| TERMS OF REFERENCE<br>EmpowerHer: Enhancing Women and Girls' Sexual and Reproductive Health and Water, Sanitation, and Hygiene Project in Bauchi State, Nigeria | |
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| **Project Title and Reference** | **1111.1 Conduct formative and participatory research, in-depth assessment of behavioural determinants for adolescent MHH, SRH, SGBV.** |
| **Background** | In Bauchi State, access to safe and inclusive water, sanitation, and hygiene (WASH) services and hygiene behaviours remains significantly limited, particularly in settings critical to the health, dignity, and empowerment of women and girls, such as healthcare facilities (HCFs), schools, and public spaces.[1] Only 35% of HCFs in the State meet basic WASH service standards, with just 8% having access to sanitation and 10% to handwashing facilities. In schools, the situation is similarly dire: only 37% have basic WASH access, 46% basic sanitation, and 32% handwashing facilities.[2] These deficiencies increase the risk of infectious disease transmission, limit good practices/behaviours, menstrual health and hygiene (MHH) and contribute to maternal and neonatal health complications, particularly for adolescent girls, pregnant women, and nursing mothers.<br><br>This WASH gap is closely linked to broader issues of gender inequality and poor reproductive health outcomes in the State.[3] Bauchi reports one of the highest adolescent birth rates in the country, with [4] about 25.3% of adolescent girls in the State have already begun childbearing. Although girls' school attendance improved from 43% in 2012 to 70% in 2022, the out-of-school rate remains alarmingly high at 61.1%. The lack of gender-sensitive WASH infrastructure has been consistently identified as a major barrier to girls' continued education, MHH, and ability to engage in safe and dignified daily life.<br><br>Cultural and social taboos around menstruation, sexuality, reproductive health, and hygiene practices continue to shape the experiences of adolescent girls, many of whom face stigma, silence, or misinformation about their sexual and reproductive health, both at home and within health systems. These taboos, alongside inadequate WASH access and poor infrastructure, limit their agency and autonomy.[5] Rising inflation and the |

[1] Nigeria Health Watch & FMWR, 2021
[2] WASH NORM 2021 by National Bureau of Statistics
[3] dhsprogram.com/pubs/pdf/PR157/PR157.pdf
[4] UNICEF Nigeria, FCDO, Nigeria, FCDO, UNICEF's girls' education programme sends an additional 1.5 million girls to school in northern Nigeria
[5] World Bank Group. 2017. A Wake Up Call: Nigeria Water Supply, Sanitation, and Hygiene Poverty Diagnostic.

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| | unaffordability of menstrual products, worsened by the economic fallout of the COVID-19 pandemic, have pushed some girls to adopt unsafe coping mechanisms, including transactional sex and school absenteeism during menstruation, amongst others. In remote and hard-to-reach areas, long treks to access water further expose women and girls to sexual and gender-based violence (SGBV).<br><br>These intersecting barriers highlight the need for more than just infrastructure availability in households, schools, and HCFs. Sustainable change requires an understanding of local beliefs, social and hygiene behavioural drivers, aspirations, and gendered power dynamics. Formative research is therefore essential not only to uncover the social, cultural, and environmental determinants of current hygiene practices but also to guide the co-creation of inclusive and transformative solutions.<br><br>This formative research will generate the evidence base needed to design hygiene behaviour change interventions integrated with MHH and SRH behaviours that are grounded in local realities across Misau, Katagum, and Tafawa Balewa Local Government Areas (LGAs). It will explore how WASH services and hygiene behaviours including hand hygiene, food hygiene, water and sanitation related behaviours, menstrual health, adolescent, SRH, and healthcare-seeking behaviours especially among women and girls in hard-to-reach or underserved communities. By informing strategies that are gender-responsive, culturally appropriate, and equity-driven, the research will support the EmpowerHer project's goal of strengthening systems that not only improve health outcomes but also enhance agency, reduce poverty, and foster inclusive community development.<br><br>This formative research will build on the findings from the baseline and GESI assessments, the study conducted in Kirfi LGA in May 2019, which informed the rollout of the *Clean Family, Happy Family* campaign. It will also draw on insights from the *EmpowerHer* gender analysis, and, where available, baseline data on knowledge, attitudes, beliefs, and practices related to menstruation, hygiene, puberty, contraception, SRH rights, and sex education. |
| **Rationale for Formative Research** | Despite ongoing efforts to advance gender equality and improve access to sexual and reproductive health and rights (SRHR) in Bauchi State, women and girls, particularly adolescents, continue to face persistent and intersecting challenges. These challenges are shaped by harmful social norms, stigma surrounding menstruation and sexuality, weak health systems, and limited access to gender-responsive climate change-resistant WASH services. |

