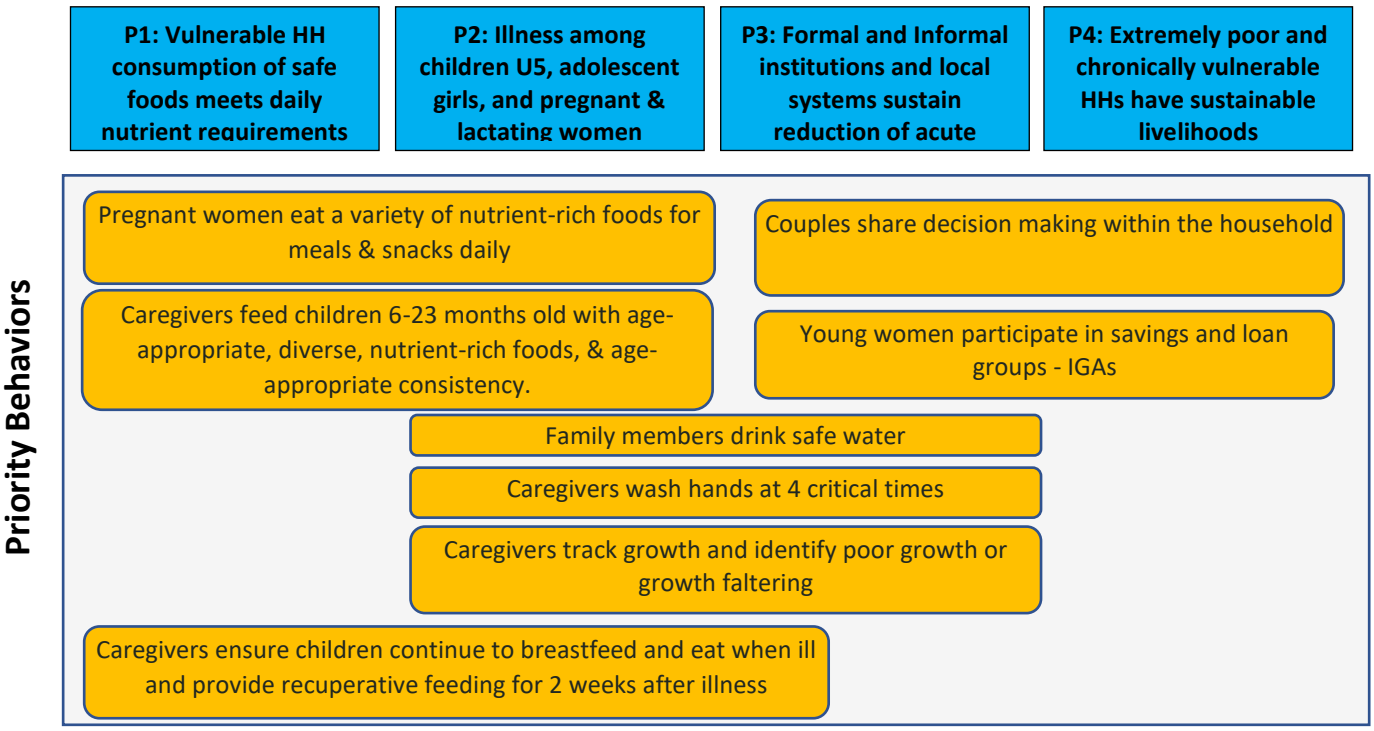
Part 2:

3.Map pathways to change for select priority behaviors, including the identification of factors impeding or motivating the practice of identified behaviors.

4.Identify feasible social/ community-oriented interventions (i.e., social change) that can be tested and iterated to complement identified facilitators and mitigate the barriers, by creating community environments more conducive to sustainable positive behavioral change.