For many girls, the lack of MHH support contributes to recurring absenteeism in school and missed opportunities for learning and social participation. In healthcare settings, women seeking antenatal, delivery, or postnatal care are often confronted with poor WASH conditions that compromise their dignity and safety. At home and in public spaces, the absence of safe and accessible WASH facilities combined with silence around sexual and reproductive health limits girls' ability to make informed decisions about their bodies and their futures.

These barriers are not only health-related; they are rooted in broader systemic issues of poverty, gender inequality, and weak institutional coordination. While infrastructure remains critical, it is now widely recognized that physical access to WASH services must be matched with targeted behavioral change initiatives that consider local beliefs, motivations, and lived experiences. For adolescent girls, in particular, supportive environments that normalize menstruation, promote open communication, and provide trusted sources of information on menstruation, and sexual reproductive health are essential to achieving real and lasting change.

The EmpowerHer project is designed to respond to these challenges by integrating SRHR and MHH into WASH (and hygiene behaviour change) interventions in ways that are inclusive, gender-transformative, and locally acceptable, affordable and driven. To design effective and relevant hygiene behaviour change (HBC) components under this project, there is an urgent need for context-sensitive, participatory formative research.

**Specifically, this formative research is needed to:**

- Identify context-appropriate approaches for driving hygiene behaviour change within integrated WASH–SRHR programming.
- Understand the behavioral determinants (social, cultural, economic, environmental, psychological/emotional) of current sanitation and hygiene behaviours.
- Explore motivational drivers (e.g., nurture, affiliation, disgust, pride+) and community aspirations for improved WASH, SRH and MHH outcomes.
- Document barriers and enablers to accessing hygiene and menstrual health and SRH products and services, especially for women and adolescent girls. The research should uncover why people do or do not practice safe hygiene or seek SRH services even when facilities or services exist.

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| | • To ensure that the needs of marginalized groups (girls with disabilities, out of school adolescents, young adolescents) are not overlooked and examine how power affects access to services, products and decision making.<br>• Inform the design of inclusive, gender-transformative hygiene behaviour change interventions, based on the Assessing, Building, Creating, Delivering, and Evaluating (ABCDE) Behaviour-Centred Design (BCD) model.<br>• Provide evidence to tailor Hygiene, SRHR, MHH and WASH behavioral insights and delivery mechanisms to community realities in Bauchi<br><br>Through this process, the formative research will not only strengthen the evidence base for EmpowerHer project but also ensure that project interventions resonate with the lived experiences of women, girls, men, and boys across Misau, Katagum, and Tafawa Balewa LGAs paving the way for healthier, more empowered, and resilient communities. |
| **Objectives of the Formative Research** | Formative research will provide evidence on behavioral determinants including barriers, motivators, norms, and opportunities related to hygiene behaviour, menstrual health, and integration with sexual and reproductive health and rights (SRHR) services in Tafawa Balewa, Misau, and Katagum LGAs of Bauchi State.<br><br>**General Objective**<br>To generate contextual evidence on sanitation and hygiene behaviours and their linkages to menstrual health, gender norms, and SRHR access among target populations in selected Bauchi LGAs, with the aim of developing an inclusive, gender-responsive, and behaviour-centred hygiene promotion strategy and proof of concept intervention packages under the EmpowerHer project.<br><br>**Specific Objectives**<br>WaterAid will seek the services of a consultant to:<br><br>**1. Assess current practices and behaviours**<br>• Assess hygiene, sanitation, SRH, and MHH knowledge, attitudes, practices, and social norms among community members in schools, households, and primary HCFs.<br>• Examine prioritized behaviours such as handwashing with soap, food hygiene, safe water use, toilet use and child faeces disposal, |