Summary Findings and Lessons Learned

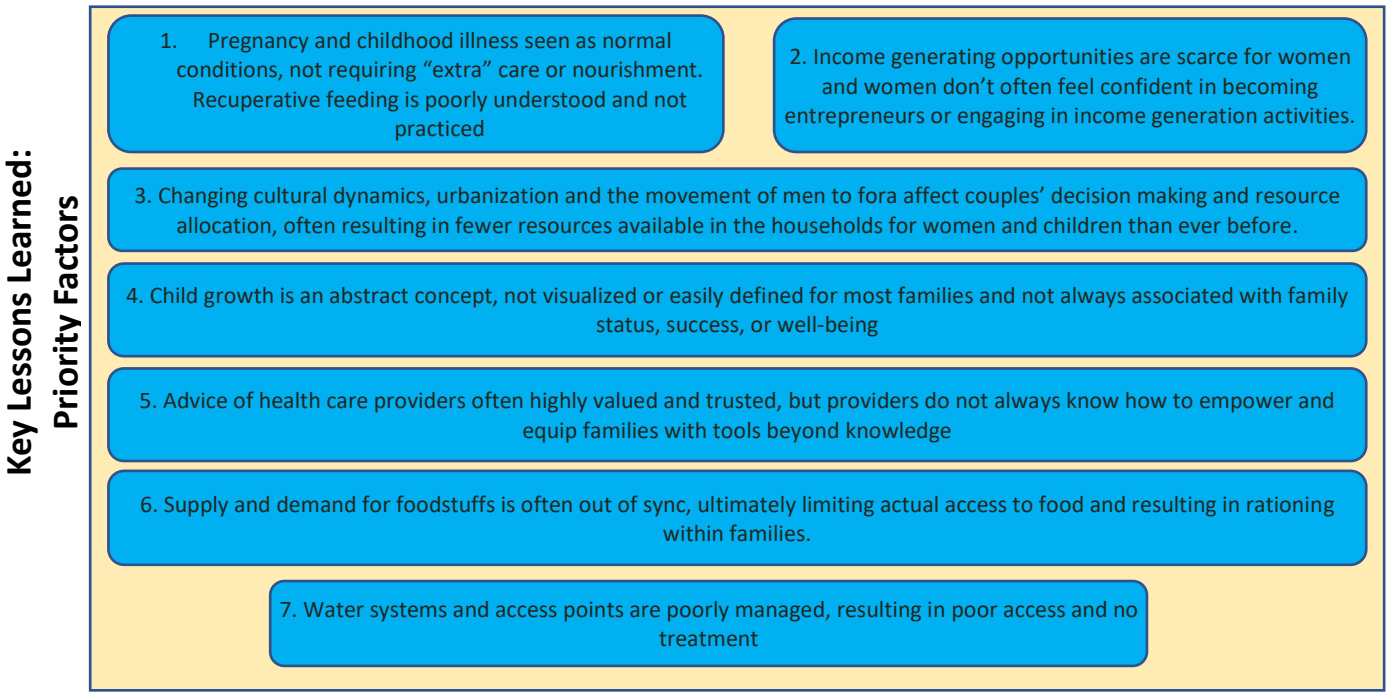
Part 1: Nawiri began its SBC assessment by considering a long menu of potential behaviors known to contribute to Global Acute Malnutrition (GAM), guided by a prioritization tool developed by USAID Advancing Nutrition. To determine which behaviors were most relevant for the Nawiri context, we assessed the current practice of the potential behavior, as well as its potential to impact on GAM in both counties. Through this process, as well as through a detailed examination of age-stratified rates of GAM (noting that GAM is far more acute in older infants and toddlers), the high prevalence of common childhood illness (nearly 30%), and seasonal fluctuations in food consumption, the team identified the following behaviors as critical for change, linked to the four key project purposes:



These behaviors were validated through a process of Nawiri team and county stakeholder meetings and formed the basis for the primary field work in Part 2 of the assessment.

Part 2: Part 2 of the assessment consisted of a series of 42 key informant interviews, 38 paired interviews, 52 focus groups, and 6 county-level workshops. Participants in these sessions included families, community leaders, service providers and a variety of individuals serving different roles in the community. The sample was taken from a broad section of Nawiri communities and represented families known to have malnourished children, as well as those with children who were moderately malnourished and/ or healthy.

Interviews focused on uncovering the incentives/ motivations and challenges to practicing priority behaviors. Findings relating to challenges of access to nutritious foods were largely consistent with what is known globally and in other parts of Kenya about young child feeding, but the study also revealed some critical issues specific to these areas that had not previously been well articulated. These factors can be summarized as:



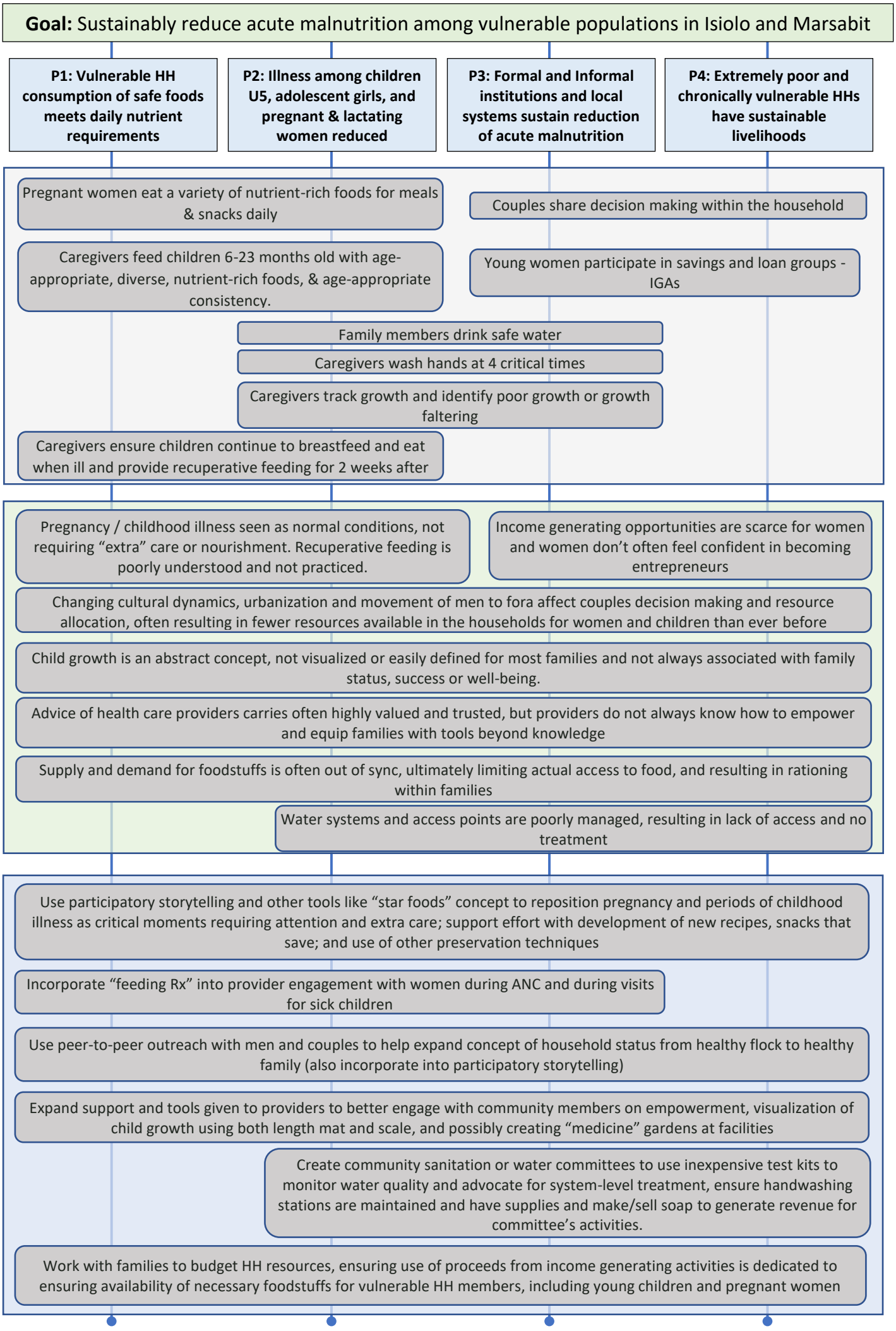
In particular, the challenges around recuperative feeding were especially critical, given the extremely high rate of illnesses. Families viewed childhood illness as a normal occurrence requiring very little special attention, especially after the child had recovered from the illness. The concept of "catching up" and returning to a baseline nutritional status after illness was not present. Additionally, a family's success, status or future promise was not seen as connected to childhood growth, and growth itself seemed a relatively abstract concept. Gender dynamics and male status, especially in a changing culture with greater access to cities, also play a critical role in whether or not the priority behaviors are practiced. Due to major issues of access especially to healthcare, existing human resources in communities need to be used, working within the CHS policy environment (providing structure, roles and responsibilities), to strengthen the first line of care for these communities. E.g., Traditional Birth Attendants (TBAs), now Community Based Referral Agents (CBRAs) teams could be expanded to include home economics personnel, nutritionists and local medicine men/ women among others, reflecting the multi-sectoral approach Nawiri is spearheading and equipping all with the skills and tools necessary to support their work and enhance impact.

Applying the Findings and Lessons Learned

In order to address these factors, Nawiri has defined a set of specific programming implications to guide implementation. NB because many programming implications will address multiple factors, they are presented in a way which indicate all factors that will be addressed by a particular SBC strategy.