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| | MHH practices, SRH-linked hygiene behaviours (ANC, delivery, PNC), and willingness/ability to pay for hygiene and sanitation products.<br><br>**2. Identify barriers, drivers, and determinants of behaviour**<br><br>• Document socio-cultural, economic, psychosocial, gender, attitudinal, and institutional barriers to good hygiene, MHH, and SRH practices.<br><br>• Explore behavioural drivers and motivations (e.g., aspirations, fears, social norms) that influence the adoption or neglect of hygiene behaviours.<br><br>• Identify risks to sustained behaviour maintenance and service delivery in schools, HCFs, and communities.<br><br>**3. Map enabling and inhibiting factors within systems**<br><br>• Assess WASH, SRH, and MHH promotion interventions already in place and their effectiveness.<br><br>• Review existing governance, coordination, and community structures (e.g., WDCs, IPC committees, peer-education groups, CSO's) that influence hygiene and SRH/MHH outcomes.<br><br>• Assess local capacity and supply chain mechanisms for hygiene and menstrual products (availability, affordability, accessibility).<br><br>**4. Explore communication, touchpoints, and participation pathways**<br><br>• Map existing communication channels for hygiene, SRH, and MHH promotion and assess their effectiveness and acceptability across target groups (boys, men, adolescent girls in/out of school, women, PWDs, community influencers).<br><br>• Identify promising touchpoints in schools, HCFs, and communities for inclusive SRHR/WASH interventions.<br><br>• Assess daily routines in schools, households, and PHCs to determine high-potential entry points for behaviour change activities, and willingness to engage (including men and boys).<br><br>**5. Assess public health risks and intersectional vulnerabilities**<br><br>• Document public health risks associated with current practices and poor access to WASH, SRH, and MHH services—especially risks to maternal, neonatal, and adolescent health in WASH-deficient facilities. |

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| | • Explore the links between gender inequality, WASH gaps, poor SRH outcomes, and vulnerabilities such as SGBV and economic shocks.<br>• Assess the extent to which SRH and climate change programmes integrate hygiene behaviour change and WASH.<br><br>**6. Generate actionable insights for programme design and sustainability**<br><br>• Identify and prioritize negatively practiced behaviours through participatory mapping and community ranking.<br>• Generate insights to inform the design of gender-transformative, disability-inclusive behaviour change interventions that align with the Behaviour-Centred Design framework and the *EmpowerHer* project outcomes (women empowerment, agency, governance, integrated services).<br>• Assess measures for long-term sustainability of WASH/SRHR/MHH interventions, including the role of user communities and local structures in implementation. |
| **Deliverables** | ◦ **Research protocol, tools and methods** in English and in the local dialect (Hausa) which is appropriate and suitable within the research areas to meet all objectives and answer all research questions; WA will also offer formative research tools so that consultant can review and select, review, refine and consolidate from the tool's kits.<br><br>The consultant must present the methodology for carrying out the formative study and should consider that the study must be through primary data collection, secondary data review of all the targeted communities:<br>◦ Report detailing in full the results of the formative research. The table of content for the report needs to be agreed with WA.<br>◦ A single, integrated analysis report on the approaches and recommended communication strategies.<br>◦ Presentation slides and dissemination workshop for the formative research (half a day workshop).<br>◦ A final research report for the accomplishment of the aforementioned tasks.<br>◦ An **Inception report**, which should include a detailed description of methodology, work plan, and data collection tools that respond to this ToR.<br>◦ A **draft report** with key findings on all behaviours, and research questions in the study, including the motives, barrier, behavioral determinants, touch points analysis as per the Behaviour Centered Design (BCD) checklist including, |

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| | a. A **summary of findings** of all the behaviours as per BCD analysis,<br>b. **Detailed recommendations** on Behaviour Change Communication final strategy, and action plan, including milestones<br>c. A **Validation workshop** with selected stakeholders on the key findings in the draft report (presented through PowerPoint).<br>d. A **Final report** informed by the main study and feedback received from stakeholders during the validation workshop and all interactive sessions with WaterAid and electronic copies of all data sets collected as part of the exercise. The final report will utilize the report template and summary extraction form, to be shared by WA, to help inform the HBC activities.<br>e. Presentation of findings during the creative process<br>f. **An electronic copy** of all quantitative and qualitative data sets collected as part of this study. |
| **Methodology** | **Study Design**<br>The formative research will adopt a mixed-method approach incorporating both qualitative and quantitative methods to generate rich, contextual, and actionable insights. The research will be descriptive and exploratory in nature, employing a cross-sectional study design. Data will be collected from households, healthcare facilities (HCFs), and schools across the three project LGAs (Tafawa Balewa, Misau, and Katagum) in Bauchi State.<br>The methodology will reflect the intersectionality of WASH, Sexual and Reproductive Health and Rights (SRHR), and Menstrual Health and Hygiene Management (MHHM), particularly for women, adolescent girls, persons with disabilities, and other marginalized groups.<br><br>**Data Collection Approaches**<br>The consultant(s) will use the following methods:<br>• Desk review to understand how WASH / hygiene being featured into the SRHR strategy and understand the Gov modalities of delivering the SRHR program in Nigeria and explore it possible integration.<br>• Key Informant Interviews (KIIs): With government officials (RUWASSA, PHCDA, Ministry of Health/Education), CSOs, traditional leaders, WASH/Health/SRHR officers, and service providers.<br>• Participatory Focus Group Discussions (FGDs): With segmented groups (e.g., adolescent girls (in and out of school), mothers, men, boys (in and out of school), teachers, and persons with disabilities) in communities, schools, and health centers. |

- Structured Observations: all key behaviours including sanitation, handwashing, waste management, and MHHM facilities and practices in HCFs, schools, and households.
- Household Surveys: Administered using mobile data collection tools to gather quantitative data on all key hygiene behaviours and sanitation practices, product use, and SRHR/MHHM behaviour.
- Spot check (Facility Assessments) at HHs, schools and HCFs: Of WASH and MHHM infrastructure, SRH services, water supply availability, incinerators, and waste disposal mechanisms in schools and PHCs.
- Behavioral Walkthroughs & Transect Walks: To understand practical barriers in schools, PHCs and communities.
- Market Surveys: To assess the supply chains, affordability, and availability of hygiene and sanitation products, including menstrual products and other menstrual hygiene materials.

**Study Participants and Settings**

The formative research will engage diverse participants across three primary settings:

**1. Schools from 69 targeted**

- Students (in-school adolescents, boys and girls) Teachers
- School Management Committees (SMCs)

**2. Healthcare Facilities (HCFs) from 58 targeted facilities**

- Health workers (clinical and non-clinical staff)
- Health Management Committees (HMCs)
- Pregnant women, lactating mothers, and guardians of under-1year children accessing services

- **3. Communities from 1,036 targeted communities** Women and men (including caregivers/guardians of young children)
- Adolescent girls and boys (out-of-school youth)
- Persons with disabilities
- Local leaders and influencers (traditional, religious, and social leaders)
- WASH Management Committees (where present)
- Sanitation and hygiene entrepreneurs

**4. Public Spaces**

- Participants in marketplaces and motor parks
- Community influencers and vendors interacting in these spaces.

**Sampling Strategy**

To ensure the research yields valid, representative, and actionable insights for the EmpowerHer SRHR-WASH-MHH intervention design, a multi-stage purposive and stratified sampling strategy will be employed. This approach will ensure representation across key demographic and geographic variables—such as gender, age, disability status, and service access—across Katagum, Misau, and Tafawa Balewa LGAs. The project targets 1,035 communities, 69 schools, and 58 Health Facilities in 37 wards across the 3 LGAs. The final sample size and distribution will be collaboratively determined from the target areas with the consultant and project partners based on population diversity, operational feasibility, and the need to generate meaningful insights for all key groups, including adolescent girls, women, and people with disabilities. The consultant will also ensure that the HCFs that are selected for construction work should be included as part of the sample location for the formative research, but other locations can be randomly sampled.

Sampling considerations will include:

- LGA representation (Tafawa Balewa, Misau, Katagum)
- Urban–rural mix
- Schools with and without functional MHHM facilities
- PHCs with high maternal and child health service uptake

**Data Analysis**

- Quantitative data will be collected using mWater and will be analyzed using statistical software (e.g., SPSS, Excel) to generate frequencies, cross-tabulations, and trend summaries.
- Qualitative data will be analyzed thematically using NVivo or similar tools, with attention to recurring themes, motivational drivers, and social norms.
- Triangulation of findings from different data sources will strengthen the validity and utility of the results.

**Key Questions to be Addressed**

1. **Assess Current Practices and Behaviours**

- What are the existing behaviours, knowledge, and social norms related to:
    - Handwashing at critical times (in schools, PHCs, communities)?
    - Food hygiene (handling, preparation, serving, child feeding)?
    - Safe water use (collection, transport, storage, treatment)?
    - Toilet use and safe disposal of faeces (including child faeces)?