Key Lessons Learned (numbers in Section B)	Adaptation or implication	Link to DIP or TOC
1, 4, 5, 6	Use participatory storytelling and other tools like "star foods" concept to reposition pregnancy and periods of childhood illness as critical moments requiring attention and extra care; support effort with the development of new recipes, non-perishable snacks and the use of other preservation techniques.	P1: SP1.1 & 1.2 P2: SP 2.1
1, 5	Incorporate "feeding requirements" into provider engagement with women during ANC and during visits for sick children. Work with the county teams to develop an expanded "community-based service provider team" involving other community-based health and nutrition-related workers, including TBAs (now CBRAs), community health assistants (CHAs), social workers, nutritionists and home economics teams, to enhance the service provision teams at community level.	P1; SP 1.1 & 1.2 P2: SP 2.1
1, 2, 3, 4, 6	Use peer-to-peer outreach with men and couples to help expand the concept of household status, from healthy flock to healthy family (also incorporate into participatory storytelling).	P3; SP 3.1 & 3.2
1, 5	Expand support and tools given to providers to better engage with community members on empowerment, the visualization of child growth using both length mat and scale, and possibly creating "medicine gardens" at facilities.	P1; SP 1.1 & 1.2 P2; SP 2.1
2, 3, 7	Create/ support community sanitation or water committees to use inexpensive test kits to monitor water quality and advocate for system-level treatment, ensure handwashing stations are maintained and have supplies and make/sell soap to generate revenue for committee's activities.	P2; SP 2.2 P3; SP 3.1
1,2, 3, 4, 6, 7	Work with families to budget HH resources, to support the use of proceeds from income generation activities to help ensure the availability of necessary foodstuffs for vulnerable HH members, including young children and pregnant women.	P3; SP 3.1 & 3.2

The full SBC Pathways to Change is reflected by the below framework:


Goal: Sustainably reduce acute malnutrition among vulnerable populations in Isiolo and Marsabit
P1: Vulnerable HH consumption of safe foods meets daily nutrient requirements
P2: Illness among children U5, adolescent girls, and pregnant & lactating women reduced
P3: Formal and Informal institutions and local systems sustain reduction of acute malnutrition
P4: Extremely poor and chronically vulnerable HHs have sustainable livelihoods
Priority Behaviors
Pregnant women eat a variety of nutrient-rich foods for meals & snacks daily
Couples share decision making within the household
Caregivers feed children 6-23 months old with age-appropriate, diverse, nutrient-rich foods, & age-appropriate consistency.
Young women participate in savings and loan groups - IGAs
Family members drink safe water
Caregivers wash hands at 4 critical times
Caregivers track growth and identify poor growth or growth faltering
Caregivers ensure children continue to breastfeed and eat when ill and provide recuperative feeding for 2 weeks after
Key Lessons Learned: Priority Factors
Pregnancy / childhood illness seen as normal conditions, not requiring "extra" care or nourishment. Recuperative feeding is poorly understood and not practiced.
Income generating opportunities are scarce for women and women don't often feel confident in becoming entrepreneurs
Changing cultural dynamics, urbanization and movement of men to fora affect couples decision making and resource allocation, often resulting in fewer resources available in the households for women and children than ever before
Child growth is an abstract concept, not visualized or easily defined for most families and not always associated with family status, success or well-being.
Advice of health care providers carries often highly valued and trusted, but providers do not always know how to empower and equip families with tools beyond knowledge
Supply and demand for foodstuffs is often out of sync, ultimately limiting actual access to food, and resulting in rationing within families
Water systems and access points are poorly managed, resulting in lack of access and no treatment
Priority Programming Implications
Use participatory storytelling and other tools like "star foods" concept to reposition pregnancy and periods of childhood illness as critical moments requiring attention and extra care; support effort with development of new recipes, snacks that save; and use of other preservation techniques
Incorporate "feeding Rx" into provider engagement with women during ANC and during visits for sick children
Use peer-to-peer outreach with men and couples to help expand concept of household status from healthy flock to healthy family (also incorporate into participatory storytelling)
Expand support and tools given to providers to better engage with community members on empowerment, visualization of child growth using both length mat and scale, and possibly creating "medicine" gardens at facilities
Create community sanitation or water committees to use inexpensive test kits to monitor water quality and advocate for system-level treatment, ensure handwashing stations are maintained and have supplies and make/sell soap to generate revenue for committee's activities.
Work with families to budget HH resources, ensuring use of proceeds from income generating activities is dedicated to ensuring availability of necessary foodstuffs for vulnerable HH members, including young children and pregnant women

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Nawiri