- Menstrual hygiene management (knowledge, practices, taboos)?
- SRH-linked hygiene behaviours (ANC, delivery, PNC)?

- What hygiene/SRH/MHH products, prompts, or cues are available and being used in schools, PHCs, and communities?
- What is the willingness and affordability of households, schools, and PHCs to purchase and maintain hygiene and sanitation products and facilities (e.g., soap, water, toilets, menstrual products)?
- What platforms (school clubs, women's groups, radio, community meetings) are currently leveraged for promoting these behaviours?

**2. Identify Barriers, Drivers, and Determinants of Behaviour**

- What physical, socio-cultural, economic, attitudinal, and institutional barriers hinder hygiene, MHH, and SRH practices?
- What behavioral drivers and motivators (aspirations, fears, norms, role models) influence adoption or neglect of good practices?
- What does speaking openly about menstruation and SRH mean for girls, women, boys, and men in the community?
- What risks or challenges exist for sustaining behaviour change and service delivery in schools, communities, and PHCs?

**3. Map Enabling and Inhibiting Factors within Systems**

- What WASH, SRHR, and MHH interventions already exist, and how effective are they?
- What governance, coordination, and community structures (e.g., WDCs, SMCs, HMCs, IPC committees, CSO's, peer groups) influence hygiene and SRH/MHH outcomes?
- What hygiene and sanitation products are currently available, accessible, and affordable (including menstrual products)?
- What are the user preferences, and what barriers exist to access and sustained supply (supply chain gaps)?
- What is the willingness and affordability level of schools and PHCs to operate, manage, and maintain WASH facilities and SRH services (e.g., cleaning, refills, soap and water provision, staffing)?

**4. Explore Communication, Touchpoints, and Participation Pathways**

- Who do adolescent girls, boys, women, and men trust and listen to for hygiene, SRH, and MHH information?

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| | • Who should deliver MHH/SRHR messages to make them acceptable and trusted?<br>• What existing and preferred channels of communication exist (media, peer groups, religious leaders, teachers, health talks, etc.)?<br>• What are promising touchpoints in schools, PHCs, households, and communities for inclusive SRHR/WASH interventions?<br>• How do daily routines of schoolchildren, caregivers, health workers, and households create opportunities for behaviour change?<br>• Are there potential areas for product innovation or placement of visual cues/nudges in schools, PHCs, households, and communities to promote hygiene, SRHR, and MHH behaviours?<br><br>**5. Assess Public Health Risks and Intersectional Vulnerabilities**<br>• What WASH- and SRHR-related illnesses are prevalent in the communities?<br>• What are current knowledge levels and health-seeking behaviours in response to these illnesses?<br>• How do gender inequalities, disability, poverty, and cultural/religious beliefs influence hygiene, SRH, and MHH practices?<br>• What barriers (physical, attitudinal, institutional) prevent girls from attending school during menstruation?<br>• How do poor WASH conditions in PHCs and schools pose risks to maternal, neonatal, and adolescent health?<br>• To what extent do SRH and climate change programmes integrate hygiene behaviour change and WASH services?<br><br>**6. Generate Actionable Insights for Programme Design and Sustainability**<br>• Which negatively practiced behaviours should be prioritized for change, and how can participatory mapping/ranking be used to identify them?<br>• What motivators (aspirations, fears, social norms) offer the strongest opportunities for driving sustainable behaviour change?<br>• What strategies are needed to ensure gender-transformative, disability-inclusive behaviour change interventions (aligned with Behaviour-Centred Design and EmpowerHer outcomes)? |

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- How can local structures and user communities sustain WASH/SRHR/MHH interventions beyond the life of the project?
- What are the gaps in capacity at local government and community levels to coordinate and sustain integrated WASH–SRHR efforts?

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<tr><td>Objective Matrix for Formative Research</td><td>
<table>
<tr><th>Objectives</th><th>Key Tools</th><th>Techniques / Methodology</th></tr>
<tr><td>1. Assess current WASH, MHHM, and SRHR practices among women, adolescent girls, men, boys, people with disabilities and other residents in communities, schools, and PHCs. Also assess physical, social, demographic, economic, and cultural determinants.</td><td>- BCD checklist and framing workshop<br>- Observation checklist for HHs, schools, PHCs<br>- Questionnaires for HHs and school/PHC actors<br>- FGD guide by gender/age</td><td>- Structured HH visits, Q&A<br>- Full-day structured observation per setting<br>- FGDs with segmented groups<br>- Framing workshop to identify social and cultural contexts</td></tr>
<tr><td>2. Identify key barriers and motivators for behaviour change (e.g., emotional drivers, social norms, aspirations) in relation to WASH, MHHM, and SRHR practices</td><td>- Behaviour function exercise<br>- Storytelling and "ideal future" scenarios<br>- Motives mapping tools<br>- Barrier analysis tree</td><td>- FGDs with women, men, girls, PWDs<br>- Motives exercises using storytelling<br>- Barrier/problem tree in community sessions<br>- In-depth interviews</td></tr>
<tr><td>3. Identify and assess the availability,</td><td>- KII guide for local vendors, PHC staff, women leaders</td><td>- KIIs with market actors (pad sellers, latrine</td></tr>
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| | affordability, accessibility and user-friendliness of hygiene, sanitation and MHHM products and services across different population groups | - Observation checklist<br>- Review of local product/service records | builders)<br>- Community mapping of availability and cost<br>- Spot-checks in PHCs and schools<br>- Demand documentation and triangulation |
| | 4. Assess public health risks linked to current hygiene and SRHR behaviours in schools, PHCs, and households (especially among pregnant/nursing mothers, girls, and under-5s) | - Rapid observational survey<br>- "Worry box" exercises<br>- Risk perception probing questions | - Observation walkthroughs in homes and facilities<br>- HH tours to identify biological risks (fecal paths, stagnant water)<br>- Use of risk scenarios/picture prompts during interviews |
| | 5. Prioritize hygiene and sanitation behaviours that require immediate intervention. Identify timing and opportunities for message delivery | - Behaviour picture cards and ranking tools. | - Prioritization workshop using visuals<br>- Daily routine journaling and HH activity calendars<br>- Exercise to align ideal time and mode for hygiene promotion |
| | 6. Determine effective | - Media and community platform mapping tools | - Mapping sessions with |

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| | communication channels and touchpoints (media, influencers, institutions) to reach adolescents, pregnant women, PWDs, men, and traditional/religious leaders | - KII and FGD guides<br>- Questionnaire surveys | community members<br>- KIIs with media reps, school heads, PHC staff<br>- One-on-one discussions to identify trusted influencers, groups and events |
| | 7. Assess social and cultural variation in norms, beliefs and practices related to WASH, MHHM and SRHR | - Norms mapping guide<br>- Social variation profiling tool<br>- Participatory rural appraisal (PRA) toolkits | - FGDs disaggregated by sex, age, disability<br>- Storyboard exercises to compare belief systems<br>- Community theatre or storytelling to elicit beliefs |
| | 8. Understand the existing coordination and institutional arrangements among local actors supporting WASH, SRHR, and MHHM interventions | - KII tool for LGA health/WASH/education officers<br>- Document review checklist<br>- Stakeholder mapping tool | - KIIs with RUWASSA, PHCDA, Education Board, Ward Committees<br>- Review of partner MOUs, guidelines, and structures<br>- Mapping of existing local platforms (WASHCOMs, |

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| | | | SBMCs, Health Facility Committees) |

**Sampling Framework (by LGA)**

Preliminary estimated data used below can be refined with official figures from Bauchi State Bureau of Statistics and RUWASSA/PHCDA[6].

| **Categories** | **Misau** | **Katagum** | **Tafawa Balewa** |
|---|---|---|---|
| Total population[7] | 466,800 | 523,200 | 395,200 |
| Number of communities | 536 | 701 | 743 |
| Number of wards | 16 | 20 | 16 |
| Number of public schools (est.) | 213 | 343 | 286 |
| Number of PHCs | 52 | 44 | 64 |
| Avg. ANC attendance per PHC/month | 110-121 | 310-369 | 35-68 |
| Avg. immunization attendance/month | 265-323 | 70-110 | 48-60 |
| Avg. household size | 6–8 | 6–8 | 6–8 |
| Avg. number of staff in HCFs | 5-7 | 4-6 | 3-6 |
| Sanitation & Hygiene entrepreneurs | 50 | 20 | 34 |
| Presence of hard-to-reach areas | Yes | Yes | Yes |
| Dominant settlement type | Rural/peri-urban | Urban/peri-urban | Rural/remote |

[6] National Population Commission of Nigeria (web), National Bureau of Statistics (web)

[7] https://www.citypopulation.de/en/nigeria/admin/NGA005__bauchi/

**Sampling Principles**

The following principles will guide selection:

- Geographical diversity: Include at least 2–3 wards per LGA (urban, peri-urban, and hard-to-reach).
- Demographic diversity: Disaggregate data collection by gender, age (adolescents, adult women and men), marital status, disability, and pregnancy/lactation status.
- Institutional diversity: Sample schools (both primary and secondary), healthcare facilities (PHCs), and households.
- Equity focus: Ensure inclusion of marginalized groups (e.g., adolescent girls out-of-school, widows, PWDs, female-headed households).

**Suggested Sample Size Targets**

While the final sample size will be validated with WaterAid technical teams, below is an indicative target:

| Unit of Analysis | Sample Size per LGA (Misau, Katagum, Tafawa Balewa) | Total (All 3 LGAs) | Rationale |
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| **Households (HHs)** | | | |
| **Adolescent Girls and young women** | | | |
| **Out of schoolgirls & women receiving ANC/PNC Services** | | | |
| **Schools (Primary & Secondary)** | | | |
| **PHCs (Primary Health Centers)** | | | |

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| **Key Informants** | | | |
| **Focus Group Discussions (FGDs)** | | | |
| **In-depth Interviews (IDIs)** | | | |
| **Structured Observational** | | | |

**Households**: Sampling per sub-cluster (ward/community) will be consistent with the strategy (10–15 HHs). Sampling across 8–10 sub-clusters per LGA ensures coverage of dominant settlement types and hard-to-reach areas.

**Sample size determination:** We calculated the household sample using Cochran's formula for proportions with finite population correction. Assumptions: 95% confidence (Z=1.96), margin of error 10% at LGA level (e=0.10), expected proportion p=0.50, and LGA populations of Misau (466,800), Katagum (523,200), and Tafawa Balewa (395,200). We applied a cluster design effect of 1.2 (multi-stage design with 8–10 clusters/LGA and 10–15 households/cluster) and 5% non-response. This yields ≈120 households per LGA (≈360 total). Field implementation will use 10 clusters × 12 households (or 8 × 15) per LGA. School and HCF components use facility-based samples for service/behaviour assessments and key informant/FGDs and are not powered for population prevalence.

**School and Facility sampling:** The study will sample 4–5 schools per LGA (12–15 schools total) and 6–8 PHCs per LGA (18–24 PHCs total). At each school we will interview/engage 12–15 students, 3 teachers, and 1 SMC representative (total across LGAs: ~144–225 students; 36–45 teachers; 12–15 SMC members).
At each PHC we will interview 3 health staff and 1 HMC representative and conduct 6–8 client exits interviews where feasible (total across LGAs: ~54–72 health staff; 18–24 HMC members; 108–192 clients). Facility-level samples are intended to provide robust qualitative and facility-readiness data; they are not powered for population-level prevalence estimates.

**Sampling Process:**

- Stage 1 – LGA-level purposive selection: Misau, Katagum, and Tafawa Balewa LGAs are purposively selected as project intervention sites under the EmpowerHer initiative, based on population size,

presence of hard-to-reach areas, settlement typology, and existing WASH/SRHR challenges.

- Stage 2 – Ward/community selection: A minimum of 2–3 wards per LGA will be purposively selected to represent different settlement types (urban, peri-urban, rural, and remote), and to capture geographic and cultural diversity. From each ward, 2 communities will be randomly selected for household interviews and institutional visits.
- Stage 3 – Institutional selection (PHCs and Schools): Primary Health Centers (PHCs) and public schools (both primary and secondary) will be selected using a mix of purposive and random sampling. Criteria will include immunization and ANC attendance levels, presence or absence of functional WASH facilities, accessibility, and representation across typologies (e.g., urban vs rural facilities).
- Stage 4 – Household selection: Systematic random sampling will be used to select households within each selected community. At least 10–15 households per community will be interviewed, with a focus on including households with adolescent girls, pregnant/lactating women, caregivers, and persons with disabilities.
- Stage 5 – Participant selection for FGDs/IDIs: Stratified purposive sampling will be employed to identify participants for FGDs and in-depth interviews. Categories will include adult women and men, adolescent boys and girls (both in and out of school), persons with disabilities, and caregivers. Selection will be guided by age, gender, vulnerability, and social roles.

**Special Considerations**

- Disaggregated data will be collected by sex, age, disability status, education level, marital status, and household size.
- Cultural sensitivity: Female data collectors and facilitators will be prioritized for interviews involving women and adolescent girls, particularly in conservative communities.
- Community entry: Traditional leaders, religious authorities, and health officials will be engaged in advance to support sensitization, obtain community consent, and ensure participant safety and cooperation.
- Language & accessibility: Data collection tools will be translated into local languages, and inclusive methods will be used for persons with

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| | disabilities (e.g., sign language interpreter or caregiver-assisted responses). |
| **Timeframe** | This consultancy work is expected to be completed within 8 weeks with total working days not exceeding 40 days including preparation, agreeing the research methods, field work, sharing preliminary finding, designing the approaches, report writing, and sharing of the finalised reports and presentations with WaterAid. |
| **Indicator (s)** | # of completed assessment reports on hygiene behaviours, climate vulnerability, gender analysis |
| **Proposed Budget Breakdown** | The consultant will provide an estimated budget that covers all costs required to produce a high-quality output. Financial proposal should indicate professional fees, including level of people and number of days and out of pocket costs like travel, per diems, etc. This will be assessed and agreed as per the laid out financial and procurement rules and regulations in WaterAid. Final approval will be given by WaterAid Nigeria in consultation with our partners. |

The final report will provide a comprehensive, yet practical analysis to support the EmpowerHer project. It will include: a background section contextualized to sanitation and hygiene practices in Bauchi, with a strong focus particularly in Katagum, Misau, and Tafawa Balewa LGAs; a review of relevant literature and policy frameworks (including institutional structures and enabling environments); clearly stated research objectives; a description of the research methods; and a presentation of the findings. These findings will cover prevalent hygiene and sanitation practices, their underlying determinants, community motivations, key barriers, and strategic touch points across different settings healthcare facilities, schools, and households. The report will conclude with a set of practical, gender-responsive recommendations for designing inclusive and sustainable hygiene behaviour change interventions tailored to the realities of the communities we serve.

All data and outputs generated from this research will remain the property of WaterAid Nigeria. The consultant shall not use or disseminate any part of the findings without prior written consent from WaterAid Nigeria, in line with ethical and data governance protocols.

**Ideal consultant profile**

- Experienced in undertaking formative research, preferred on participation of girls and children with disability in school setting, HCFs and communities.
- Has proven experience with formative and qualitative research skills especially in behaviour change and public health projects.
- Proven experience in quantitative and qualitative research methodology,

- Having demonstrable knowledge and experience on hygiene, behaviour change, WASH, or education (girls' education) or right to education, disability and inclusion,
- Practical and demonstrable understanding of safeguarding and ethics in research.
- Deep understanding of gender equality and social inclusion frameworks, experience integrating gender, disability and social inclusion lenses into data collection and analysis.
- Has working knowledge of behavioural and social change frameworks such as the ABC Approach and apply them in health and WASH programs.
- Extensive knowledge in MHH, SRH, WASH, specifically knowledge on youth programming and community barriers and sensitivity in Northen Nigeria contexts.
- Knowledge of ethical research and safeguarding principles particularly when working with adolescents and in facilitation of participatory approaches.
- Ability to translate findings into actionable recommendations for programming

**Coordination and Supervision**

The consultant will work closely with relevant stakeholders across the three target LGAs Katagum, Misau, and Tafawa Balewa to ensure strong coordination and alignment with existing structures. Key stakeholders will include representatives from the Bauchi State Rural Water Supply and Sanitation Agency (RUWASSA), the State Primary Health Care Development Agency (SPHCDA), the State Universal Basic Education Board (SUBEB), Local Government Authorities, traditional and religious leaders, and selected community-based groups. Establishing rapport and mutual understanding with these stakeholders is expected before field activities begin.

The consultant will be directly supervised by a designated staff from WaterAid Nigeria and will receive an initial project briefing from WaterAid and its implementing partners, including FAcE-PaM and WODASS. Ongoing support and communication will be maintained through a mix of email, phone calls, virtual check-ins, and in-person meetings as needed throughout the duration of the assignment.